

Rehab Net News Update

R E H A B I L I T A T I O N N E T W O R K O F A R K A N S A S

BECKY'S SCHEDULE

May 1	ArPTA Course & Mtg
May 5	AFCU Ambassadors Luncheon
May 11	ASAE Business Expo
May 18	CMSA Meeting

Important Numbers

Becky's Cell 479-858-2760

Lobbyists:

Bill Phillips
(501) 329-3111 or
Bradley Phillips
(501) 269-2723

ArklaMed—Rick Pate
(870) 864-8896

AR State Board of PT
Web site <http://www.arptb.org>

ArPTA Web site <http://www.arpta.org>

APTA Web site <http://www.apta.org>

AFLAC Anneke Bollman (479) 264-4623

www.rehabnet-ar.com
User = rna Password = 10144
For member only section

Medicare Documentation Requirements

1. The medical record must identify the physician responsible for the general medical care.

2. The services are to be furnished according to a plan of care certified by the physician or NPP. The signature and professional identity of the person who established the plan, and the date it was established must be recorded with the plan. (Pub 100-3, Chapter 15, section 220.1.1, 220.1.2, 220.1.3)

All providers rendering therapy must document the appropriate history, examination, diagnosis, functional assessment, type of treatment, the body areas to be treated, the date that therapy was initiated, and expected frequency and number of treatments. This documentation must be maintained in the patient's file.

3. Documentation should indicate the prognosis for potential restoration of function in a reasonable and generally predictable period of time or the need to establish a safe and effective maintenance program.

4. Documentation must be available upon request to indicate the medical necessity of continued treatment beyond the provisions of this policy. This information can be submitted in the narrative field of the electronic claim, or on the CMS -1500 form.

5. Documentation in the medical record must support the medical necessity, type, frequency and duration of services provided. Documentation of the medical necessity of multiple heating modalities (97018, 97024, 97026, and 97034) on the same date of service must be available for review. Such use must show all were needed toward the restoration of function.

6. CPT 97010 is a bundled service effective January 1, 1997, and is not separately billable.

7. For the sake of simplicity, the ICD-9-CM codes listed in the "Covered ICD-9 Diagnosis" section of this policy often span across a family of codes. In some cases, there will be a combination of three, four, and five-digit codes in the span. The codes listed on the claims should always be at the highest level of specificity. Claims lacking highest specificity codes will be denied.



CLINICS IN THE SPOTLIGHT



Steadman's Physical
Therapy
321 Section Line Road,
Suite E
Hot Springs, AR 71913
(501) 520-0504

Steadman's Physical Therapy is one of Rehab Net's newest members. Eddie Steadman, PT, opened his private practice at the first of this year. We welcome him to our group.

Eddie at this time is the sole therapist at his clinic but business is building fast. Steadman's Physical Therapy provides general physical therapy with an emphasis on orthopedic and sports medicine.

Marylyn Timbs runs the front desk and handles the billing for Eddie. Marylyn worked with Eddie at their previous employer so she is familiar with the physical therapy environment and is a great asset to Eddie.

Eddie received his MSPT from the University of Central Arkansas in 1999. Since that time he has worked in various different settings such as acute care, home health, physician owned practice, and private practice. He told Rehab Net that he decided to return to private practice rather than be a part of a large corporate system. He is enjoying the freedom of owning his own business.

Eddie states his goals are to be known in his community as a well respected physical therapist who is skillful in the evaluation and treatment of patients and athletes with either physical limitations or persons wishing to improve upon their current physical capabilities, so that their maximum rehab potential is met.

ArPTA Course Offerings

May 8, 2010	The Shoulder: Assessment & Treatment at SACC in El Dorado Speaker Steve Forbush, PT, PhD
July	PTA Supervision and Reimbursement Issues at NWACC

For more information call Becky at 866-548-6003

Signature Guidelines for Medical Review

This article is based on an article reissued by the CMS on April 26, 2010 for physicians, non-physician practitioners and suppliers submitting claims to Medicare Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors, Carriers, and DMEs for services provided to Medicare beneficiaries. As this question comes up periodically I felt we might benefit from some key points presented.

Contractors who review Medicare claims include MACs, Affiliated Contractors (AC), the CERT contractors, Recovery Audit Contractors (RAC), etc. These contractors are tasked with measuring, detecting, and correcting improper payments as well as identifying potential fraud in the Fee for Service (FFS) Medicare Program.

The previous language in the Program Integrity Manual (PIM) required a "legible identifier" in the form of a handwritten or electronic signature for every service provided or ordered. CR6698 updates these requirements and adds E-Prescribing language.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used must be a **hand written** or an **electronic signature**. Stamp signatures are not acceptable.

The AC, MAC and CERT reviewers shall apply the following signature requirements:

If there are reasons for denial unrelated to signature authentication. If the criteria in the relevant Medicare policy cannot be met but for a key piece of medical documentation which contains a missing or illegible signature, the reviewer shall proceed to the signature assessment.

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead may make use of the signature authentication process.

