Don’t be tripped up by fall assessments
How, when, and why to conduct them at your facility

Therapists in skilled nursing facilities may be able to conduct fall assessments in their sleep, but providers across all rehab settings should know how to thoroughly assess a patient—especially if they treat Medicare beneficiaries.

Prime candidates for fall assessments include patients who have recently suffered a stroke, those with dementia and Alzheimer’s, and patients who have had prior falls, says Janie Krechting, assistant professor in the department of behavioral sciences, Aging Services and Administration program at the College of Mount St. Joseph in Cincinnati.

“Seventy-five percent of people who fall will fall again,” says Krechting, who also cites patients with vision and hearing problems as potential fall victims. Other potential fall triggers can include Parkinson’s disease, neuropathies, high or low blood pressure, vertigo, or osteoporosis.

Objective mobility tests
Various evaluations are available for therapists to use during their assessments. Called “objective mobility tests,” they allow therapists to score patients’ ability in activities such as walking, reaching, and balance.

“These tests are a predictor of how safe a patient will be in the community,” say Kate Brewer, PT, MBA, GCS, director of clinical services and program.

Do-it-yourself rehab marketing
How to get your name out to both consumers and physicians

If you still use the standard holiday fruitcake to improve physician relations with your facility, it’s time to try something new.

In the current competitive rehab environment, you must do all you can to show patients and referring physicians that your facility is the place to receive treatment—and you don’t need to spend lots of money to do it.

Market to both parties
You never know how or why a patient might choose you over another therapist, so give him or her every opportunity to choose you.

Although direct access is available for non-Medicare patients, in most cases, your patients still need to obtain a referral from their physician before they begin therapy. At the very least, they may ask their doctor whom he or
Fall assessments

development for Greenfield (WI) Rehabilitation Agency. “Functional ability and balance ability tests are very important if there are any walking impairments.”

Developing a program

At Beaumont Health Center in Royal Oak, MI, patients can participate in Balance for Life, a personalized fall prevention program. Designed to decrease an individual’s risk of falling and maximize safety and independence, the program uses OT, PT, vision and aquatic therapy, vestibular rehab, day rehab, speech-language pathology, and nurse case coordination.

“Patients are identified by their doctor, and then we try to figure out why they are falling,” says Kelly Keim-Johnson, CBIS, neuro supervisor at Beaumont. “The PT or OT will then determine whether we need to go into the home.”

Home visits

For outpatients, a home visit can occur at any time during treatment.

The best way to observe patients’ fall potential is to shadow them while they perform typical daily tasks, says Brewer. “Watch them go through their typical day navigating through their home and use your skills as a therapist to assess them,” says Brewer. “For example, does their telephone cord stretch across the floor?”

If possible, also have any of the patient’s family members or other caregivers attend home or therapy visits. “Make sure there is a lot of education for the family,” says Keim-Johnson. “We encourage the families to come and talk about risks that might be in the home and explain the [patient’s] home exercise program.”

Reimbursement details

There is no specific Medicare form to fill out for a home visit and no specific codes to use for reimbursement purposes. Document your assessment in the patient’s medical record and consider using the following codes for reimbursement, says Brewer:

★ 97116—gait training
★ 97530—therapeutic activities
★ 97537—community/home integration (if the patient is active in his or her community and does frequent car transfers)

“As part of a thorough plan of care, your goal is to return [patients] to their prior level of function and to make sure the gains they’ve made in therapy can carry over into their home life,” says Brewer.

Remember that you can’t bill for the time you spend traveling to and from the patient’s home. Brewer estimates that the average home visit, excluding travel time, takes 45 minutes.

Create a checklist

Because there is no standard Medicare form to use, customize any fall assessment checklists to the needs of your individual facility. Brewer says paying attention to the following basic elements factors will ensure that you complete an accurate assessment:

★ Car transfers
★ Entering the home (e.g., steps, locking and unlocking the door, mailbox accessibility)
★ Living room mobility (e.g., on carpeting, on throw rugs, etc., sofa transfer, recliner transfer, accessible television, and telephone)
★ Kitchen mobility (e.g., sitting and standing from kitchen chairs, using the sink, dishwasher, stove, and getting items from the refrigerator to the counter, microwave, etc.)
★ Bathroom mobility (e.g., accessible with assistive device, in and out of shower or tub)
★ Bedroom mobility (e.g., getting in and out of bed, retrieving clothing safely)

Brewer also suggests looking for throw rugs or cords that could be tripping hazards; reducing clutter; and ensuring that there is adequate lighting for bathroom use at night, laundry and a cordless phone are accessible, and that the patient is able to prepare light meals.

