Outpatient home therapy: An untapped market for therapists

To some, home therapy is a niche market for existing facilities to add to their list of services. To others, it is their entire function as rehab providers. Either way, there is a growing need for therapists to treat patients in their own homes, which, according to Medicare regulations, is different from the services provided by home health agencies.

Home therapy refers to services rendered to patients who need outpatient therapy in their homes. Home health, however, usually refers to a federally mandated Medicare and Medicaid program that provides skilled-care services in homes or alternative community settings.

Get a handle on the ins and outs of providing home therapy and how you can begin offering it to patients in your area.

Why outpatient home therapy?
There are a variety of reasons for which patients needing rehab would want or need treatment in their homes rather than in outpatient facilities. These scenarios could include the following:

Speech-language pathologists plan for the future in their rehab field

Speech-language pathologists (SLPs) are considered part of the rehab community, but in many ways they are often treated differently than occupational and physical therapists by CMS and other agencies responsible for reimbursement. Although the value of speech-language treatment code 92507 was lowered this year, SLPs saw increased rates in evaluation codes due to successful advocacy by the American Speech-Language-Hearing Association (ASHA) of Rockville, MD. “We were able to describe how long [the treatment] takes and what equipment is necessary,” says Steve White, PhD, director of healthcare economics and advocacy with ASHA. “Based on that information, CMS was able to raise the rate.”
The patients can’t get to the clinic due to a lack of transportation.

Physically getting to the clinic may be so taxing for patients that they cannot participate in therapy after arriving at the facility.

The patients do not qualify as homebound but have mobility problems that prevent them from receiving therapy in a clinic setting.

The patients are so busy that it is more time-efficient for them to receive therapy in the home.

The patients are confused easily, and their families would prefer to have therapy provided in familiar surroundings.

**Reimbursement**

At first glance, billing for outpatient therapy provided in the home doesn’t seem much different from billing for services rendered in an outpatient facility.

“All rules and regulations that apply to outpatient rehab facilities also apply in a person’s home,” says **Rick Gawenda, PT**, director of rehabilitation for Detroit Receiving Hospital in Michigan. Just remember that if you operate in a private practice, you must change the code in form locator 24B (place of service) to 00-12, the code for home, when you fill out the CMS 1500 form.

You may think that without overhead such as rent and other expenses, you can keep more of what you earn. But you also need to consider that the reimbursement is the same whether you see patients in your facility or you use up a tank of gas and an extra hour of your time driving to and from their homes. You will not receive reimbursement for transportation costs or additional time related to seeing patients at their homes.

It is true that in a corporate facility, a therapist may evaluate and treat 20 patients a day. However, if you provide home therapy as an individual therapist, you may need to only see a fraction of these patients to receive the same financial return.

“We have no overhead and no middlemen,” says **Peter R. Kovacek, MSA, PT**, president of In Home Rehab, LLC, in Harper Woods, MI. “A typical PT with us would see four patients and [his or her] income at the end of the day would be more than if [he or she] had a typical job as a therapist.”

But Gawenda and other experts caution that just like any other practice, there’s more to consider than Medicare reimbursement. You will also need to answer the following questions:

- Who will do your billing?
- What equipment will you use?
- How much malpractice insurance will you need to purchase?
- How will you reach potential patients?
- Will you have employees?

When determining if home therapy is an option, consider the following factors:

**Geography**

First contemplate the geography of the area you serve or plan to serve. If you are located in an urban area where you could provide rehab to many clients within a short distance, you may find that you spend minimal time traveling and little money on gas.

In many cases, however, the patients who are most in need of home therapy are those who are geographically spread out. A therapist needs to consider both of these scenarios and how each relates to his or her location.

**Client base**

Unless you are adding a home-therapy component
to an existing outpatient rehab facility, you will not have a building that clients can visit. Therefore, you will have to make yourself accessible in other ways. “You need to do a little front-end marketing to the physicians, because most people who need [skilled care] at home end up [under a home health agency plan of care],” says Frances J. Fowler, president of Fowler Health Affiliates, Inc., in Atlanta.

