APTA recognizes that in the above situations it may be possible to add the time spent with each individual patient and bill for these services with an appropriate one-on-one code when the one-on-one time requirements are met. This also may be the most efficient approach. However, APTA also supports the interpretation that would allow these professional services to be billed under the group code, which is an untimed code, all other requirements for professional services having been met. The duration of the group session to which the code is applied should be sufficient to ensure that professional ("skilled") services are provided.

CMS has established a correct coding initiative edit that prohibits billing for group therapy along with certain therapeutic procedure CPT codes (97110, 97112, 97116, 97140, 97530, 97532, 97533) in the same session unless a –59 modifier is used in certain settings. To be reimbursed for both services, the providers documentation must support that the group therapy and the therapeutic procedure were performed during separate time intervals.

Lastly, APTA does not interpret Transmittal 1753 as prohibiting payment for a supervised (unattended) modality and a one-on-one service being delivered to two patients in the same time interval. For example, Patient A is receiving unattended electrical stimulation at the same time as patient B is receiving therapeutic exercise.

Patient Care Scenarios

Assumptions:

- These scenarios involve Medicare patients, unless otherwise stated.
- These scenarios could only be applied if consistent with state law in the state in which they are being applied.
- According to Medicare regulations, a qualified physical therapist practitioner is a person who is licensed as a physical therapist by the State in which practicing, and who has graduated from a physical therapy curriculum approved by: 1) The American Physical Therapy Association (APTA), or 2) The Committee on Allied Health Education and Accreditation of the American Medical Association, or 3) The Council on Medical Education of the American Medical Association and the American Physical Therapy Association *[42CFR484.4]*. These regulations also identify criteria for individuals educated as physical therapists before 1966, or who were educated outside the United States. Note: A physical therapist receiving a physical therapy degree on or after January 1, 2002, requires a master's or doctoral degree from a professional physical therapy education program that has been accredited by a national accreditation agency recognized by the United States Department of Education.
- APTA defines a physical therapist as a person who is a graduate of an accredited physical therapist education program and is licensed to practice physical therapy. The terms "physical therapist" and "physiotherapist" are synonymous.
- According to Medicare regulations, a qualified physical therapist assistant is a person who is licensed as a physical therapist assistant, if applicable, by the State in which practicing, and 1) Has graduated from a 2-year college-level program approved by the American Physical Therapy Association; or 2) Has 2 years of appropriate experience as a physical therapist assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that these determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as a physical therapy assistant after December 31, 1977 *[42CFR484.4]*.
- The APTA defines a physical therapist assistant as a technically educated health care provider who assists the physical therapist in the provision of physical therapy interventions. The physical therapist assistant, under the direction and supervision of the physical therapist, is the only paraprofessional specifically educated to provide physical therapy interventions. The physical therapist assistant is a graduate of a physical therapist assistant associate degree program accredited by the Commission on Accreditation in Physical Therapy (CAPTE).
- APTA defines physical therapy aides as any support personnel who perform designated tasks related to the operation of the physical therapy service. Tasks are those activities that do not require the clinical decision making of the physical therapist or the clinical problem solving of the physical therapist assistant.
- Medicare regulations require "personal" (meaning in-room) supervision of PTAs furnishing services in private therapist practices. Medicare requires "general" supervision (meaning periodic inspection and PT availability by telecommunication) of PTAs furnishing services in skilled nursing facilities (SNF), comprehensive outpatient rehabilitation facilities, certified rehabilitation agencies, and home health agencies. Direct supervision (meaning on-premises) is required in physician practices. If states have more stringent PTA supervision regulations than Medicare, then providers must follow state regulations when furnishing services to Medicare

CPT Code 97535

Posted on June 14th, 2010 by admin in Billing and Coding, Reimbursements

Do you provide patients with information on how they should modify their normal daily activities from an ergonomic and injury prevention point of view? Can you bill patients or insurance companies for this type of work?

The answer is absolutely **YES.** You can charge patients and insurance companies for this type of service. The CPT code that most accurately describes this procedure is 97535.

CPT code 97535 is self-care/home management training (i.e., activities of daily living and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes.

