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Outpatient therapy: Myths and risks

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Outpatient therapy, particularly physical therapy, continues to be an area of concern for providers, regulators, investigators, adjudicators, and legislators. With Centers for Medicare & Medicaid Services (CMS) having entered an enlightened era of reducing provider burden, outpatient therapy providers are not necessarily "feeling the love," save the elimination of functional limitation reporting (FLR) for dates after 1/1/2019. Physical therapy has continually been a topic on the OIG's Work Plan; therapy over the $2,040 annual therapy threshold is subject to CMS medical necessity review; data analytics are driving CMS therapy reviews under the Targeted Probe and Educate (TPE) program; and the Health and Human Services Office of Inspector General (OIG) and the Department of Justice, including various United States Attorney's offices, seem to keep therapy on the top of their radar.

With all the reviews, reports, and whistleblower activity, it seems therapy providers would revisit and update a compliance risk assessment, incorporate these case studies in compliance education and training, or at the very least, take to late night reading and studying the transparently available CMS rules and policy. Providers often look to social media groups to find answers to questions on key areas of therapy risk. More often than not, providers accept answers that are incorrect, out-of-date, or not applicable for one reason or another. Providers that have compliance programs and hotlines report that clinicians ask questions about basic therapy documentation coding and billing requirements, often identifying therapy CEU courses and social media groups as the source of inaccurate and misleading information.

This article identifies a few of the top therapy myths and inaccurate information that gains a life of its own in social media groups. Each of these identified areas of concern also may pose an area of risk to be addressed in the provider's compliance program and risk assessment.

Referrals/orders for therapy

A physician order is always required for therapy services, even if the therapist is operating under direct access laws in their state of practice. Myth or risk?

It is a myth that a referral or an order is required for outpatient therapy services. A referral or order is not required if the physical or occupational therapist is complying with direct access rules in their state of practice. The practice of speech-language pathology is autonomous; therefore, a physician referral is not required for practice. Direct access allows for a therapist to evaluate a patient in the absence of an order, but may have the number of treatment visits limited following the evaluation until a physician referral is obtained.

A referral/order may be required by CMS if evaluation was the only service performed. If the evaluation concludes that no further therapy is needed, the evaluation charge will be paid if there is a referral or if the evaluation is sent for certification. An evaluation serves as the plan of care (POC) if it contains a diagnosis; further, CMS assumes that the amount, frequency, and duration of therapy are incorporated into the evaluation by the very nature of the one-time visit for an evaluation. When a beneficiary receives a therapy evaluation without a referral

or order and does not require treatment, a physician referral/order or certification of the evaluation is required for payment of the evaluation. CMS further instructs that a delayed referral/order that is dated after the evaluation shall be interpreted as certification of the plan to evaluate the patient.

Given that most therapy evaluations also include some therapy intervention, such as instruction in a home exercise program or modalities for pain relief, there are limited examples when the evaluation is the only service. For example, a surgeon may request a physical therapy evaluation to determine if the patient would benefit from therapy and limits the referral to "evaluation" only, rather than "evaluate and treat." If therapy was complete on the date of the evaluation, then the POC must be certified, because services were provided.[1] Comprehensive Outpatient Rehabilitation Facility (CORF) providers should review the applicable rules and policies on referrals and certification that are unique to CORFs.[2] ,[3]

Providers should also look to their local coverage determination (LCD) or other Medicare Administrative Contractor (MAC) educational resources for additional guidance. Novitas, the MAC for Jurisdictions JH and JL, states in LCD L35036 that:

> Outpatient therapy must be under the care of a Physician/Non-physician provider (NPP). An order (sometimes called a referral) for therapy services, documented in the medical record, provides evidence of both the need for care and that the patient is under the care of a physician. Payment is dependent on the certification of the plan of care rather than the order, but the use of an order is prudent to determine that a physician is involved in care and available to certify the plan.[4]

Therapy providers that are subject to CMS review, for example under the TPE program, are routinely asked to provide a copy of the physician order as part of the documentation requested for review. Myth or risk?

Providers responding to a TPE that do not have the requested therapy order should identify in a TPE cover letter that CMS does not require an order if the POC is certified. The cover letter should also appropriately cite the CMS reference and applicable LCD reference. As noted above from Novitas, "the use of an order is prudent." Having an order for therapy, even when not required, may likely save a denial and resultant appeal for the purpose of pointing out CMS requirements that the reviewer may have overlooked.