eGlobalTech

CBR201702: Physical Therapy

Webinar Questions & Answers

March 29, 2016
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CONTENTS

INTRODUCTION

These questions were excerpted from the CBR201702: Physical Therapy (PT) webinar presented on Wednesday, March 29, 2017. You have the option to view the entire recording of the comparative billing report (CBR), listen to the audio-only version or view the webinar text. You may also open a PDF of the slides or select a specific section of the webinar. All of these options are available from the CBR website page titled **CBR201702 Webinar** (https://www.cbrinfo.net/cbr201702-webinar).

The CBR project has made every reasonable effort to ensure the accuracy of the information and web links provided in the CBR materials at the time of publication; however, Medicare policy changes frequently, so the information and links within the material may change without further notice. It is the responsibility of the provider to remain up-to-date with Medicare program requirements.

CBR materials are prepared as a service to the public and are not intended to grant rights or impose obligations. The information provided in the CBR is intended to be a general summary. It does not supersede or alter the coverage and documentation policies outlined in the Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and National Coverage Determinations (NCDs) for the Medicare Administrative Contractors (MACs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs). All coverage and documentation policies are located on the Centers for Medicare & Medicaid Services (CMS) website on the page titled **Medicare Coverage Database** (https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).

Please refer any specific questions you may have to the MAC or DME MAC for your region. We encourage providers to review the specific statutes, regulations, and other interpretive material for a full and accurate statement of their contents. A listing of all MACs can be accessed from the website of CMS at the following link: **Review Contractor Directory – Interactive Map** (http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

GENERAL

Q. Can I receive continuing education units (CEUs) for attending a CBR webinar?

A. CMS does not offer CEUs for attending CBR webinars at this time, but you may receive CEUs from some other organizations. For information related to CEUs, select this link: **Continuing Education Credits** (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Continuing-Education.html).

Q. I joined the webinar late. Can I get a copy of the slides or the recording?

A. A recording of the CBR201702 webinar, as well as the slides, are currently available on the CBR website. To access these, please visit our web page at **CBR201702 Webinar** (https://www.cbrinfo.net/cbr201702-webinar).

Q. I work in a group practice where some therapists received CBRs and others did not. Why is that if we all work for the same group?

A. Claims data reviewed for CBRs are based on the individual provider NPI, not the group NPI. CBRs were sent only to individual providers with different billing patterns than their peers. If some providers in your practice did not receive reports, it means CBRs were not created for them. If you have additional questions/concerns, please contact our CBR Support Help Desk by telephone at 1-800-771-4430 or by email at **CBRSupport@eglobaltech.com**.

Q. What are the implications of receiving this CBR for our clinic?

A. There is no assumption of wrongdoing for receiving CBR201702. This report was created to allow you to compare your billing patterns to other physical therapists in private practice. Claims data was reviewed for therapists who submitted claims with Current Procedural Terminology (CPT®) codes 97001, 97002, 97035, 97110, 97112, 97140, 97530, and HCPCS code G0283.

Q. If you get a CBR letter stating "Significantly Higher," does that automatically mean you will be audited?

A. No. The CBR team does not perform any audits of claims and does not have access to or review the medical records of beneficiaries. We do recommend, however, that providers conduct self-audits to identify any possible coverage and/or coding errors. If you would like additional information on beginning the self-audit process, please visit our CBR website page at the link titled **Self-Audit Help** (http://www.cbrinfo.net/self-audit-help.html).

Q. We received CBR reports for two providers who are no longer on our staff and were not on staff during the time frame the data covers. Can you explain why we received reports for these individuals?

A. Please return or shred the letters you received and contact our office with the names of the providers who are no longer employed by your practice. The providers in question may not have updated their contact information since leaving your practice. CBRs are faxed to the numbers or mailed to the addresses that are listed in the CMS National Plan and Provider Enumeration System (NPPES). If you have additional questions/concerns, you may contact the CBR Support Help Desk by telephone at 1-800-771-4430 or by email at **CBRSupport@eglobaltech.com.**

Q. Are these reports used for anything other than informational?

A. No. Each CBR is private and is sent only to the individual provider. It is not shared with the MAC, the OIG or the general public. However, CMS has contracted with the CBR team for this service and does receive reports on the analyses. CMS also has the ability to request additional information as necessary.

Q. Is there any place we can see our charges for the CPT® codes for our area? We want to ensure our rates are comparable.

A. To view the results of the analyses for each state and the nation, please select the following link: **CBR201702 Statistical Debriefing** (https://www.cbrinfo.net/cbr201702-statistical-debriefing.html).

Q. What do we need to do if we did not receive a CBR letter?

A. There are no additional steps necessary whether you received a CBR or did not receive a CBR. We have faxed or mailed CBRs to all providers who were selected to receive CBR201702: Physical Therapy. If you did not receive a report, it is likely that a CBR was not created for you. You can, however, download a sample CBR by visiting the following page: **CBR201702 Sample CBR** (https://www.cbrinfo.net/cbr201702-sample-cbr). If you have additional questions, please contact the CBR Support Help Desk by email at **CBRSupport@eglobaltech.com** or by telephone at (800) 771-4430.