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It ain’t just a river in Egypt
Learn to navigate through the new denial and appeal process

By now you’ve probably heard that CMS changed the Medicare denial and appeal process. Yes, this will require you to do some reading to find out how the changes affect you. But the good news is that the information you need is all right here, and it’s not that complicated.

On March 8, Congress published an interim final rule in the Federal Register outlining revisions to the appeals process. Previously, Medicare Part A and Part B appeals differed in terms of appeal levels. Now, there are five levels of appeal for both parts:

1. Redetermination
2. Reconsideration
3. Administrative law judge (ALJ) hearing
4. Department appeals board
5. Federal district court

The reconsideration level was previously known as the fair hearing level for Medicare Part B and did not exist for Part A appeals. It took effect May 1 for providers who submit claims to fiscal intermediaries (FI) and will take effect January 1, 2006, for providers who submit claims to carriers. See p. 5 for CMS–20033, Medicare’s reconsideration request form.

“In the past, the reconsideration level was a fair hearing. Now, the first two levels are both desk reviews,” says Kate Brewer, PT, MBA, GCS, director of clinical services and program development for Greenfield (WI) Rehabilitation Agency.

In other words, you won’t state your case either in person or via telephone unless you make it to the third level of appeal, the ALJ hearing.

In some ways, this change is a simplification because you won’t have to schedule an appointment to appeal the denied claim. Instead, you must write a letter that documents why the claim should be paid, similar to the first level of appeal.

“All additional information you can include will help you pull the case together,” says Brewer. “And a letter that’s well-thought-out and tells why the claim should be paid will help.”

Now, it’s even more important to get your point across in a letter and include any relevant supporting documentation. “The review is only done based on the information you submit,” says Rick Gawenda, PT, director of physical medicine and rehab at Detroit (MI) Receiving Hospital. “Make sure you send everything in, because you don’t get in front of anyone until the ALJ [level].”

Other reconsideration details
Another major change in the appeals process involves the criteria for evidence submission. Qualified independent contractors (QIC) now conduct reviews at this level, and you must submit all evidence to appeal your claim to them at the reconsideration level. Prior to these changes, you could submit new evidence at any level.

However, you can add additional information to the appeal if you are able to demonstrate just cause. But keep in mind that if the QIC accepts that information, it may result in a delay on your appeal.

Want to learn more?
The How-To Manual for Rehab Denials and Appeals: Navigating the Medicare Process is hot off the presses. Written by Kate Brewer, PT, MBA, GCS, and published by HCPro, this book and accompanying CD-ROM will show you how to successfully appeal a denied claim and avoid denials in the first place.

Visit www.bcmmarketplace.com/Prod.cfm?id=3344 or call customer service at 800/650-6787 for additional information.
Denial

< p. 3

decision for that claim.

Examples of evidence include missing documentation, additional nursing notes, lab reports, or any other part of the medical record that can strengthen your appeal of the claim.

One more important detail involves deadlines. The QIC has 60 days to make a decision about your claim. If you don’t receive a decision within two months, you can automatically proceed to the ALJ level because the QIC’s adjudication period expired.

CMS must make decisions on appeals at the redetermination stage within 60 days from the date it receives your appeal and within 90 days at both the ALJ and department of appeals board levels.

It’s important that your therapists know about these changes, because they will most likely be the ones writing appeal letters. “[The letters] should come right from the therapists because they know what they did and why the therapy services should be covered under Medicare,” says Gawenda.

And while you’re at it . . .

Because you’ll need to make these changes known to your staff and colleagues, take the time to ensure that the appeals process runs smoothly at your facility.

Consider setting up a weekly or biweekly meeting between the therapy department director or manager and the business office manager. Through these meetings, the therapy department can gather information about frequently denied claims and other reasons for denials and avoid them in the future.

“Some therapists don’t even know their claims are being denied because of a lack of knowledge,” says Gawenda. “Someone will have to take the initiative to be the initial contact, and it will probably have to be someone from the therapy department.”

An example is the use of modifier 59. If it is not appended to any line items in your claim that need it, those charges will be rejected.

You can resubmit with the correct modifier and receive reimbursement without going through the appeal process if you know this is happening. If not, your staff may continue to make this mistake and fail to recoup money that could easily be recovered.

