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Eli's Rehab Report

Coverage Determinations: Get Up to Speed On These Coding and Coverage Scenarios

You could be bleeding cash, if you don't keep these guidelines in mind.

Accurate coding and billing is essential if you hope to secure appropriate payment for your therapy and rehabilitation services. Get expert answers to these common scenarios.

Consult Guidelines for Tricare Coverage

Question: I remember hearing that **Tricare** covers speech therapy but we keep getting denials for it, and I can't find any guidelines. Can you advise?

Answer: Tricare does include coverage for speech therapy to treat speech, language and voice dysfunctions that occur due to diseases, injuries, birth defects, hearing loss and pervasive developmental disorders, the payer says on its website. However, if you've been struggling to collect for these services from Tricare, you could be treating a patient that doesn't meet the criteria.

Speech therapy is not covered for disorders resulting from educational deficits, myofunctional tongue thrust therapy, videofluoroscopy evaluations, maintenance therapy that doesn't require a skilled level or special education services. If your patient falls into this category, chances are that the services will be only available to Tricare patients on a cash-pay basis, and you should request that the patient or parent sign an advance beneficiary notice (ABN) in these instances.

Resource: For more on this topic, visit the Tricare website at www.tricare.mil/CoveredServices/IsItCovered/SpeechTherapy.aspx?sc_database=web.

Know What Supports Inpatient Rehab Care

Question: I'll be transferring from our acute care facility to work in our inpatient rehabilitation hospital in a few weeks. What kinds of cases can I expect to be coding for?

Answer: First, you'll need to know that Medicare regulations state that inpatient rehabilitation is only covered when the service is considered reasonable and medically necessary based on the patient's needs and situation. Physicians rely on documentation in the patient's acute care record and preadmission screenings to justify admission to an IRF (inpatient rehabilitation facility). Patients might be admitted to an IRF for situations such as:

- Following an inpatient hospital stay for rehabilitation that led to little improvement in the patient's condition
- After an inpatient stay for cerebrovascular accident (CVA) with residual mental and/or physical impairments that might benefit from more intensive treatment
- After an inpatient admission for an acute problem that requires further rehabilitation (such as a hip fracture). The original presenting problem could be traumatic or infectious.

Also watch for cohesive, convincing documentation of common criteria used to justify the need for inpatient rehab services. These often include the need for 24-hour medical supervision and nursing care, and several hours of rehab care at least 5 days a week. The admitting physician should also document that the patient can make significant improvements through inpatient rehab services.

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Find Out What Justifies 97112

Question: We often bill the code for neuromuscular re-education of movement for our cerebral palsy patients, but our new office manager says he isn't sure we're meeting the requirements for this code. Can you fill me in on the limitations for billing 97112?

Answer: Code 97112 (Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities) identifies a therapeutic procedure that CPT® defines as a "manner of effecting change through the application of clinical skills and/or services that attempt to improve function." The therapist must have one-on-one contact with the patient to bill for this procedure.

These services may be provided "incident-to" a physician's services, in which case the physician would have to supervise the therapist directly in his office.

Most carriers allow a maximum of 12 visits per month for this service, which uses stretching, strengthening and specialized biomechanical exercises to allow patients to find new ways to rest, hold, balance and move their bodies. Most carriers dictate that you cannot report more than two units of 97112 at any given session.

Remember, a "provider" is a PT, OT, PTA, OTA, or MD, not a rehab aide, personal trainer, athletic trainer, etc. You should also check your state regulations to verify that your provider is able to provide these services.