Unlocking the Mystery of Third Party Reimbursement In Kinesiotherapy

Provided by the American Kinesiotherapy Association

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This document is not intended to provide legal or consulting advice. It is for educational purposes only. Please retain an attorney or consultant for specific information for your practice.
Introduction

Bridging the gap between KT and payer

“How do we get paid?” . . .
A challenging question every health care provider faces, regardless of specialty and health insurance company.

The purpose of this reimbursement manual is to provide a basic understanding of health care reimbursement and compliance prior to filing claims for Kinesiotherapy services.

Physical medicine budgets are getting ever tighter, demands on rehab specialists’ time and skills are increasing. Rehabilitation providers face more battles with insurance companies who do not want to pay for covered services. If the insurance does pay, each payor has creative “loop holes” to reduce payment through various forms or payment reduction methods. The major concern for Kinesiotherapists is being recognized by insurance carriers as an approved provider of therapy services in the outpatient setting.

There are no absolute answers – no “magic bullet” to solve how Kinesiotherapists (KT) can get paid by the health insurance industry.
However, the more you understand about the health care system in the United States and methods used by providers to get reimbursed by insurance, the more likely you and your organization are to achieve reimbursement results.

There are a number of things when done systematically and consistently, will help reduce problems with insurers and keep a KT practice stay compliant.

Yes, the word “compliant”. In the United States all health care providers are heavily regulated by State and Federal reimbursement rules and regulations.

The information below will provide you with tools regarding potential third party reimbursement and guidance regarding compliance when filing claims for payment.

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**Key Elements to Reimbursement**

**Understanding the reimbursement environment**

Before filing an insurance claim for your outpatient therapy services, it is important to verify whether a Kinesiotherapist is considered an “approved” therapy provider by the insurance plan or carrier. The best way to verify this is to call the major insurance carriers and ask!

Call the provider relations or provider enrollment department. If they cannot assist you, they should be able to direct you to someone who can.

The AKTA embarked on a KT credentialing project over the past several years. To determine credentialing eligibility, they found it was necessary to submit a provider enrollment application to carriers. The information below provides a description of a five-step process to help you understand the enrollment procedures of most carriers. Medicare and Medicaid do not recognize KT's as therapy providers, but managed care companies vary in their rules. So don’t be afraid of submitting an application!
Provider Enrollment
A 5 Step Process!

First Step: The first step to the reimbursement puzzle is to obtain a provider application from the insurance carrier. Some applications can be obtained on-line through the provider enrollment page of the carrier’s web site.

You may have to request an application be mailed to you. It is critical to fill out the application completely. If a question the application does not apply to your situation, do not leave it blank! Write “N/A” or “not applicable”.

Blank fields in the application can cause the application to be rejected (or returned).

Second Step: Once the application is completed, be sure to attach copies of all requested documents. Each insurance carrier may request slightly different information.

The information required by the insurance carriers is to identify you as an individual, verify your clinical training, education and credentials and determine whether you will meet criteria set forth for their credentialing process through the NCQA (National Committee on Quality Assurance) – a golden standard with health insurance plans. NCQA “grades” payors – there is more information later in this manual about NCQA!

The table below provides a general checklist of what most carriers will require (may not be all inclusive):
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<th>Individual Information</th>
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<tr>
<td>Current Address (address registered with the ATKA)</td>
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<td>Contact Information (phone, Email, Fax)</td>
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<td>Copy of resume or curriculum vitae</td>
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<td>Copy of driver’s license</td>
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<td>Copy of Social Security Card</td>
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<th>Employment Information</th>
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<tr>
<td>Site address (where therapy will be rendered)</td>
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<tr>
<td>Billing address (if different than address above)</td>
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<tr>
<td>If credentialing through your employer, TAX ID/EIN #</td>
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<tr>
<td>If credentialing as an individual provider, your NPI #</td>
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<td>State(s) in which you treat patients</td>
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<td>Insurers you already have a Provider # with (if any)</td>
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<tr>
<td>Certificate of liability insurance (individual or covered by employer)</td>
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<th>Education Information</th>
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<tr>
<td>Copy of College Diploma</td>
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<tr>
<td>Copy of advanced education (MS, PhD, etc) degrees</td>
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<tr>
<td>Name of Kinesiotherapy School attended</td>
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<tr>
<td>Copy of Specialty certifications (wound care, McKenzie, etc)</td>
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<td>List of current professional memberships</td>
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<tr>
<td>Copy of all adverse legal action</td>
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<td>Copy of Registry, including current card/certificate</td>
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<tr>
<td>Continuing education within the last 3 years</td>
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**Third Step:** Draft an impressive cover letter to accompany your application. It should be a formal letter which includes a date, your name and address, phone number, their address and opening salutation.

The body of the letter should provide some explanation of your profession. Many insurance carriers do not know about the field of Kinesiotherapy. This is an opportunity for you to educate!

The closing should be “Respectfully” with your original signature in blue ink and your name typed or printed beneath your signature. An example of information you can include in your letter is provided below. Be sure to customize it to accurately reflect your education and experience:

Kinesiotherapists possess a unique skill set that blends a knowledge base in exercise with specialized training to apply rehabilitation exercise in a variety of settings, which is ideally suited in assisting workers with a return to their usual and customary duties. Services and documentation can be defined as “medically necessary” during the acute phase of treatment and should be reimbursed by the patient’s insurance carrier. Please accept the enclosed application to enroll as a therapy provider under your insurance plans.

Kinesiotherapist competencies are governed by the council on professional standards for kinesiotherapy (COPS-KT), which maintains the scope and standards of kinesiotherapy practice. COPS-KT is comprised of three boards: the Board of Registration, the Continuing Competency Board, and the Committee on Accreditation of Kinesiotherapy Programs (in collaboration with CAAHEP - the Commission on Accreditation of Allied Health Educational Programs). The current minimum requirements for obtaining RKT status include:

- **Possess a bachelor's degree in Kinesiotherapy, or exercise science with an emphasis in Kinesiotherapy from an accredited college or university.**
- **Satisfy the following ten minimum core course requirements (or their equivalents): general psychology, human anatomy, human physiology, first aid, exercise physiology, therapeutic exercise, kinesiology, motor learning, statistics, organization and administration.**
- **Provide official transcripts that demonstrate the applicants’ minimum grade point average of 2.5/4.0 for those courses, with a grade of C or higher for each course.**
- **Provide a written letter of sponsorship from a Registered Kinesiotherapist documenting at least 1000 hours of clinical education under the supervision of the RKT.**
♦ Passage of the written portion of the KT Registration Examination [if graduated from a university with a program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP)].

♦ Passage of the written and oral/practical portion of the KT Registration Exam (if graduated from a university with the externship curriculum).

For over 60 years, Kinesiotherapists have served a vital role in the delivery of Physical Medicine and Rehabilitation services. KT's practice individually, and as members of comprehensive rehab programs. Additional information regarding the profession is available at akta.org. I request the application attached be processed with approval for claims to be considered for therapy payment according to the beneficiary’s insurance plan.

**Fourth Step:** Submitting the application should be done timely after procuring the application form. Carriers may change their application process and if you submit an outdated form, your application could be rejected. Shipping the application should be done in a secure fashion. It contains proprietary and private information about you! It is also important to have the ability to prove it was delivered.

If the insurance carrier only provides a PO Box address, send it Priority Mail through the postal service with delivery confirmation. If a street address is available, you may want to consider UPS or FedEx delivery with signature required.

After you have confirmed delivery of your application, contact the carrier’s provider enrollment department to confirm your application has been received. Believe it or not, carriers are notorious for losing applications! Be sure to ask how long before you hear back from the credentialing committee regarding your application.

**Fifth Step:** Following up is important. Your application may be processed differently as soon as the committee realizes research is needed to better understand your profession. So, don’t be afraid to include additional information to insert along with your application for the committee to review.

It can take from 2-3 months to 6 months for an application to be reviewed. You should receive a letter requesting more information, returning your application due to a field left incomplete, receive a letter of denial or an acceptance letter. If you do not follow up on your application during this time, it is possible for your paperwork to get “lost in the shuffle”!

**Checking-in by phone every 3-4 weeks is highly recommended unless provider enrollment warns you not to contact them.**
State of Health Insurance – an Overview

Fewer are Insured – Health Care Plans, Employers and the Public are Feeling the Economics of Unemployment

Employment means health insurance is more affordable and available to patients. When the unemployment rate increases, more of the population becomes uninsured. When a worker is discharged or loses their job involuntarily, COBRA insurance becomes available.

