2025 APTATN Fall State Meeting

APTA Tennessee
A Chapter of the American Physical Therapy Association

September 27, 2025

1

1

BCMS
BUSINESS & CLINICAL MANAGEMENT SERVICES, LLC

15 Useful Compliance Hacks for Therapy Providers

Jody Swearingen, DPT, OCS, STC, COMT, CHP
APTATN Fall Meeting 2025
September 27, 2025

2

2

My Personal Objective for this Course is

To keep you from digging for the answers!

3

CEU Objectives---

1. Utilize the Delayed Plan of Care provision effectively
2. Explain Plan of Care Technical Denials
3. Recognize that an Order, Prescription, or Referral ≠ POC
4. Enumerate Supervision Requirements
5. Recognize that the Rendering Provider must be Billing Provider
6. Demonstrate Documentation of Total Visit Time
7. Utilize CPT Code Definitions-HIPAA
8. Carry-out Safe Transmission of PHI
9. Choose Specific Words/wording to Demonstrate Skilled Intervention
10. Explain Physical Therapy Private Practice Site Visits
11. Employ Proper Unit Counting Methodology
12. Articulate How and When to Use Advanced Beneficiary Notice
13. Comply with Progress & Discharge Report Documentation
14. Describe What Puts a Provider on the Radar
15. Carryout Effective Record Submitting Processes

4

4

Hack # 1 Delayed Plan of Care Provision

Appropriate when:

- Plan of Care Certification (POC) exceeds 60 days, including:
  - An initial POC (eval) without a referral
  - Any subsequent POC for this episode
- The patient has been under the care of the intended certifier of the POC for the POC duration
- The patient is under the care of a physician/NPP in the attending group for the POC duration
- Therapist has evidence that the POC was developed and that attempts to obtain the POC certification were made

 5

5

Cont. Hack # 1

- The physician/NPP certifies the POC, at any later day, accompanied by a documented reason for the delay by the therapist.
- Additional support documentation (communication with the attending MD/NPP, status updates, phone calls, etc.) should be supplied when the delay is greater than six (6) months.

 6

6

1 Samples of Delayed POC Explanations

The POC certification or recertification was delayed (sample reasons below)

- We failed to obtain a signed Plan of Care after making (insert the number of times) attempts and finally requested that the patient contact the physician to obtain the certification.
- We failed to obtain a signed Plan of Care after making (insert number of times) attempts; we eventually resorted to:
  - A personal delivery of the Plan of Care to the physician's office for certification
  - Making a personal phone call to the physician's office regarding the Plan of Care
- We made a clerical error and failed to send the subsequent Plan of Care; however, we did have a referral from the patient's doctor.
- The attending physician relocated without a forwarding address, but we did have a referral.
- The attending physician was out of the country, but we did have a referral.
- The attending physician's office could not locate the Plan(s) of Care faxed to them.

Note: The explanation is to accompany the certified Delayed POC; both are required

 7

7

Hack # 2 Technical Denial: No Certified POC

The absence of an initial certified Plan of Care (without a referral) or subsequent recertification (with or without a referral) means the statutory requirement of certification (timely or delayed) has not been met. This results in a technical denial, i.e., no payment by Medicare.

A technical denial for services provided by a Part B PT supplier may result in beneficiary liability!

Important! Discuss the above consequence with the patient when the POC is reviewed, so they have advanced notice.

MBPM Chp.15 Section 220.1.3 E

 8

8

Hack # 3 POC With or **Without** a Referral

A referral/order does not equal a Plan of Care unless it contains all of the Plan of Care content requirements.

An initial Plan of Care without a referral should be certified within 30 days, and the certification period begins with the initial evaluation.

Effective 1-1-2025, a physician/NPP patient referral waives the requirement for a signed Initial Plan of Care. **Remember,** recertifications must be signed and dated.

Effective 1-1-2025, the **Initial** Plan of Care, accompanied by a referral, must be sent to the physician/NPP within 30 days; **however it does not require the referrer's signature**.

Valid certification must contain all of the Plan of Care elements and have the dated signature(s) of the developer and the certifier (if applicable).

The physician/NPP is certifying that the patient is under his/her care during the Plan of Care period and concurs with the Plan.