Keep in mind that a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation and not the following:

- ◆ If the signature is illegible, ACs, MACs, and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- ◆ If the signature is missing from an order, ACs,

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Letter From the Editor

Medicare is about to drive us all batty with their extensions and further extensions and we will probably get yet more extensions of the fee schedule. Not to mention their not doing completely away with the therapy cap. At least it was extended till the end of the year. I will keep monitoring the fee schedule for you.

One of the greatest benefits to Rehab Net since I began working with the ArPTA is that I now get all the communications on legislation and other important information that I can now share with you all.

Our Lobbyist Bradley Phillips informed me this week that Tommy Wren (D) is running for State Representative District 71. Tommy's wife is Ann Wren, PT. He may be someone who can help us in the future if he wins. Sadly I am not familiar with Tommy or Ann but would love to hear from any of you who do know them.

Becky A. Sewell
Executive Director

It's Here!
Rehab Net Fun Day!
June 5, 2010 at Wild River Country

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MACs and CERT **shall disregard** the order during the review of the claim.

- ◆ If the signature is missing from any other medical documentation, ACs, MACs and CERT shall accept a signature attestation from the author of the medical record entry.

The following are the signature requirements that the ACs, MACs, RACs and CERT contractors will apply:

- ◆ Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence.
- ◆ **Definition of a handwritten signature** is a mark or sign by an individual on a document to signify knowledge, approval, acceptance, or obligation.
- ◆ For medical review purposes, if the relevant regulation, NCD, LCD, and other CMS manuals are silent on whether the signature must be dated, the reviewer shall review to ensure that the documentation contains enough information for the reviewer to determine the date on which the service was performed/ordered.
- ◆ **Definition of a Signature Log:** Providers will sometimes include, in the documentation they submit, a signature log that identifies the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers will consider all submitted signature logs regardless of the date they were created.
- ◆ **Definition of Attestation Statement:** In order for an attestation statement to be considered valid for Medicare medical review purposes, the statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information.
- ◆ Providers will sometimes include in the documentation they submit an attestation statement. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Should a provider choose to submit an attestation statement, they may choose to use the following statement:

"I, _____, hereby attest that the medical record entry for ___[date of service]___ accurately reflects signatures/notations that I made in my capacity as ___[insert provider credentials]___ when I treated/diagnosed the above Medicare beneficiary. I do hereby attest that this infor-

mation is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

- ◆ While this sample statement is an acceptable format, at this time, CMS is neither requiring nor instructing providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers so long as the contractors do not provide identical requirements or suggestions for the form or format of the attestation. The above format is approved by the Office of Management and Budget and therefore it is not mandatory.
- ◆ Claims reviewers will not consider attestation statements where there is no associated medical record entry or from someone other than the author of the medical record entry in question.
- ◆ If a signature is missing from an order, claim reviewers will disregard the order during the review of the claim.
- ◆ Reviewers will consider all attestations that meet the guidelines regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date.
- ◆ The following are the signature guidelines in Section 3.4.1.1.B.c as shown in the manual revision attachment of CR 6698:
 - ◆ In the situations where the guidelines indicate "**signature requirements met**," the reviewer will consider the entry.
 - ◆ In situations where the guidelines indicate "**contact provider and ask a non-standardized follow up question**," the reviewer will contact the person or organization that billed the claim and ask them if they would like to submit an attestation or signature log within 20 calendar days. (Reviewers will not contact the provider if the claim should be denied for other reasons.)
 - ◆ In the situations where the guidelines indicate "**signature requirements NOT met**," the reviewer will disregard the entry and make the claims review determination using only the other submitted documentation.

REHAB NET



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Rehab Net Listservs

To join the office staff listserv send an email to:

RehabNetOffice-subscribe@yahoogroups.com

To join the Owners listserv send an email to:

RehabNetMgmt-subscribe@yahoogroups.com

Starting in May, most information will be sent out via our listservs and this will be where you are directed to send questions when seeking advice from other office managers and other owners.

The Continuing Extension Act of 2010 Extends Zero Percent Medicare Physician Fee Schedule (MPFS) Update

Reference: CMS List-Serv Message 041610; JSM 6623-10240

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Part A and B Providers

On April 15, 2010, President Obama signed into law the "Continuing Extension Act of 2010." This law extends through May 31, 2010, the zero percent update to the MPFS that was in effect for claims with dates of service January 1, 2010 through March 31, 2010. The law is retroactive to April 1, 2010. Consequently, effective immediately, claims with dates of service April 1 and later, which were being held by Medicare contractors, are being released for processing and payment. Please keep in mind that the statutory payment floors still apply and, therefore, clean electronic claims cannot be paid before 14 calendar days after the date they are received by Medicare contractors (29 calendar days for clean paper claims).

Given the uncertainty regarding MPFS claims with dates of service June 1, 2010, and later, please watch your listservs and your contractor's website for more information.

Rehab Net will also try to keep you informed of further legislation on the Medicare Physician Fee Schedule.



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