The American Recovery and Reinvestment Act of 2009 (ARRA) provides for premium reductions and additional election opportunities for health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly called COBRA.

Eligible individuals pay only 35 percent of their COBRA premiums and the remaining 65 percent is reimbursed to the coverage provider through a tax credit.

The premium reduction applies to periods of health coverage beginning on or after February 17, 2009 and lasts for up to nine months for those eligible for COBRA during the period beginning September 1, 2008 and ending December 31, 2009 due to an involuntary termination of employment that occurred during that period. The TAA Health Coverage Improvement Act of 2009, enacted as part of ARRA, also made changes with regard to COBRA continuation coverage.

Although individuals only pay 35 percent of the premium, many cannot afford insurance under COBRA due to the high cost of the premium itself.


Employment fell in construction and in transportation and warehousing; while temporary help services and retail trade added jobs. Each state, city and region is suffering in a different manner, at a different recovery rate. As of March 2nd, 2010 - we find that our US economy is still in crisis.
Last year’s $787 billion stimulus plan was just not enough to pull us out of the recession. Millions of Americans received stimulus checks in 2009 to help their finances but there are still millions to go. Thus the Obama government is taking a fresh approach to economic aid in 2010 with some helpful changes to the Stimulus Plan. The 2010 Federal Stimulus Plans aims to:

- Create 3.5 million jobs in America by the end of 2010
- Decrease federal taxes
- Provide financial relief for struggling families
- Increase assistance available to homeowners
- Provide assistance for business owners
- Increase funding for programs like Government Grants to help US citizens

An aging population means increase in Medicare-covered patients. Baby-boomers began turning age 60 in 2006. More and more of the population now have Medicare as primary insurance. Medicare has strict rules regarding who is qualified to provide therapy services reimbursed by CMS.

**Medicare Benefit Policy Manual**

220 - Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance

**Medicare Guidelines**

For KT's working directly under physician supervision, understanding and compliance to CMS rules for “incident to” are critical. CMS also runs the health care arena when it comes to defining a “qualified” physical medicine practitioner. If you are billing insurance other than Medicare, be sure to contact the insurance carrier to determine whether your service can be billed under the physician’s provider number on the claim form. You must also ask if a Registered Kinesiotherapist is qualified to provide therapy services under that particulate health plan prior to filing any claims. The information below is definitions from the Medicare Benefit Policy Manual.

A **“Qualified Professional”** means a physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician’s assistant, who

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is licensed or certified by the state to perform therapy services, and who also, may appropriately perform therapy services under Medicare policies. Qualified professionals may also include physical therapist assistants (PTA) and occupational therapy assistants (OTA) when working under the supervision of a qualified therapist, within the scope of practice allowed by state law. Assistants are limited in the services they may provide (see section 230.1 and 230.2) and may not supervise others.

“Incident to” a Therapist
There is no coverage for services provided incident to the services of a therapist. Although PTAs and OTAs work under the supervision of a therapist and their services may be billed by the therapist, their services are covered under the benefit for therapy services and not by the benefit for services incident to a physician/NPP. The services furnished by PTAs and OTAs are not incident to the therapist’s service.

Qualifications of Auxiliary Personnel
Therapy services appropriately billed incident to a physician’s/NPP’s service shall be subject to the same requirements as therapy services that would be furnished by a physical therapist, occupational therapist or speech-language pathologist in any other outpatient setting with one exception.

When therapy services are performed incident to a physician’s/NPP’s service, the qualified personnel who perform the service do not need to have a license to practice therapy, unless it is required by state law. The qualified personnel must meet all the other requirements except licensure. Qualifications for therapists are found in 42CFR484.4 and in section 230.1, 230.2, and 230.3 of this manual. In effect, these rules require that the person who furnishes the service to the patient must, at least, be a graduate of a program of training for one of the therapy services as described above.

Regardless of any state licensing that allows other health professionals to provide therapy services, Medicare is authorized to pay only for services provided by those trained specifically in physical therapy, occupational therapy or speech-language pathology. That means that the services of athletic trainers, massage therapists, recreation therapists, kinesiotherapists, low vision specialists or any other profession may not be billed as therapy services.

Documentation is necessary for many reasons, such as malpractice, risk mitigation and for reimbursement.

As The Centers for Medicare and Medicaid Services (CMS) has become the gold standard for health care it becomes incumbent upon KTs to learn Medicare guidelines, even if they do not treat Medicare patients. Many payers do not have internal rules for reimbursing physical medicine and adopt Medicare rules for reimbursement.

However there are a number that have no set guidelines- in these cases, since Medicare guidelines are the strictest you will probably find adhering to them makes sense. Chances are if you are compliant with the myriad Medicare guidelines you will be compliant with just about all payers.
Physical Medicine & Rehab [PM&R] – Time Services

When billing any of the timed services in the PM&R section of CPT, Medicare has created an industry standard

**Medicare Compliance**

**Rounding Therapy Time**

Direct one-on-one < 8 minutes should not be billed

1 units: > 8 min to < 23 min
2 units: > 23 min to < 38 min
3 units: > 38 min to < 53 min
4 units: > 53 min to < 68 min
5 units: > 68 min to < 83 min
6 units: > 83 min to < 98 min
7 units: > 98 min to < 113 min
8 units: > 113 min to < 128 min

As the saying goes, “knowledge is power”. The more you know and apply; the better will be your outcomes. You will also be prepared to move into the future.

**Reimbursement Basics**

As a health care provider, appropriate standards of care must be proven in writing in the patient’s medical record. Billing and reimbursement starts in the medical record as well. The information below outlines the key elements used in the United States by health care providers as the foundation of any form of reimbursement.
Key: Before reimbursement, your **documentation** must be compliant.

If it isn’t documented, it didn’t happen. If it isn’t documented, you cannot bill for it. This means you cannot bill the patient privately (fee for service) and you cannot bill any insurance.

This element cannot be sidestepped, shortchanged or neglected. The treating KT must document each visit and prove the patient was seen face to face and treatment indeed took place in the manner, time, conditions documented and in accordance with the plan of care initiated at the first patient visit. Documentation is not only critical to getting paid timely: it is essential for risk management and compliance.

KTs are well trained, qualified providers. No excuses will be allowed for less than professional, detailed documentation.

The AKTA provides a documentation manual for Kinesiotherapists. Please contact the AKTA for a copy! It has recently been updated to provide documentation and coding guidance for Kinesiotherapists.

**What is Documentation and Why is it Important to Payors?**

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time.

- Communication and continuity of care among physicians and other health care professionals involved in the patient's care;

- Accurate and timely claims review and payment; appropriate utilization review and quality of care evaluations; and

- Collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.
**What do Payors Want & Why?**

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- The site of service;
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- That services provided have been accurately reported.

The next critical element: **Appropriate coding.** Assigning a procedure code (CPT) and diagnosis code (ICD-9-CM) supported by your documentation is required before billing for any rehab service.

Appropriate code assignment is the first line of defense against problem payers, and the critical tie-in to documentation. The KT must assign ICD-9-CM codes appropriate to each patient’s problems being treated within the scope of the KT’s training and qualifications. ICD codes are updated each October 1st. ICD coding will be changing with the implementation from ICD-9-CM to ICD-10-CM on October 1, 2013.

Procedure codes are 2-tiered: CPT (Current Procedural Terminology) written by the American Medical Association (AMA); and HCPCS level II codes (Healthcare Common Procedural Coding System) written by the Centers for Medicare and Medicaid (CMS).

The procedure codes must match what was actually done to the patient at each visit and if required by the procedure code, therapy time of the patient during the procedure.
These codes will be the first interaction an insurance company has with any provider. Why is coding so important? Here are just a few answers to this question!

1. CPT codes are required by employers to monitor productivity of therapy providers. CMS assigns Relative Value Units (also known as “RVUs”) per CPT code that employers use to calculate and evaluate productivity.

2. Coding is required to be assigned to claim forms submitted to insurance carriers (payors) for any form of reimbursement. CPT codes report the services provided. ICD9 codes report the condition being treated. Coding guidelines must be applied. Coding guidelines require code assignment according to documentation for that date of service.