Q. Where was the information obtained in the CBR?

A. Claims with the CPT® and HCPCS codes covered in CBR201702 were obtained from the CMS Integrated Data Repository (IDR). The analyses were based on claims for services rendered from July 1, 2015 to June 30, 2016. For information on the IDR, please visit the link titled, **CMS Integrated Data Repository (IDR)** (https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/IDR/index.html).

Q. Do you have a copy of a completed initial evaluation and also a progress note that we can bring to the physical therapy department to teach them correct documentation issues?

A. Documentation requirements for therapy services are listed in the *Medicare Benefit Policy Manual.* Documentation should include an initial evaluation, plan of care, certification of the plan by a physician/nonphysician practitioner (NPP), progress notes and treatment notes. For more documentation details, please select the following link: ***Medicare Benefit Policy Manual* (Chapter 15, Section 220.3)** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf).

Q. Is this webinar addressing both inpatient and outpatient?

A. CBR201702 webinar focused on physical therapists in private practice (specialty 65) who submitted claims for Medicare Part B services using the PT codes covered in this CBR. The place of service submitted on the claim was not factored into this analysis.

Q. To clarify, were ICD-10 codes considered as part of this CBR process?

A. No. ICD-10 codes were not included in the CBR201702 analyses.

Q. Was there any consideration given to the diagnoses treated when comparing utilization between clinicians?

A. For CBR201702, claims data was reviewed for physical therapists in private practice (specialty 65) who submitted claims with CPT® codes 97001, 97002, 97035, 97110, 97112, 97140, 97530 and HCPCS code G0283.

Q. Did this CBR report go to all outpatient physical therapists?

A. No. CBRs were sent to 15,000 physical therapists in private practice. We selected the recipients by analyzing paid claims data to determine which providers were billing differently than their peers.

Q. Are there potential issues for a practice located close to senior communities versus a more generalized population?

A. CBR measures were compared to providers by the practice location state and the nation. No further location statistics were analyzed in this study. CBR201702 examined the percentage of beneficiaries whose claims were submitted with the KX modifier, the average minutes of

therapy per visit, and the average allowed charges per beneficiary. If interested in viewing the results for each state and the nation, please select the following link: **CBR201702 Statistical Debriefing** (https://www.cbrinfo.net/cbr201702-statistical-debriefing).

Q. Is it taken into account in your reporting that the percentage of our Medicare patients in our clinic are more than half our business and are more complex?

A. Please remember that receiving a CBR is not necessarily indicative of any billing errors on your part. We realize that some patients require more care than others, and there may be legitimate reasons that your billing is different than that of your peers. For this reason, we encourage you to perform a self-audit of claims to verify that you have the documentation to support your billing. Information to assist you with beginning a self-audit process is found on the CBR web page at the link titled, **Self-Audit Help** (http://www.cbrinfo.net/self-audit-help.html).

Q. Will we receive a new CBR next year? If so, will it have a comparison of results from this year to next year?

A. A decision has not yet been made regarding a repeat of the physical therapy CBR in 2018; however, CMS sends announcements about CBR topics through its Listserv. Providers can sign up to receive announcements by inserting their email address in the box marked, **"Receive Email Update"** at the bottom right of the following website link: **Listserv** (https://www.cms.gov/Medicare/Coverage/InfoExchange/listserv.html). Announcements are also made via social media.

Q. After receipt of a CBR, is the practitioner expected to take steps to improve CBR results?

A. CMS does not expect a reply from a provider to a CBR. The purpose of CBRs is to allow providers to compare their billing to that of their peers. It may be advantageous for a provider to perform self-audits to ensure their billing and coding patterns are in compliance with Medicare guidelines. Resources that may be helpful are available on the CBR web link: **Self-Audit Help** (http://www.cbrinfo.net/self-audit-help.html).

Q. Does the CBR take into account geographic cost regions and differences in CPT® code payment amounts based on where you are located? Could this impact your average cost?

A. Medicare Physician Fee Schedule (MPFS) amounts for CPT® codes vary from area to area. Medicare has developed a geographic practice cost index (GPCI) to account for the variation in

practice expenses for states and the nation. More information on the GPCI is available on the following CMS link: **Documentation and Files - National Physician Fee Schedule and Relative Value Files** (https://www.cms.gov/apps/physician-fee-schedule/documentation.aspx).

Q. Are state and national data available for those of us who aren't eligible for a CBR but would still like to do a self analysis and compare against the data used in the CBR?

A. To review the data on physical therapy for each state and the nation, please select the following web link: **CBR201702 Statistical Debriefing** (https://www.cbrinfo.net/cbr201702-statistical-debriefing). In addition, we recommend that providers review representative samples of their claims on a regular basis to ensure proper coding, billing and documentation. If you need assistance with beginning your own self-audit process, please select the following web link: **Self-Audit Help** (http://www.cbrinfo.net/self-audit-help.html).