“If no one knows, that $35 can become $10,000 over time if you’re in a big hospital,” says Gawenda. “The business office should look at the remittance advice to see that the entire claim was paid. If not, [it] should send the rejected line items back to the therapy department.”

Editor’s note: Visit www.cms.hhs.gov/forms/CMS20033.pdf to download CMS-20033.

Clarification

Please note that in BRRR’s June issue, the coding corner column on p. 8 should have stated that iontophoresis treatment requires direct one-on-one contact by the rehab provider.

Upcoming Events

Audioconferences:

July 28—Rehab Documentation Strategies for Optimal Reimbursement (source code: B072805A)

November 3—Coding and Billing for Rehab (source code: B110305A)
Medicare reconsideration request form

1. Beneficiary’s name: ____________________________

2. Medicare number: ____________________________

3. Description of item or service in question: ____________________________

4. Date the service or item was received: ____________________________

5. I do not agree with the determination of my claim. MY REASONS ARE:

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

6. Date of the redetermination notice
   *(If you received your redetermination more than 180 days ago, include your reason for not making this request earlier.)*

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

7. Additional information medicare should consider: ____________________________

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

8. Requester’s name: ____________________________

9. Requester’s relationship to the beneficiary: ____________________________

10. Requester’s address: ____________________________

    __________________________________________________________

11. Requester’s telephone number: ____________________________

12. Requester’s signature: ____________________________

13. Date signed: ____________________________

14. ☐ I have evidence to submit. (Attach such evidence to this form.)

    ☐ I do not have evidence to submit.

15. Name of the Medicare contractor that made the redetermination: ____________________________

**NOTICE:** Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under federal law.

*Source: CMS Form 20033.*
she recommends.

To make sure your name is the first mentioned, keep in regular contact with referring physicians. Your short list should include both physicians who regularly refer to you as well as those who have a specialty practice that may dovetail with the services you provide.

Also gather information about physicians who have offices geographically near your facility but with whom you don’t yet have an established relationship. They could be the key to boosting your caseload.

Physicians have a lot of influence over where your potential patients receive therapy, but your current patients are also a great referral source. If patients feel that you treated them well and helped them improve in a timely manner, they’re likely to recommend you in the future to friends, family members, or coworkers who need therapy.

“Don’t ignore either [physicians or patients],” says Lynn Steffes, PT, president of Steffes & Associates, a consulting firm in New Berlin, WI. “Your greatest source of referrals can be your patient’s family and friends.”

Creative ideas

Here are a few strategies that have worked for facilities across the country:

• **Patient alumni programs or reunions.** These annual or biannual gatherings encourage current and former patients and their families to get together. It also allows your staff to introduce new programs or specialties to the group. Former patients who have improved with the help of therapy services can also be an inspiration to current patients.

CPL Family of Centers in Middletown, CT, which has 21 rehab departments across the country, invites former patients to its reunions and encourages them to bring their families. “We have been thinking of ways to get more involved with the community and create some buzz,” says Joy Harris, MS, OTR/L, corporate director of rehabilitation services for CPL Family of Centers. “We organize a party and plan icebreaker activities for the attendees. The therapists can also network and conduct a brief introduction to new rehab programs.”

• **Second visit tour.** On your patients’ second visit to your facility, have a staff member take them on a tour of the facility, explain their benefits and payment arrangements, and give them a brochure detailing the services you offer.

“You want to send them away singing your praises,” says Steffes. “You’re obviously going to take fabulous care of them, but you really want to make sure they leave with a connection.”

Wait until the second visit because during the patient’s initial evaluation, you may not know whether he or she definitely needs therapy, and the patient may also be preoccupied with completing paperwork.

• **Make yourself magnetic.** Everyone has business cards, but if you add a magnet to the back of yours, you can create a permanent marketing piece, says Steffes.

• **Mention family and friends.** As your patient’s episode of care ends, encourage him or her to contact you with any additional problems. For example, your dentist doesn’t permanently discharge you, says Steffes, because you will return to him or her the next time you need dental work done.

Similarly, mention that you can also see any family members who may need rehab in the future. “Tell your patient[s] that you’re willing to see anyone in their family who wants to come in for a free, 10-minute screening,” says Steffes. “You’re their therapist, but you’d also like to become their family’s therapist.”

All of these strategies become even more important as physician-owned clinics continue to pop up, and the physician owners try to keep their patients in-house for rehab. “It’s important for a patient to say,
‘I already have a therapist,’ " says Steffes.