3. CPT codes help assign the correct fee or price to invoices for self-pay patients. Overcharging self-pay patients is a violation under consumer-protection laws. Many states have additional rules with penalties. Therefore, coding is important whether you file a claim to insurance or all charges directly from the patient.

**Therapy Procedure Coding**

**A Two-Tier System**

**Tier 1: CPT Coding Assignment**

The AMA writes the CPT book which contains the first level of procedures codes in our coding system in the United States. The Physical Medicine & Rehabilitation (PM&R) Section is dedicated to therapy service codes. CPT also contains necessary modifiers required on your claim to avoid unnecessary “bundling” of services. Modifier -59 to report a separately identifiable services is most commonly used in therapy & rehab.

CPT codes are updated each January 1st each year. Many codes remain the same, but some codes may be deleted and replaced with a new code. Due to new technology, new codes are added each year. Some code may have wording revisions. Thus, it is important to purchase a new CPT each year. Ordering your book in the early fall will help ensure delivery before January 1st.
Any code changes reflected in the new CPT book must be reflected on your claim forms with patient dates of service beginning January 1st each year. Sometime just reviewing the CPT code and description isn’t sufficient to understand documentation and code assignment requirements. “CPT Assistant References” are found beneath many of the CPT codes in the CPT book. This is an authoritative guide to the CPT book. Guidelines to help providers determine documentation required to assign a code is found in this publication by the AMA. The CPT Assistant is an additional subscription charge and not included when you purchase your annual CPT book.

Coding Guidelines will be addresses below. Examples of typical KT services and CPT Assistant guidelines are provided.

Tier 2: HCPCS Level II Coding Assignment

Services and modifiers are available in HCPCS Level II created by the Centers for Medicare & Medicaid Services or CMS. Even though KTs do not (should not) treat and/or bill Medicare for therapy services, HCPCS Level II codes and modifiers are also recognized by insurance carriers.

This is a requirement under the Administrative Simplification Act which is part of HIPAA law. Therefore, providers filing claims to insurance should also be familiar with this code book. It is updated and published by CMS each year with an effective date of January 1st to coincide with CPT updates.

CPT Assistant

When deciding whether one CPT code is appropriate versus another, the best reference is the CPT Assistant publication written by the American Medical Association (AMA). Purchasing a monthly subscription of the CPT Assistant is a separate cost from the purchase of your annual CPT book. Issue features:
Coding Communication to keep you informed - Discover the most timely, up-to-date information on codes and trends in the coding industry;

Clinical Vignettes that offer insight into confusing codes;

Coding Consultation covers your most frequently asked questions;

Anatomical illustrations, charts and graphs for quick reference;

Information on par with that published in the Federal Register.

CPT® Assistant December 2009, Volume 19, Issue 12
Medicine: Physical Medicine and Rehabilitation

Question: When reporting the CPT physical medicine and rehabilitation time-based codes, should the medical record documentation reflect the amount of time spent with the -patient while supervising therapeutic exercise, e.g., four units of code 97110, Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility?

Answer: Certain physical medicine services are timed codes based on a 15-minute unit. Multiple units can be reported on a date of service for one or more procedures based on the aggregate amount of time spent by a qualified healthcare professional in direct contact with the patient. As with any 15-minute timed code, it is important to recognize that a substantial portion of the 15-minutes must be spent in performing the pre-, intra-, and postservice work in order to report the timed code. If only a few minutes are spent performing the physical medicine service, the code should either not be billed or Modifier 52 should be appended to the code. The provider has the responsibility to document that the services rendered are medically necessary, skilled, and of good practice.

Coding Consultation: Questions and Answers
CPT Assistant, April 2005

Question: Is it appropriate to report code 97116, Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing), and code 97150, Therapeutic-procedure(s), group (2 or more individuals), when a patient is receiving gait training in a group setting?

AMA Comment: From a CPT coding perspective, group therapeutic procedures include codes 97110-97139. If any of these procedures are performed with two or more individuals, then only 97150 is reported. CPT code 97150 is reported separately for each member of the group. The specific type of therapy should not be coded in addition to the group therapy code. Group therapy procedures involve constant attendance of the physician or therapist but, by definition,
Coding Consultation: Questions and Answers
CPT Assistant, April 2005

Question: Is it appropriate to report code 97116, Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing), and code 97150, Therapeutic-procedure(s), group (2 or more individuals), when a patient is receiving gait training in a group setting?

AMA Comment: From a CPT coding perspective, group therapeutic procedures include codes 97110-97139. If any of these procedures are performed with two or more individuals, then only 97150 is reported. CPT code 97150 is reported separately for each member of the group. The specific type of therapy should not be coded in addition to the group therapy code. Group therapy procedures involve constant attendance of the physician or therapist but, by definition, do not require one-on-one patient contact by the physician or therapist. CPT code 97150 should be reported per session regardless of the time involved because it is not a time-based code.

CPT® Assistant February 1997
Medicine, 97150 (Q&A)

Question: When reporting CPT code 97150, Therapeutic procedure(s), group (2 or more individuals), should another code(s) be reported in addition to the group code to specify the type of therapy?

AMA Comment: Group therapeutic procedures include CPT codes 97110 - 97139. If any of these procedures are performed with two or more individuals, then only report 97150. Do not code the specific type of therapy in addition to the group therapy code.

CPT® Assistant September 1996

CPT Code 97116

97116  Therapeutic procedure; one or more areas, each 15 minutes; gait training (includes stair climbing)

This revision clarifies that stair climbing should be reported with the gait training code. This is an editorial change and does not alter the nature of the code; however, it further clarifies what it may include as an integral part of the procedure.

Vignette for 97116: A 72-year-old female, status post left total hip surgery, is being seen for gait training, as well as for instruction in step climbing. She is instructed by the therapist in partial weight bearing on the left leg through the use of a walker, with specific attention to foot placement to avoid hip rotation. She is also instructed in the gradual increase of weight bearing
with use of weight shifting, while using the walker, and in the safe use of a walker to safely climb two steps leading into her home.

**CPT codes 97535 and 97537**

97535 Self care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes

97537 Community/work reintegration training (eg, shopping, transportation, money management, vocational activities and/or work environment/modification analysis, work task analysis), direct one on one contact by provider, each 15 minutes

These codes (97535 and 97537) were added to distinguish components of treatment that have previously been reported under 97540, 97114 (deleted in CPT 1995), or HCPCS level 2 code H5300. These codes include therapist work on both physical and cognitive patient deficits that result from a wide range of physical and mental diagnoses and interfere with the patient's independent functioning in the specified areas. For clarity, codes 97540 and 97541 were deleted.

Without training in safe techniques and in the use of specialized assistive technology, patients with cognitive, physical sensory, or perceptual deficits can be a danger to themselves or others, when faced with the distractions in their community. Patients who return to work following an interruption resulting from such diagnoses as mental illness, heart disease, severe burns, head injury, or musculoskeletal injury are at risk to develop symptoms that require additional medical intervention, if potential hazards are not considered, with regard to their specific work tasks and environments.

*Vignette for 97535:* The patient is a 65-year-old woman recently discharged from the hospital with a diagnosis of CVA resulting in a right hemiparesis. The patient lives alone and wants to be able to remain in her home. The initial evaluation has revealed performance deficits in bathroom activities and meal preparation. At the home site, the therapist recommends and sets up the proper adaptive equipment in the bathroom, so the patient can safely transfer to toilet and bathtub by using compensatory techniques.

In the kitchen, the therapist teaches and observes meal preparation using one-handed techniques and special adaptive equipment. The therapist must assure that the patient's functional level is sufficient to perform necessary self-care and home-management activities within safe limits (eg, picking items off floor, lifting pots from stove, reaching items in cupboards, opening drawers).

*Vignette for 97537:* A 35-year-old computer programmer with a diagnosis of Guillain-Barre syndrome is being treated in an outpatient department for residual weakness, which has limited his ability to return to community and work activities. After evaluation, the therapist identifies the transportation and work environment as two barriers to his ability to return to his former functional level. The therapist determines the type of driving adaptation needed, trains him in the use of the equipment (including on-road practice), and trains him in car transfer techniques.
Additionally, with the patient, the therapist analyzes the essential job functions. At the work-site, the therapist analyzes the work environment to identify any factors with potential negative impact on balance/stability, posture and safe extremity function. The therapist reports all findings to the patient, and the employer (if necessary), recommends necessary changes in routine (eg, stretching periods) or assistive technology (eg, ergonomic seating, computer access), and provides equipment purchasing information to the patient and/or employer.