9

9

Hack # 3 POC **With or Without** a Referral

Medicare does not require a referral (order) to process payment **for medically necessary services.**

Payment is dependent on the certification of the plan of care rather than the referral (order), but the use of a referral (order) is prudent to determine that a physician is involved in the patient's care and available to certify the plan.

Direct access is permitted by CMS, but the certifying physician's NPI must be affixed to the claim

10

10

Hack # 4 Supervision Requirements

Medicare defines three levels of supervision for services provided by healthcare professionals, particularly in the context of outpatient therapy, diagnostic tests, or services performed by non-physician practitioners.

They are:

- **General Supervision**: The physical presence of the qualified professional is not required during the performance of the procedure.
- **Direct Supervision**: The physical presence of the qualified professional is required in the office suite or facility during the performance of the procedure.
- **Personal Supervision**: Personal in-room supervision by the qualified professional is required during the performance of the procedure.

 11

11

4 History of AV General Supervision

2020-2021:
The pandemic-related flexibilities implemented by CMS in 2020 were extended into 2021, which permitted "direct supervision" to be achieved through real-time audio-visual interactive communication (virtual supervision). Meaning that the supervising therapist was not required to be present in the same location as the assistant.

2022:
The above flexibilities continued into 2022, allowing PTs, OTs, and SLPs to supervise their assistants (PTAs, OTAs, SLPAs) virtually.

2023:
The flexibilities were extended to allow virtual supervision via real-time audio and video technology through the end of 2023.

2024:
The flexibilities were extended to allow virtual supervision via real-time audio and video technology through the end of 2024.

2025:
The 2025 Medicare Physical Fee Schedule Final Rule approved the general supervision of physical therapist assistants by physical therapists and occupational therapy assistants by occupational therapists in private practice settings.

 12

12

4 PTA General Supervision Per CMS

Risk mitigating tips for the supervision of assistants:

- The supervising therapist should be available on a regularly scheduled basis to review the services of the assistant.
- The supervising therapist must be able to verify that he/she is on-call and readily available physically or through telecommunication for consultation.
- The assistant must have a written Plan of Care/plan of treatment from the therapist for the patient visit.
- The supervising therapist should have a predetermined plan for emergencies, including the designation of an alternate supervising therapist.
- The assistant should document that the patient's care was delivered via the general supervision of an identified therapist.
- The supervising therapist and the assistant must comply with all rules and regulations set forth by the state licensing board.
- While Medicare does not require co-signatures on the assistant's patient records, state law might require that validation and the co-signature must be attained in that situation.

 13

13

4 Supervision of a Therapy Student Per CMS

- Medicare requires that professional students from an accredited program be personally supervised. It stipulates that the supervising therapist must be physically present with the student during patient care and available to provide continuous and direct oversight or intervention.
- Medicare permits billing for the services performed by the professional student under the personal supervision of the supervisor of record.
- Medicare does not permit individuals who have graduated but have not passed their national exams, with or without temporary licensure, to treat or bill Medicare beneficiaries under any circumstances or supervision.

 14

14

Hack # 5 Rendering Provider = Billing Provider

In order to qualify to bill Medicare directly as a therapist in private practice, each therapist must be enrolled as a private practitioner and employed or contracted by a Part B enrolled supplier.

Per Medicare: MBPM Chapter 15 Section 230.4
Medicare 855B, 855i, and 855r

15

5 Enrolling to Receive Medicare Payment

Per Medicare's Program Integrity Manual:

"No provider or supplier shall receive payment for services furnished to a Medicare beneficiary unless the provider or supplier is enrolled in the Medicare program. Further, it is essential that each provider and supplier enroll with the appropriate Medicare Administrative Contractor. We use the term "enrollment" generally to include activities a provider or supplier undertakes to enroll in the Medicare program and maintain enrollment in good standing, which includes, but is not limited to, initially enrolling, revalidating enrollment, and reporting changes of information as described within this chapter."

Note: Therapists working in Rehab Agencies do not have to be individually enrolled.
PIM Chp. 10 Section 10.1.2

16

5 Contradictory Provision on Enrollment??

MBPM Chapter 15 Section 230.4 B

Each therapist in private practice (TPP) should be enrolled as a Medicare provider. If a therapist is not enrolled, the services of that therapist must be directly supervised by an enrolled therapist. Direct supervision requires that the supervising private practice therapist be present in the office suite at the time the service is performed. These direct supervision requirements apply only in the private practice setting and only for therapists and their assistants.