So if a physician has a patient who seems to be doing well but can’t quite make it to an outpatient facility, make sure you present your home therapy services as an option. Likewise, if you feel that your patients have improved to the point where they can make it to an outpatient facility, consider referring them to one you feel would benefit them.

“If, after an evaluation, a therapist felt that the patient needed [to receive rehab] at an outpatient clinic due to equipment needs or safety issues, that therapist should find a clinic for [him or her],” says Gawenda. “It’s what’s best for the patient, not what’s best for the therapist financially.”

In addition, other clients will come to you from a peer-to-peer referral. “Therapists know therapists—we’re a very close-knit group,” Kovacek says. He says that a therapist might offer these services to a patient by saying, “It seems like it’s difficult for you to get here—would it be better for someone to come and work with you at your home?”

Distinguishing yourself and your services from home care is another important clarification. To receive reimbursed home care, patients must meet homebound requirements and receive care from a home health agency under Medicare Part A. To receive home therapy, however, a patient does not have to qualify for home care under Medicare. It is important that potential clients know this.

As with an outpatient facility, you can choose to do your billing in-house or to outsource it. At Kovacek’s practice, which contracts with more than 20 therapists, both physical and occupational therapists turn in their documentation to the central office, and then the facility outsources the actual billing. But before he sends those bills out, Kovacek makes sure to check them for accuracy—what he calls a “100% review in real time.”

“Every bill and every [clinical] note is reviewed every day,” he says. “If there’s a problem with a note, we discuss it with the therapist before the bill goes out.”

You will also need to decide whether home therapy is something you would like to offer as an individual therapist or whether you would like to create a business that provides this service to a larger group of clients. The latter option requires either hiring or contracting with additional therapists.

In Kovacek’s practice, each therapist is a partner and earns money according to how many clients he or she sees rather than a fixed wage. “PTs and OTs should not be employees,” says Kovacek. “Everyone owns [his or her] own practice.”

Although some states allow direct access to therapy for patients, Medicare still requires a physician referral. It’s important, especially if you work with an aging population, that you develop positive relationships with your patients’ primary care doctors. If your patients don’t have physicians, encourage them to find one, says Kovacek.

Before embarking on any home therapy endeavor, take the time to research all of the factors that could make or break your entrance into the world of home therapy.

“The actual complexities are no different from a bricks and mortar [practice],” says Kovacek. “But the way you analyze your business might be different.”

So if you make sound decisions based on the type of rehab you want to provide, your geographic location, and the needs of the patients you plan to serve, you may not become a millionaire, but you can make money as an in-home therapy provider. “While you won’t touch as much [money], you can keep more of it at the end of the day,” says Kovacek.
Speech-language evaluation—CPT code 92506—$131.43
✓ Clinical dysphagia evaluation—CPT code 92610—$131.43
✓ Modified barium swallow—CPT code 92611—$131.43

Despite these increases, SLPs who work with OTs and PTs are sometimes puzzled that those disciplines bill in timed units when SLPs generally do not. “Our [procedures] don’t have timed units because our evaluations and treatments tend to last longer than in OT or PT,” says White.

There are two exceptions to this rule: evaluations for prescription of speech-generating augmentative and alternative communication devices for the first hour (CPT code 92607) and each additional 30 minutes (CPT code 92608).

Therapy-cap aftermath
When therapy caps were under enforcement from September through the beginning of December 2003, SLP shared a $1,590 cap with physical therapy. The cap triggered a downward shift in speech-therapy utilization by Medicare beneficiaries, according to Janet Brown, MA, CCC-SLP, director of healthcare services in speech-language pathology for ASHA. “Maybe [patients] elected to use the $1,590 for physical therapy instead,” says Brown. “Or maybe they went to physical therapy first.”

Like organizations for OTs and PTs, ASHA is working with CMS to propose an alternative to the cap, whose moratorium ends in 2005.

