

## **DOCUMENTATION GUIDES – OCCUPATIONAL THERAPISTS**

The following information was sent to Occupational Therapists via letter dated September 23, 2009.

Consultants from the state of Kansas, who perform peer reviews for Blue Cross and Blue Shield of Kansas (BCBSKS), recently decided communication needed to be sent to their peers with the purpose of informing you of two main concerns and recommended solutions. The groups' stated goals are to assist Occupational Therapists in obtaining appropriate compensation for their services provided and improving the process in performing these reviews. The two main areas of concern are:

- 1) **Documentation of medical necessity**
- 2) **Documentation of services provided**

### **MEDICAL NECESSITY DOCUMENTATION**

Do you require evidence of necessity before you pay for something? So does BCBSKS. Before BCBSKS can appropriately reimburse you for services, it must be determined if services are documented and can be supported by your records as being medically necessary. Medical necessity is required as a fiduciary steward and is a standard of care that is supported by the profession of occupational therapy, as well as all payer sources (See references). In many instances, this requires that you or your office remit all appropriate and legible documentation for the claim in question.

When records are requested from you, consider what documentation will support the provision of and need for the services, and what a peer reviewer will be able to use to discern the medical necessity without knowing the patient as well as you do.

### **DOCUMENTATION STANDARDS**

The following medical record standards (not all inclusive) are required; and if not met, may result in delay or denial of payment:

- 1) Documented referral from appropriate referral source.
- 2) Documented name (on each page of the record) and birth date of beneficiary
- 3) **Legible** handwriting (if it is not readable, it will be denied)
- 4) Avoidance of abbreviations (use only standard abbreviations well known to your peers)
- 5) Each CPT code submitted for payment must have the appropriate documentation to support the service rendered. Clearly document what you performed to differentiate between each service utilized – 97110, 97112, 97530, 97535, etc.
- 6) Initial evaluation that includes:
  - a. Diagnosis (medical and occupational therapy)
  - b. Complete history and thorough systems review (patient stated problems, co-morbidities, medications, review of past-present care)

- c. Objective, functional, measurable data (at a minimum):
- ROM (relate to function deficits and sx)
  - Neuro (relate to function deficits and sx)
  - Tissue integrity (trigger pts, pain patterns, spasms, relate to function deficits and sx)
  - Movement pattern deficits (relate to function deficits and sx)
  - Functional deficits (relate to sx)
  - Posture (relate to function deficits and sx)
  - Strength (relate to function deficits and sx)
  - Specific Tests (relate to function deficits and sx)
- d. Clearly delineated, measurable, time-framed goals that relate to **function**
- Description of movement or activity
  - Connect to specific function deficit or sx
  - Measurable & Time-framed (What does patient need to be doing before DS?)
  - Identify who will accomplish the goal
- Examples:
- *"Pt. Improve shldr flex to 160 to reach into cupboards at home 3 wks"*
  - *"Pt. Reduce and control pain to 2 / 10 to enable pain free sleeping 2 wks"*
  - *"Pt. Safely walk inside home no external assistance 2 wks"*
  - *"Pt. Increase mid scapular strength 4+ / 5 to reduce pain to 1 / 10 and sit at computer all day for work 4 wks"*
- e. Clearly stated plan of care delineating what will be provided, at what frequency and duration
- Examples:
- *"Gt train walker, 100', indep, no falls or stumbles for goal #3"*
  - *"T Ex isotonic, closed chain, progress no weight to 3 lbs, related to goal #4"*
  - *"US, 1.5w/cm@ X 8 minutes Left trap and levator, decrease spasms, trigger pts, increase circulation, pain modulation for goal #2"*
  - *"Discharge to Specialty Exercise Program"*
- f. Clearly stated **medical reason and rationale** for **each** modality utilized – 97010, 97014, 97035, etc—especially when utilizing more than one modality to the same area and same session
- 7) Daily Notes that include:
- a. Statements that demonstrate the skill required by the OT or OTA, under the supervision and
  - b. Direction of an OT, not just statements of completion of activities (this can be seen on the flow sheet). Why can't patient perform their own exercises at home?
  - c. Statements that demonstrate co-founding factors that delay progress
  - d. Time In and Time Out
  - e. Time for each CPT code billed
- Examples:
- *Subjective complaints / descriptive / numerical pain / percentage of improvement*
  - *Complicating factors*
  - *Flow sheet (show progression and skill)*