Clarification: The provision above infers treatment under supervision not billing for services. Claims must be held until the TPP is officially enrolled with Medicare and assignment of benefits confirmed.

 17

17

Hack # 6 Counting Visit Time

VISITS OR TREATMENT SESSIONS begin at the time the patient enters the treatment area (of a building, office, or clinic) and continue until all services (e.g., activities, procedures, services) have been completed for that session and the patient leaves that area to participate in a non-therapy activity. It is likely that not all minutes in the visits/treatment sessions are billable (e.g., rest periods).

- Full visit time and activity inclusion:
  - Substantiates, via documentation, all activities performed, whether billable or not
  - Validates oversight in the event of litigation

 18

18

Hack # 7 CPT Code Definitions-HIPAA

This Means	
	All providers must use ***only*** the current version of the AMA's CPT codes
	All payers i.e., health plans must use ***only*** the current version of the AMA's CPT codes
	All CPT code definitions apply to ***all*** payers and patients

19

19

7 HIPAA Requires Standardization

The Standard Transaction and Code Sets provision of HIPAA require that all covered entities use the most current version of the AMA's Current Procedural Terminology (CPT) codes.

Non-covered entities include, but are not limited to:

- Workers' Compensation payers
- Third Party Liability payers i.e., auto/accident
- Educational Programs
- Disability Plans
- Those who do not transmit any information in an electronic form in connection with an adopted standardized transaction

20

20

7 American Medical Association

It controls the CPT Codes

Numbering	Definition	Timing

21

7 One on One Applies to All Covered Entities[1]

- When direct one-on-one patient contact is provided, the therapist should bill the specific CPT code (per definition) if adequate skilled service time has been invested to achieve a unit or units.
- These direct one-on-one minutes may occur continuously (using the 8' rule or the AMA unit counting rule), or in notable episodes (for example, 10 minutes, initially, and 5 minutes later).

[1] Covered Entities = Healthcare Providers, Health Plans, and Health Care Clearinghouses

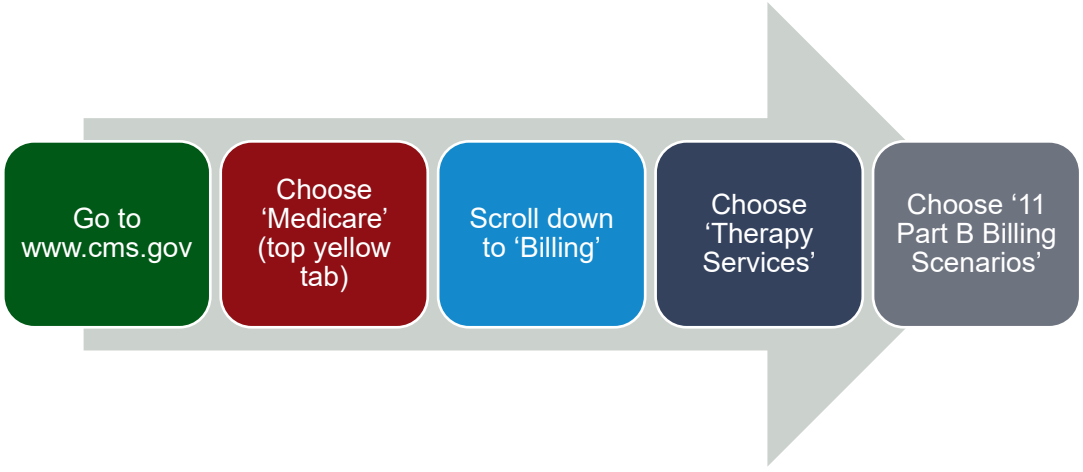
22

7 Group Therapy

- Group therapy consists of the concurrent (in the same period) treatment to two or more patients who may or may not be doing the same activities.
- If the therapist is dividing attention among patients, providing brief but skilled intervention, or giving the same instructions to two or more patients at the same time, it is appropriate to bill each patient one unit of group therapy, 97150 (untimed).