Direct access for SLPs
SLPs cannot bill Medicare directly and cannot obtain Medicare provider numbers as individuals, according to Amy Hasselkus, MA, CCC-SLP, associate director of healthcare services in speech-language pathology for ASHA.

Their alternative is either to work for physicians who bill on their behalf or to create a rehab agency that provides a range of therapy services, one of which is speech therapy.

“It’s been a problem distinguishing our issues from [those of] OTs and PTs,” says Hasselkus. “We’ve always had direct access, but we’re looking for SLPs to become independent providers.”

Like PTs and OTs, SLPs are looking for a form of direct access, but their needs are different. To them, direct access is the ability to establish a private practice and bill Medicare directly for reimbursement. House bill 1995 and Senate bill 568, which would amend the Social Security Act to allow this access. Both bills were introduced last spring and are currently in committee.

Pediatrics
There is a growing need for speech-language pathologists and audiologists in pediatrics, says Brown. Individual states usually provide reimbursement for these services, and each state may have different requirements, so SLPs must become familiar with local policies.

“Each state will vary on how it funnels funds for [patients ages] zero to three,” says Brown. “Often, school systems or the [state] department of mental health may contract with outpatient facilities to provide these services.”

But rehab is often a coordinated effort because at the same time that a child may need an SLP for assistance with swallowing difficulties, he or she may also need the services of other types of therapists. For example, the child might also need a physical therapist for proper positioning or an occupational therapist for hand-eye coordination related to proper feeding, says Brown.

Editor’s note: This article is part of BRRR’s ongoing effort to cover topics of interest to all therapy disciplines. If you have additional story ideas, please e-mail Victoria Groves, BRRR managing editor at vgroves@hcpro.com or call 781/639-1872, ext. 3433.
By now, almost everyone in the rehab industry is familiar with the term “direct access.” But depending on what type of therapy you practice and who your patients’ payers are, its meaning can vary quite a bit.

As part of the Medicare Prescription Drug, Improvement and Modernization Act that passed in December 2003, the Medicare Payment Advisory Commission (MedPAC) will conduct a study on allowing Medicare beneficiaries direct access to therapy services. The findings of the study are due to Congress by January 1, 2005.

But direct access is already provided to occupational therapy patients in over 40 states, according to Christina Metzler, federal-affairs director with the American Occupational Therapy Association (AOTA).

“We already have it in most of our states as part of our licensure,” says Metzler. “And in many cases, third-party payers are making the decisions on the requirements.” This distinction holds true for physical therapists as well. In February, Ohio became the 39th state to allow residents direct access to physical-therapy services.

In South Carolina, patients have direct access to occupational therapy, which means that OTs do not need a physician’s referral to initiate or continue services. But the state does not regulate the policies of third-party reimbursement sources or employers who would prefer physician referrals. So each licensed OT must individually investigate the patients’ policies, which may affect their ability to be reimbursed.

What about Medicare?
Metzler goes on to say Medicare is the 800-pound gorilla in the room. Even with direct access at the state level, any regulatory changes in the Medicare program must be industrywide.

For example, the Medicare Patient Access to Physical Therapists Act of 2003 is currently in committee in both the House and the Senate. If passed, it would amend the Social Security Act to authorize physical therapists to evaluate and treat Medicare beneficiaries without a physician referral.

The bill would also provide for treatment of outpatient speech-language pathology services separately from outpatient physical-therapy services.

AOTA wants all skilled therapies to receive the same treatment under the Medicare program. “We believe that if Congress does something for one of the therapies, it should be done for all,” says Metzler.

Additionally, AOTA aims to define and protect occupational therapy’s full scope of practice. Current issues of concern include continuing-education requirements, OT involvement in orthotics and prosthetics, and low-vision services.

Visit www.aota.org to learn more about AOTA.
Most therapists would rather spend time helping their patients than reading manuals or filling out forms. But part of the job is ensuring that you record the services you provide so that you and your facility can receive adequate reimbursement. For them, documentation doesn’t have to be a drag if you keep in mind this expert advice.