*CPT Code 97542*

97542 Wheelchair management/propulsion training, each 15 minutes

This code describes what is increasingly becoming a specialized service due to the technological advancements in wheelchair design. This activity was previously reported under 97540 or 97114 (deleted in CPT 1995).

*Vignette for 97542:* A 29-year-old C4 quadriplegic, with complete right shoulder disarticulation and left above knee amputation, has been fitted with a powered wheelchair and custom seating system. After an assessment of the seating system in conjunction with his functional goals, the therapist determines that the system must provide stabilization, support and balance, as well as pressure management. To achieve these goals, the therapist trains the patient in the safe operation and management of the wheelchair in order to achieve independent mobility in his home and community environment.

*CPT Code 97703:*

97703 Checkout for orthotic/prosthetic use, established patient, each 15 minutes

*Vignettes for 97703:* Orthotic: A 56-year-old female with a diagnosis of rheumatoid arthritis is seen for a follow-up checkout subsequent to a metacarpal phalangeal flexible implant arthroplasty. The therapist has previously fitted the patient with a dorsal dynamic orthosis that provides correction of residual deformity and permits metacarpal flexion and extension in desired plane and range. The patient's edema has decreased and she complains of pressure on the ulnar styloid. The therapist reassesses the fit and makes adjustments to the orthosis.

Prosthetic: A 40-year-old man with a left below knee amputation is seen two months after being fitted for a prosthesis consisting of a conventional socket with supra condylar suspension and each foot. The therapist reassesses the patient's need for additional modifications to the socket of the prosthesis following a stump revision. The therapist documents the fit of the prosthesis and checks the patient's comfort and safety during gait and standing activities.
Diagnosis Code Assignment

The condition(s) being treated through the therapy plan of care have ICD9 codes assigned.

Medical necessity is reported on the claim form to insurance through the diagnosis ICD-9-CM (ICD9) codes. Four (4) codes can be assigned on paper claims, eight (8) codes assigned on electronic claims per CPT or procedure code. If the ICD9 does not support the reason for the therapy service, the CPT code will be denied payment.

ICD9 codes are updated annually, each October 1st. There is an alphabetical index to reference the condition to a numeric code. The tabular index is where you verify that the numeric code to be assigned is appropriate, checking for “exclusions” in the code definition.

If the patient’s record has information which is described in the exclusion, the guidelines may prohibit that code assignment and reference you to a different, more accurate code.

There are “manifestation” guidelines which require more than one code to describe the patient’s condition. There are combination codes where one code reports more than one condition.

Guidelines are free and posted on the CDC (Centers for Disease Control) and CMS web sites. Here is a link to obtain your free ICD9 guidelines. Scroll down to the bottom of the page and click on the current guidelines. This link also provides access to ICD10 information!

http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/

A new coding system is coming into common use soon in the United States, called ICD-10-CM. Frequently asked questions on ICD10 are below.
**MYTH:** The October 1, 2013 compliance date for implementation of ICD-10-CM/PCS should be considered a flexible date.

**FACT:** All Health Insurance Portability and Accountability Act (HIPAA) of 1996 covered entities MUST implement the new code sets with dates of service, or date of discharge for inpatients, that occur on or after October 1, 2013.

**MYTH:** Implementation planning should be undertaken with the assumption that the Department of Health and Human Services (HHS) will grant an extension beyond the October 1, 2013 compliance date.

**FACT:** HHS has no plans to extend the compliance date for implementation of ICD-10-CM/PCS; therefore, covered entities should plan to complete the steps required in order to implement ICD-10-CM/PCS on October 1, 2013.

**MYTH:** Noncovered entities, which are not covered by HIPAA such as Workers’ Compensation and auto insurance companies that use ICD-9-CM may choose not to implement ICD-10-CM/PCS.

**FACT:** Because ICD-9-CM will no longer be maintained after ICD-10-CM/PCS is implemented, it is in noncovered entities’ best interest to use the new coding system. The increased detail in ICD-10-CM/PCS is of significant value to noncovered entities. The Centers for Medicare & Medicaid Services (CMS) will work with noncovered entities to encourage their use of ICD-10-CM/PCS.

**MYTH:** State Medicaid Programs will not be required to update their systems in order to utilize ICD-10-CM/PCS codes.

**FACT:** HIPAA requires the development of one official list of national medical code sets. CMS will work with State Medicaid Programs to ensure that ICD-10-CM/PCS is implemented on time.
MYTH: The increased number of codes in ICD-10-CM/PCS will make the new coding system impossible to use.

FACT: Just as an increase in the number of words in a dictionary doesn’t make it more difficult to use, the greater number of codes in ICD-10-CM/PCS doesn’t necessarily make it more complex to use. In fact, the greater number of codes in ICD-10-CM/PCS makes it easier to find the right code. In addition, just as it isn’t necessary to search the entire list of ICD-9-CM codes for the proper code, it is also not necessary to conduct searches of the entire list of ICD-10-CM/PCS codes.

The Alphabetic Index and electronic coding tools will continue to facilitate proper code selection. It is anticipated that the improved structure and specificity of ICD-10-CM/PCS will facilitate the development of increasingly sophisticated electronic coding tools that will assist in faster code selection. Because ICD-10-CM/PCS is much more specific, is more clinically accurate, and uses a more logical structure, it is much easier to use than ICD-9-CM. Most physician practices use a relatively small number of diagnosis codes that are generally related to a specific type of specialty.

MYTH: ICD-10-CM/PCS was developed without clinical input.

FACT: The development of ICD-10-CM/PCS involved significant clinical input. A number of medical specialty societies contributed to the development of the coding systems.

MYTH: There will be no hard copy ICD-10-CM and ICD-10-PCS code books. When ICD-10-CM/PCS is implemented, all coding will need to be performed electronically.

FACT: ICD-10-CM and ICD-10-PCS code books are already available and are a manageable size (one publisher’s book is two inches thick). The use of ICD-10-CM/PCS is not predicated on the use of electronic hardware and software.

MYTH: ICD-10-CM/PCS was developed a number of years ago, so it is probably already out of date.

FACT: ICD-10-CM/PCS codes have been updated annually since their original development in order to keep pace with advances in medicine and technology and changes in the health care environment. The coding systems will continue to be updated until such time that a decision is made to “freeze” the code sets prior to implementation. For instance, the health care community may request that ICD-9-CM and ICD-10-CM/PCS codes not be updated on October 1, 2012 and be frozen with the October 1, 2011 updates. If the freeze is approved through formal rulemaking, it would provide a year or more of stability and an opportunity to develop coding products and services.

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training materials. ICD-10-CM/PCS could then be updated again on October 1, 2014, after providers have had a year of experience under the new coding system.

MYTH: Unnecessarily detailed medical record documentation will be required when ICD-10-CM/PCS is implemented.

FACT: As with ICD-9-CM, ICD-10-CM/PCS codes should be based on medical record documentation. While documentation supporting accurate and specific codes will result in higher-quality data, nonspecific codes are still available for use when documentation doesn’t support a higher level of specificity. As demonstrated by the American Hospital Association/American Health Information Management Association field testing study, much of the detail contained in ICD-10-CM is already in medical record documentation but is not currently needed for ICD-9-CM coding.

MYTH: Implementation of ICD-10-CM/PCS can wait until after electronic health records and other health care initiatives have been established.

FACT: Implementation of ICD-10-CM/PCS cannot wait for the implementation of other health care initiatives. As management of health information becomes increasingly electronic, the cost of implementing a new coding system will increase due to required systems and applications upgrades.

MYTH: ICD-10-CM-based super bills will be too long or too complex to be of much use.

FACT: Practices may continue to create super bills that contain the most common diagnosis codes used in their practice. ICD-10-CM-based super bills will not necessarily be longer or more complex than ICD-9-CM-based super bills. Neither currently-used super bills nor ICD-10-CM-based super bills provide all possible code options for many conditions.

The super bill conversion process includes:

- Conducting a review that includes removing rarely used codes; and
- Cross walking common codes from ICD-9-CM to ICD-10-CM, which can be accomplished by looking up codes in the ICD-10-CM code book or using the General Equivalence Mappings (GEM).
**MYTH:** The GEMs are intended to facilitate the process of coding medical records.