Q. Is there an example of an ABN form for a patient to fill out in the clinic? I need more clarification on that subject?

A. Providers may issue an Advance Beneficiary Notice (ABN) Form CMS-R-131 to Medicare beneficiaries before rendering services to advise them that Medicare may deny payment for a service/item because it is not covered or medically necessary. The ABN gives a beneficiary the chance to decide whether to get the service (which may not be covered) and accept financial responsibility. If the beneficiary does not get written notice (ABN) before receiving the service, the provider may be financially liable if Medicare does not pay. Please be aware that the ABN has been revised (effective 6/21/2017) to inform beneficiaries of CMS nondiscriminaton practices. If needed, beneficiaries can request the ABN in an alternative format. More detailed instructions about the ABN are available at the following web links:

- **Fee-For-Service ABN** (https://www.cms.gov/MEDICARE/medicare-general-information/bni/abn.html)
- **Medicare Advance Beneficiary Notice** (https://www.cms.gov/Outreach-and EducationMedicareLearning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf)

CLINICAL AND BILLING

Q. We treat a high population of unhealthy individuals. Are we supposed to stop treating patients prior to reaching the KX modifier?

A. The CBR team recognizes that billing patterns can differ for many reasons. One of those may be because you are treating a higher number of beneficiaries with severe illnesses. If the therapy cap has been met and additional services are needed, the KX modifier should be appended to the claim to show a therapy cap exception, along with documentation to support medical necessity. More information on the KX modifier can be found at the link, ***Medicare Claims Processing Manual,* Chapter 5, Section 10.3.3** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf).

Q. Are diagnosis codes being considered for post-op patients in this CBR?

A. No, diagnosis codes were not considered for post-op patients in CBR201702. The focus of this report was on physical therapists in private practice who submitted claims with procedure codes 97001, 97002, 97035, 97110, 97112, 97140, 97530, and G0283. A sample report is available for review on the CBR website at **CBR201702 Sample CBR** (http://www.cbrinfo.net/cbr201702-sample-cbr).

Q. When a provider's average charges are higher than the state's average, is it taken into consideration that the patient may have attended more visits and improved in our facility and did not need to go for injections etc., at another facility?

A. Practice patterns can differ for various reasons, which may include geographic location and patient acuity levels. Some practitioners have sub-specialties or distinctive focuses that are not apparent in claims data. If your CBR shows your utilization differs significantly from your peers and you don't know the reasons, you may want to choose a few charts that are representative of your normal utilization and perform a self-audit using the information we provided. If you need assistance with beginning an audit process, please visit the following CBR website: **Self-Audit Help** (http://www.cbrinfo.net/self-audit-help).

Q. If we typically see patients two times per week, our time with the patient is going to usually be longer than patients we see three times weekly. Why do we get penalized for this difference in practice when the overall time per week is less than three times?

A. Receiving a CBR is not punitive and it does not necessarily mean that anything is wrong with the way you are billing for physical therapy services. You received a CBR because your billing is different from the peers in your state and the nation. Please be aware that we did not review any of your medical records or identify any overpayments. If you have additional questions and/or concerns about your CBR, please contact the CBR Support Help Desk by telephone at 1- 800-771-4430 or by email at **CBRSupport@eglobaltech.com**.

Q. Are CBRs available for therapy providers in skilled nursing facilities (SNFs), or a CBR comparing billing of small and large physician owned practices?

A. At this time, we do not have a CBR addressing physical therapists based in SNFs; nor do we have CBRs addressing billing differences between large and small practices or physician owned practices. We are always open to topic suggestions. To stay informed about upcoming CBR topics, please sign up to receive announcements at the CMS website link: **Listserv** (https://www.cms.gov/Medicare/Coverage/InfoExchange/listserv.html).

Q. Does a signed plan of care from a physician supersede/ replace the need for a prescription?

A. The *Medicare Benefit Policy Manual* states "Although there is no Medicare requirement for an order, when documented in the medical record, an order provides evidence that the patient both needs therapy services and is under the care of a physician." Additionally, CGS Administrators LCD L34049 states "Orders (sometimes called referrals) and certifications are common means of demonstrating such evidence of physician involvement…**Certification, which is a coverage condition for therapy payment**, requires a dated physician/NPP signature on the therapy plan of care or some other document that indicates approval of the plan of care. A certification often differs from an order or referral in that it must contain all required elements of a plan of care." Payment is based on the certification of the plan of care, not the order. An order is not required but helps established that the beneficiary is under the care of a physician. For detailed information, see the following web links:

- ***Medicare Benefit Policy Manual* Chapter 15, Section 220.1.1** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf)
- **CGS Administrators LCD L34049** (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34049&ver=18&Date=10%2f01%2f2015&DocID=L34049&bc=iAAAABAAIAAAAA%3d%3d&)

Q. How often do you need to get a new plan of care signed by the referring physician?

A. A plan of care may be certified for a maximum of 90 calendar days from the date of the initial treatment. Should the patient require continued therapy, recertification would be necessary. Recertification of the plan is needed for a significant modification to the therapy or at least every 90 days. Detailed information is available at the following link: ***Medicare Benefit Policy Manual,* Chapter 15, Section 220.1** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf).