23

7 One-on-One & Group Scenarios



24

Hack # 8 Safe Transmission of PHI

When encryption is not an option, PHI transmitted or communicated without patient authorization must be de-identified.

PHI Identifiers:

1. Names
2. All geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code…
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
4. Phone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social Security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code

25

25

Hack # 9 Words to Support Skilled Intervention

Added	Assessed	Cued: manually/ verbally	Demonstrated	Educated
Facilitated	Instructed	Modified	Monitored	Progressed
	Provided	Reviewed	Trained	

Note! These words are very helpful when documenting maintenance therapy.

26

26

Hack # 10 Physical Therapy PTPP Site Visits

Physical Therapy Private Practices are classified as a Moderate Risk Level for Fraud, per CMS. Because of the risk level, PTPP must undergo a cursory site visit from CMS' National Site Visit Contractor (NSVC).

Site visits are mandated under the following situations:

1. Initial application by the group or a physical therapist
2. Revalidation of the group or a physical therapist
3. New or changed location

27

27

10 PTPP Site Visit Timing & Focus

Focus of the Site Visit---NSVC attempt to verify the following externally:

- Is the facility open?
- Are personnel at the facility?
- Are patients at the facility?
- Is the facility operational?

Timing of the Site Visit

- Not initiated until the MAC approves the application/revalidation
- Monday-Friday (excluding holidays) during posted hours; if no posted hours, then the visit will be conducted between 9 a.m. and 5 p.m.
- Second attempt will be made if facility appears operational

28

28

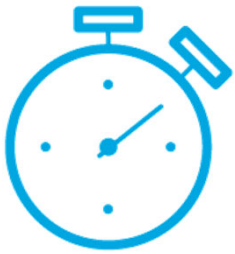
Hack # 11 Unit Counting Methodology

"Left-Overs" can be valuable as can "Being Different"!

29

11 Medicare's 8 Minute Rule

- 1 unit ≥ 8' through 22'
- 2 units ≥ 23' through 37'
- 3 units ≥ 38' through 52'
- 4 units ≥ 53' through 67'
- 5 units ≥ 68' through 82'
- 6 units ≥ 83' through 97' etc.



30

11 AMA >50% Methodology

- Time is the face-to face-time with the patient.
- Unit of Time is attained when the mid-point is passed. Fondly termed “Greater than 50% Rule” or “Greater than the Mid-Point”

NOTE: Read your contract and/or the payers payment policies to determine which payment methodology the utilize (i.e., 8’ Rule or the AMA >50% Rule)

31

11 The Major Difference Is . . .

- **Medicare’s** methodology does *NOT* consider the CPT code billed but rather the total minutes billed for 1:1 codes
- **AMA’s** methodology counts minutes by 1:1 CPT codes billed which is why utilizing different codes can yield additional unit(s) of service.

32

11 What Happens to Those 7'?

CMS 8' rule scenario from Transmittal 1019 – An Example

33

33

11 Appropriate Coding/Billing

Appropriate billing for 40 minutes is for *3 units*

Bill 2 units of 97110 and 1 unit of 97140.

1. Count the first 30 minutes of 97110 as 2 full units
2. Compare the remaining time for 97110 (33-30 = 3 minutes) to the time spent on 97140 (7 minutes) and bill the larger, which is 97140.

34

34

11 Time Example "A" Comparing >50% to the 8' Rule

AMA Rule	Medicare Rule
• 8 min. 97110	• 8 min. 97110
• 8 min. 97140	• 8 min. 97140
• 8 min. 97530	• 8 min. 97530
• Total Time = 24'	• Total Time = 24'
• **Total Units = 3**	• **Total Units = 2**

35[35]

35

11 Time Example "B" Comparing >50% to the 8' Rule

AMA Rule	Medicare Rule
• 16 min. 97110	• 16 min. 97110
• 8 min. 97140	• 8 min. 97140
• Total Time = 24'	• Total Time = 24'
• **Total Units = 2**	• **Total Units = 2**

36[36]

36

11 Time Example "C" Comparing >50% to the 8' Rule

AMA Rule	Medicare Rule
• 33 min. 97110 • 7 min. 97140 • Total Time = 40' • **Total Units = 2**	• 33 min. 97110 • 7 min. 97140 • Total Time = 40' • **Total Units = 3**

