

PHYSICAL MEDICINE & REHAB CODING ALERT

The practical monthly adviser for ethically optimizing coding reimbursement and efficiency for physical medicine and rehabilitation practices and clinics

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Acute Rehab:

Inappropriate Referrals Throwing Other POCs for a Loop?

► *Get tips on more efficient patient screenings for therapy*

If you work in an acute rehab setting, you're probably familiar with a growing trend of inappropriate therapy referrals that are chewing up a good portion of your time — and taking away from your other plans of care.

Experts have noted it too. "The demand for therapy evaluations has probably increased four-fold in the last four years," says **Fran Fowler, FAAHC**, president of Fowler Healthcare Affiliates Inc. in Atlanta. Perhaps it's due to the nursing shortage, but hospital staff has less and less time to get patients out of bed. And when physicians take note, they may order therapy evaluations in hopes that patients may qualify and get out of bed.

"But many referrals don't qualify for therapy, and the therapists spend a lot of their time doing evaluations — which leaves the patients who really could use rehab in a lurch," Fowler says. So therapists in acute care must create screening methods that quickly evaluate whether the patient doesn't qualify for skilled therapy or he actually does need a full eval.

Start With Good Staff Education

The best way to keep inappropriate therapy referrals at a minimum is to educate others at your hospital. See what your peers are doing along these lines to ensure appropriate therapy referrals.

Physicians: "We have a hospitalist program, and one of the acute PTs attends the rounds every morning, which is about 30 minutes," says **Cindy Sayce, OTR/L**, director of acute care and inpatient rehab programs for FirstHealth of the Carolinas in Pinehurst, N.C. "The PT takes a laptop with access to therapy documentation so she can answer questions on whether patients are already being seen, etc., and she can also educate the hospitalist on appropriate referrals through the rounding."

If you have residents at your facility, you'll also want to reach out to them so they're informed about appropriate therapy referrals wherever they take their career. "We educate residents at our hospital on what would be an inappropriate referral," says **Susan Davis, PT, MBA**, director of acute rehab at Moses Cone Health System in Greensboro, N.C. "We also give a typical spiel on what PT, OT and SLP consist of and these therapists' roles in the acute care setting."

Nursing staff: Make sure your nursing staff is educated too. You don't want a nurse suggesting to the physician that a patient needs rehab when the nurse may simply need to walk or transfer the patient. "We [therapy staff] often work with nursing staff to make sure they feel comfortable on an individual basis with moving patients, and we may even take them through a transfer," Davis says. The key is to make sure nursing staff is doing everything they can that's within their scope of practice before calling on rehab.

You can also take the approach of, "if you [nursing] help us [therapy] by assisting the easy patients, then we will have more time to get the more involved patients out of bed," Sayce says.

Hospital administration: Putting a bug in a bigwig's ear isn't a bad idea either. For example, administration should know that it's much cheaper for a well-trained CNA to assist patients out of bed, compared to the cost of a PT, Sayce says. "Most physicians, as well, are getting more involved in controlling their cost per case, so you can use that angle with the doctors as well."

Modify Your Eval Process

Another way to ensure you have ample time to treat patients who really need therapy is to make your evaluation process as efficient as possible. Most therapists look at preadmission status for starters, but if you do have

an inappropriate referral, try using a screening form to weed out patients right away who don't need or wouldn't benefit from therapy. "Within acute care, we have a shorter form that just hits the highlights and has all the information we need from a regulatory standpoint to ensure the patient doesn't have any subtle therapy needs," Davis says. "But we would use a much more in-depth form for a stroke patient, for example."

Another way: "We might decide to do a screen if we can tell from a chart review and a quick discussion with the nurse that the patient may not need skilled therapy," Sayce says. As for billing, FirstHealth has a charge setup that does not have a dollar value but does assist in calculating the man-hours of the staff that completed the screen, she adds.