Q. We have PT with a patient who had total knee surgery; however, after releasing the patient from care, the physician signed a progress note to continue treating the patient twice weekly for three weeks. Do we need to discharge the patient since the MD released patient?

A. The CBR team recommends that you contact your MAC regarding your question, as we do not review medical records or offer medical advice; however, Title 42 of the Electronic Code of Federal Regulations (e-CFR) states one of the conditions for therapy services is that the "services are or were furnished while the individual is or was under the care of a physician." Please refer to the following links for additional information:

- **Title 42 e-CFR 424.24(c)** (https://www.ecfr.gov/cgi-bin/text-idx?SID=e6623f300177053c2a2d0e5b8f918436&mc=true&node=se42.3.424_124&rgn=div8)
- ***Medicare Benefit Policy Manual* Chapter 15, Section 220.1.1** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf)

Q. Does the CBR consider when clinicians are using the KX modifier as the result of the cap being exhausted at a different provider?

A. The CBR only considers whether a beneficiary is indicated with the **KX** modifier on claims, submitted by the current rendering provider. It does not consider that the limit was exhausted by a different provider. We suggest that you review your records and ensure that the services are medically necessary and justification is in the medical record.

Q. If CPT® code 97163 requires 45 minutes face-to-face time and I see this patient for 60 minutes, can I then bill 1 additional unit that day?

A. National Government Services (NGS) gives the following guidance about billing in LCD L33631: "Do not bill for a therapy initial evaluation for each therapy discipline on more than one date of service. If an evaluation spans more than one day, the evaluation should only be

billed as one unit for the entire evaluation service (typically billed on the day that the evaluation is completed). Do not count as therapy 'treatment' the additional minutes needed to complete the evaluation during the subsequent session(s)." For additional details, see the following web link: **NGS LCD L33631** (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspxLCDId=33631&ver=18&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord = physical+therapy&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAAAAAAA%3d%3d&).

Q. Is documentation the only defense for patients that come back? For example, what if a patient has right total knee arthroplasty (TKA) in the spring and left TKA in the fall, or two other separate medical problems requiring therapy?

A. Medicare pays for covered services that are billed correctly with documentation supporting medical necessity. According to CMS, the Medicare Access and Chip Reauthorization Act of 2015 (MACRA) "modified the requirement for manual medical review for services over the $3,700 therapy thresholds. MACRA eliminated the requirement for manual medical review of all claims exceeding the thresholds and instead allows a targeted review process. MACRA also prohibits the use of Recovery Auditors to conduct the reviews. CMS has tasked Strategic Health Solutions as the Supplemental Medical Review Contractor (SMRC) with performing this medical review on a post-payment basis." More information is available at the following link: **Therapy Cap-Manual Medical Review of Therapy Claims Above the $3,700 Threshold** (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/TherapyCap.html).

Q. My electronic medical record (EMR) automatically applies the KX modifier after billed charges exceed the Medicare cap. This amount is obviously not the amount paid out by Medicare, so should I have that fixed? Does my application of the KX modifier hurt me in the end?

A. According to the *Medicare Claims Processing Manual,* "When exceptions are in effect and the beneficiary qualifies for a therapy cap exception, the provider shall add a KX modifier to the therapy HCPCS code subject to the cap limits. The KX modifier shall not be added to any line of service that is not a medically necessary service." Appending the KX modifier when the therapy cap has not been reached is considered incorrect coding. To view additional details, select the following link: ***Medicare Claims Processing Manual,* Chapter 5, Section 10.3.3** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf).

Q. If a beneficiary has multiple visits, with only one visit with a KX modifier, is that patient counted the same as patients with higher visit counts with the KX modifier?

A. Yes. Once the beneficiary has reached the cap and the KX modifier is used, then the beneficiary is considered to have exceeded the therapy cap.

Q. Could 2 units be 30 minutes or up to 23 minutes?

A. A chart in CGS Administrators LCD L34049 can be utilized to determine the total allowable units based on the **Timed Code Treatment** minutes. LCD L34049 states: "The first step when billing timed CPT® codes is to total the minutes for all timed modalities and procedures provided to the patient on a single date of service for a single discipline. For example, a patient under an OT plan of care receives skilled treatment consisting of 20 minutes of therapeutic exercise (CPT® 97110) and 20 minutes of self-care/home management training (CPT® 97535). The total **Timed Code Treatment Minutes** documented will be 40 minutes. In addition, the combined time of 40 minutes will determine the total number of timed code OT units that shall be billed for the day. Whether a single timed code service is provided, or multiple timed code services, the skilled minutes documented in **Timed Code Treatment Minutes** will determine the number of units billed." For additional guidance, select this web link: **CGS Administrators LCD L34049** (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34049&ver=18&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord= physical +therapy&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAAAAAAA%3d%3d&).