- *Observation of movement / measurements / function gain – loss / skill need / education of patient*
    - \* *Type and amount of manual, visual, verbal cues*
    - \* *Why needed*
    - \* *"Constant verbal and tactile cues for shldr flex without substitution. Ther ex resulted increase shldr flx to 120 to comb hair, still unable to reach into cupboards at home".*
  - *Factors that modify frequency / intensity / progression*
    - \* *"Performing shldr flex and abd ex incorrectly resulting increased impingement."*
    - \* *"Painted bedroom with repeated overhead mvts increased pain"*
    - \* *"Computer station ergonomic corrections not made, enhances poor posture and muscle imbalances aggravating sx"*
  - *Statement of clinical decision and problem solving*
    - \* *"Poor control and contraction transverse ab muscles resulting in continued compression and sheering lumbar with pain and radicular sx requires neuro-ed ex and educ."*
    - \* *"Poor blood sugar control resulting fatigue and avoidance of exercise. Speak to MD."*
    - \* *"Quad control in open chain good, transition into controlled functional closed chain in preparation for running."*
  - *Plan for next visit = intervention and objective*
- 8) Progress notes (or re-eval) completed every 10 treatment sessions or every 30 days (whichever is less) that include:
- a. Statements of pertinent subjective nature
  - b. Comparison of **objective, functional, measurable data** (at a minimum as indicated ROM, Strength, Neuro, Ambulation, Special tests, etc.)
  - c. Clearly delineated and **updated** measurable, time-framed goals that relate to **function** (i.e., what does the patient need to be doing before discharge from therapy?)
  - d. Clearly stated, **updated** plan of care delineating what will be provided, frequency and duration
  - e. Clear stated medical **reason and rationale** for continuance of **each** service utilized
    - *Evaluate status and modify plan. May simply mean continue current goals but state why*
    - *Billing 97002 – Re-Eval*
      - \* *Unanticipated change*
      - \* *Failure to respond*
      - \* *New direction or plan*
    - *Compare similar data points*
    - *Goals addressed, updated*
    - *Reasons for lack of progress, changes needed*
- 9) Flow sheets that include:
- a. Date of service, area being treated, and name of OT or OTA providing services
  - b. Clearly delineated CPT Code
  - c. **Activity** completed for each CPT code including name of activity, repetitions, weights, resistance, etc.
  - d. Modalities (parameters, time frame, and specific location(s) treated)

**RESPONSIBILITIES**

It is imperative that you and your staff are fully aware of the professional, fiduciary, and legal standards/requirements of complete and thorough documentation. A BCBSKS professional relations representative is readily available to assist you. Please refer to the important resources at the end of this document that will increase the successful and timely adjudication and remittance of payment for the valuable services you provide.

BCBSKS and Occupational Therapy peer review consultants strive to provide you the information necessary to meet the requirements of documentation to successfully and timely adjudicate claims for remittance of payment for the valuable services you provide. Please contact your BCBSKS professional relations representative should you have questions or require additional information.

**RESOURCES**

- 1) Medicare documentation standards <http://www.cms.hhs.gov>
- 2) BCBSKS policies and procedures  
<http://www.bcbsks.com/Customerservice/Providers/index.htm>
- 3) Your BCBSKS contractual agreements
- 4) Kansas statutes and rules/regulations <http://ksbha.org/statutes.html>  
<http://ksbha.org/regs.html>

**EXAMPLES OF RED FLAGS:**

- Duplicative services or physiologic effects
- Misuse of CPT codes
- Billing/use of 97124 and 97140 for the same body part on the same DOS
- # of units / treatment greater than BCBSKS policy allowable
- Billing/use of 97002 on each DOS
- Upcoding (e.g. 97032 instead of 97014)
- Use of unlisted procedure and modality codes
- Billing/use of two or more superficial heating modalities to the same body part – Use of 97010, 97014, 97035 same body part, same session with no documented rationale and objective data to support necessity for **each** modality
- Continued use of modalities for periods greater than 10 treatment sessions with no documented rationale and objective data to support patient improvement and ongoing treatment.

