Eli's Rehab Report

Get Paid for Hip Replacement Rehabilitation

Earlier this year, just weeks before his 90th birthday, former President Reagan fell and broke his hip, necessitating an involved surgical process to repair the break and a lengthy regimen of physical therapy. Often, this type of injury results in hip replacement surgery. According to the American Academy of Orthopaedic Surgeons, approximately 310,000 hip replacement operations are performed each year in the United States. Physiatrists, physical therapists and occupational therapists often are called on to help the patient through rehab following hip replacement surgery. Knowing the coding rules for the modalities and services involved can help speed the billing process.

Physiatrists Rehab Billing Guidelines

In many cases, an orthopedic surgeon performs the hip replacement (27132), and a physiatrist is called into the hospital to begin the patients rehabilitation following the surgery. This can confuse billers who are unsure whether the physiatrists care is included in any global fees associated with the surgery. The global period guidelines apply only to the surgeon specifically performing the procedure or any other doctor of the same specialty within his or her group practice, says **Carol Pohlig, BSN, RN, CPC,** a reimbursement analyst for the office of clinical documentation in the department of medicine at the University of Pennsylvania in Philadelphia. Therefore, an independent physiatrist who is visiting the patient after surgery to coordinate rehabilitation would not have to bill using any separate diagnoses or modifiers, says Pohlig.

The physiatrist would bill for his or her evaluation of the patient following surgery using the subsequent hospital care codes (99231-99233) or inpatient consultation codes (99251-99263), if the visit met all of the requirements of a consultation. (According to CPT 2001, the physiatrist should not bill the initial hospital care codes [99221-99223] unless he or she is the admitting physician and is providing the first hospital inpatient encounter.)

If the surgeon transferred care of the patient to the physiatrist following the surgery for postoperative treatment only, the physiatrist could bill for the procedure using modifier -55 (postoperative management only). The surgeon would bill for his or her portion of the hip replacement using modifier -54 (surgical care only).

If the physiatrist visited the patient after surgery for a reason unrelated to the hip replacement, he or she could bill independently of the surgery. For example, if the patients hip was replaced due to osteoarthritis of the hip (715.15, V43.64), but the physiatrist was visiting the patient to perform a trigger point injection on an unrelated muscle pain in the neck, the visit would be coded 99232 for the inpatient evaluation and 20550 (injection, tendon sheath, ligament, trigger points or ganglion cyst), with the **ICD-9 Code** 729.1 (myalgia and myositis, unspecified). Because the insurer will see that the physicians are part of the same practice, they may assume that the physiatrists services are related to the hip replacement surgery and erroneously assume that his or her services fall within the global period. Because of this, physiatrists should bill modifier -24 (unrelated evaluation and management service by the same physician during a postoperative period) with the trigger point injection.

Therapy Following Surgery

After the surgery, the patient probably will go home or transfer to a rehab facility. Regardless of the location, the patient will undergo several weeks, often months, of physical and occupational therapy to help learn to walk, bend and perform necessary activities without placing undue strain on the new joint. Such care requires great coordination between the physician overseeing the patients rehabilitation and the therapists involved.

The first step in the patients rehabilitation would be writing a plan of care, says **Laureen Jandroep, OTR, CPC, CCS-P,** owner of A+ Medical Management and Education, a coding and reimbursement consulting firm and a national CPC

training curriculum site in Egg Harbor City, N.J. The therapist would perform an initial evaluation, assessing the patients abilities and determining where the focus areas will be.

A physical therapist would bill for this initial evaluation using 97001, whereas an occupational therapist would bill using 97003. Medical necessity determines whether insurers will reimburse for both therapists to perform initial evaluations. But in the case of total hip replacements, most carriers will pay for both.

The best education a hip replacement patient needs from a therapy standpoint are the THR (total hip replace-ment) precautions, the most important of which are pre-cautions related to bending, Jandroep says. Bending tends to put stress on the new joint, so the patient has to learn how to perform activities of daily living (ADL) in a new way.