Q. What conclusion would you draw if a provider had low KX modifier utilization?

A. A low percentage of beneficiaries with the KX modifier would indicate that the provider is seeing fewer beneficiaries who are over the therapy cap. The CBR does not attempt to explain reasons for the variations among providers, but does provide information so a provider can see how he/she compares to his/her peers on the selected metrics.

Q. What are the expectations for the number of units/visit for physical therapy?

A. A therapy session should rarely be longer than 30 to 60 minutes unless it involves an evaluation. If longer sessions are required, there must be documentation of the medical necessity for the longer duration. Some codes may only be billed once a day while other codes may be billed up to two or four times in one day. Again, the documentation should support the medical necessity. Additional information is available at this web link: **CGS Administrators LCD L34049** (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34049&ver=18&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord= physical +therapy&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAAAAAAA%3d%3d&).

Q. How should I handle billing for patients 75 – 95 years old who require significantly more visits and time? I would like to see peer group with additional filters added for statistical purposes.

A. Based on the ages of your patient population, it appears that your practice patterns could differ from your peers; however, age group is not one of measures for this CBR201702. This CBR is an analysis of the different billing patterns among physical therapists in private practice. If your CBR shows your utilization differs significantly from your peers and you don't know the reasons, you may want to choose a few charts and perform a self-audit. If you need assistance with beginning an audit process, please visit the following CBR website: **Self-Audit Help** (http://www.cbrinfo.net/self-audit-help).

Q. What exactly do you mean by a delayed certification, and what are the time frames for this?

A. Certification is considered timely when it is signed by a physician/NPP within 30 days of the initial treatment plan. CMS guidelines state the following: "Delayed certification and recertification requirements shall be deemed satisfied where, at any later date, a physician/ NPP makes a certification accompanied by a reason for the delay. Additional guidance on delayed certification is found at the following link: ***Medicare Benefit Policy Manual,* Chapter 15, Section 220.1.3** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf).

Q. Can Physician Assistants sign a plan of care?

A. According to the *Medicare Benefit Policy Manual,* a physician or NPP may certify the plan of care. The service must be within the scope of practice for a NPP in the State in which he/she practices and it must be medically necessary. The *Medicare Benefit Policy Manual* states that a physician must establish a plan of care in a comprehensive outpatient rehabilitation facility (CORF), as the "CORF services benefit does not recognize an NPP for orders and certification." For more details about the plan of care, select this web link: ***Medicare Benefit Policy Manual,* Chapter 15, Section 220.1** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf).

Q. Is it appropriate for physical therapists to use both CPT® codes 97116 and 97530?

A. Yes. Physical therapists can bill CPT® code 97116 (gait training) and therapeutic activity (CPT® code 97530).

Q. If all of our tables do not exceed the comparisons, except the total allowed charges table, is it taken into consideration that the patient may be receiving beneficial relief more frequently instead of incurring more charges/services such as injections somewhere else?

A. Showing significance in a measure is not an indication of wrong doing. The CBR is educational and allows the provider to see areas where their billing practices are different than their peers. It is suggested that you conduct a self-audit in order to understand if your billing is being done according to the guidelines.

Q. Is there a limitation on how often a patient is eligible for evaluation? Is it 90 days between evaluations?

A. Continuous assessment of a beneficiary's progress is not considered a reevaluation and is not separately payable. Documentation must support the need for further testing after the initial evaluation. Some reasons a reevaluation would be warranted include new clinical findings, failure to respond to the therapeutic interventions in the plan of care or a significant change in the beneficiary's condition. Additional information can be found in the ***Medicare Benefit Policy Manual,* Chapter 15, Section 220.1** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf).

Q. When it comes to beneficiaries with KX modifiers, did you take into account Direct Access clinics as opposed to clients who are under a physician's care who might have more of a complicated history?

A. The CBR team is aware that practice patterns differ for various reasons, including geographic location and patient acuity levels. Some practitioners have sub-specialties or distinctive focuses that aren't apparent in claims data. Other providers practice in rural or under-served, urban areas where they may see a higher proportion of illnesses in Medicare beneficiaries. The CBR is educational and allows the provider to see areas where their billing practices are different than their peers. It does not indicate any wrongdoing.

Q. Is it your suggestion to have an ABN signed at all PT visits if it can be reasonably expected that the PT maximum will be reached while carrying out the PT plan of care?