**Doc marketing**

Physicians are busy and may not read the brochure you dropped off at their office or attend that information session you organized. Instead of continuing to bark up that same tree, try a new tactic.

Set up a presentation in the physician and staff break room. The rehabilitation department at Ephraim McDowell Health in Danville, KY, periodically sets up in the physicians' break room and provides lunch or brunch, along with material about what services their facility offers.

“I really believe we’re doing better with this [approach] than with anything else,” says Ron Barbato, PT, corporate director for rehabilitation at Ephraim McDowell Health. “We started with the doctors we thought would be the most responsive, and we track their therapy referrals.” Also remember to disclose that you provided the food, says Barbato.

- **Win over the gatekeepers.** Physicians aren’t the only individuals to whom to market. Nurses, nurse practitioners, case managers, and receptionists can also help get your name to the top of a doctor's referral list. “There are a lot of people who have input on where a patient goes,” says Harris. “The more you can make these people aware of your programs and what makes you different, the more likely you are to get referrals.”

- **Send a postcard.** Harris’ facility is beginning to send targeted postcards that profile a patient success story to physicians. With the patient’s permission, the center includes a photograph and information about how well the patient did in therapy. Ideally, the patient’s treatment would be in line with the physician’s specialty area. For example, a postcard describing a patient in therapy for a hip fracture would be sent out to orthopaedic physicians.

- **Create a patient satisfaction survey.** At Harris’ facility, administrators collect information about patients’ satisfaction with factors such as physical environment, food, and nursing care. Now, they also collect information on rehab services.

Staff compile a three-month summary and send the information to the referring physician, who will hopefully anticipate similar positive outcomes for future referrals.

**Community involvement**

If you want to try broader ranging public relations techniques, consider the following:

- **Invite the press.** For events like the therapy reunion Harris mentioned, send an invite to a local reporter or put a press release in the newspaper.

- **Be a source.** Offer to speak with a local reporter about effective gardening techniques in the summer or safe shoveling positions in the winter. Approach him or her with a story idea, not just a pamphlet with information about your services, says Nancy Beckley, MS, MBA, president of Bloomingdale Consulting Group in Brandon, FL.

“It’s all about developing a relationship and then finding a reason to have members of the media stop by,” says Beckley. For example, an OT might ask local food editors to come by and look at adaptive equipment for kitchens. “Invite them to your rehab kitchen and have lunch with them, using the time to teach them about your adaptive equipment.”

- **Zero in.** The more specific you can be in your marketing, the better, says Beckley. If you treat athletes, consider marketing directly to high school players, or even more specifically, to high school players who participate in a specific sport. Or if you primarily offer hand therapy but have a great carpal tunnel program, market to that specific group.

**Be creative!**

The fruitcake may not be completely passé, but there are better ways to show patients and physicians that you’re the best therapist for the job.

“We still do the gift basket, but we go way beyond that,” says Harris. “[Physicians] want to know that the patients who go to you will be satisfied. We have to show them that the quality of care is going to be good.”
medical diagnosis provided by the physician or the treatment diagnosis determined by the therapist after the initial PT examination. The medical and treatment diagnosis can be the same.

In addition, more third-party payers are interested in the treatment diagnoses based on the initial therapy examination to explain why the patient requires skilled therapy services rather than the physician's medical diagnosis—especially if there is a difference between the two.

Q: Can we charge for whirlpool use and have additional charges for wound debridement and wound dressing, or should we capture the debridement and dressing under the whirlpool charge?

A: If you provide selective debridement (97597 or 97598) to a wound and also provide whirlpool (97022) to the same wound that you debride, you cannot bill separately for the whirlpool because it is included in the CPT code descriptors for 97597 and 97598.

Either bill 97597, if the total wound surface area was less than or equal to 20 sq cm, or 97598 if the total wound surface area was greater than 20 sq cm.

If, for example, you debride a wound on the right calf and place the left lower extremity in a whirlpool due to an open wound, then you could bill both 97597 or 97598 (depending on the total wound surface area) and 97022.

Also append modifier 59 to 97022 to have both CPT codes reimbursed, and your documentation must support the medical necessity of both treatments.

In addition, you can’t bill separately for dressings as these are included in the reimbursement for 97597, 97598, and 97022.

Q: I need advice on using V codes for PT billing in an outpatient clinic. Is a V code appropriate to identify a knee replacement patient? If not, what ICD-9 code signals payers that this patient has received postsurgical care?