37

11 AMA "B" & "C" Why 2 and Not 3?

When the same CPT codes are billed under the AMA using the "Greater than 50% Rule" it applies to each CPT code AND the full unit (i.e., 15') is the expected time. Therefore, to attain:

1 unit 97110	2 units 97110	3 units 97110
• No less than 8 minutes of care to bill 1 unit • Total minutes = 8	• 15 minutes of unit 1 • No less than 8 minutes of unit 2 • Total minutes = 23	• 15 minutes of unit 1 • 15 minutes of unit 2 • No less than 8 minutes of unit 3 • Total minutes = 38 minutes

38

Hack # 12 Advanced Beneficiary Notices

An Advanced Beneficiary Notice (ABN) is a waiver of liability. It is a notice that a provider or supplier must present to a patient in advance of receiving services or items that he/she believes or knows for a fact that Medicare will not consider as covered benefits.

The ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. It is not used for items or services provided under the Medicare Advantage (MA) Program.

39

12 When are ABNs Mandatory?

On January 1, 2013 Limitation of Liability (LOL) protections were implemented and while there is no 'Therapy Cap' the ABN reporting requirements are still in place.

Therapists must issue an ABN prior to delivering services over the KX Threshold if the services are not medically necessary in order to transfer financial liability to the patient.

CMS prohibits therapists from routinely providing blanket or generic ABNs and states "that unless there is a specific, identifiable reason to believe Medicare will not pay for services they should be delivered and billed with the "KX" modifier".

40

12 GA Modifier Description

The **ABN** is used to advise the beneficiary prior to treatment that the item/service does not:

- Meet medical necessity requirements and/or
- KX Threshold overages cannot be justified
- The GA modifier must be affixed on the claim for that service
  - This is considered a waiver of liability making the patient fully responsible for payment of the item or service.

41

12 GX Modifier Description

The **GX** Modifier is a voluntary notice of liability to the patient and is not required by Medicare.

- It is used to provide the beneficiary with a voluntary notice of his/her liability
- It does not require the patient to complete the 'choice' sections of the ABN as it is merely a voluntary notice

According to Medicare there are very few instances that would necessitate the use of this modifier.

42

12 GY Modifier Description

The **GY** modifier is used to advise Medicare that the item or service to be provided or used by the patient:

- Is not statutorily covered
- Does not meet the definition of a Medicare benefit
- The ABN is not required in the above situation it may be offered when the beneficiary wishes to file a secondary payer and a denial is necessary to obtain payment

This does not apply to services over the KX Threshold, only to other non-benefit services i.e., wellness & injury prevention, dry needling, laser, etc.

 43

43

12 GZ Modifier Description

The **GZ** modifier is used when:

- The beneficiary was NOT advised prior to obtaining an item or service that the item or service does not meet medical necessity requirements
- The provider may not pass financial liability over to the patient as it must be assumed by that provider

 44

44

12 Never Render an ABN

When services over the KX Threshold have documented medical necessity, the therapist must:

- File the claim(s) with the KX affixed ***because it indicates medically necessary care; it would be contradictory to render an ABN also because its use indicates non-covered or non-medically necessary services.***
- Therapy services that the therapist believes are medically necessary over the $3,000 must also be filed with the “KX” modifier.

45

12 Never Render a CMS ABN . . .

. . . to patients with Medicare Advantage plans that have implemented a KX Threshold

Instead, inquire as to what form, if any, should be utilized for notifying Medicare Advantage patients of non-covered services.