**FACT:** Mapping is not the same as coding:

- Mapping links concepts in two code sets without consideration of patient medical record information; and

- Coding involves the assignment of the most appropriate code based on medical record documentation and applicable coding rules/guidelines.

The GEMs can be used to convert the following databases from ICD-9-CM to ICD-10-CM/PCS:

- Payment systems;
- Risk adjustment logic;
- Quality measures;
- Payment and coverage edits; and
- A variety of research applications involving trend data.

**MYTH:** Each payer will be required to develop their own mappings between ICD-9-CM and ICD-10-CM/PCS, as the GEMs that have been developed by CMS and the Centers for Disease Control and Prevention (CDC) are for Medicare use only.

**FACT:** The GEMs are a crosswalk tool developed by CMS and CDC for use by ALL providers, payers, and data users. The mappings are free of charge and are in the public domain.

**MYTH:** Medically unnecessary diagnostic tests will need to be performed in order to assign an ICD-10-CM code.

**FACT:** As with ICD-9-CM, ICD-10-CM codes are derived from documentation in the medical record. Therefore, if a diagnosis has not yet been established, the condition should be coded to its highest degree of certainty (which may be a sign or symptom) when using both coding systems.

In fact, ICD-10-CM contains many more codes for signs and symptoms than ICD-9-CM, and it is better designed for use in ambulatory encounters when definitive diagnoses are often not yet known. Nonspecific codes are still available in ICD-10-CM/PCS for use when more detailed clinical information is not known.
MYTH: Current Procedural Terminology (CPT) will be replaced by ICD-10-PCS.

FACT: ICD-10-PCS will only be used for facility reporting of hospital inpatient procedures and will NOT affect the use of CPT.

To find additional ICD-10-CM/PCS information, including the GEMs and educational resources, visit http://www.cms.hhs.gov/ICD10 on the CMS website.

Understanding the Health Insurance Industry

Modern managed health care grew out of a desire to reform the traditional health care system, or the fee-for-service method of charging for health care.

Fee-for-Service (FFS)

Under the fee-for-service method, doctors and hospitals got paid for each service they performed. There were no limits on their treatment decisions; doctors or hospitals could order as many tests as they felt necessary, for example. Doctors and hospitals made a lot of money under this system because they decided the prices charged for every visit. However, patients did not always benefit because their insurance companies would often only pay a percentage of the fees being charged. For example, if a doctor charged $100 for a checkup, but the insurance company felt that $80 was a fair price, the patient would have to pay the extra $20, until a certain deductible was met. (A deductible is the amount of money, as determined by the health care plan, a patient must pay for services before the health care plan will pay for any medical bills.)

The different types of fee-for-service include indemnity plans and reimbursement plans. In an indemnity plan, the insurer sets an amount that it will pay for a specific medical service. In a reimbursement plan, the patient must pay all fees up front and then file claims to be reimbursed by the insurer. Fee-for-service health care is no longer widely in use. Most people today have some kind of managed care insurance.
Capitation

Sometimes doctors reach an agreement with a managed care organization called capitation, wherein the doctor is paid per person. Under this agreement, doctors accept members of the plan for a certain set price per member, no matter how often the member sees the doctor. For example, the doctor may be paid $20.00 per member every month and that amount doesn’t change if the member comes in for five appointments that month or none.

Managed Care

There are many kinds of managed care organizations, but there are some common characteristics among them. All managed care organizations supervise the financing of medical care delivered to members. They all are concerned with cost-effectiveness, or saving money. By buying services in bulk, for many members at a time, managed care organizations can get lower prices with doctors and hospitals. Managed care organizations also reduce costs by limiting choice, which means providing members with a list of doctors from which to choose and lists of labs where tests can be performed. Even doctors are provided with lists of medicines from which to choose. Different plans have different restrictions on choice. Many people feel that limited choices are the downside of managed care. Generally, a member can expand the possible choices if he or she is willing to pay more.

At the same time, managed care organizations take care of the delivery system for their members. For example, they manage who provides the health care, where it is provided, and the different kinds of doctors in their particular system. Nurses, doctors, therapists, pharmacists, and hospitals are all a part of the delivery system.

The Referral Process

Understanding the referral process is critical to navigating the managed care organization. Managed care organizations require patients to get a referral from the primary care physician (the doctor responsible for a patient's total health care) in order to see a specialist. A referral is like a permission slip from the primary care physician. It allows patients to seek treatment from a specialist when the primary care physician is unable to treat the patient’s problem.

This is one way to keep insurance costs down. Without a referral, the patient may be charged full price for any medical care received by a specialist. Plans deal with referrals in different ways. Certain regular health visits may not require a referral. For example, women can often see a gynecologist (doctors who specialize in treating the female reproductive system) without getting a referral from the primary care physician. The complexities of the referral process may be a factor in the choice of an insurance plan.
Types of Managed Health Care Plans
Managed health care is an alphabet soup of confusing abbreviations: HMOs, PPOs, POS. What do they all mean? Surprisingly, many people do not know.

♦ HEALTH MAINTENANCE ORGANIZATIONS (HMO). HMOs were designed to provide one-stop-shopping for patients: everything a patient might need with no hidden costs. An individual or an employer pays for health coverage in advance by paying the health coverage premium (the amount paid for an insurance policy). Provided a patient stays within the plan, there will not be any additional costs except for copayments, if applicable.

Health maintenance organizations are called such because HMOs generally cover preventative care, such as yearly checkups and immunizations. HMOs have a self-interest in keeping people healthy because healthy people don't spend a lot of money on health care. HMOs want to promote preventive health care so problems are caught or stopped before they can start. HMOs also control the quality of health care for members. The majority of services must be pre-approved by the primary care physician. The referral process allows all service to be reviewed by the HMO for necessity, appropriateness, and cost.

Of course, there are good parts and bad parts of this system. Good HMOs use referrals to screen out bad or inappropriate medical practices. However, bad HMOs can use referrals to limit care that is really necessary for the health of the patient. One criticism of HMOs is that decisions about the necessity or appropriateness of care are made not by doctors but by business people who may care more about cost than quality of care.

There are several different kinds of HMOs. The two most common are staff model HMOs and independent practice associations (IPAs). The staff model HMO is the best example of the one-stop-shopping approach. The doctors, medical records, labs, and pharmacy are all housed within one location. Sometimes services may be off-site from the central location. Patients may have to go to another location to see a specialist, but the specialist must still work for the same HMO system.

IPAs are made up of doctors, both primary care physicians and specialists, who see plan members in their own offices, instead of under one roof. Doctors may participate in several different IPAs. One advantage to IPAs is that there may be a larger selection of doctors and specialists from which to choose than in a staff model HMO. It's necessary to weigh these advantages against the convenience of the staff model HMO to make the best choice for oneself. Some people will have more choices than others. They will either ask their insurance company what kind of HMOs are available for them depending on what they can afford, or they will have to pick whatever their employers offer them.

There are several more types of HMOs, but the major difference among the types is in the details of the agreement made between the managed care organization and the doctors, such as patient access to doctors, referrals, and payment arrangements.

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♦ PREFERRED PROVIDER ORGANIZATION (PPO). A preferred provider organization is another kind of health plan in which members have their health care paid for only when they choose from a network of doctors and hospitals. The network is a group of health care providers who have contracts with the PPO. The health care providers agree to offer a discount rate to PPO members.

The PPO coordinates referrals and reviews treatment recommendations from participating doctors. A PPO can offer more choice and flexibility in choosing a doctor than an HMO. However, if a member sees a doctor outside of the network, the member will be required to pay part, or all, of the fee.

♦ POINT OF SERVICE (POS). A point of service plan offers the most choice to the individual by combining HMOs, PPOs, and more traditional health care plans. The member can choose at the time of each visit, or what’s referred to as “the point of service,” which doctor to see. For example, while a patient may choose to use a primary care physician from an HMO for a regular checkup, he or she may later decide to go out of network for another service, such as to a cardiologist, or heart specialist. Therefore, the patient chooses, each time there is a need for a doctor, who he or she is going to see.

A POS plan has different levels of cost to the member. For example, a member can see a doctor in the HMO for no extra cost, a doctor in the PPO network for some out-of-pocket cost, or even go to a doctor outside of the HMO or PPO for a higher out-of-pocket cost.

The PPO may still require referrals from a primary care physician. Since plans vary, members should fully understand the costs and restrictions before visiting a doctor.