**Be specific**

When therapists complete initial evaluations, they must write down goals for the patient and establish a feasible timeline in which to reach these goals. The biggest mistake therapists make is setting goals that are not objective, quantifiable, or functional enough, according to Ann Lambert Kremer, OTR/L, MHSA, CPC, senior manager at Baker Newman & Noyes in Portland, ME.

For example, if for one patient you have set a goal of improving ambulation, be sure to add you would like her to transition from a walker to a straight cane and walk 150 ft. Add that this is the distance to and from her front door to her mailbox to clearly explain why you chose this goal and how achieving it will increase her independence and improve her quality of life.

When you write your progress notes, if you only write “walked 50 ft,” you force a reviewer to look back at the initial evaluation, says Kremer. Instead, write “patient walked 50 ft with a straight cane—one-third of the way to her goal.”

“Therapists often write an assessment of where they are on that date but don’t compare it to where they were or where they want [the patient] to be,” says Kremer.

In addition, though, your daily notes may be brief, Kremer suggests that your weekly notes always hark back to your patient’s initial goals.

Instead of simply writing that “initial goals continue to be realistic,” indicate that, in line with the evaluation, “goals will be met in four more visits” or “treatment will be extended for three more weeks.” Also, add information like “the bicycle exercises were too painful and had to be eliminated,” and go on to explain what activities you will do with the patient instead, says Kremer.

In short, your daily notes need to support the charges, and your weekly notes need to address progress toward the patient’s goals.

**Reimbursement**

When you document, do so in minutes. Instead of converting the minutes you provide therapy to your patients into units, write down the exact minute total and allow one person in your facility—preferably the biller—to convert those minutes into units.

For example, a therapeutic exercise (CPT code 97110) is billed at $29.69 per unit, says Gail Neustadt, NHA, MA, CCC-SLP, a consultant for Flagship Rehab in Cumberland, Maryland. If a patient received 37 minutes of treatment, the charge to Medicare would total $55.38 for two units of service. If the patient received 38 minutes of treatment, the charge to Medicare would increase to $83.07 for three units of service.

To understand why this one-minute translates into an extra unit, you must understand unit calculations, even if you aren’t going to be converting minutes to units yourself. According to CMS’ Program Memorandum (PM) AB-00-14, therapy services are billable to Medicare in 15-minute intervals.

For example, if you perform eight to fewer...
than 23 minutes of therapy, you would report one unit. Twenty-three to fewer than 38 units would count as two units, and so on. Remember that if you provide fewer than eight minutes of therapy, you shouldn’t report any units.

“Since most PT and OT CPT codes are time-based, it’s easy to leave money on the table if you are off by one or two minutes in service delivery,” says Neustadt. “Use a timer and do not stop therapy unnecessarily until the buzzer goes off.”

**Best practices**

Here are more pointers that will help your facility get a gold star in documentation:

- **Know your codes.** It’s essential that therapists understand CPT coding, says Neustadt. “Take a coding course and keep up with the appropriate codes [with the help of] therapists, billing staff, the rehab director, or the health information management staff member,” says Neustadt.

- **Remember these three questions.** If your notes are bare boned, you may want to utilize questions that could prompt more detail, says Kremer. The additional information will increase the probability that your claim is paid.
  - Was a licensed physical therapist needed to perform these services?
  - Were the services rendered medically necessary?
  - Does the documentation support the time that was billed?

- **Write what's important.** Because your notes are actually legal documents, include essential information and leave out subjective observations. “Some therapists just start writing,” says Neustadt. “[Instead,] say what you do, do what you say, and write it in the payer’s language.”

For example, a maintenance program designed by a therapist may be called a “skilled maintenance program” by Medicare, but some HMOs may label it a “functional program” instead. Remember your audience when you are writing your notes.

- **Watch out for hospital diagnoses.** If you work in a hospital outpatient facility, watch the ICD-9 codes entered for services to your patients, says Kremer. “The therapist needs to confirm that the ICD-9 code on the admitting paperwork is the code necessitating her services,” says Kremer.