Usually, coding for this scenario would involve an occupational therapist (OT) reporting the ADL training using 97535 (self care/home management training [e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment] direct one-on-one contact by provider, each 15 minutes) because this code includes several aspects of training the patient in how to return to his or her daily activities. A physical therapist (PT) normally would bill for the training using 97112 (therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception).

Coders should note that physical and occupational therapists are governed by their state licensure laws. Both therapists usually are licensed to provide both services (an OT could bill 97112, or a PT could bill 97535). But because the OTs work often combines the training with instruction on how to manage daily activities without bending at the hip (e.g., how to put on their socks and shoes, etc.), they normally bill using the ADL code. In contrast, the PTs work more often involves strength and balance training, so they bill 97112 more often. This is where coordination of care between the team members comes into play for each facility setting. Payers usually dont want to pay OTs and PTs for the same code.

In addition to training in THR precautions, Jandroep says, the therapist would help the patient begin ambulat-ing again, using a combination of muscle strengthening and gait training. We would want to work on muscle strength-ening for the legs, but also for the upper body because the patient may have trouble manipulating a walker if they have weak grip strength, so we may work on that as well.

Gait training is coded 97116, while the muscle strengthening aspect of the training would fall under 97110 (therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility).

Physical and occupational therapists also offer the patients transfer training teaching them how to transfer from a wheelchair into the bed or the bathtub, or teaching them how to transfer from a chair to their walker. Wheelchair training is billed as 97542, while the actual transfer training is usually billed using 97535, the ADL code.

Use Caution When Therapists Co-manage Patients

Coders should note that, despite the number of therapists treating the patient at the same time on any one modality, only one unit of each code should be billed per 15-minute interval. For example, according to HCFAs AB-00-14 transmittal issued March 13, 2000, If gait training for a patient requires both a therapist and an assistant (or even two therapists) to manage the patient on the parallel bars, each 15 minutes the patient is being treated can count only as one unit of 97116. Time that the patient spends resting or waiting to use a piece of equipment should not be billed.

If the therapists see the patient on the same day but for different reasons, however, both therapists normally can be reimbursed for their services. For example, if the hip replacement patient requires a walker, the physical therapist might see the patient in the morning to train him or her on the walker. The PT would bill 97116 for the gait training that morning.

Later that afternoon, an occupational therapist visits with the patient, who is practicing using her walker. The OT works with the patient in a mock-kitchen setup, teaching her how to place the walker in a safe position while reaching into an

upper cabinet or opening the refrigerator door, so the patient learns how to manipulate the walker in a home setting safely. The OT would bill **CPT 97530** (therapeutic activities, direct [one-on-one] patient contact by the provider [use of dynamic activities to improve functional performance], each 15 minutes) for these training activities.

Use of Modalities

Therapists also can perform specific modalities to ease pain and increase flexibility. I often use manual therapy techniques when Im teaching a THR patient to use their leg and hip again, says **Amy Nasser, PT,** a practicing physical therapist in Kansas City, Mo. Joint mobilization and myofascial release are included in the manual therapy techniques code, so it can be helpful to use it for each session. I have also used whirlpool, aquatic therapy and paraffin baths for hip replacement patients.

Manual therapy techniques should be coded using 97140. Whirlpool is coded 97022, aquatic therapy is coded 97113 (when performed with therapeutic exercises), and paraffin baths are coded 97018. Although most Medicare carriers reimburse for these modalities for hip replacement patients moving toward the goal of mobilization, most carriers will not reimburse for two types of hydrotherapy on the same day (such as whirlpool and aquatic therapy). Each practice should consult its Medicare carriers guidelines before performing more than one modality per day to determine limitations on frequency, diagnosis and billing with other modalities.

Remember that all documentation for therapy should clearly note the time devoted to each therapeutic treatment and who rendered the care and each modality. In addition, the patients chart should include a copy of the current treatment plan with signatures of the supervising physician and therapist. Documentation also must include the date the supervising physician last saw the patient.