A: Depending on the third-party payer, a V code may or may not be appropriate if you seek reimbursement. Even with Medicare carriers and fiscal intermediaries (FI), some payers allow the use of and will reimburse for V codes when they describe the patient’s primary diagnosis and some do not.

Check with your specific payer to verify whether it accepts V codes as a primary diagnosis.

Personally, I do not believe V codes accurately describe why the patient requires skilled therapy services; I feel there are more appropriate ICD-9 codes.

In your example of a post-knee replacement patient, perhaps he or she receives PT services due to difficulty walking (719.7), contracture of the knee joint (718.46), effusion of the knee joint (719.06), pain in the knee joint (719.46), any combination of the above, or possibly for other reasons that a more appropriate ICD-9 code could describe on the claim form.

One of the diagnoses listed above could be the medical diagnosis provided by the physician or the treatment diagnosis determined by the therapist after the initial PT examination. The medical and treatment diagnosis can be the same.

Submit questions to BRRR Managing Editor Victoria Groves at vgroves@hcpro.com or fax questions to 781/639-2982.
Matter of fax
Protect your patients and yourself with proper faxing etiquette

With a slip of your finger, you could hit the wrong button on your fax machine, and instead of sending important patient information to the doctor’s office, you could send it to another company or individual with a similar fax number.

Even without being under the shadow of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this is a violation of your patient’s privacy and something you should avoid. Here’s how:

1. **Validate your fax numbers.** Do this annually, at a minimum. Chances are, that for the fax numbers you frequently use, you will find out quickly whether one has changed. But in general, take a few minutes and verify numbers that you fax on a regular basis. “It’s good practice to verify on a routine basis so that you always know to whom you are faxing,” says Melissa Dill, MS, OT, a consultant with Health Evolutions in Indianapolis.

2. **Make sure your fax machine is in a private area.** This is a HIPAA privacy requirement for good reason. Not only do you fax your patients’ protected health information, but you receive it as well.

3. **Make sure the organizations you fax abide by HIPAA.** Send each company you fax a form on which you verify its contact information and also whether it is HIPAA-compliant. It should fax the document back to you so you will have documentation in the event that one of your patient’s privacy is violated.

4. **Put important numbers on speed-dial.** This way, you won’t dial the wrong number by accident, and you’ll probably save yourself time as well.

“If a provider uses good release of information practices, it will limit its liability,” says Dill. “Patients don’t want to think that their healthcare provider is treating their information in a less than confidential manner.”

After faxing, log the information in the patient’s record, which includes what you faxed, to whom, and the date.

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BRRR Q&A

Editor’s note: Nancy J. Beckley, MS, MBA, president of Bloomingdale Consulting Group in Brandon, FL, answered the questions below. Please 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.

Who does Medicare consider to be a non-physician practitioner (NPP) and who does it qualify as a physician? We are trying to determine who is able to write orders for our patients to attend therapy.

In Medicare’s Benefit Policy Manual (CR 3648), under Chapter 15, Section 220, Medicare defines NPPs as
- physician assistants
- clinical nurse specialists
- nurse practitioners

These healthcare providers may—state and local laws permitting—provide, certify, or supervise therapy services when they follow the appropriate rules.

In the context of authorizing outpatient rehabilitation therapy services, physicians include doctors of medicine, osteopathy (including osteopathic practitioners), podiatric medicine, and optometry (for low-vision rehabilitation only). Medicare does not consider chiropractors and doctors of dental surgery/dental medicine to be physicians for therapy purposes, and these individuals may neither refer patients for rehabilitation therapy services nor establish therapy plans of care.

However, from a marketing perspective, a chiropractor can refer a patient to your clinic. But that patient would also need to be under the care of a physician or NPP qualified under the Medicare statute. It is that qualified Medicare physician who will write the referral, certify the plan of care, and show evidence of involvement in the patient’s care.

Has Medicare issued a new policy regarding certification timelines? If so, where can I find the reference?

Medicare eased the timelines for physician or NPP certification of the plan of care with the publication of Transmittal 34 on May 6. It requires certifications for each 30-day interval of treatment when the certification occurs before or during the interval.

CMS also includes an accommodation for delayed certification, which should include one or more certifications or recertifications on a single signed and dated document. You can meet certification and recertification requirements at a later date when a physician or NPP makes a certification accompanied by a reason for the delay. Certifications are acceptable without justification for 30 days after they are due.

In the transmittal, Medicare specifically commented on delayed certification: “Delayed certifications should include any evidence the provider or supplier considers necessary to justify the delay.”