For example, the admissions clerk may know that the patient was admitted to the hospital for uncontrollable diabetes and use the corresponding code, even though the patient is seeing a physical therapist due to numbness in the feet. Choose the correct code on the admitting paperwork for the present illness and the present intervention, says Kremer.

- **Study your local medical review policy (LMRP).** If Medicare reimburses for a particular service, you still must determine whether that service is reimbursable under your LMRP. Save yourself time in documentation and claim submission by knowing what will and will not be reimbursed in your geographic area.

**Thanks for your input!**

A big thank you to everyone who participated in BRRR’s annual reader survey. We will use the results to make this newsletter an even better resource for our subscribers in the coming year. As a way of expressing our gratitude to the subscribers who took the survey, we randomly chose two readers to receive a $100 cash prize.

Congratulations to Barb Tipton, MHS, PT, in East China, MI, and Joy Harris in Medford, MA!
Make those modifiers work for you

Simplify your billing process by mastering these codes

Modifiers are easy to omit. But forget one, and you could receive a claims denial for a service that was reasonable and necessary—and for which the payer simply needed a bit more information or clarification.

Here is a primer on the most common therapy modifiers—when to include them and why. If you make good use of these codes, you should see your reimbursements improve and your headaches decrease.

**Modifier 22**

Modifier 22 is uncommon, but when used, it further explains billing for services that are greater than what is usually required for the listed procedure. This modifier requires documentation that the procedure was unusual. It is sufficient to allow carriers to adjust compensation when the service is beyond the expected variation in how a procedure is performed, according to CMS.

“You usually will see this [modifier] in conjunction with debridement or a uniboot,” says Jim Hall, CPA, general manager Rehab Management Services, LLC in Cedar Rapids, IA. “It’s unusual and is probably unique to individual practices.”

**Modifier 25**

This modifier identifies significant separate evaluation and management services provided on the same date as a procedure or other service. For example, it would be used in a physician-owned therapy clinic where the physician performed his or her component of the evaluation and then sent the patient down the hall for a therapy evaluation.

“[Use 25 when] the physician evaluation was done separately from the therapist’s evaluation, but could still have been done in the same office on the same day,” says Rick Gawenda, PT, director of outpatient rehab at Detroit Receiving Hospital in Michigan.

**Modifier 50**

When appropriate—and if the procedure code descriptor does not already indicate a bilateral procedure—use modifier 50 to describe procedures that are performed bilaterally. For example, if a therapist performs electrical stimulation on the right shoulder and then on the left shoulder, he or she should include modifier 50, provided that both procedures are supported by the appropriate documentation.

**Modifier 59**

According to the 2004 CPT guidelines, modifier 59 is “used to identify procedures and services not normally reported together but are appropriate under the circumstances.”
Therapists use modifier 59 when they encounter a Correct Coding Initiative (CCI) edit, says Hall. These edits are pairs of CPT or HCPCS Level II codes that are not separately payable except under certain circumstances and are applied to services billed by the same provider for the same beneficiary on the same date of service.

For example, billing for mechanical traction in conjunction with manual therapy or gait training in conjunction with therapeutic activities could result in a denial if you don’t use the modifier.

In certain circumstances, a therapist might perform two different procedures—for example, thirty minutes each of pool therapy and land exercises. If he or she then bills for two units of each procedure and does not use modifier 59, Medicare will not pay for both.

“CMS will see the [land] therapy as a component,” says Gawenda. “The modifier tells CMS that the therapist performed the different procedures at separate and distinct times.” He also notes that the documentation must support this claim.

While this modifier currently refers to Medicare reimbursement alone, Hall says that some insurance carriers are also adopting the use of modifier 59. “Fifty-nine is very frequently used with Medicare when you bump up against a CCI edit,” says Hall. “But we’re seeing 59 creeping into other insurance providers repertoires as well.”