A. Each provider must decide whether to give a patient an ABN. This form can be signed by Medicare beneficiaries before treatment to advise them that Medicare may not pay for services/items that are not covered or medically necessary. If the provider does not give a beneficiary an ABN prior to receiving services, the provider could be financially liable if Medicare does not pay the services provided. For complete information about the ABN, please select the following web links:

- **Fee-For-Service ABN** (https://www.cms.gov/MEDICARE/medicare-general-information/bni/abn.html)
- **Medicare Advance Beneficiary Notice** (https://www.cms.gov/Outreach-and EducationMedicareLearning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf)

Q. Do the new evaluation code guidelines consider time as a reference and not a requirement?

A. Yes. Effective January 1, 2017, CPT® code 97001 for PT evaluation was replaced by three new codes. Typical face-to-face times for PT evaluations for the new codes are:

- **20 minutes for CPT® 97161** – low complexity
- **30 minutes for CPT® 97162** – moderate complexity
- **45 minutes for CPT® 97163** – high complexity

In addition, CPT® code 97002 was replaced by new CPT® code 97164 for PT reevaluation. The new PT codes require the **"GP"** modifier. Please review the following American Physical Therapy Association (APTA) document for detailed information: **Quick Guide to the 3 Levels of Physical Therapy Evaluation** (http://www.apta.org/uploadedFiles/APTAorg/Payment/Reform/NewEvalCodesQuickGuide.pdf).

Q. Why were these eight codes chosen to review?

A. CBR201702 is a repeat of CBR201511: Physical Therapy that was disseminated in November, 2015. We selected the same codes for both CBRs to determine if changes have occurred in the billing patterns of physical therapists in private. The results of both CBRs can be reviewed at the web page link titled **All CBR Releases** (https://www.cbrinfo.net/all-cbrs.html).

Q. Does illegible flow sheets/documentation typically lead to incomplete or insufficient marks from CMS?

A. Many claim denials occur because providers do not submit sufficient documentation or the documentation submitted is illegible. In order for reviewers to determine medical necessity and compliance with Medicare regulations, the documentation must be present and legible.

For additional guidance, see the *MLN Matters®* publication titled **Importance of Preparing/ Maintaining Legible Medical Records - MLN Matters Number: SE1237** (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1237.pdf).

REPORT SPECIFICS

Q. How do the average charges compare to the Medicare fee schedule?

A. The average charges measurement is per beneficiary for the entire year. Therefore, it also takes into account not only the charges on each visit, but also the number of visits by each beneficiary. Variations may very well be justifiable due to location or other supporting documentation. For more information on the fee schedule, please visit the CMS website at the link, **Physician Fee Schedule Look-Up Tool** (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSLookup/index.html).

Q. Does this report take into consideration variations among therapy specialties? For instance I am the only hand PT in KS, so of course I bill orthoses at a higher rate than my peers.

A. Differences in specialties are not taken into account. There are many possible valid reasons for a provider to bill differently from their peers. The CBR highlights areas where there are differences with your peers and allow you to review your processes to understand why you are different.

Q. How many providers from CBR201702 were in the first sampling from CBR201511?

A. A total of 8,085 PT providers received CBR201511, and of those, we selected 6,233 providers to receive CBR201703. Both CBRs can be accessed at this CBR link: **All Webinars** (https://www.cbrinfo.net/all-webinars.html).

Q. Can you explain how the beneficiary count was achieved in Table 2? The total seems different from CPT® codes 97001 and 97002 counts.

A. The number of visits and beneficiaries are unduplicated counts for each row (specific CPT®/HCPCS code) and the total. A beneficiary receiving multiple services in the list would be counted in the beneficiary count in each applicable row; however, this beneficiary would be

counted only once in the total row. To review an example, please select the following web link: **CBR201702 Sample CBR** (https://www.cbrinfo.net/cbr201702-sample-cbr).

Q. Can you please define significantly higher and higher one more time?

A. Your metrics were compared to your state and the nation, using either the chi-square or t-test at the alpha value of 0.05. There are four possible outcomes for the comparisons between the provider and the peer groups:

- **Significantly Higher** is displayed if the provider's value is higher than the value of the peer group and the statistical test used confirms significance.
- **Higher** is displayed if the provider's value is higher than the value of the peer group, but the statistical test does not confirm significance.
- **Does Not Exceed** is displayed if the provider's value is not higher than the value of the peer group.
- **N/A (Not applicable)** is displayed if the provider does not have sufficient data for comparison.

It is important to note that significance is based on the total number of charges, services, visits, or beneficiaries and the variability of those values.

Q. If we are ranked as higher or significantly higher for the average allowed charges per beneficiary, does that mean we should change our fee schedule?

A. Not necessarily. Average charges per beneficiary are for the entire year, which includes multiple visits for many beneficiaries. This measure is meant to show an overall utilization of these services. We would suggest you conduct a self audit to understand what is causing your total to be significantly higher than your peer group. If you need assistance with beginning an audit process, please visit the CBR website at **Self-Audit Help** (http://www.cbrinfo.net/self-audit-help).