Carve Outs

Carve outs are medical services that are separated from the rest of the services within a health care plan. These services are contracted for separately from all other medical services. Carve outs often include mental health and substance abuse treatment, dental and vision care, and pharmacy benefits. Some plans offer these services as a piece of their regular coverage while other plans “carve out” the services, and members choose whether or not the coverage is desired, for an additional premium cost. Specialty HMOs can be set up for one set of medical services, such as dental services.

Specialty HMOs operate just like regular HMOs but may have different rules about referrals, so it’s important to check out the requirements for making use of these benefits. Check out the fees for seeing specialty providers and the process for getting referrals. There may also be separate lists for participating physicians in specialty areas like counselors, therapists, and dentists.
Managed Indemnity

The managed indemnity is the final option for patients choosing fee-for-service plans. A member of a managed indemnity plan can choose to see any doctor. However, members must get prior approval for outpatient procedures and hospitalizations. Managed indemnity plans do not always cover preventative health care visits, and members sometimes have to file claim forms for certain services.

There are many kinds of managed health care organizations. Every managed care plan has rules for using its services, especially for referrals. These rules can be complicated but are important for an individual to understand when choosing a health care plan. The trick is to assess one's needs for health care and match those needs with the most accommodating managed care plan. A little homework early on can make for a productive relationship with the managed care organization.

Kinesiotherapist may not be recognized as an approved provider under most managed care plans. The best way to find out is to contact the major insurance companies in your region by calling the Provider Relations Department.

If the Provider Relations Department cannot assist you, ask to speak with the Provider Enrollment Department. They may ask you to submit a provider enrollment application.

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Managed Care Contracting Considerations

The information below provides some guidance regarding managed care contracting.

The 15 Questions to Ask before Signing a Managed Care Contract information sheet is from the American Medical Association (AMA) www.ama-assn.org.
15 questions to ask before signing a managed care contract

1. How important is this contract to your practice?
   - What does the contract mean in terms of revenue and expenses?
   - How would you replace any patients and/or revenue you might lose?
   - What are your alternatives to this contract?

2. How does the contract define “medically necessary” care?
   - Does the contract use an objective standard, such as a “prudent physician” standard, or does it give the managed care organization (MCO) wide flexibility in determining what is medically necessary?

3. How does the MCO verify that a patient is enrolled in a plan?
   - When a patient comes into your office, is there a quick and efficient mechanism to verify that the patient is covered by the MCO and to determine whether the patient is an enrollee covered by an MCO plan (e.g., telephone line or Web site)?
   - Is this clearly spelled out in the contract or a policy manual that you have reviewed?
   - Does the MCO stand by this information, or does it reserve the right to reverse itself?

4. How do you determine whether medically necessary services are covered by a patient’s benefit plan?
   - Does the MCO have a quick and efficient mechanism to determine whether medically necessary services you intend to provide to a patient are covered under the patient’s benefit plan?
   - Is this clearly spelled out in the contract or a policy manual that you have reviewed?
   - Does the MCO stand by this information, or does it reserve the right to reverse itself?

5. Does the contract (or administrative manual) clearly designate any and all services and procedures subject to prior authorization requirements?
   - If not, physicians should insist on getting this information in writing.
   - Does the MCO provide for an efficient and reliable mechanism to obtain prior authorization, which is available 24 hours a day, seven days a week?

6. What is your claims payment under this contract?
   - Does the contract provide enough information for you to determine what you will be paid for the services you provide?
   - Does it include a comprehensive fee schedule? If not, insist that the MCO provide fee schedules for the 20–50 most commonly billed procedures. Also insist that the MCO provide you with detailed information on payment methodology, including recognition of CPT® codes and guidelines. MCO reimbursement policies should be transparent so that you can determine your reimbursement under the contract.
7. Is claims payment sufficient?
   - What are your costs to provide the services required under the contract? While this is not an easy determination, you should have a general idea of the overhead and other expenses associated with running your practice.
   - If the contract does not compensate you beyond your practice expense, you may lose money on the contract. If you think that you are losing money on some of your contracts, it may be a worthwhile investment to retain a practice management consultant to determine why and to reconsider those contracts.

8. What are your rights to appeal a claims payment decision?
   - Does the contract provide specific procedures to appeal a claims payment decision? If the contract refers to administrative policies and procedures, review these procedures specifically to determine your appeal rights.
   - Is the appeals process fair, or is it weighted heavily in favor of the MCO?
   - Is there any independent review permitted as part of the internal appeals procedure?

9. Can the MCO change claims payment terms unilaterally?
   - If so, does the contract require the MCO to provide you notice of any claims payment changes?
   - Is there a mechanism for you to terminate the contract if you object to the changed reimbursement terms?

10. Does the MCO have an obligation to pay you promptly?
    - Does the contract include a specific payment time period, and does the MCO agree to pay interest if it delays payment beyond that time period? Many states have laws that require prompt payment of claims.
    - If your state has a prompt payment law or fair business practice act, does the contract comply with the time frames and interest penalties and other claims processing and payment provisions?

11. Does the contract give the MCO the right to unilaterally “offset” alleged “overpayments” from amounts otherwise due?
    - If so, does the contract require the MCO to explain such offsets to the physician? Is there a mechanism for the physician to appeal offsets? Does the contract limit the time frame for these payment offsets?
    - Many MCOs conduct retrospective audits of physician practices several years after services are rendered and then either demand return of sums allegedly “overpaid” or automatically deduct payment without explanation to physicians.

12. What products are you required to participate in?
    - Does the contract allow you to select which products you participate in? Or does the contract require you to participate in “all products?”
    - Does the contract allow you to terminate one product, or does termination in one product automatically terminate your participation in all products?

13. Does the contract require compliance with a prescription drug formulary?
    - If so, what flexibility do you have to go off-formulary when your medical judgment dictates a non-formulary drug?

14. Does the contract allow the MCO to “rent” you to other entities?
    - This relates to so-called “silent PPOs,” where a physician signs a discounted fee-for-service contract with an MCO, and then, without informing the physician, the MCO “sells” or “rents” its physician network to a third party, such as a third-party administrator. The third party gets the advantage of whatever discount the MCO has negotiated with the physician. Broad definitions of the term “payer” or “participating entities” are signals that the contract may permit this type of activity. Clarify this with the MCO.
ADMINISTRATIVE SIMPLIFICATION

Requirements of health care providers filing claims to insurance carriers

Health Insurance Portability & Accountability Act (HIPAA)
Administrative Simplification Enforcement Tool

The Department of Health and Human Services (HHS), specifically the Office of E-Health Standards and Services (OESS) is responsible for all HIPAA Administrative Simplification enforcement except for Privacy, which is enforced by the Office for Civil Rights.

What is Administrative Simplification?

If you file claims to insurance carriers, this is a portion of the law that is important to understand. Administrative Simplification is part of the 1996 HIPAA rule containing provisions for providers and insurances to follow when filing and processing claims. The rule establishes national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. As the industry has implemented these standards, and increased the use of electronic data interchange, the nation's health care system is transitioning to become increasingly effective and efficient.
As a therapy provider, if you file a claim to insurance electronically there are 2 ways to do this: directly or through a clearing house. Either method – there is an electronic format required under Administrative Simplification. If the claims are not filed in the appropriate format, the insurance company is not required to accept or process the claims.

When the claims are filed, the provider must only use the accepted “data sets” under the rule. For therapy, the approved data sets are: CPT, HCPCS level II and ICD9 codes assigned according to coding guidelines and any insurance company requirements under your contract.

OESS is an office within the Centers for Medicare & Medicaid Services (CMS), but for purposes of HIPAA enforcement, OESS operates as a separate entity and is completely detached from CMS’s Medicare and Medicaid related activities.

What is the ASET Enforcement Tool?

ASET is an electronic tool provided by the OESS to assist health care providers, payers, clearinghouses and others to submit complaints regarding all enforceable Administrative Simplification provisions, except for Privacy.

Enforceable complaints are complaints regarding a provision where the compliance date has already passed (e.g. Transactions and code sets post October 16, 2003).

This electronic tool enables individuals or organizations to fill out a complaint against an entity whose actions they believe violate an Administrative Simplification provision that is currently enforceable.

If you feel you have a HIPAA complaint, please read the information presented.

Why is ASET necessary?