Smart: Good use of technicians can also make your evals more efficient. For example, "if a therapist has three or four evaluations to do in the morning, he may take a technician with him to set up the patient room and to explain to the patient what's about to happen," Davis says. "Then after the eval, the technician can help wrap up the room while the therapist is doing the documentation."

Location, Location, Location

If all else fails, or if staff education and eval modification seems like a tall order at the moment, the simplest

CONTACT INFORMATION

We would love to hear from you. Please send your comments, questions, tips, cases and suggestions for articles related to physical medicine and rehab coding, reimbursement and/or compliance to Lindsey Rushmore at lindseyr@eliresearch.com.

Mail: PO Box 413006, Naples, FL 34101-3006

Phone: (800) 508-2582 **Fax:** (800) 508-2592

Executive Editor: Lindsey Rushmore
(lindseyr@eliresearch.com)

Consulting Editor: Rick Gawenda, PT
(rgawenda@dmc.org)

Managing Editor: Mary Compton, PhD, CPC
(maryc@eliresearch.com)

Vice President, Development & Editorial:
Bridgett Hurley, JD, MA

President: Samantha Gardiner Saldukas
(sam@medville.com)

Director of Sales: Bill Streight
(bills@medville.com)

Medallion Group Manager: Aleshia Elismond
(aleshia@medville.com)

Live Conference Manager: Lacy Keith
(lacyk@medville.com)

Audioconference Director: Tracy L. Thomas
(tracyt@eliresearch.com)

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of changes can help speed the eval process and give therapists more time to work with patients. Moses Cone, for example, focuses heavily on ensuring that everything the therapist needs is in a convenient location. "We have carts that our therapists use that have things they would likely use to treat or evaluate patients," Davis says. A cart might have things like oxygen tubing, a cane, pulse oximeters, and sanitary booties for walking, among other things.

"We also have some storage space now at three different locations in the hospital, so if the patient needs something, such as a wheelchair, the therapist doesn't have to go to the other end of the hospital to get it," Davis says. In addition, the hospital places specialty equipment (e.g., a bariatric walker) in a centralized location.

Good idea: It also helps to think "location" with staff, as well. "We've gone to floor assignments so that our therapists are assigned to a couple of floors, and they're on those floors pretty much all day," Davis says. This helps them establish relationships with nursing staff, which leads to better information about the patients and who may really need therapy.

So in the end, whether you decide to do a complete overhaul of processes to avoid inappropriate referrals, or you decide to take baby steps, every little thing counts. The key is to keep open communication with every person involved with the patient. □

Billing:

Heads Up: New ABN May Cut Need for NEMB

► **CMS' updated, revised ABN was effective March 3**

If you still struggle with understanding the difference between the ABN and the NEMB forms, your prayers have been answered.

Earlier this month, CMS unveiled its new advance beneficiary notice (ABN), and the new form not only replaces both the previous ABN-G (for physicians and therapists) and ABN-L (for laboratories) but also incorporates the notice of exclusions from Medicare benefits (NEMB) form. CMS expects this new, combined form to "eliminate any widespread need for the NEMB in voluntary notification situations," according to the new ABN Form Instructions document.

The NEMB's previous purpose: In case you weren't familiar with exactly when you were supposed to use the ABN rather than the NEMB, keep in mind that in the past, ABNs were only for procedures that Medicare might not cover but didn't apply to procedures that were statutorily excluded from Medicare benefits. That was where the NEMB came in — you were able to use it for services such as therapy services beyond the therapy caps (that didn't fall under an exception) because Medicare never covered them.

Now CMS will accept the new ABN form for either purpose, noting in its ABN instructions that "the revised version of the ABN may also be used to provide voluntary notification of financial liability."

Don't worry: Although Medicare contractors began accepting the new ABN form on March 3, CMS has implemented a six-month transition period. Therefore, you aren't required to submit the new form until Sept. 1.

Important note for SNFs: You're not required to use the revised ABN form for Part B supplies and services. Instead, watch for a revision of the current SNF ABN that CMS plans to release before Sept. 1, 2008.