Please review your contracts to determine if the MA payer follows Medicare’s requirements

46

12 It's a No, No!

Medicare will not honor a transfer of liability to the beneficiary when the therapist employs any of these procedures:

Routine ABN	Generic ABN	Blanket ABN	Blank ABN
• No specific or identifiable reason to believe Medicare will not pay	• ABN states "Medicare may not pay"	• Issuing ABNs for all services/ items	• Requesting that patient's sign a blank ABN

47

47

Hack # 13 Progress & Discharge Reports

PTA may complete the first 4 blocks

- # 1 Date of PR or DC Report
- # 2 Beginning & Ending Date of PR or DC
- # 3 Tests & Measures, Standardized Tests
- # 4 Objective Reports of Subjective Comments

- The PT/OT must render 1 billable unit in the 10 Visit PR
- The PT/OT must complete all other aspects of the PR or DC
- The PT/OT must sign the reports; note: "assisted by" if applicable

48

48

13 Progress Report: Content Requirements

1. Date of the Progress Report (PTA/OTA)
2. Progress Report Period (the beginning and end date of this Progress Report) (PTA/OTA)
3. Objective reports of patient's subjective statements (PTA/OTA)
4. Objective measurements, standardized tests OR descriptive/quantitative changes in status (PTA/OTA)
5. Each goal must be compared and documented in a functional and quantitative manner to the status of the previous report

 49

49

Progress Report: Content Requirements

6. Assessment of the patient's status per goal indicating action to be taken to continue progressing which could also include modification and/or termination of a goal and/or intervention (indicating if and when met, rationale for modification/termination and achievement level)
7. Plan for continuation or discontinuation of treatment (based on evaluation and assessment results)
8. Recertification/Plan of Care Signatures (as applicable)
9. Dated signature & designation of clinician completing the report and notation of "assisted by" the PTA/OTA, if applicable

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50

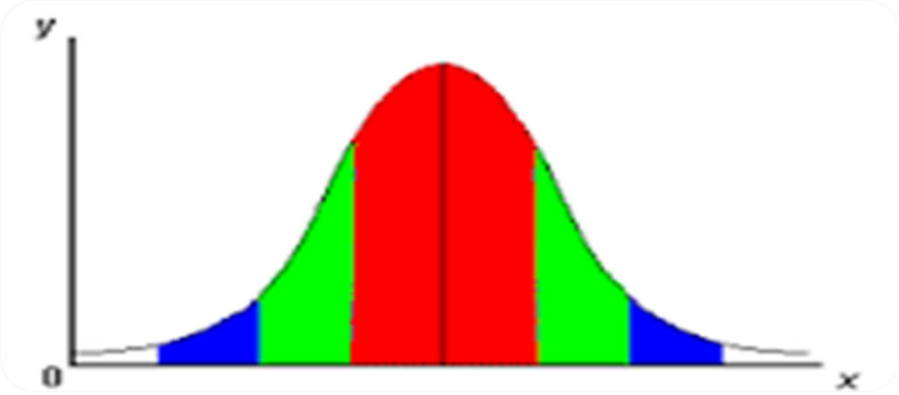
Hack # 14 What Puts a Provider on the Radar?

BEING an OUTLIER!

51

51

14 Avoid Either End of the Curve



The blue and white areas on the graph = auditor flags

52

52

14 Payer and Auditor Focus

According to the Office of Inspector General (OIG) they are looking at both ends (the outliers) of the bell curve and so are most other payers' fraud and abuse divisions.

The outliers are:

Those that ***exceed*** the norm	Those that are ***under*** the norm

53

53

14 Progressive Coding

Therapeutic Exercise is the foundation for most of our services

Purpose	Intervention	Result
1. Improve Strength, Endurance, ROM and Flexibility	• Treatments should be more than just progressing exercise…once you start progressing the exercises intensity, dosage, etc. you should use that strength and ROM to improve balance, gait, ADL's, functional activities, etc. and code accordingly	• Demonstrated Progress

54

54

14 What is Redundant Coding?

Defined as utilizing the same code(s) regardless of:

- Code Definition
- Actual Activity Performed
- The Intervention's Purpose

55

55

14 Impact of Redundant Coding

- Red Flag for aberrant coding…payer audit
- Requests for refund
- False Claim Violations
- Civil Penalties
- Criminal Penalties

56

56

14 Remember! Definition, Purpose & Progress

- Think of the CPT code **definition** when documenting and billing!
- Think of **purpose**, not equipment when coding! e.g., physioball
  - Core Stabilization---97110
  - Balance---97112
  - Dynamic Activities---97530
- Think of coding to **show progress**!
  - Moving from basics to advanced activities e.g., Limb or muscle group (97110) to full body involvement---functional challenges (97530)

57

57

14 What Do Your Claims Reveal?

Your choice!