Q. What conclusions would you draw if a provider had high KX modifier utilization but low average charges/beneficiaries?

A. A significantly higher percentage of beneficiaries with the KX modifier means that a larger percentage of your beneficiaries have exceeded the therapy cap, but have been given services that are medically necessary and justification is in the medical record. This percentage does not take into account the type or quantity of services administered at the time of the visit. The average charges per beneficiary takes into account the frequency of the visits, the type of visits, and the fee schedule that is relative to your locality.

Q. Why are allowed charges included since the GPCI varies by locality? What do you suggest we do if we are compared as higher or significantly higher for the average allowed charges per beneficiary?

A. The geographic practice cost index (GPCI) is applied in the calculation of fee schedule payments and accounts for the variations of amounts paid in different states and the nation. Average allowed charges per beneficiary are for the entire year, which includes multiple visits for many beneficiaries. This measure is meant to show an overall utilization of these services. We suggest that you conduct a self-audit to understand what is causing your total to be significantly higher than your peer group. For information on the GPCI and on conducting a self-audit, see the following web links:

- **Self-Audit Help** (http://www.cbrinfo.net/self-audit-help)
- **Documentation and Files - National Physician Fee Schedule and Relative Value Files** (https://www.cms.gov/apps/physician-fee-schedule/documentation.aspx)

Q. How were the 15,000 chosen and is there a follow up study planned for those of us chosen?

A. The 15,581 providers were chosen because they were significantly higher than their peers in at least one of the comparisons. Additionally, these providers had at least 50 distinct beneficiaries and at least $30,000 in allowed charges for the CPT® codes included in this CBR. CBR201702 is a follow up from CBR201511. There are no immediate plans to conduct an additional follow up study at this time.

Q. Why is this statistical analysis considered reasonable?

A. This report is informational only and provides comparison of the provider and their peers. It allows the provider to see places where their billing pattern is different than their peers. No statistical analysis can account for all of the variations seen in an individual provider's practice. This analysis provides a set of measures and comparisons that will allow the provider to see differences and serve as a starting point for self-analysis to ensure that your billing practices are correct and in line with Medicare guidelines.

Q. For the average national total billing per patient, how do you account for the different reimbursements by locality?

A. Average allowed charges per beneficiary are for the entire year, which includes multiple visits for many beneficiaries. This measure is meant to show an overall utilization of these services. We would suggest you conduct a self audit to understand what is causing your total to be significantly higher than your peer group. The national measure is not adjusted for locality; however, the state measure will account for this somewhat.

Q. How do you know if a procedure was done in 10 minutes or 12 minutes or 15 minutes? I understand that the calculations were done assuming everyone used 15 minutes for the procedures.

A. We understand that these services represent a range of times. Unfortunately, the CBR team only has access to the claims data and not supporting documentation. Fifteen minutes was used as a standard length of time for comparison purposes.

Q. Is there any accommodation made for usage comparisons for more areas with higher allowable amounts like Northern NJ?

A. The state comparison accounts for this somewhat, in that it narrows the geography to NJ. The national comparisons are not adjusted by locality.

Q. Are there averages for Table 2 (i.e. charges, services, total visits & beneficiaries)?

A. In the interest of space, the average utilization by state and the nation are not provided in the CBR. However, the averages and percentages for each of the metrics provided in Tables 3-5 are available for each state and the nation on the CBR website at **CBR201702 Statistical Debriefing** (https://www.cbrinfo.net/cbr201702-statistical-debriefing).

Q. What does it mean if I was significantly higher in average minutes but did not exceed charges per beneficiary? Can I relate the two and say that I'm under-billing, or are the two not related?

A. For an individual visit, these measures would relate. In the CBR, the average minute per visit, which is calculated from the services is on a "per visit" basis. The average charge per beneficiary is on an annual basis. In this case, it would be possible that you may be seeing the patients for longer times per visit, but for less visits than your peers.

Q. Under the amount billed portion, I was well below the national and state average in this category. So, it seems that this would indicate that I am providing more for less and saving money in the end. Any input about this?

A. Average allowed charges per beneficiary are for the entire year, which includes multiple visits for many beneficiaries. This measure is meant to show an overall utilization of these services, which in your case was lower than your peer groups, which could be a good thing. Since you received the CBR, you were shown to be significantly higher in at least one of the other measures. You may want to conduct a self-audit of your claims to understand why that area is higher. If you need assistance with beginning an audit process, please visit the CBR website at **Self-Audit Help** (http://www.cbrinfo.net/self-audit-help).

Q. What conclusion would you draw if a provider had high or significantly higher average minutes/visit?

A. This shows that you are billing more time-related services than your peers. We would suggest that you review your billing to ensure you are billing correctly. There are many possible reasons why you might be spending more time with your patients at each visit and you are different than your peers on this measure. We would suggest you conduct a self-audit to ensure that you are using best practices. We can not stress enough that billing differently than your peers does not necessarily indicate any wrongdoing. See the following web link for audit assistance: **Self-Audit Help** (http://www.cbrinfo.net/self-audit-help).