Other essentials

Additional therapy modifiers you should know by heart include those required specifically by Medicare for OT, PT, and speech pathology. According to CMS, for any applicable rehabilitation-therapy service that is rendered, providers or suppliers must report one of the following therapy modifiers, effective since January 1, 2003:

- GN—services delivered under an outpatient speech-language pathology plan of care
- GO—services delivered under an outpatient occupational therapy plan of care
- GP—services delivered under an outpatient physical therapy plan of care

“If you are a physical therapist and you have a Medicare patient, you have to use a GP modifier,” says Hall. CMS also notes that these therapy modifiers do not allow a provider to deliver services that they are not recognized by Medicare to perform.

- **Use a form that fits your needs.** “One-size-fits-all fits no one,” says Kremer of forms that encourage documentation of OT, PT, and speech pathology on a single sheet. “If you’re working on a team and you’re all documenting on the same form, there’s not enough space for you to write what you need to,” she says. Consider using multiple forms or attaching additional sheets that give you room to document properly.

- **Train your staff.** Because there are very few bona fide documentation experts, periodic training can always benefit therapists. “If you’ve got green staff, send them to a formal training program,” advises Neustadt. “For experienced staff, schedule training annually and conduct weekly team meetings.” These meetings could include discussions of new guidelines and new CPT codes to help staff members document more effectively.

It may also help to set up a mentoring system for new employees. “Every new employee should have a mentor looking over his or her notes,” says Kremer. “In a facility, there’s always someone who’s really good. Encourage [that person] to train others.”

- **Self audit.** Kremer suggests doing a self-audit four times a year. Pull a random stack of charts and compare the documentation they contain with the guidelines you’ve established in your staff-training sessions.
Editor’s note: Nancy J. Beckley, MS, MBA, president of Bloomingdale Consulting Group in Brandon, FL, answered the questions below. Submit questions to BRRR Managing Editor Victoria Groves at vgroves@hcpro.com or complete the form on p. 11 and fax it to 781/639-2982.

Our fiscal intermediary (FI) in Montana will not reimburse us for VitalStim™. It’s very frustrating, as the device helps patients so much. Do you have any ideas for us or studies we can refer to?

VitalStim is a new, FDA-approved procedure that treats people suffering from dysphasia, also known as the inability to swallow. It can restore enough swallowing function to reduce or eliminate the need for tube feedings.

I also checked for information at the Montana Medicare Web site at www.medicare.bcbsmt.com to see whether there was a local medical review policy (LMRP) regarding speech-language pathology. Although I didn’t find one, Chapter S of the outpatient billing manual may be the key to obtaining reimbursement for this procedure:

“Speech pathology services must be reasonable and necessary to the treatment of the individual’s illness or injury and must relate directly and specifically to a written treatment regimen established by the physician after any needed consultation with the qualified speech pathologist, or by the speech pathologist providing such services.”

My suspicion is that the Montana Medicare payer may not deem VitalStim therapy “an acceptable standard of practice” and may view it as experimental in nature. This FI may not have had the opportunity to review outcome studies of patients who have received this therapy. You may want to contact the manufacturer of VitalStim to see whether it has such studies available.

Also, keep in mind that there are other therapies that benefit Medicare beneficiaries that must be a benefit of the Medicare insurance program to be eligible for Medicare reimbursement.

Another option is to check with the Montana Speech Language Hearing Association at www.mshaonline.org to see if it can assist you, as well as the Medicare reimbursement specialist at the American Speech Language Hearing Association at www.asba.org.

We are an outpatient rehab facility (rehab agency/ORF) and recently had surveyors visit us. After the survey, they told us they would file a report that we are not in compliance with regulations. We received our certification seven years ago and do not feel that our standards have fallen. We have 45 days to prepare a response. What should we do and what are the consequences of this report?

You didn’t mention who the surveyors were, but I suspect that it was your state agency because you did not mention medical records or reimbursement. Each state holds a contract with CMS to conduct initial surveys of rehab facilities governed under Part A regulations.

For outpatient rehab, these facilities include rehab agencies, CORFs, and hospital outpatient departments. To clarify, services provided by these entities are reimbursable under Medicare Part B, but the providers are part of the Medicare Part A program. They will conduct your initial survey according to the Conditions of Participation for your specific program.