### **BCBSKS POLICIES**

While this is not a totally exhaustive listing, these are some of the more common policies that apply to Occupational Therapy (as well as other providers):

1. BCBSKS limits the number of CPT codes billed per date of service to **FOUR (4)**. (*Blue Shield Report* Newsletter March 15, 2000)
  - a. Claims with greater than 4 services will require submission of **all** appropriate medical records **AT THE TIME OF SUBMISSION OF THE CLAIM**. See **Documentation standards** previously outlined in this letter to determine what documentation needs to be submitted with the claim.
  - b. The claim will be denied and returned with a request for records if they are not received with the claim.
2. BCBSKS limits the number of **UNITS** allowed per CPT code per date of service (BUSINESS PROCEDURE MANUAL):  
[http://www.bcbsks.com/CustomerService/Providers/Publications/professional/manuals/pdf/unit\\_limitation.pdf](http://www.bcbsks.com/CustomerService/Providers/Publications/professional/manuals/pdf/unit_limitation.pdf)
3. BCBSKS has limitations on services provided for **CPT code 97535** (*Blue Shield Report* Newsletter August 30, 2005)
  - a. "**DENY** content of service to other codes billed same setting in the following situations":
    - 1) Home exercise program
    - 2) Instructions for use of DME such as TENS units, cervical traction
    - 3) Instructions for orthotics or prosthetics such as AFO's, compression stockings
    - 4) Instructions for home care such as correct posture or sleeping positions
4. Vertebral Axial Decompression therapy must be billed using HCPCS code S9090. (*Blue Shield Report* May 28, 2003)
  - a. Reimbursement based on CPT code 97012
  - b. VaxD, IDD, DR 5000, DR 9000, SpinaSystem, and similar vertebral axial decompression therapy are subject to this billing policy
  - c. **ALLOW ONE (1)** unit per day based on documented medical necessity
5. Accident Related Documentation
  - a. Payment for services related to an accident is NOT the same as those services for general medical coverage. In the event the services are being rendered as related to an accident, it is imperative that your documentation is clear and concise about:
    - 1) The details of the accident (simple statements like "they fell on 4-10-09" are insufficient)
    - 2) The objective, functional, measurable data that supports the medical problems that are a direct result of the accident and need for occupational therapy services.

**DOCUMENTATION CHECKLIST for SUBMISSION of RECORDS  
ACCIDENT**

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**Details of accident**

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**Initial evaluation that includes:**

1. Diagnosis (medical and occupational therapy)
2. History, patient stated problems, co-morbidities, medications review of past-present care
3. Objective functional, measurable data (at a minimum as indicated ROM, Strength, Neuro, Ambulation, Special tests, etc.)
4. Clearly delineated, measurable, time-framed goals that relate to function
5. Clearly stated plan of care delineating what will be provided, frequency and duration
6. Clearly stated medical reason and rationale for each modality utilized

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**Daily Notes that include:**

1. Statements that demonstrate the skill required by the OT or OTA under the supervision and direction of an OT
2. Statements that demonstrate co-founding factors that delay progress
3. Tim In and Time Out
4. time for each CPT Code billed

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**Progress notes completed every 10 treatment sessions or every 30 days (whichever is less) that include:**

1. Statements of pertinent subjective nature
2. Comparison of objective, functional, measurable data (at a minimum as indicated ROM, Strength, Neuro, Ambulation, Special tests, etc.)
3. Clearly delineated and updated measurable, time-framed goals that relate to function
4. Clearly stated, updated plan of care delineating what will be provided, frequency and duration and why continued care is medically necessary.
5. Clearly stated medical reason and rationale for continuance of each modality utilized

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**Flow sheets that include:**

1. Date of each service
2. Clearly delineated CPT code
3. Activity completed for each CPT Code including name of activity, repetitions, weights, resistance, etc.
4. Modalities (parameters, time frame, and specific location(s) treated)

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**Patient's name on each page of the records**

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**Record legible?**

**DOCUMENTATION CHECKLIST for SUBMISSION of RECORDS  
NON-ACCIDENT****Initial evaluation that includes:**

1. Diagnosis (medical and occupational therapy)
2. History, patient stated problems, co-morbidities, medications, review of past-present care.
3. Objective, functional, measurable data (at a minimum as indicated ROM, Strength, Neuro, Ambulation, Special tests, etc.)
4. Clearly delineated, measurable, time-framed goals that relate to function
5. Clearly stated plan of care delineating what will be provided, frequency and duration
6. Clearly stated medical reason and rationale for each modality utilized

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1. Statements that demonstrate the skill required by the OT or OTA under the supervision and direction of an OT
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4. Time for each CPT Code billed

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**Patient's name on each page of the records****Record legible?****Does the record reflect why more than 4 CPT Codes were utilized?****Does the record reflect why more than allowable number of units per CPT code utilized?**