

The *Misunderstood* Modality

Getting reimbursed can be difficult enough, but throw misunderstood agents into the mix, and things get even more complicated

By Jolynn Weiler

Ever see a reimbursement denial come across your desk and wonder incredulously where that claims reviewer learned about rehab?

Well, maybe he didn't.

"The people who are doing first level reviews for insurance companies often don't have a clinical or health background. They usually just have high school degrees," said Mary Lundy, MS, PT, PCS, author of *Reimbursable Documentation in Rehab: A Staff Workbook* (Harper Woods, MI: KovacekManagementServices Inc., 1998). "The people with health care backgrounds usually don't even see the records until they get to a second level review—if they get that far."

Understanding that, documentation needs to be slick if it's going to make it down the narrow chute to reimbursement. "I's need to be dotted, "T's need to be crossed, and blanks need to be filled. And that's just to get through the first level. What second level reviewers need to see is the clinical nitty gritty: the physical impairment, how it interferes with function, and what the therapist is doing about it.

Throw a modality into the mix, and things can get a little more touchy. Knowing what's going on in the minds of claims reviewers and what other PTs are doing can help, though. Before picking up that pen to document a hot pack or a half hour of electrical stimulation, take a look at what the experts say. It just might keep you, and the reviewers, from unnecessary hassle.

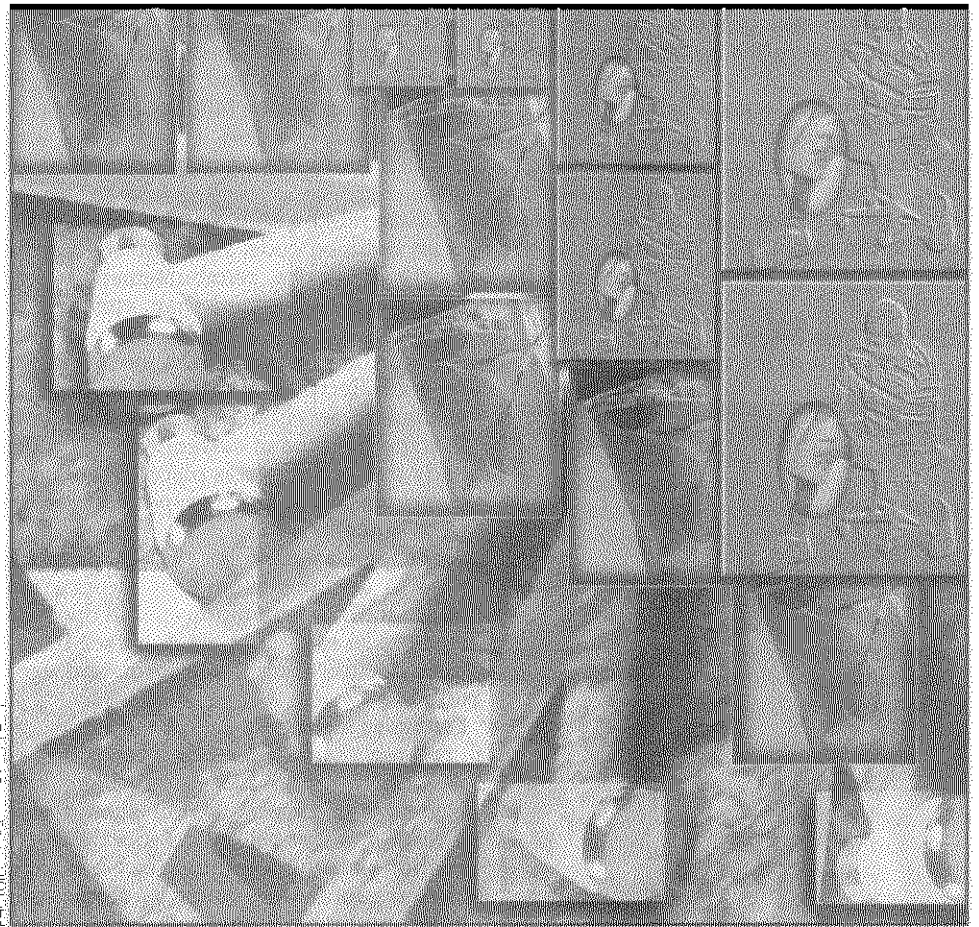
Feeling the Heat

The impression is out there. And claims reviewers, as well as PTs, are starting to react.

"I sat in a big meeting one time with a third party payer, and I heard the people who worked for this HMO say to a group of therapists, 'We want to close down the gas station PT practices,'" said Lundy. "They were talking about the places where patients would go for weeks and weeks and just get hot packs, and there would be no evidence that anybody was getting better."

Although it's a minority who abuse the system, the majority has ended up bearing the consequences. Eagle-eye claims reviewers are now quick to couple the terms "hot pack" and "cold pack" with "overuse," and billing for the modalities has undergone some change.