Correction

Please note that BRRR’s April 2004 Q&A contained an editorial error. The question regarding reimbursement for physical-therapy aides should have indicated that aides must not provide services reimbursed under Part B, regardless of the level of supervision.
The state surveyors use a checklist when they review your facility and follow the guidelines listed in the State Operations Manual (SOM). Once you pass your initial survey, you receive your Medicare provider number and begin the enrollment process with the Medicare payer you have chosen.

A general rule of thumb is that your state will continue to review each approved facility every few years. However, this has not generally been the case, and many facilities have not had an updated survey for well over two years.

By the time you read this, you should have received a copy of the report from the state agency listing the noted deficiencies at your facility and asking you to file a corrective plan of action. In some instances, you may need to update policies and procedures, or you may need to have equipment inspected.

For example, surveyors may have noted that you did not have a recent fire inspection or fire drill. You would complete your corrective plan of action by having a fire inspection completed and documented and by later posting the report in the administrative office.

Once you have completed items in deficiency, you are ready to collect your documentation (e.g., logs, policies, receipts, etc.) and prepare your corrective plan of action for submission.

If the state agency has alerted you to a return visit, be prepared for an unannounced arrival within the specified number of days it has given. If you do not comply with the Conditions of Participation on the second visit, you will be in jeopardy of having the surveyors report to Medicare that you have continued not to meet the requirements for certification.

At this point, Medicare may provide you with a notice of intent to decertify you from participation in the Medicare program. However, Medicare will also provide you with the opportunity to offer a final rebuttal or repeal.

Note that the state agency, which makes sure each facility meets the Conditions of Participation, has no governance over the review of medical records for the purpose of reimbursement. That is the function of the Medicare intermediary. The state agency, in its review of your medical records, may note that you are not in compliance.

For instance, you may not have a physician’s signature authorizing the plan of care. When this comes to the ultimate attention of the FI, it is entirely likely that all of claims under an “unauthorized” plan of care would be denied for reimbursement retroactively.

I wish you well, and caution you to take the concerns of the state agency seriously. Its issue upon review is not the quality of your services, as measured in patient outcomes and satisfaction, but rather your compliance with the rules and regulations.

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**BRRR Q&A**

Name: _________________________________  Rehab setting: ________________________

My question is: _________________________________________________________________

__________________________________________________________

Please tell us how to contact you in case we need more information.

Fax this form to BRRR Managing Editor Victoria Groves at 781/639-2982.
Physical therapy gets a Botox injection

Botox may be best known as a way to erase the furrow from your brow, but a new study shows injections of this chemical may also significantly reduce chronic neck pain when used in combination with physical therapy, according to the American Journal of Pain Management. In the study, researchers looked at the effects of combining a single Botox injection delivered to the affected neck muscle with standard physical therapy. After three months of follow-up, the participants were asked to rate their neck pain on a scale of one to 10. Researchers found that the combination treatment lowered self-reported pain from a rating of six to four, a reduction of nearly 40%.

Manual therapy a hands-on approach to healing

An increasing number of American physical therapists have acquired advanced training for certification in manual therapy, according to the Ithaca [NY] Journal. This is a growing trend that recognizes the effectiveness of manual therapy in treating a wide range of neuro-musculoskeletal problems. When muscle or soft tissue is tightened, manual therapy helps to encourage correct movement. These therapists use their hands to guide their patients’ bodies toward pain-free mobility and functionality.

Pushing paper may mean pushing away patients

A recent survey of OTs found that preparing reports consumes much of their time, which could have been spent assessing breast-cancer patients, according to Women’s Health Weekly. OTs working with breast cancer patients provide a variety of therapeutic interventions, and those surveyed spent a significant amount of time facilitating educational programs, teaching relaxation techniques, and exploring strategies for managing breathlessness and fatigue. However, documentation and report writing consumed the largest proportion of OTs’ time, the study concluded.