4 ABN Tips to Remember

Although the ABN form has changed, many of the previous ABN "best practices" remain the same. The following is a quick look at four important ABN facts.

(continued on next page)

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1. Understand the function of the ABN. If you discover that a patient's upcoming therapy may not be payable by Medicare, but the patient still wants you to perform the service, the ABN will let the patient know that he may be responsible for paying the noncovered portion, and you're required to issue an ABN in this case.

If, however, the service you're providing is statutorily noncovered by CMS, you can choose to voluntarily provide the patient with the revised ABN, notifying her that this service is not covered by Medicare and that she is responsible for payment — in other words, exactly how you would have handled using an NEMB form.

Remember: ABNs help patients decide whether they want to proceed with a service even though they might have to pay for it. A signed ABN ensures that your clinic will receive payment directly from the patient if Medicare refuses to pay. Without a valid ABN, you cannot hold a Medicare patient responsible for the denied charges, says **Kara Hawes, CPC-A**, with Advanced Professional Billing in Tulsa, Okla.

2. Keep fresh copies of the ABN close by. "The patient has to sign the ABN form at the time of service, otherwise the form is not valid," Hawes says. "When the claim is denied without an ABN, Medicare will not allow you to be reimbursed for the service or collect money from the patient."

3. Explain the ABN to the patient. ABNs help the patient understand his options. Once you have completed the ABN and discussed it with the patient, he can: 1) sign the ABN and assume financial responsibility for the therapy services in question; 2) cancel the therapy; or 3) reschedule the therapy for future dates when he can afford it, or when Medicare may cover the procedure.

4. Know your billing modifiers. When you expect Medicare to deny all or part of a service, you should append the correct modifier to the service code so Medicare's explanation of benefits (EOB) will properly outline when the patient has to pay. Use the following descriptions to guide your modifier choice:

- **Modifier GA** (*Waiver of liability statement on file*) is used when the service provider believes the service is not covered, and the office has a signed ABN on file," says **Dena Rumisek**, a biller in Grand Rapids, Mich.

For example, you have a Medicare patient who has reached all of her therapy goals and wants to continue therapy for a few maintenance sessions.

- **Modifier GY** (*Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, it is not a contract benefit*) applies when Medicare excludes the service and you're using the new ABN as you would have used the NEMB in the past.

- **Modifier GZ** (*Item or service expected to be denied as not reasonable and necessary*) means that you didn't issue an ABN when you probably should have, and you cannot bill the patient if Medicare denies the service. □

Compliance:

Are You on Your Revalidation Process Game?

► **Don't let these new Medicare provider requirements come as a surprise**

If you bill Medicare at your practice or facility, it's time to get a strong handle on Medicare's "revalidation process" if you haven't already. Why? If you're not in compliance, it's only a matter of time until your carrier or fiscal intermediary can put the kibosh on your billing privileges.

Background: According to CMS ruling 42 CFR 424.515 in the April 21, 2006, *Federal Register*, all Medicare providers must revalidate their Medicare information on file, via a CMS-855 form, within 60 days of receiving a written revalidation request from their CMS fiscal intermediary or carrier, say **Lyndean Brick, JD**, senior vice president of Murer Consultants Inc. in Joliet, Ill.

Sounds simple enough, but many providers have never filed a complete CMS-855, which can make the revalidation process quite difficult, Brick says. And you may even receive an on-site survey if CMS discovers enough discrepancies.

But that's not all. "Generally speaking, once a provider submits a complete CMS-855, either in response to a revalidation request or otherwise, the provider must then revalidate his or her entire CMS-855 filing once every five years — or within 90 days after any change in his or her Medicare provider information," Brick says.

Know What CMS Is Looking For

If you're not sure what kind of information you need to have lined up for CMS for revalidation, check out a

copy of the Medicare enrollment form online at www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf.

You'll notice that the agency requires a slew of information ranging from your practice name to your licensure status. You may find that pieces of this required information are out of date for your practice or facility, and if that's the case, it's time to fix that fast and submit a fresh 855 form to CMS.

