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### WHO MAY PERFORM INCIDENT-TO SERVICES IN PT CODES

In the February 2009 issue of our newsletter, we had the following, which is NOT correct...

#### ELECTRICAL STIM—WHO CAN BE IN ATTENDANCE

*"We received clarification from CMS that says that the "constant attendance" codes can now fall within the "incident-to" guidelines of Medicare and this is huge news if you have an electrical stimulation device, such as Sanexas, Matrix, Hokamed, etc... This is contrary to what we've taught in the past—which was that it had to be the doctor or mid-level only.*

*This means that instead of the physician or mid level or physical therapist remaining IN the room with the patient the entire time they are on the device, any employee (MA, LVN, CPA, etc) can stay in the room with the patient and you can use the constant attendance codes. We do want to caution you, though, that Medicare is very clear in that for each 15 minutes the patient is on the device, you CANNOT charge more than one CPT code—regardless of how many electrodes or suction cups you have on the patient."*

*We published the above after numerous (5) emails were exchanged between several employees of CMS and myself, where I repeatedly asked them to clarify and repeat since they were telling me that ANY employee could perform incident-to under supervised AND constant attendance codes, and I wanted to make very sure of the information before I tell our clients that something is legal.*

**4 days later, I received another email from the CMS employees that completely contradicted the ones received the week before—and this one had CMS references. IT SAID:**

**" I want to provide a follow-up to the communications our office sent you last week concerning "incident to" and physical therapy services. Medicare has very specific requirements on the qualifications of personnel who may provide physical therapy services "incident to" the services of a physician or non-physician practitioner. The qualification requirements are detailed in section 230.1 of Chapter 15 in Medicare's Benefit Policy Manual." I**

**So, I went to CMS and looked up the Manual and downloaded the Chapter 15 in a PDF file and put it on my site at:**

**<http://www.donself.com/documents/MBPM-15-230.pdf>**

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**“For outpatient PT services that are provided incident to the services of physicians/NPPs, the requirement for PT licensure does not apply; all other personnel qualifications do apply. The qualified personnel providing PT services incident to the services of a physician/NPP must be trained in an accredited PT curriculum. For example, a person who, on or before December 31, 2009, graduated from a PT curriculum accredited by CAPTE, but who has not passed the national examination or obtained a license, could provide Medicare outpatient PT therapy services incident to the services of a physician/NPP if the physician assumes responsibility for the services according to the incident to policies. On or after January 1, 2010, although licensure does not apply, both education and examination requirements that are effective January 1, 2010, apply to qualified personnel who provide PT services incident to the services of a physician/NPP.”**

I replied to him, along with 5 other CMS personnel in the same CMS office:

**“Thank you and I have read Section 230.1 several times and if I am understanding it correctly, a Medical Assistant or LVN or RN cannot be the ones performing any physical therapy services (97001—97799) UNLESS they have been trained in an accredited PT curriculum.”**

He replied with more information that some may not greatly appreciate:

**“Additionally, I would bring to your attention that nearly all of the Physical Medicine & Rehabilitation services (CPT codes 97001-97799) require direct, one-on-one patient contact; not just the “Constant Attendance” modality services (97032-97039). Examples of the limited exceptions to this are the “Supervised” modalities (CPT codes 97010-97028) and CPT 97150 for group therapy where the PT (or physician) must be present with the patients/beneficiaries but need not provide one-on-one direction.”**

This clarifies that not only does the person doing the “physical medicine” service (97001—97799) must be someone that has been trained in an accredited PT curriculum but that the physician must at least “see” the patient while the patient is in the office.

**I have not seen where this will affect your non Medicare patients as CPT doesn't have anything like this and I haven't heard where any private carriers have adopted this policy either. I believe it DOES affect your Medicare patients getting Electrical Stimulation (regardless of what fancy word your sales rep called it, such as neuromuscular re-education, manual therapy, vaso-pneumatic therapy, etc...**

Since we opened the can of worms—let's also make SURE you understand that you CANNOT use 2 timed or attended codes for the same 15 minute segment, regardless of what the device salesperson says the machine does or doesn't do.

Medicare Benefit Policy Manual, 100-2, Chapter 15, sections 220 and 230 cover the timed codes.

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### **Billing - CPT Codes: Not Permitted**

*“In the same 15-minute (or other) time period, a therapist cannot bill any of the following pairs of CPT codes for outpatient therapy services provided to the same, or to different patients. Examples:*

1. *Any two CPT codes for "therapeutic procedures" requiring direct one-on-one patient contact (CPT codes 97110-97542);*
2. *Any two CPT codes for modalities requiring "constant attendance" and direct one-on-one patient contact (CPT codes 97032 - 97039);*
3. *Any two CPT codes requiring either constant attendance or direct one-on-one patient contact - as described in (a) and (b) above -- (CPT codes 97032- 97542). For example: any CPT code for a therapeutic procedure (eg. 97116-gait training) with any attended modality CPT code (eg. 97035-ultrasound);*
4. *Any CPT code for therapeutic procedures requiring direct one-on-one patient contact (CPT codes 97110 - 97542) with the group therapy CPT code (97150) requiring constant attendance. For example: group therapy (97150) with neuromuscular reeducation (97112);*
5. *Any CPT code for modalities requiring constant attendance (CPT codes 97032 - 97039) with the group therapy CPT code (97150). Forexample: group therapy (97150) with ultrasound (97035);*
6. *Any untimed evaluation or reevaluation code (CPT codes 97001-97004) with any other timed or untimed CPT codes, including constant attendance modalities (CPT codes 97032 - 97039), therapeutic procedures (CPT codes 97110-97542) and group therapy (CPT code 97150)”*

### **Billing - CPT Codes: Permitted\***

*“In the same 15-minute time period, one therapist may bill for more than one therapy service occurring in the same 15-minute time period where "supervised modalities" are defined by CPT as untimed and unattended -- not requiring the presence of the therapist (CPT codes 97010 - 97028). One or more supervised modalities may be billed in the same 15-minute time period with any other CPT code, timed or untimed, requiring constant attendance or direct one-on-one patient contact. However, any actual time the therapist uses to attend one-on-one to a patient receiving a supervised modality cannot be counted for any other service provided by the therapist.”*

So—in spite of what your equipment salesperson may have told you or your billing person to code (such as a 97112 and a 97032 for each 15 minutes), Medicare is VERY specific about what is and isn't allowed and they ARE auditing physicians. You do NOT want to be caught in an audit because it would be very easy for them to prove that you SHOULD HAVE known the correct coding, in which case they are able to assess fines and penalties in addition to the recoupment and interest.

**If this is going to make a dramatic impact on your income—please let us know, as we may be able to help. We have other services that will increase your monthly income by more than \$15K per month that Medicare does approve, and they will help save lives at the same time.**