Navigating the Maze: Cardiopulmonary Billing and Reimbursement

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Disclosures

Both speakers are partners in PT Cardiopulmonary Educators, LLC a private company that produces web based cardiopulmonary education in basic and advanced topics.
Objectives

• Discuss billing in physical therapy for all patients including patients with cardiac and pulmonary dysfunction
• Differentiate billing for cardiac rehab and pulmonary rehab from billing for physical therapy
• Discuss Medicare billing guidelines for these patients
• Determine appropriate billing and reimbursement for different cases
Billing and Coding in Physical Therapy

• CPT coding: utilize the 97000 series for billing
  – 97001 Initial evaluation—timed intervals
  – 97002 Re-evaluation—timed intervals
  – 97110 Therapeutic Exercise (Therapeutic Procedure)
  – 97112 Neuromuscular Training
  – 97116 Gait Training
  – 97150 Group Therapeutic procedures---not timed (2 or more individuals)
  – 97530 Dynamic activities to improve functional performance (Therapeutic Activity)
  – 97535 Self care and home management
  – 97750 Physical performance test
  – 97140 Manual Therapy
  – 94761 Pulse Oximetry Multiple Determination---not timed
  – 94620 Simple Exercise Test with oximetry---not timed
CPT Coding Rules

• Only one eval code may be billed each day……including PT Eval, Re-eval, Physical Performance Test

• No group may be billed with an evaluation code on the same day

• If using a “timed “ code…use following rules
  – Bill one timed code if see patient 8min – 22 min
  – Bill two timed codes if see patient 23-37 minutes
  – Bill three timed codes if see patient 38-52 minutes
  – Bill four timed codes if 53-67 minutes
Billing for more than one

• If seeing more than one patient in an hour
  – Example: 2 CHF patients seen by ONE PT
    • 97150 for group
    • 97110 for number of direct one on one minutes

• If 2 patients in one hour…each patient would get 2 units of 97110

• EACH PT cannot bill more than 4 one on one units per hour…. 
ICD-10

- Chapter 3: Disease of the blood and blood-forming organs and certain disorders involving immune mechanism (D50-D89)
- Chapter 4: Endocrine, Nutritional and Metabolic Diseases (E00-E89)
- Chapter 5: Mental, Behavioral and Neurodevelopmental disorders (F01-F99)
- Chapter 6: Diseases of the Nervous System (G00-G99)
- Chapter 7: Diseases of the Eye and Adnexa (H00-H59)
- Chapter 8: Diseases of the Ear and Mastoid (H60-H99)
- Chapter 9: Diseases of the Circulatory System (I00-I99)
- Chapter 10: Diseases of the Respiratory System (J00-J99)
- Chapter 11: Diseases of the Digestive System (K00-K95)
ICD-10

• Chapter 11: Diseases of the Digestive System (K00-K95)
• Chapter 12: Diseases of the Skin and Subcutaneous system (L00-L99)
• Chapter 13: Diseases of the Musculoskeletal and Connective Tissue Systems (M00-M99)
• Chapter 14: Diseases of the Genitourinary System (N00-N99)
• Chapter 15: Pregnancy, Childbirth, Puerperium (O00-O9A)
• Chapter 17: congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
• Chapter 18: Symptoms, signs and abnormal lab and clinical findings not elsewhere classified (R00-R99)

Billing and Coding in Physical Therapy

• **Most common ICD 10 for Cardiopulmonary:**
  - [http://www.apta.org/uploadedFiles/APTAorg/Payment/Coding_and_Billing/Coding/ICD10/ICD10_CardiovascularPulmonary.pdf](http://www.apta.org/uploadedFiles/APTAorg/Payment/Coding_and_Billing/Coding/ICD10/ICD10_CardiovascularPulmonary.pdf)

• Check with payer to determine appropriate first-listed diagnosis
Cardiac Rehabilitation

• Guidelines for billing and coding directed by Medicare


  NCD 20.10

• 20.20.1 includes chronic heart failure…a change as of 2014

• 20.31.2 for Ornish Program for Reversing Heart Disease
Cardiac Rehabilitation

• CR codes for billing
  – Incident to physician billing…NOT billing under PT codes
  – PT CAN be involved in CR but they are billing incident to physician
  – Utilize two codes:
    • 93797 no continuous monitoring
    • 93798 continuous ECG monitoring
  – These are bundled codes…no separate billing for dietitian, psychosocial or any other charges
  – Generally reimbursed $50/visit for medicare, $120-$150/visit for private insurance
Cardiac Rehab Diagnoses