Important: As you update your information, consider consistency a top priority. Why? "One of the biggest problem areas we find is that providers aren't consistent with names, among other things in their legal documentation," Brick says. For example, a rehab practice may have opened with the name Mountain Rehab, but it bills as Mountain Sports Rehab, yet its information on file with CMS may say Mountain Pain and Rehab. And CMS won't go for that.

Critical: And now, with NPIs going into full-swing, the practice or facility name and other information you've filed on your NPI application must match your legal documentation. "Even if one little thing gets out of whack and CMS catches it, its contractors can stop reimbursement," Brick says, "even something as small as your IRS information not matching your NPI information."

Helpful: See the article at right for a list of questions you should ask when you audit your information on file.

Keep an Eye on the Timing

The CMS revalidation process is being enforced over a five-year period that went into effect last year, and the initial revalidation effort focused on Medicare contractors' top-100 billers. But that doesn't mean you should wait for your carrier or FI to contact you. "CMS will continue to push forward with their revalidation efforts with smaller healthcare organizations as the effort phases in," Brick says. And you're much better off being prepared with your most up-to-date information on-hand than to be scrambling to get your ducks in a row and risk having your billing privileges revoked.

So long story short, Medicare providers have a lot of housecleaning to do in their legal documentation so they can turn in a clean and up-to-date 855 form. And from here on out, anytime you have even the slightest change in your legal information, even if it's something as small as an address change, you need to notify Medicare of that change within 90 days.

Resources: See the rule's text at http://a257.g.akamaitech.net/7/257/2422/13nov20061500/edocket.access.gpo.gov/cfr_2006/octqtr/pdf/42cfr424.515.pdf. □

Practice Pointers:

Top-12 Questions to Ask When Assessing Revalidation Compliance

► ***If your answer isn't 'yes' to these items, it's time to do some digging***

1. Is the provider's Medicare correspondence address on file current and reliable? If not, the provider may not receive a revalidation request, which may cause the filing deadline to be missed.
2. Does the provider have processes in place to track pertinent information on new and existing board members and managing employees?
3. Does the provider actively track all practice locations that are billed as provider-based?
4. Is the provider prepared to submit all required supporting documentation with a complete CMS-855, such as legal formation documents, IRS tax ID confirmations, state licenses, certifications, EFT bank account letters, and NPI confirmations?
5. Do the provider's NPIs accurately reflect applicable provider numbers and taxonomy codes, legal business names, etc.?
6. Has the provider filed a complete CMS-855 in the last 12 months? If so, the provider may be exempt from the revalidation process.
7. Does the revalidation application accurately reflect all practice locations?
8. Are Section 5's included for all organizational owners and managers, including chain home offices?
9. Are Section 6's included for all board members and at least one W-2 managing employee?
10. Does the provider retain copies of all Medicare enrollment applications, including initial enrollments, changes of ownership, changes of information, and revalidations?
11. Does the provider file CMS-855 changes of information within 90 days of all changes to practice locations, board members, managing employees, owners, authorized officials, and delegated officials?
12. Does the provider have a CMS-issued provider-based determination for each practice location listed in the 855 (if applicable)?

Editor's note: List of questions provided by Murer Consultants Inc. □

CLINICAL REHAB ROUNDUP

In this recurring feature, *Physical Medicine & Rehab Coding Alert* provides summaries of a cross section of recent clinical studies. Here's what's new this month.

Teaching Techniques Get Low-Back Patients Back to Work Faster

“Effects of education on return-to-work status for people with fear-avoidance beliefs and acute low back pain.” Godges JJ, Anger MA, Zimmerman G, Delitto A. *Phys Ther.* 2008 Feb;88(2):231-9. Epub 2007 Dec 4.

Researchers noted that people with acute low-back injury and fear-avoidance beliefs can remain off work for an extended time. With that in mind, they designed a study to determine whether education and counseling on pain management, physical activity and exercise could significantly decrease the number of days that people with low-back injury are off work.