This should be reported for devoting time to provide a separate and distinct procedural service to the patient for the purpose of the following:

~ Instructing the patient in managing an injury at home and preventing a secondary injury

~ Instructing the patient on how to prevent future exacerbations

Examples of ADL instruction include showing patients how to pick items off the floor, lifting pots from stove, reaching items in cupboards, opening drawers and exercises to help hasten the healing process.

Documentation for CPT code 97535 should relate the ADL instruction to the patient's expected functional goals and indicate that it is part of an active treatment plan directed at a specific goal.

Some common diagnoses codes that "link to" or "combine with" 97535 are the following:

723.4: Cervical radiculitis

724.1: Thoracic spine pain

724.4: Thoracic or lumbosacral neuritis or radiculitis, unspecified

719.7: Difficulty in walking

724.3: Sciatica

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724.6: Lumbosacral or sacroiliac pain, instability, ankylosis

I am a firm believer that if you provide a service to your patients, you should bill for that service. You should incorporate 97535 into your treatment plans if clinically indicated.

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7 Comments

Health Care Service Corporation (HCSC) (BCBS of IL, OK, NM, and TX) to cover CPT Code 97535 (ADL training)

AOTA recently received word that HCSC policy (THE803.010) is being changed to "*consider 97535 medically necessary when treatment is expected to result in significant functional improvement and the services are intended to enable a patient to perform activities of daily living.*"

HCSC's previous policy stated that "*OT or PT consisting of the following services **are considered not medically necessary:***
Training in self-care and/or home management skills (e.g., activities of daily living, compensatory training, meal preparation, safety procedures, use of adaptive equipment, etc.)

Training to facilitate reintegration into community and/or work environment (i.e., shopping, money management vocational activities, etc.)"
The new policy, as proposed by BCBS of TX, would state, "*In addition to the above criteria, OT services that **may be considered medically necessary** include treatments that are expected to result in significant functional improvement, and are for the purpose of enabling the patient to perform activities of daily living.*
*OT services that consist of non-essential, self-help, or recreational tasks **are considered not medically necessary**, including training to facilitate reintegration into community and/or work environment (i.e., shopping, money management, educational and vocational activities, gardening, driving, etc.")*

AOTA first became aware of denials of CPT codes 97535 (ADL training) and 97537 (community reintegration training) from occupational therapist in Illinois, at which time a letter was sent requesting that HCSC include these codes as covered.(http://www.aota.org/Practitioners/Reimb/News/Letters/BCBS.aspx?FT=.pdf)

After receiving a negative response, AOTA called HCSC and was told that they would reconsider the request based on evidence of medical necessity.

In March 2010, AOTA sent a second letter with evidence supporting the medical necessity of these codes (http://www.aota.org/Practitioners/Reimb/News/Letters/Follow-up-Codes.aspx?FT=.pdf) and repeatedly followed up with the HCSC medical policy medical director. In May 2011, AOTA received a letter confirming that the policy would be changed to cover 97535 but not 97537.

The HCSC Medical Policy Medical Director (BCBS of TX) posted a proposed change to the policy (as quoted above) for public comments from June 1 to 15. The comment period is now closed. This proposed change has not been posted to the Web sites in Illinois, Oklahoma, and New Mexico.

Although, AOTA is pleased that HCSC has reversed its non-coverage of ADL training, we would like to see 97537 added in the future. Also, there are a number of additional concerns about the way the policy is written.

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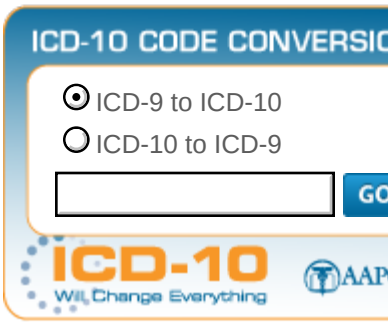

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LABELS

Coverage for chiropractic services

Community/Work Reintegration Training (CPT Code 97537)

Community reintegration is performed in conjunction with other therapeutic procedures such as gait training and self-care/home management training. The payment for community reintegration training is bundled into the payment for those other services. Therefore, these services are not separately reimbursable by Medicare.

Services, which are related solely to specific employment opportunities, work skills, or work settings are not reasonable and necessary for the diagnosis and treatment of an illness or injury and are excluded from coverage by Section 1862(a)(1) of the Social Security Act.

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LABELS: COVERAGE FOR CHIROPRACTIC SERVICES

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