Redundant Coding	Progressive Coding
• Shows little skill or progression	• Shows clinical decision making; skill & progress

58

58

Hack # 15 Submitting Records to Medicare

Additional Documentation Request (ADR)

- Is generated by a Medicare Contractor
- Is conducted to determine if payment is appropriate
- Has specific submission criteria
- Has a fixed timeframe for record submission

59

15 Who Conducts Medical Record Reviews?

Medicare Fee-for-Services reviews are conducted by:

- Comprehensive Error Rate Testing Program Contractors (CERT)
- Medicare Administrative Contractors (MACs)[1]
- Office of Inspector General (OIG)
- Recovery Audit Contractors (RACs)[2]
- Supplemental Medical Review Contractors (SMRCs)
- Unified Program Integrity Contractors (UPICs)
- Others

- Note: [1] MACs Medical Review Department = Medical Director, RN's, other clinicians, and specially trained support staff
- [2] SMRC do not mention 'other clinicians' as reviewers

60

15 The Process Starts Here!

- Assign a responsible person to sort your mail and faxes
- Instruct the mail sorter to prioritize all mail from payers
- Open mail & determine if it is an Additional Documentation Request (ADR) or notice of an audit. Save the envelope!
- Bring all ADR's/Audit notices immediately to your attention. Time is of essence!

61

61

15 Do It Right the First Time

If you receive a request for records or an audit notice:

- Read AND re-read the request AND the directions AND stay involved in the process
- Meet and/or beat submission deadlines
- Use the correct form, if noted in instructions
- Provide ALL support documentation from the beginning of care through the DOS requested

62

62

15 Continue Doing it Right

- Put the documents in an orderly and legible form per the letter directives
- Make a copy of everything submitted for yourself
- Send documents via a traceable vendor or the payer's secure portal
- Engage a reliable consultant if you are unsure of why, how, when, etc.

63

63

15 Don't Be a No-Show

If a Medicare contractor or other payer requests records, you **must** provide them within the specified timeframe.

The consequence of not doing so is that they can consider the payment an error or an overpayment and will solicit payment from you or initiate a recoupment from subsequent payments due!

64

64

15 Reminders!

- If you engage a consultant, be certain to obtain a signed Business Associate Agreement before any Protected Health Information (PHI) is exchanged.
- Don't send the CMS Additional Documentation Request (ADR) letter with PHI in it via email unless it is encrypted.
- If you fax it, please make certain it is transmitted to a stand-alone fax…not an internet-based fax line.

65

QUESTIONS?

I will gladly entertain questions that are specific to this presentation.

Please email your questions to Jody Swearingen at swearingenj@bcmscomp.com

Kindly include the name of the presentation in the email subject line

66

Presenter's Biography

Dr. Jody Swearingen is a highly respected outpatient physical therapist and the Vice President of Client Compliance for Business and Clinical Management Services, LLC. His duties at BCMS include, but are not limited to, implementing the Compliance Program and resources, providing client education and product delivery, consulting on audits and appeals, and offering guidance on client regulatory matters. With a career spanning over two decades, Jody is known for his expertise and commitment to advancing the field of physical therapy.

He earned his Master's in Physical Therapy from the University of Tennessee at Chattanooga in 2002 and later completed his Doctorate at the University of St. Augustine. Jody holds Board Certification in Orthopedics and specialty certification in Sports Therapy, alongside his Orthopedic Manual Therapy Certification from Maitland Seminars. He has also received his certification as a Certified HIPAA Professional in 2025.

Active in professional organizations, Jody serves as President of the Tennessee Chapter of the APTA, having previously held the position of Vice President for three years and Treasurer for five years. His extensive involvement with the APTATN includes various roles on the Board of Directors. He has been recognized with the Outstanding Service Award from the APTA-TN Chapter in 2015 and the Alumni of the Year Award from the University of Tennessee at Chattanooga in 2017.

Dr. Swearingen is also an experienced speaker, presenting on compliance topics at both state and national conferences, reflecting his deep knowledge and dedication to the profession.

67

Disclaimer

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Please note: These educational materials are summaries and must not be interpreted as legal documents. The official information is contained in the relevant laws and regulations

68

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69

69

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70

70