Thirty-four people who were unable to return to work following a work-related episode of low-back pain and who exhibited fear-avoidance beliefs participated in this study. Participants who scored 50 points or higher on the Fear-Avoidance Beliefs Questionnaire were split into an education group and a control group, each of which received conventional physical therapy intervention. Participants in the education group, however, received education and counseling on pain management tactics and the value of physical activity and exercise.

Findings: All participants in the education group returned to regular work duties within 45 days, while one-third of the participants in the comparison group remained off work at 45 days. Researchers concluded that education and counseling on pain management, physical activity, and exercise can reduce the number of days off work in people with fear-avoidance beliefs and acute low-back pain. □

How TENS Can Help Balance Control

“TENS to the lateral aspect of the knees during stance attenuates postural sway in young adults.” Laufer Y, Dickstein R. *Scientific World Journal.* 2007 Nov 26;7:1904-11.

Researchers, noting that somatosensory input is essential for postural control, conducted a study that examined the effects on postural sway of sensory input delivered via transcutaneous electrical nerve stimulation

(TENS) applied to the knees. Twenty healthy, young volunteers had electrodes from a dual-channel portable TENS unit adhered to the skin overlying the lateral and medial aspect of both knees. Researchers obtained postural sway parameters during static bipedal stance with an AMTI force platform. They tested four stimulation conditions with eyes open and with eyes closed: no TENS, TENS applied bilaterally, and TENS applied to either the right or the left knee. Participants underwent two eight-trial blocks, each trial lasting 30 seconds. Stimulation consisted of a biphasic symmetrical stimulus delivered at the sensory detection level, with a pulse duration of 200 microsec and a pulse frequency of 100 Hz.

Findings: TENS application induced significant reductions in mean sway velocity and in the medio-lateral dispersion of the center of pressure, with no corresponding effect on the anterior-posterior dispersion. Researchers concluded that electrical stimulation delivered at the sensory detection level to the lateral aspects of the knees may be effective in improving balance control and that this effect may be directionally specific. □

NEWS BRIEFS

CMS: Medicare Dubs NGS Newest MAC

If you're providing rehab services in Connecticut or New York, be prepared to send your Medicare claims to a new payer later this year. CMS recently awarded National Government Services (NGS) a contract to administer Part A and Part B Medicare claims payment in these states, according to a March 18 press release.

This makes NGS the new Part A/Part B Medicare Administrative Contractor (A/B MAC) for New York and Connecticut. NGS will immediately begin implementation activities and will assume full responsibility for the claims processing work in its jurisdiction no later than November 2008, CMS announced.

Background: NGS, headquartered in Indianapolis, is the sixth new A/B MAC named by CMS, and the agency expects a total of 15 new A/B MACs to cover every state and the District of Columbia by 2011. CMS awarded the first A/B MAC contract in July 2006 to Noridian Administrative Services, headquartered in Fargo, N.D.

When contracting reform is fully implemented, all the Medicare fiscal intermediaries and carriers will be replaced by MACs responsible for both Part A and Part B claims processing. For beneficiaries and providers, the new structure will mean that they each will have a single point of contact with the Medicare program, CMS said.

When it becomes operational, the A/B MAC for Connecticut and New York will be the contact for all Medicare providers and physicians in the two states, while beneficiaries will pose their claims-related questions to a Beneficiary Contact Center, the release said.

Other states: To see a list of new contractors and the states they cover, visit www.cms.hhs.gov/MedicareContractingReform/.

Lobbying:

Fall Prevention Gets National Attention

Medical and eldercare policy groups are putting pressure on Congress to fund fall-prevention programs. Twenty-two groups including the National Association for Home Care & Hospice are calling on Congress to spend \$20 million on fall prevention under the Centers for Disease Control and Prevention.

About “1.8 million older adults were treated in emergency departments for injuries from falls, 433,000 were hospitalized, and nearly 16,000 died,” the coalition said in a release. “CDC reports the mortality rate from falls among older Americans has increased 39 percent between 1999 and 2005.”

