Therapy Coding in Long-Term Care Facilities

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Patients or residents are admitted to long-term care (LTC) facilities for a variety of reasons. While there, many receive some type of therapy, from physical to speech, during their stay. This article reviews the various procedures that may be provided to a resident at an LTC facility as well as Medicare's reinstated financial limitations.

Physical and Occupational Therapy

Physical therapy is a common service provided in LTC facilities. Before services can begin, residents must undergo a comprehensive initial evaluation. The service is reported with CPT code 97001. It includes, but is not limited to, tests and measures such as taking the resident's history and reviewing various systems such as blood pressure, heart rate, and gross range of motion. The tests and measures depend upon the reason for the therapy, but they may include areas such as gait and locomotion during functional activities or body mechanics during self-care. The evaluation is used to develop a plan of care for managing the resident's treatment.

The plan of care is developed before therapy sessions begin and should include the type of therapy medically necessary, frequency and duration of therapy sessions, and the resident's diagnosis and anticipated goals. For Medicare requirements, the plan needs to be reviewed and updated every 30 days. A resident may be re-evaluated at any time during treatment.

The re-evaluation is reported with code 97002. The re-evaluation is used to determine the resident's progress toward the original goals and may cause the plan of care to be modified or redirected for future sessions. Since the evaluation and re-evaluation are comprehensive, additional codes are not reported, as those services are part of the evaluation.

Once the plan of care has been established the resident may begin therapy sessions. The code range for therapeutic procedures is 97110–97546; most of the codes in this range require direct supervision, which is considered one-on-one contact with the resident. The codes in this section are time-based, with the exception of 97150, Therapeutic procedure(s), group (two or more individuals), so it is important that the therapist document the time spent providing treatment to the patient. As always, the documentation must support the code assignment. (Note: if the group code 97150 is assigned for each patient, it is not necessary to assign the specific therapeutic procedure code in addition to the group code.)

The modalities codes are divided by supervised applications (97010–97028) or constant attendance (97032–97039). For example, these services may be reported for applying hot or cold packs to various areas. If the modality is supervised then the service does not require direct one-on-one contact. The codes for constant attendance are time-based. Keep in mind that not all third-party payers reimburse for every modality, such as application of hot or cold packs.

Occupational therapy involves providing treatment directed at improving the resident's skill required for daily living activities. These services typically include adaptive equipment training or self- or home-care management training. The code for occupational therapy evaluation is 97003; re-evaluation is reported with 97004. The occupational evaluation is a comprehensive evaluation that supports the resident's need for services. The re-evaluation is similar to the physical therapy re-evaluation as a measure for determining progress toward the original goal.

Speech Therapy

The codes for speech therapy services are either 92507 or 92508. The selection is based upon whether the treatment is provided in an individual or group setting. Code 92507 is reported for the individual setting, while 92508 is the group, two or more. The evaluation for speech therapy is identified with code 92506.

Medicare's Financial Limitations

Effective January 1, 2006, Medicare reinstated the financial limits (or caps) on therapy services. The rate is $1,740 for physical and speech therapy; occupational therapy has its own limit of $1,740. The dollar caps are for Part B therapy services. However, the Deficit Reduction Act of 2003 calls for an exception process for these limits.

Certain conditions or situations are eligible for an automatic exception. If the resident's condition does not qualify for the automatic exception, the provider or beneficiary may start the manual exception process by requesting the exception in writing. For further information regarding the diagnoses and situations that qualify for automatic exception, go to www.cms.hhs.gov/apps/media/press/release.asp?Counter=1782.

References

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