Q. Can you explain why an average time of 47.97 minutes versus a national average of 45.67 minutes is considered significantly higher when it falls within the same range for number of allowable billed units?

A. The CBR report is an educational tool designed to provide information to you on how you compare to your peers on these selected metrics. Receiving the CBR does not indicate any wrong-doing.

Q. Do charges per beneficiary take into account if a patient is seen multiple times in the year for different diagnosis, body parts, etc.?

A. Average allowed charges per beneficiary are for the entire year, which includes multiple visits for many beneficiaries. This measure is meant to show an average of the overall utilization of all of the services that you have provided to your beneficiaries. It does not adjust for different patient acuity levels.

Q. Why is it statistically valid to consider a solo practitioner a "peer" to a practitioner in a large practice? Many larger groups have visit quotas for PTs, which can be substantially different than what a solo practitioner will do.

A. The CBR team is aware that practice patterns differ for various reasons, including geographic location and patient acuity levels. Some practitioners have sub-specialties or distinctive focuses that aren't apparent in claims data. Other providers practice in rural or under-served, urban areas where they may see a higher proportion of sicker Medicare beneficiaries.

Q. Could you explain slide 40 from the webinar presentation regarding the number of claim lines?

A. The statistical test used to compare these percentages is the chi-square test and it is very sensitive to the sample size. This means that large differences in percentages often do not show significance when the sample size is small, and very small differences in percentages may show as significant for large sample sizes. The more data that you have, the less likely the measure occurs by chance. In general, the more data you have for this measure, the more precise the test can be. To listen to a recording of the CBR201702 webinar, select the following web link: **CBR201702 Webinar** (https://www.cbrinfo.net/cbr201702-webinar).

Q. Is the calculation in Table 5 due to over charging per visit or too many visits?

A. Average allowed charges per beneficiary are for the entire year, which includes multiple visits for many beneficiaries. This measure is meant to show an overall utilization of these services. It could be an indicator of either over charges per visit or too many visits. We would suggest that you review your billing practices to understand this pattern and ensure you are meeting the guidelines. For information on conducting a self-audit, see the following web link: **Self-Audit Help** (http://www.cbrinfo.net/self-audit-help).

Q. What are the reasons that New Jersey, New York and Maryland measure highest among the states?

A. We did not attempt to provide any assumptions or reasons for variation among the states; however, the Medicare fee schedule amounts are adjusted according to practice costs in an area. Information on the fee schedule is available at **Documentation and Files - National Physician Fee Schedule and Relative Value Files** (https://www.cms.gov/apps/physician-fee-schedule/documentation.aspx).

Q. If my average minutes per visit are significantly higher, does that mean I am providing more units to the patient?

A. Yes. The minutes are calculated from the billing of services. In this case, what is measured is equivalent to the number of services billed per visit (for the codes indicated) multiplied by 15 minutes.

REFERENCES

CBR201702 Webinar (https://www.cbrinfo.net/cbr201702-webinar)

Medicare Coverage Database (https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx)

Review Contractor Directory – Interactive Map (http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/)

Continuing Education Credits (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Continuing-Education.html)

Self-Audit Help (http://www.cbrinfo.net/self-audit-help.html)

CBR201702 Statistical Debriefing (https://www.cbrinfo.net/cbr201702-statistical-debriefing.html)

CBR201702 Sample CBR (https://www.cbrinfo.net/cbr201702-sample-cbr)

CMS Integrated Data Repository (IDR) (https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/IDR/index.html)

***Medicare Benefit Policy Manual*, Chapter 15, Section 220** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf)

Listserv (https://www.cms.gov/Medicare/Coverage/InfoExchange/listserv.html)

Documentation and Files - National Physician Fee Schedule and Relative Value Files (https://www.cms.gov/apps/physician-fee-schedule/documentation.aspx)

Medicare Advance Beneficiary Notices (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf)

***Medicare Claims Processing Manual*, Chapter 5, Section 10.3.3** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf)

CGS Administrators LCD L34049 (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34049&ver=18&Date=10%2f01%2f2015&DocID=L34049&bc=iAAAABAAIAAAAA%3d%3d&)

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NGS LCD L33631 (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33631&ver=18&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=physical+therapy&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAAAAAAA%3d%3d&)

Therapy Cap-Manual Medical Review of Therapy Claims Above the $3,700 Threshold (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/TherapyCap.html)

Quick Guide to the 3 Levels of Physical Therapy Evaluation (http://www.apta.org/uploadedFiles/APTAorg/Payment/Reform/NewEvalCodesQuickGuide.pdf)

All CBR Releases (https://www.cbrinfo.net/all-cbrs.html)

Importance of Preparing/Maintaining Legible Medical Records - MLN Matters Number: SE1237 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1237.pdf)

Physician Fee Schedule Look-Up Tool (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSLookup/index.html)

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