According to the CDC, more than \$19 billion annually is spent on treating the elderly for the adverse effects of falls, the coalition reported.

Speech-Language:

Premera Blue Cross Says OK to SGDs

Good news for speech-language pathologists using private health plan Premera Blue Cross: This payer has reversed its policy that excluded coverage of speech-generating devices (SGDs) and other augmentative and alternative communication (AAC) devices for autism-related speech-language disorders, according to a news e-mail from the American Speech-Language Hearing Association (ASHA).

Before, Premera would only cover SGDs and AACs as “medically necessary,” if SLPs used them to treat speech-language impairments that were not “primarily” due to autism or other pervasive developmental disorders. That was based on Premera’s Corporate Medical Policy (CP.MP.PR.1.01.502), last updated Oct. 9, 2007, that considered SGDs and AACs devices for autism “investigational,” ASHA said in its announcement.

ASHA links this policy change to its recent advocacy actions, reporting that it “urged Premera Blue Cross to reconsider its policy in light of supportive literature findings as well as current national and local practice standards” that encourage SLPs to use SGDs and AAC devices to treat autism-related speech-language disorders.

New way: Premera’s policy change will offer coverage under the same criteria for SGDs and AAC devices to treat speech-language disorders, regardless of whether they are related to autism or of other etiologies, ASHA said in its message.

Don’t miss: Want to hear more about AACs? Tune in to the *Eli*-sponsored audioconference “How to Establish Augmentative and Alternative Communication (AAC) Options in the Healthcare Setting” on June 25. Sign up at www.audioeducator.com/industry_conference.php?id=1009. □

READER QUESTIONS

Give Re-Cert Periods an Efficient Edge

Question: *Is it OK to re-evaluate a patient or perform a progress note at the sixth visit and then again at the 12th visit, as long as we do this within the recertification or certification period? If we wait until the 10-visit mark, we could lose out on a week’s worth of time with the patient if we have to do a recertification at that point. Any suggestions?*

Alabama Subscriber

Answer: CMS policy says you must write a progress report once every 10 visits or once every certification interval — whichever comes first. But there’s nothing saying you can’t write progress reports more often. Say you marked your progress report period after six visits (e.g., between the dates of April 2 and April 12); then, the patient returns for five more treatments between April 14 and April 22, after which you write another progress report. That’s OK.

(continued on next page)

As for waiting until the 10-visit mark, if you write the progress report and know that the patient is going to need therapy beyond the certification interval, you can use that progress report as an updated plan of care. Then you can send that to the patient's physician for his signature, and he can sign it ahead of time. Just include on that last page "recertification from xx to xx" with a spot for the physician's signature and date, and that can cover up to 90 calendar days.



Is Your Daily Documentation Enough? Beware the Treatment Grid

Question: *I work in a SNF and have a question regarding our Med B patients. How often are we expected to document therapy treatments? Do we need daily documentation, or is our daily treatment record enough? We use a daily treatment grid, so is it really necessary to write an actual note every day we see that patient?*

Delaware Subscriber

Answer: The bare-minimum documentation requirements from CMS say you need daily notes, which must include the date, specific interventions and modalities you provided that support the CPT codes you're billing, along with your (the therapist's) signature.

In addition, you must document the total time spent providing time-based interventions and total treatment time, which is the summation of timed and untimed interventions.

Whether your daily treatment grid is sufficient is hard to determine without actually seeing your grid. You should use more than just a grid for daily notes. It's a good idea for therapists to write the patient's response to treatment after every treatment in addition to any progression/modifications of the treatment plan. Just a grid by itself listing what is done is not the best thing.

— Reader Questions were answered by **Rick Gawenda, PT**, director of PM&R at Detroit Receiving Hospital and owner of Gawenda Seminars. □

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President, Seminars Plus, Calif.

Allison M. Waxler
Policy Analyst, Practice Management
American Academy of Physical
Medicine & Rehabilitation, Ill.

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