With its January 1997 Medicare fee schedule, the Health Care Financing Administration began bundling hot/cold >



packs with other interventions, disallowing any separate billing for the abused modalities. Instead, the relative value for applying a hot/cold pack was distributed among all 7,000-plus CPT codes. "So, in effect, the relative value for an ultrasound includes a very small part of a hot pack," explained Helene Fearon, PT, owner of Fearon Physical Therapy in Phoenix, and national lecturer on Medicare reimbursement.

Private insurers, often quick to pick up on Medicare payment policy, are also starting to say no to hot/cold pack reimbursement, even if it doesn't always follow that they, too, are bundling the modality. Since many don't use the Medicare fee schedule, reimbursement for hot/cold packs doesn't come in any form from those payers.

Is it even an issue? According to Lundy, the trend among PTs is not to bother billing for hot/cold packs anymore. Fearon acknowledged that that's the case with her practice, pointing out that therapy time and dollars can be better spent. "We feel that it's not necessarily a skilled service," she said. "It's important preparation for treatment, so we consider it part of our costs of providing care. Patients can also put heat and ice on at home, and we often instruct them to do that."

The ultimate decision to bill or not is up to the therapist, of course, and Fearon had a word of advice for those who decide to bill. "If they want to get reimbursed for moist heat or cold, then they need to document the reason they're using it, where they're placing the heat or ice, and the purpose of the treatment," she said.

The Essentials of E-Stim

A confused payer isn't really a payer at



all. So, if it's reimbursement they're after, PTs need to have a handle on the specifics, and communicate them accordingly.

This is especially true when documenting electrical stimulation, a modality that Fearon said often gets questioned. "A lot of payers confuse the different types," she said. "And a lot of times it's because the documentation they're receiving isn't all that great."

Starting at the beginning, e-stim falls into two billing categories: attended and unattended. A therapist who actively uses the modality for point stimulation or other such "hands-on" intervention, and is present with the patient throughout the service would bill for attended e-stim. Conversely, a therapist who positions and attaches electrodes to the patient, sets up the machine, leaves, and returns periodically to ensure machine settings are still correct and that the patient is still comfortable would bill for unattended e-stim.

A timed service, attended e-stim is typically billable in 15-minute units; so a therapist billing for 30 minutes would bill for two units of e-stim.

Furthermore, both codes for e-stim cover a patient's entire body. These codes both have the descriptor of one or more areas. For example, e-stim on an elbow for seven minutes and a knee for eight would comprise one billable unit, not two separate units, unless it is attended and the therapist can document two units of care.

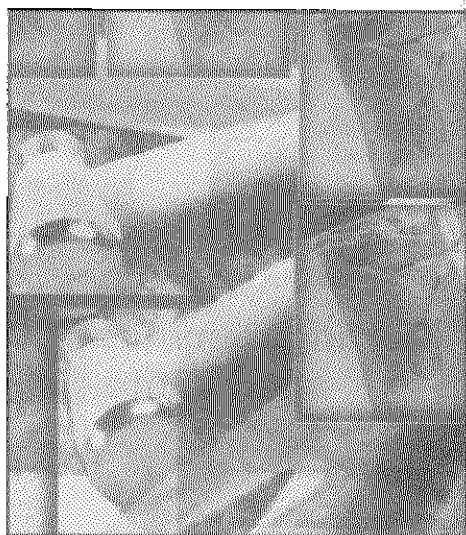
Unattended e-stim, on the other hand, is an untimed code. No matter what the length of service, reimbursement is less for unattended e-stim than attended e-stim.

According to Fearon, documenting the type of electrical stim being utilized is absolutely essential, along with details like specific type of current, where on the body the modality was placed, the reason e-stim was used, and its expected (or realized) outcome.

"People say they can't take that much time to document, but that information can literally be communicated in one sentence," she said. "But we don't see therapists documenting this information very often."

Combining Modalities

Fearon shared a couple of other tips as well. Ultrasound that goes above and beyond one 15-minute unit should also include a "why" behind it. Since the intervention usually doesn't exceed one unit, anything more than one will automatically be questioned by payers, she said.



Should a therapist combine modalities, like a hot pack and a whirlpool, the reason behind it needs to be recorded in the documentation, too.

"If you were going to use multiple heating modalities for a patient, that would be a red flag to the payer," said Fearon. "Maybe there's a good reason, but the payer will automatically look at it as duplicative or question the necessity of both interventions."

Bridging the Gap

In interviewing 15 claims reviewers for research for her book, Lundy said the No. 1 reason given for denying payment was a lack of documentation to justify what was being billed.

While solid documentation can bridge that communication gap, PTs need to keep in mind the audience they're writing for to ensure the interventions are made clear. That's especially true for modalities, given their somewhat misunderstood nature.

"We spend a lot of time in school learning about the physical properties of these modalities, and we know there is a lot of scientific physiology that goes behind them," said Lundy.

"But the people reviewing claims don't understand the level of physiological understanding that's behind the use of these agents."

It's about answering the questions before they're asked, and communicating in a way that replaces jargon with to-the-point phrases. So explain away, but don't get carried away. When it comes to documentation, direct and simple can work wonders in cutting through confusion—and turning payers back into payers. ■

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