The Office of E-Health Standards and Services (OESS) in the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for overseeing the non-privacy provisions of the Administrative Simplification Act, will use a complaint-driven approach for enforcement.

When OESS receives a valid HIPAA complaint through the ASET system, OESS will notify the entity involved in the dispute that a complaint has been filed against them.
Following notification of a valid complaint, OESS will facilitate resolution of the dispute. The entity that the complaint is filed against will have the opportunity to demonstrate compliance, its good faith efforts to comply, or submit a corrective action plan.

If you believe you have a valid complaint against an entity that must comply with the HIPAA Administrative Simplification provisions, carefully review the information provided here. OESS will use the information you provide through the complaint process to help resolve the complaint.

The primary goal of the enforcement process is to foster voluntary compliance.

Who can use ASET?

Anyone can use ASET to file a HIPAA complaint.

This tool cannot be used to file a complaint about HIPAA’s privacy provisions. Privacy complaints should be directed to the Office for Civil Rights (OCR), the federal agency responsible for enforcing HIPAA Privacy requirements. Click here (www.hhs.gov/ocr/hipaa) to leave this site and go to OCR's website for more information on filing a privacy complaint.

If you are uncertain about your covered entity status, or would like clarification on other HIPAA related issues, you may contact CMS for additional help.

You may contact the CMS HIPAA Hotline at 1-866-282-0659 or submit your questions to CMS’ HIPAA email address at askhipaa@cms.hhs.gov.

What is the complaint process?

Each ASET user must register with OESS and create a user identification name and password.

The user must have a valid email account to create a user ID. This user name and password will be used for ongoing access to ASET.

Once registration is completed, the user can enter ASET to file a complaint.
To file a complaint the user must provide information regarding the complainant, the specifics of the complaint, and the party that the complaint is being filed against.

Once all the information is entered, the system processes the complaint. If the complaint is a transactions and code sets complaint, the complainant may be asked to upload data files and conducts any necessary testing on data files that have been uploaded, the complaint is then referred to OESS for analysis.

The complainant may be asked for additional information.

### What HIPAA Resources are available?

Before filing a complaint with OESS, all covered entities should read the pertinent information on OESS' enforcement approach.

The documents, as well as many other valuable resources, are available on the CMS HIPAA website. ([www.cms.hhs.gov/hipaa/hipaa2](http://www.cms.hhs.gov/hipaa/hipaa2))

Filing a HIPAA complaint with OESS should be a last resort effort to resolve your issues consulting various HIPAA resources.

For technical assistance on specific issues, refer to the applicable guides. For example, for a transaction and code sets complaint, refer to the official HIPAA Implementation Guides available for download at the Washington Publishing Company website ([www.wpc-edi.com](http://www.wpc-edi.com)).

You may also seek answers to technical questions from the organizations responsible for developing the standards. For assistance with the ANSI X12 transactions, go to the X12 website ([www.X12.org](http://www.X12.org)). For technical assistance with the National Drug Codes standards, go to the NCPDP website ([ncpdp.org](http://ncpdp.org)).

If you are a patient please attempt to resolve the issue with the provider and payer prior to registering a complaint. Guidance for each HIPAA provision is available.
About NCQA

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans. We are governed by a Board of Directors that includes employers, consumer and labor representatives, health plans, quality experts, policy makers, and representatives from organized medicine.

NCQA’s mission is to provide information that enables purchasers and consumers of managed health care to distinguish among plans based on quality, thereby allowing them to make more informed health care purchasing decisions. This encourages plans to compete based on quality and value, rather than on price and provider network. Our efforts are organized around two activities, accreditation and performance measurement, which are complementary strategies for producing information to guide choice. These activities have been integrated under NCQA’s Accreditation ’99 program, which includes selected performance measures in such key areas as member satisfaction, quality of care, access, and service.

Health Plan Report Card

NCQA’s Health Plan Report Card is an interactive tool designed to help patient find a health plan!

NCQA is a private nonprofit organization committed to improving the quality of our nation's health care. NCQA sets standards for the quality of care and service that health plans provide to their members. Health plans that meet NCQA standards receive NCQA Accreditation, which is nationally recognized as a seal of approval.

NCQA’s Health Plan Report Card can help answer questions such as Does this health plan provide good customer service? Will patients have access to care needed? Does the plan check doctors and/or provider qualifications?

NCQA Accreditation is used by most of the nation's Fortune 500 employers, federal and state governments, and consumers like you to help select among competing health plans.
Only NCQA's Health Plan Report Card is based on a rigorous evaluation of clinical quality, member satisfaction and a comprehensive assessment of key systems and processes.

NCQA’s Health Plan Report Card has results on hundreds of health plans that care for commercially insured individuals and Medicare and Medicaid beneficiaries. You can create a customized Report Card that shows results for the health plan or plans you want to know about.

Managed Care Terminology

Government Reference List from Health & Human Services (HHS)

The following terms are commonly used in the managed care community. The inclusion of any term, however, does not constitute an endorsement or recommendation by the Department or any of its agencies or employees. HHS does not endorse any product or service provided by any other organization.

**Accreditation**--The process by which an organization recognizes an institution as meeting predetermined standards

**Actuarial Soundness**--The requirement that the development of capitation rates meet common actuarial principles and rules.

**Adjusted Average Per Capita Cost (AAPCC)**--The estimated average fee-for-service cost of Medicare benefits for an individual by county of residence. It is based on the following factors: age, sex, institutional status, Medicaid, disability, and end stage renal disease status. HCFA uses the AAPCCs as a basis for making monthly payments to TEFRA contractors.

**Adverse Selection**--The problem of attracting members who are sicker than the general population, specifically, members who are sicker than was anticipated when developing the rates of reimbursement for medical costs. **Affiliated Provider**--a health care provider or facility that is
part of the Managed Care Organization's network, usually having formal arrangements to provide services to the MCO's member.

**Alternative Delivery Systems**--A phrase used to describe all forms of health care delivery except traditional fee-for-service, private practice. The term includes HMOs, PPOs, IPAs, and other systems of providing health care.

**Ambulatory Care**--All types of health services that are provided on an outpatient basis, in contrast to services provided in the home or to persons who are hospital inpatients.

**Benefits**--The payment for, or health care services provided under terms of a contract with a MCO.

**Capitation**--A dollar amount established to cover the cost of health care services delivered for a person during a specified length of time. The term usually refers to a negotiated per capita rate to be paid periodically to a health care provider by a MCO. The provider is then responsible for delivering or arranging the delivery of all health services required by the covered person under the conditions of the provider contract. This term may also refer to the amount paid to a MCO > by HCFA or a State.

**Carve Out**--One or more services excluded from those required to be provided under the capitation rates. These services may be paid on a fee-for-service or other basis.

**Case Management**--A process and technique to manage the care of specific health care needs (often multiple) in a way that is designed to achieve the optimum patient outcome in the most cost-effective manner.

**Case Manager**--A nurse, doctor, or social worker who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.

**Closed Access**--A managed health care arrangement in which covered persons are required to select providers only from the plan's participating providers.

**Competitive Medical Plan (CMP)**--A status, established by TEFRA and granted by the Federal government, to an organization that meets specific requirements enabling that organization to obtain a Medicare risk or cost based contract.

**Copayment**--A cost-sharing arrangement in which a member pays a specified charge for a specified service (e.g., $10 for an office visit). The member is usually responsible for payment at the time the service is rendered.

**Cost Contract**--A TEFRA contract payment methodology option by which HCFA pays for the delivery of health services to members based on the HMO's reasonable cost. The plan receives an interim amount derived from an estimated annual budget, which may be periodically adjusted.
during the course of the contract to reflect actual cost experience. The plan's expenses are audited at the end of the contract to determine the final rate the plan should have been paid.

Cost Sharing--A general set of financing arrangements in which a covered member must pay a portion of the costs associated with receiving care. (See also copayment, coinsurance and deductible).

Deductible--A specified amount of money a member must pay before insurance benefits begin. Usually expressed in terms of an "annual" amount.

Diagnosis Related Groups (DRG)--A system of classification for inpatient hospital services based on diagnosis, age, sex, and the presence of complications. It is used as a means of identifying costs for providing services associated with a diagnosis and as a mechanism to reimburse hospital and selected other providers for services rendered.

Employer Mandate--Under the Federal HMO Act, describes conditions when federally qualified HMOs can mandate or require an employer to offer at least one federally qualified HMO plan of each type (IPA/network or group/staff). (Sunsetted in 1995).