- Stable angina in past 12 months
- Heart transplant
- CABG
- PTCA
- Stent
- Valve surgery
- Heart failure...6 weeks after acute admission
Cardiac Patients seen in Physical Therapy

• Indications:
  – Other diagnoses or those with secondary Cardiac diagnosis
  – HF patients recently discharged but less than 6 weeks from D/c from hospital for acute admission
  – EF > 35%
  – LVADs

• GAP program…or long term program
  – Utilize PT diagnosis AND medical diagnosis
  – Utilize 97000 series for billing for services

• Send to Cardiac Rehab for Medicare benefits when finished with GAP program
So...what do you think so far????
Pulmonary Rehabilitation

- Medicare NCD 240.8
- Pulmonary Rehab toolkit from aacvpr.org
  - [https://www.aacvpr.org/Portals/0/Resources/PRReimbursementToolkit_FINAL.pdf](https://www.aacvpr.org/Portals/0/Resources/PRReimbursementToolkit_FINAL.pdf)
- Codes: G0424
  - Bundled code
  - Includes actual exercise, education, oximetry, any six minute walk tests or other tests for Rehab
  - One payment per hour session…can bill max of 2 hours/day
  - Payment approximately $55.94 per hour with $11.19 co-pay
Pulmonary Rehabilitation

• Three items for G0424 billing criteria:
  – 1-Medicare (either primary or secondary)
  – 2-Physician documentation of COPD diagnosis
  – 3-GOLD classifications Stage II, III, IV

• Stage I COPD
  – $FEV_1 \geq 80\%$ normal, $FEV_1/FVC < 0.70$

• Stage II COPD
  – $FEV_1$ 50-79% normal, $FEV_1/FVC < 0.70$

• Stage III COPD
  – $FEV_1$ 30-49% normal, $FEV_1/FVC < 0.70$

• Stage IV COPD
  – $FEV_1 < 30\%$ normal, or $< 50\%$ normal with chronic respiratory failure present* (requires long-term oxygen therapy)
Pulmonary Rehabilitation

• The G0424 billing code does not:
  – Cover any other pulmonary diagnosis.
  – Cover restrictive disease
  – Cover Stage I COPD

• The G0424 billing code does:
  – Require a licensed health care provider to deliver the service
  – Have a limit of 72 lifetime hourly sessions
  – Must use the KX modifier for sessions > 36 and must be medically necessary
Pulmonary Rehabilitation

• Restrictive Disease
  – Some MACs still have a LCD which covers all other diagnoses beyond COPD
  – Billing is done by PTs using 97000 codes for their specific services, and RTs billing the G0237, G0238 and G0239 codes for their services
  – These patients can always be seen in Physical Therapy and billed using the 97000 series
Functional Reporting in Outpatient

• All practice settings that provide outpatient PT or OT services must report on billing form the Functional Limitation Codes
• Mobility: Walking and Moving around
  – G8978 – current status at therapy onset
  – G8979-- projected goal status
  – G8980 – discharge status
• Changing and Maintaining Body Position
  – G8981-- current status
  – G8982 – projected goal status
  – G8983 – discharge status
Functional Limitation Reporting continued

• Carrying, Moving and Handling Objects
  – G8984 – current status
  – G8985 – projected goal status
  – G8986 – discharge status

• Self Care
  – G8987 – current status
  – G8988 – projected goal status
  – G8989 – discharge status
Severity Modifiers

- CH – 0% impaired/restricted
- CI – at least 1% but less than 20%
- CJ – at least 20% but less than 40%
- CK – at least 40% but less than 60%
- CL – at least 60% but less than 80%
- CM – at least 80% but less than 100%
- CN – 100% impaired
Functional Reporting

• Need to report at least 2 G-codes and 2-modifiers (current and goal) at initial, every 10th visit and discharge (discharge and goal)
• 1.5% reimbursement penalty if not reported
Therapy Cap

- $1940 for speech and PT per calendar year unless there is a KX modifier that is accepted for higher than cap of $3700
- Appeal to insurance carrier for additional sessions due to medical need
- Peer to Peer conference sometimes required
Co-Pay issues in CR & PR

- Some insurance companies have a copay PER VISIT which tends to add up in outpatient setting

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Ambulatory Payment Classification (APC)</th>
<th>Payment Rate</th>
<th>Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>93797 (CR without ECG)</td>
<td>5771</td>
<td>$103.92</td>
<td>$20.79</td>
</tr>
<tr>
<td>93798 (CR with EKG)</td>
<td>5771</td>
<td>$103.92</td>
<td>$20.79</td>
</tr>
</tbody>
</table>