For a long delayed certification (more than six months), add additional documentation with the delayed certification (e.g., an order, progress notes, telephone contact, requests for certification, or the signed statement of a physician or NPP) indicating why the patient needs care and that he or she was under the care of a physician at the time of the treatment. The contractor may then request such documentation for delayed certifications if it is required for review.

If a clinic needs to hire a PT on short notice (shorter than it takes to get an individual PT provider number), should we bill for the services this PT provides under the clinic’s group number, locum tenens, or the existing PT’s provider number?

Locum tenens is a Latin term that, literally translated, means “one holding a place.” In lay terms, locum tenens are therapists who fill staff vacancies through temporary assignments. A locum tenens therapy situation arises when a therapist, licensed to practice in another state (or licensing jurisdiction), applies for a temporary license issued for a specified period of time. This type of therapist...
may not necessarily have a Medicare provider number. Obviously, don’t assign him or her to the clinic’s group number.

CMS stated that a provision in the \textit{Medicare Carriers’ Manual} allows for physician locum tenens but does not apply to therapists in private practice. Therefore, a therapist who goes on vacation or is out for various reasons cannot have another therapist come into the office and substitute for him or her. Under a solo private practice setting, patients would have to go to another office to receive their PT or wait until the PT returns, unless there is a group practice situation.

In this situation, because you reference another physical therapist in the clinic, which appears to be a group practice, the other therapist should treat the Medicare patients. If this other locum tenens therapist has a current license to practice in your state, and the carrier has received the provider enrollment application, he or she can provide services to Medicare beneficiaries. However, you cannot submit the claims for those services until the provider number is available. Please check with your Medicare contractor and obtain further clarification on this type of situation.

\textbf{Can we have students participating in initial examinations, treatment, and documentation with patients under Medicare B? Are there any restrictions on this situation?}

In Transmittal 1872, Medicare clarified its policy on treatments provided by therapy students. In general, you can only bill and be paid for the services of the therapist under Medicare Part B. Medicare will not reimburse for services performed by a student even if the student provides them under the therapist’s line of sight supervision. However, the presence of the student in the room does not make the service unbillable. The Medicare contractor can pay for direct, one-to-one patient contact services provided by the physician or therapist to Medicare Part B patients. You may also bill for group therapy services performed by a therapist or physician when a student is also present in the room.

Medicare provides the following examples in which therapists may bill and receive payment for providing skilled services in the following scenarios:

- The qualified practitioner is in the room for the entire session. The student participates in the delivery of services when the qualified practitioner directs the service, makes the skilled judgment, and is responsible for the assessment and treatment.

- The qualified practitioner is in the room, guiding the student in service delivery when the therapy student or the therapy assistant student participates in providing services, and the practitioner is not engaged in treating another patient.

- The qualified practitioner is responsible for the services and as such, signs all documentation. A student may, of course, also sign, but it is not necessary because the Part B payment is for the clinician’s service, not for the student’s services.
White House revising 2006 Medicare handbook

The Bush Administration is revamping a preliminary draft of the 2006 Medicare Handbook due to inaccuracies and misleading information, according to The New York Times. The 106-page handbook will include more detailed information about the new drug benefit for Medicare beneficiaries and will clarify differences between traditional Medicare and private insurance plans. The final version of the handbook will be mailed to beneficiaries this fall, according to the Times.

CMS proposes payment increases for IRFs

CMS has proposed an inpatient rehab facility (IRF) payment rule for 2006 to ensure that Medicare beneficiaries have access to intensive inpatient rehabilitation services when they need them, according to a CMS press release. With the market basket update, adjustments for coding changes, and changes to the outlier threshold, aggregate payments to these facilities in fiscal year 2006 are projected to increase $180 million over fiscal year 2005, a 2.9% increase. The rule also proposes to increase the payment rate adjustment for IRFs in rural areas to 24.1% from the current 19.1%, reported the release. Visit www.cms.hhs.gov/providers/irfps for additional information.

Low-level heat can improve acute low back pain

A new study indicates that continuous low-level heat wrap therapy (CLHT) can significantly reduce acute low back pain and improve function outcomes when used in conjunction with exercise, according to Biotec Business Week. Little is known about the additive effects of a combination treatment of palliative processes such as CLHT with exercise on acute low back pain. In the study, subjects who exercised with CLHT had 70% less lower back pain, 139% greater reduction in disability, and 95% improvement in functional ability as compared to subjects who exercised without CLHT, reported Biotec Business Week.

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