EQRO (External Quality Review Organization)--States are required to contract with an entity that is external to and independent of the State and its HMO and HIO contractors to perform an annual review of the quality of services furnished by each HMO or HIO contractor.

Exclusive Provider Organization (EPO)--A term derived from the phrase preferred provider organization (PPO). However, where a PPO generally extends coverage for non-preferred provider services as well as preferred provider services, an EPO provides coverage only for contracted providers; hence, the term exclusive. Technically, many HMOs can also be described EPOs.

Experience Rating--The process of setting rates partially or in whole on evaluating previous claims experience for a specific group or pool of groups.

Federal Medicaid Managed Care Waiver Program--The process used by States to receive permission to implement managed care programs for their Medicaid or other categorically eligible beneficiaries.

Federal Qualification--A status defined by the HMO Act, conferred by HCFA after conducting an extensive evaluation of the HMO's organization and operations. An organization must be federally qualified or be designated as a CMP (competitive medical plan) to be eligible to participate in Medicare cost and risk contracts. Likewise, an HMO must be federally qualified or State plan defined to participate in the Medicaid managed care program.

Fee-For-Service (FFS)--A payment system by which doctors, hospitals and other providers are paid a specific amount for each service performed as identified by a claim for payment.
**Fiscal Soundness**--The requirement that managed care organizations have sufficient operating funds, on hand or available in reserve, to cover all expenses associated with services for which they have assumed financial risk.

**Gatekeeper**--An arrangement in which a primary care provider serves as the patient's agent, arranges for and coordinates appropriate medical care and other necessary and appropriate referrals.

**Group or Network HMO**--An HMO that contracts with one or more independent group practice to provide services to its members in one or more locations.

**Guaranteed Eligibility**--A defined period of time (3-6 months) that all patients enrolled in prepaid health programs are considered eligible for Medicaid, regardless of their actual eligibility for Medicaid. A State may apply to HCFA for a waiver to incorporate this into their contracts.

**Health Maintenance Organization (HMO)**--An entity that provides, offers or arranges for coverage of designated health services needed by members for a fixed, prepaid premium. There are three basic models of HMOs: group model, individual practice association (IPA), and staff model.

**HEDIS**--The Health Plan Employer Data and Information Set is a set of performance measures developed to support health plan and Medicaid agency efforts to improve the health status of Medicaid beneficiaries, support the strengthening of health care delivery systems for the Medicaid population, promote standardization of managed care reporting across public and private sectors, and promote the application of performance measurement technology across Medicaid programs.

**HIO**--An entity that contracts on a prepaid, capitated risk basis to provide comprehensive health services to recipients.

**Individual Practice Association (IPA) model HMO**--An HMO that contracts with individual practitioners or an association of individual practices to provide health care services in return for a negotiated fee. The individual practice association, in turn, compensates its physicians on a per capita, fee schedule, or other agreed basis.

**Insolvency**--A legal determination occurring when a managed care plan no longer has the financial reserves or other arrangements to meet its contractual obligations to patients and subcontractors.

**Licensing**--A process most States employ, which involves the review and approval of applications from HMOs prior to beginning operation in certain areas of the State. Areas examined by the licensing authority include: fiscal soundness, network capacity, MIS, and quality assurance. The applicant must demonstrate it can meet all existing statutory and regulatory requirements prior to beginning operations.
Lock-in--A contractual provision by which members except in cases of urgent or emergency need, are required to receive all their care from the network health care providers.

Managed Care--A system of health care that combines delivery and payment; and influences utilization of services, by employing management techniques designed to promote the delivery of cost-effective health care.

Managed Health Care Plan--An arrangement that integrates financing and management with the delivery of health care services to an enrolled population. It employs or contracts with an organized system of providers which delivers services and frequently shares financial risk.

Medicare Supplement Policy--A health insurance policy that pays certain cost not covered by Medicare such as coinsurance, deductibles.

Network Model HMO--A health care model in which the HMO contracts with more that one physician group or IPA, and may contract with single and multi-specialty groups that work out of their own office facility. The network may or may not provide care exclusively for the HMO's members.

Open Access--A term describing a member's ability to self-refer for specialty care. Open access arrangements allow a member to see a participating provider without a referral from another doctor. Also called open panel.

Open Enrollment Period--A period during which subscribers in a health benefit program have an opportunity to select among health plans being offered to them, usually without evidence of insurability or waiting periods.

Outcome measurement--A process of systematically measuring individual or collective clinical treatment and response to that treatment.

Out-of-pocket expenses--Costs borne by the member that are not covered by health care plan.

PCCM--A Primary Care Case Management program is a Freedom of Choice Waiver program, under the authority of section 1915(b) of the Social Security Act. States contract directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. Currently, most PCCM programs pay the primary care physician a monthly case management fee in addition to receiving fee-for-services payment.

Peer Review--The evaluation of the quality of the total health care provided by Plan medical staff by equivalently trained medical personnel.

Peer Review Organization (PRO)--An organization established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to review quality of care and appropriateness of admissions, readmissions and discharges for Medicare and Medicaid.
PHP--A Prepaid Health Plan is an entity that either contracts on a prepaid, capitated risk basis to provide services that are not risk-comprehensive services, or contracts on a non-risk basis. Additionally, some entities that meet the above definition of HMOs are treated as PHPs through special statutory exemptions.

Point-Of-Service Plan--A health services delivery organization that offers the option to its members to choose to receive a service from participating or a nonparticipating provider. Generally the level of coverage is reduced for services associated with the use of non-participating providers.

Preferred Providers--Physicians, hospitals, and other health care providers who contract to provide health services to persons covered by a particular health plan.

Preferred Provider Organization--A health care delivery system that contracts with providers of medical care to provide services at discounted fees to members. Members may seek care form non-participating providers but generally are financially penalized for doing so by the loss of the discount and subjection to copayments and deductibles.

Premium--Money paid out in advance for insurance coverage.

Prepayment--A method of paying for the cost of health care services in advance of their use.

Preventive health care--Health care that seeks to prevent or foster early detection of disease and morbidity and focuses on keeping patients well in addition to health them while they are sick.

Primary Care Network (PCN)--A group of primary care physicians who share the risk of providing care to members of a given health plan.

Primary Care Provider (PCP)--The provider that serves as the initial interface between the member and the medical care system. The PCP is usually a physician, selected by the member upon enrollment, who is trained in one of the primary care specialties who treats and is responsible for coordinating the treatment of members assigned to his/her plan. (See Gatekeeper)

Professional Review Organization--An organization which reviews the services provided to patients in terms of medical necessity professional standards; and appropriateness of setting.

QARI--The Quality Assurance Reform Initiative was unveiled in 19993 to assist States in the development of continuous quality improvement systems, external quality assurance programs, internal quality assurance programs, and focused clinical studies.

Qualified Medicare Beneficiary (QMB)--A person whose income level is such that the state pays the Medicare Part B Premiums, deductibles and copayments.
Quality Assurance--A formal methodology and set of activities designed to access the quality of services provided. Quality assurance includes formal review of care, problem identification, corrective actions to remedy any deficiencies and evaluation of actions taken.

Reinsurance--An insurance arrangement whereby the MCO or provider is reimbursed by a third party for costs exceeding a pre-set limit, usually an annual maximum.

Risk Adjustment--A system of adjusting rates paid to managed care providers to account for the differences in beneficiary demographics, such as age, gender, race, ethnicity. Medical condition, geographic location, at-risk population (i.e. homeless), etc.

Risk Contract--A contract payment methodology between HCFA and an HMO or CMP that requires the delivery of (at least) all covered services to members as medically necessary in return for a fixed monthly payment rate from the government and (often) a premium paid by the enrollee. The HMO is then liable for those contractually offered services without regard to cost. (Note: Medicaid beneficiaries enrolled in risk contracts are not required to pay premiums.)

Shared Savings--A provision of most prepaid health care plans where at least part of the providers' income is directly linked to the financial performance of the plan. If costs are lower than projections, a percentage of these savings are referred to the providers.

Staff Model HMO--This model employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)--The Federal law that created the current risk and cost contract provisions under which health plans contract with HCFA.

Utilization Management--The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.

Utilization Review (UR)--A formal review of utilization for appropriateness of health care services delivered to a member on a prospective, concurrent or retrospective basis.