- Medicare patients who only have part A medicare and NOT part B are required to pay the additional 20% of rehab…which can also add up
Co-Pay Issues in CR and PR

• Ambulatory Payment Classification (APC)
  – Newly assigned for CR and PR

• Two types of Medicare:
  – Medicare Fee-For-Service (FFS)---traditional Medicare
    • May purchase a secondary to cover co-payments (MediGap Plan)
  – Alternative Medicare plan…..Medicare Advantage Plans
    • Have some leeway in setting co-pay amounts
    • Some offer no premiums and waive co-pays on primary Physician visits while increasing co-pays on other services; i.e. Physical Therapy
Alternative payment system

• APTA has submitted an alternative payment system to AMA CPT coding committee which is probably going to be accepted and started in 2016. This system would:
  – Remove the 97000 series
  – Remove the functional limitation coding
  – Describe difficulty of patient situation in the actual code
Peaceful
Case Scenarios
Standard CR patient

- Patient uncomplicated post CABG, MI, stable angina, valve, transplant, etc.
- No need for physical therapy
- Patient referred to cardiac rehab
  - Allowed 36 sessions billed using 93798
  - If Physical Therapy were needed, could attend Physical Therapy with separate referral, attend at a different time from CR and utilize a different diagnosis

- Billing: CR sessions (36) billing 93798
Patient D/C from hospital with diagnosis of HF

- Cannot attend CR for 6 weeks due to acute hospitalization for HF
- CAN attend Physical Therapy to work on their functional limitations and aerobic endurance and strength
  - Outpatient physical therapy for 6 weeks billing using 97000 series codes
  - After 6 weeks can go to CR for 36 sessions

- Billing: PT 97001 first visit
  - 94620 second visit…eval of 6 minute walk, and one or two 97110
  - Each visit to PT 97110 x number of direct one on one
  - If in group…one group charge and one 97110 x amount of one on one time
Pulmonary Rehabilitation for Qualifying COPD

- Enroll in PR for 36 sessions billed using G0424. Cannot bill six minute walk distance nor any other codes.
- Billing: 36 sessions of G0424
- Must have MD supervision
- Any licensed health care provider can provide service
Other Pulmonary Diseases Besides Stage II, III, IV COPD

• Patient cannot be seen in PR using G0424 billing code
• Can be seen in PR and billed by RT, Exercise Physiology, or Nursing using the G0237, G0238, G0239 codes OR with physical therapy using 97000 billing codes

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<tbody>
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<td>G0237</td>
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<td>$11.19</td>
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<tr>
<td>G0238</td>
<td>5733</td>
<td>$55.94</td>
<td>$18.24</td>
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<td>G0239</td>
<td>5732</td>
<td>$30.51</td>
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• Billing in PT:
  – 97001 on initial visit and any interventions: 97110 x time
  – Other visits: 97110 for one on one therapeutic exercise and 97150 for group.
Other Pulmonary diseases besides Stage II, III, IV COPD Eligible for Pulmonary Physical Therapy

- Interstitial Pulmonary Fibrosis
- Sarcoidosis
- Lung Cancer
- Cystic Fibrosis
- Pulmonary Hypertension
- Asthma, Chronic Bronchitis, Bronchiectasis
- Congenital Heart and/or Lung Disease
## Physical Therapy 97000 Billing Codes

**North Carolina**

<table>
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<tr>
<th>APC</th>
<th>Payment Rate</th>
<th>Co-Pay</th>
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</thead>
<tbody>
<tr>
<td>97001 (Eval)</td>
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<tr>
<td>97002 (Re-eval)</td>
<td>$40.83</td>
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<tr>
<td>94620 (Simple Stress Test)</td>
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</tr>
<tr>
<td>97110 (Ther Exercise)</td>
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</tr>
<tr>
<td>97150 (Group)</td>
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<tr>
<td>97530 (Ther Act)</td>
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</tr>
<tr>
<td>97750 (Phys Perf Test)</td>
<td>$32.09</td>
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[Link to fee calculator](http://www.apta.org/apta/advocacy/feecalculator.aspx?navID=10737423156)
Risk Factors For AECOPD

- Lower physical activity
- Male
- Admitted to hospital in prior year
- Greater LOS
- Oral corticosteroid use
- Co-morbidities
- Older age
- $\text{FEV}_1$ decline – more frequent exacerbations
Ready to go???
Thank You!!

Questions??