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BY AAPC

Eli's Rehab Report

Outpatient Billing: Put Your Rehab Coding and Billing Knowledge to the Test

This quick quiz will show you where you fall.

Want to stay polished on your coding and billing skills to ensure stellar reimbursement and compliance? Give this quiz a whirl, and then turn to page 21 for the answers -- where the experts chime in with their two cents.

Questions:

1) Which of the following is an example of a skilled AND billable therapy service?

a) A patient is exercising on a bike while you monitor him, and you code for therapeutic exercise (CPT 97110).

b) A patient is exercising on a bike while you actively coach the patient on technique and muscles he needs to strengthen to reduce knee pain. You code for therapeutic exercise (CPT 97110).

c) A patient is doing self stretching exercises for the shoulder using the pulleys while you are performing manual therapy on another patient.

2) You get a new Medicare patient who needs occupational therapy for two unrelated diagnoses from different physicians. How should you charge for your initial eval?

a) Put everything under one evaluation code. Code 97003 once, and append modifier 76 (Repeat procedure or service by the same physician).

b) Code 97003 twice, appending modifier 59 (Distinct procedural service).

c) Bill 97003 once if you're doing both evals on the same day; bill 97003 twice if you do the second eval on a different day.

3) What should you do if you're in a non-hospital outpatient setting, your patient exhausts a therapy cap, and she still needs skilled therapy services?

a) Bill for the services with the KX modifier, and make sure you have documentation to support the medical necessity.

b) Make the patient sign an ABN form and have her agree to pay out of pocket.

c) Do not bill for further services. Allow the patient to pay out of pocket or refer her to the nearest hospital outpatient facility.

4) You perform separate and distinct therapy procedures on one patient on the same day that fall under a column 1-column 2 CCI edit. What should you do?

a) Apply modifier 59 to one of the codes; it doesn't matter which one.

b) Apply modifier 59 to the column 1 code of the edit.

c) Apply modifier 59 to the column 2 code of the edit.

5) Your rehab department has speech therapy orders for a patient suffering from post-stroke dysphagia. What should you code as the patient's primary diagnosis?

a) 434.91 (Cerebrovascular accident)

b) 438.x (Late effects of cerebrovascular disease)

c) 438.82 (Dysphagia due to late effect of cerebrovascular accident) and 787.2x (Dysphagia)

6) How should you charge for a TENS set up and application in the clinic setting?

a) 97014 or G0283

b) 97032

c) 64550.

Outpatient Billing, quiz answers:

1) Answer: B. Even if a code is reimbursable, like 97110, bill it only for skilled services. Billing 97110 when you're just watching a patient won't fly -- because anyone can watch a patient.

"When selecting codes, remember that we are paid for what we are doing, not for what the patient is doing" says **Ken Mailly, PT,** of Maily & Inglett Consulting in Wayne, N.J. Also, when you're deciding, for example, between therapeutic exercise versus neuromuscular re-education codes, etc., keep in mind you should bill for the intent of what you're delivering, he adds.

Note: Bill for the patient education and training component of 97110. Once that's done, the rest of the time would not be billable.

2) Answer: C. Medicare won't accept modifier 79 from a therapist since it is intended for physician services, and modifier 59 is not appropriate because this case is not a CCI edit.

"If both evaluations are done on the same day, regardless of the payer, bill only one unit of the evaluation CPT code since it is un-timed," says **Rick Gawenda, PT,** director of finance for Kinetix Advanced Physical Therapy, Inc. and President/CEO of Gawenda Seminars & Consulting. "If done on separate days, the Medicare program will reimburse for a second evaluation for the second diagnosis."

Chapter 15 in the Medicare Benefit Policy Manual supports billing for two evaluations if a second condition arises during the episode of care, points out **Joanne Byron, LPN, BSNH, CHA, CMC, CPC, CPC-I, MCMC, PCS,** president and CEO of HCCS, Inc. in Medina, Ohio. "After the second condition is evaluated, then the plan of care is adjusted to include new treatments and everything is done under one plan of care, according to Medicare."

Remember: "Most insurance providers follow Medicare guidelines, but not all," Byron says. So check your patient's individual coverage guidelines.

3) Answer: C. The therapy cap exceptions process expired at the end of 2009. So you cannot bill for an exception with modifier KX. Also, you're not required to issue an ABN form since services above the therapy caps are statutorily excluded from Medicare coverage.

4) Answer: C. "Always attach modifier 59 to the CPT code that is in column 2 (or the 'exclusive' column if you're dealing with a mutually-exclusive CCI edit),"Gawenda says. "The code in column 1 does not require the modifier," he adds.

5) Answer: C. "The SLP should code for the reason he is seeing the patient, and that is dysphagia," not the CVA, says **Nancy Swigert, MA, CCC-SLP, BRS-S,** director of speech-language pathology & respiratory care at Central Baptist Hospital in Lexington, Ky. ICD-9 code 438.82 is the most specific code to describe the reason for the visit.

You'd then add the 787.2x code to describe the phase of dysphagia. "If you don't know the phase, choose 787.20 (Dysphagia; unspecified), Swigert says. Answer B would be better for your secondary or medical diagnosis, she adds.

6) Answer: A. "If you're setting up TENS in the clinic and not teaching the patient for a home unit, you would use either 97014 or G0283 depending on the payer," Gawenda says. "If you're instructing the patient on a home TENS unit, you would bill either 97032 or 64550."

Tip: For home instruction, some payers may not recognize 64550, so 97032 may be the better code, Gawenda says.