Consumer Direct Access
FAQs

What is consumer direct access?

Consumer direct access is about improved consumer choice. As of January 1, 2014, your patients can directly access your services without first getting a physician diagnosis or referral.

How will my patients benefit from direct access?

By being able to access your expert physical therapist services, your patients will save time and money because they will no longer be forced to pay twice and spend unnecessary, additional time obtaining a diagnosis from a physician. Also, your patients can be immediately treated and more quickly resume their health and get back to work.

Do I have to practice under direct access?

No. You can continue practicing as you currently do if you are more comfortable with your patients having a physician diagnosis or referral prior to providing services to them.

Are there any restrictions to directly accessing physical therapist services?

Yes. Individuals can directly access physical therapist services and receive treatment for up to 45 calendar days or 12 visits, whichever comes first. However, according to treatment data, 90 percent of patients will not require services beyond 45 days/12 visits.

What happens after the 45-day/12-visit limit?

If your patient requires additional services beyond the 45 days or 12 visits, whichever comes first, he/she will need to be referred to his/her physician for an exam and signed Plan of Care (POC). If your patient doesn't have a physician, you may refer him/her to a physician he/she chooses. And, if your patient has a diagnosis from a physician prior to the 45-day/12-visit deadline, he/she would be allowed visits beyond the time limits.

If my patient has a previous medical diagnosis are they subject to the 45-day/12 visit limit?

No. A patient with a medical diagnosis is not subject to the 45-day/12-visit limit. The limits only apply to patients directly seeking physical therapist services without a diagnosis.

If my patient is doing well and improving with physical therapist services, why is it necessary for him/her to be referred to a physician after an arbitrary time period like 45 days/12 visits?

There is no need for a referral if, within the 45-day or 12-visit timeframe, your patient improves and no longer requires services. If your patient requires further treatment and a diagnosis has not been obtained, he/she will need to see a physician/podiatrist and receive approval for the treatment plan you have developed.

How does billing work under consumer direct access?

Physical therapists practicing in states that already have direct access currently bill using ICD-9 codes. In California, there is no statutory prohibition on physical therapists assigning an ICD-9 code for a functional impairment on a claim form. Medicare regulations currently require physical therapists to append ICD-9 codes to describe the functional impairment (not the medical diagnosis) for which they are treating even when the patient has not been diagnosed by another healthcare provider, as in the case of an evaluation. In the event an ICD-9 code describing the functional impairment is not listed on the claim form, Medicare will deny payment. An Executive

Officer of the Physical Therapy Board of California confirmed that assigning an ICD-9 code for billing purposes should not be construed as diagnosis of disease.

Direct access does not preclude independent physical therapists from determining a diagnosis and reporting an ICD-9-CM code on the claim form to payers for the following reasons:

1. California law does not prohibit diagnosis by a physical therapist; it only prohibits diagnosis of disease (medical diagnosis);
2. ICD-9- CM codes are used to describe not only diagnosis of disease (medical diagnosis) but also impairments, injuries and other health conditions;
3. The Medicare 1500 claim form does not require entry of " a diagnosis of disease" in field 21; and
4. The Medicare administrative contractor in California (Noridian) has had a longstanding policy of recognizing diagnosis by physical therapists.

In addition, CMS also provides instruction with regard to reporting diagnosis codes in the Medicare Claims Manual, chapter 23 indicating that the ICD-9 CM code can reflect the patient's diagnosis, symptom, complaint, condition, or problem.

Therefore, a physical therapist in California is able to select ICD-9-CM codes to describe the diagnosis/condition or nature of injury of illness that supports the need for physical therapy services.

Will payers cover my services under direct access?

Currently, UnitedHealthcare has indicated direct access will be covered under its clinical therapy policies. Based on other states' experience with direct access, coverage from major payers occurred after direct access was approved. The California Physical Therapy Association's (CPTA's) Payment Policy Committee has met with multiple insurance carriers, including UnitedHealthcare, Blue Shield, Anthem, etc., regarding coverage for direct access. CPTA continues working aggressively to educate carriers on the benefits of direct access to secure payment for physical therapist services.

With respect to HMOs, each will need to set their own policies to allow for direct access.

Does billing under Medicare for my services change under consumer direct access?

No. The Medicare requirement of having a signed POC remains the same. You can evaluate and begin treatment while waiting for the POC to be signed within 30 days of your patient's initial visit.

How does direct access affect me if I work in a hospital-based setting?

If you work in a hospital-based setting, you will be under the policies of that setting for the implementation of direct access. Currently, Title 22 restrictions appear to preclude direct access in a hospital setting. CPTA is working to address the outdated Title 22 restrictions.

What do I need to do to get ready for consumer direct access?

- ✓ Ensure your medical screening skills are top notch and you have the right forms on hand to collect pertinent patient information.
- ✓ Now that you will be an entry point into the healthcare system for many consumers, think about providing in-service trainings to strengthen your staff's confidence and skills in providing quality care and customer service.
- ✓ Work closely with insurance carriers to ensure your patients receive the full benefit of consumer direct access.
- ✓ Make sure your patients understand they can call you first the next time they have a problem.
- ✓ Use the written disclosure statement that is on the CPTA website under Consumer Direct Access Resources or create a similar one for your office.