Codify BY AAPC

Eli's Rehab Report

7 Scenarios Strengthen Your Physical Therapy Coding Skills

See why confusing a modality with a timed procedure could land you in hot water

Your challenge is to keep up-to-date and ensure that you properly report your PT services, but you may question whether you're on top of your game. Use this helpful quiz as a measuring stick for what areas you may need to review.

Note: The questions and answers for this quiz were provided by **Rick Gawenda, PT**, director of **physical medicine** and rehabilitation at Detroit Receiving Hospital.

Knock Out This Knee Replacement Scenario

You are treating a 74-year-old male post-left knee replacement. Treatment today consists of the following:

• 18 minutes of strengthening and range-of-motion exercises for the left lower extremity
• 13 minutes of grade-3 anterior and posterior tibia joint mobilizations and patellar mobilization
• 10 minutes of gait training on a level surface with a quad cane
• 8 minutes of ultrasound to the left knee for pain reduction.

Answer: The ultrasound and therapeutic procedures provided to this patient are all time-based **CPT Codes** . To determine how many units you can bill, you must add up all the minutes. The total is 49 minutes and, using Medicare's "eight-minute rule," falls between at least 38 minutes but less than 53 minutes. This allows you to bill three units of time-based CPT codes to the Medicare contractor.

Keep in mind: You should bill the modalities/therapeutic procedures that you spent the most time providing to the patient. In this case, you would report one unit of therapeutic exercise (97110, Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility).

Code 97110 contains the phrase "one or more areas" in its descriptor. "You should therefore assume that every area you focus on is included in that code already," says **Heather Corcoran**, coding manager at **CGH Billing Services** in Louisville, Ky. Caution: "To try and collect more money for more than one area is considered upcoding," she says.

You'd also report one unit of manual therapy (97140, Manual therapy techniques [e.g., mobilization/manipulation, manual lymphatic drainage, manual traction], one or more regions, each 15 minutes) and one unit of gait training (97116, ... gait training [includes stair climbing]).

You are unable to bill for the ultrasound because the total time providing time-based modalities/therapeutic procedures limits the total number of units you can report. But you should still document that you provided the ultrasound, including all the necessary parameters.

See How You Should Code This CVA Example

You see a 76-year-old female following a cerebrovascular accident (CVA) that occurred one month ago. Treatment today consists of the following:

• 21 minutes of lower-extremity exercises
• 18 minutes of NDT techniques to improve sitting and standing balance.

Answer: You should bill neuro-developmental techniques (NDT) to improve sitting and standing balance under

neuromuscular re-education (97112, ... neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities). This is a time-based code as is therapeutic exercise (97110). The total minutes spent providing direct one-on-one therapeutic procedures is 39 minutes, which falls between at least 38 minutes but less than 53 minutes. This allows you to bill three units of time-based CPT codes to the Medicare carrier.

In this case, you should bill two units of the therapeutic procedure you spent the most time providing to the patient. The correct answer is two units of therapeutic exercise (97110) and one unit of neuromuscular re-education (97112).

Use Untimed Codes for Parkinson's Disease Therapy

You treat a 66-year-old male with a medical diagnosis of Parkinson's disease. The speech-language pathologist sees the patient to treat speech and swallowing issues. Treatment today consists of the following:

• 25 minutes of skilled interventions to improve the patient's speech and voice communication
• 25 minutes of skilled interventions to improve the patient's swallowing and feeding.

Answer: You should report the skilled interventions provided to the patient to improve his speech and voice communication under 92507 (Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual). And you should submit the skilled interventions the PT performed to improve the patient's swallowing and feeding as 92526 (Treatment of swallowing dysfunction and/or oral function for feeding).

The AMA considers these codes service-based and untimed. Because they are untimed, you should not apply Medicare's eight-minute rule to this scenario. Bill service-based interventions one unit per patient per day per discipline, regardless of the amount of time spent providing the skilled intervention. In this case, the correct billing is one unit each of 92507 and 92526.

Figure Out This Finger-Fracture Scenario

Your therapist sees a 65-year-old male with multiple healed finger fractures on his left hand and treats him with the following:

• 20 minutes of fluidotherapy
• 20 minutes grade-2 mobilization to the MPs, PIPs, and DIPs of fingers 2-4
• 15 minutes of range-of-motion and strengthening exercises.

Answer: The total time of time-based skilled interventions provided in this scenario is 35 minutes. The time-based therapeutic procedures are the joint mobilizations and range-of-motion/strengthening exercises.

Fluidotherapy is a dry whirlpool, and you should bill it under 97022 (... whirlpool). This modality is a service-based intervention, and you should not include the minutes spent providing this service in the total minutes when determining the number of time-based units you can bill. You would automatically bill one unit of 97022 regardless of the amount of time spent providing the fluidotherapy, assuming it was medically necessary and met all other requirements.

Based on Medicare's eight-minute rule, 35 minutes falls between at least 23 minutes but less than 38 minutes. This allows you to report two units of time-based CPT codes. The correct billing in this scenario would be one unit of 97022, one unit 97110, and one unit of 97140.

Consult 8-Minute Rule for Units

Your therapist treats a 65-year-old male with a medical diagnosis of osteoarthritis in his right knee. Treatment today consists of the following:

• 10 minutes of ultrasound to decrease patient's pain
• 15 minutes of the stationary bike at level 1 for warm-up

• 30 minutes of strengthening and range-of-motion exercises.

Answer: The total of time-based skilled interventions provided in this scenario is 40 minutes. The time-based therapeutic procedures include the ultrasound and range-of-motion/strengthening exercises.

The 15 minutes spent riding the stationary bike does not count toward the time-based skilled interventions because riding the bike for warm-up is not skilled therapy.

Based on Medicare's eight-minute rule, 40 minutes falls between at least 38 minutes but less than 53 minutes. This allows you to bill three units of time-based CPT codes to the Medicare contractor. The correct billing in this scenario is two units of 97110 and one unit of 97035 (... ultrasound, each 15 minutes).

7 Minutes? Check to See if You Should Code It

Your therapist sees an 81-year-old female who had her right knee replaced three weeks ago. Treatment today consists of the following:

• 33 minutes of range-of-motion and strengthening exercises
• 7 minutes of grade-3 anterior and posterior joint mobilizations.

Answer: Both of these therapeutic procedures are time-based, so you should add the minutes spent providing the therapeutic exercise and joint mobilization. The total is 40 minutes, and based on Medicare's eight-minute rule, 40 minutes falls between at least 38 minutes but less than 53 minutes. This allows you to bill three units of time-based CPT codes to the Medicare carrier.

The correct billing in this scenario is two units of 97110 and one unit of 97140. You can bill one unit of manual therapy even though you provided the skilled intervention for less than eight minutes because it is the total of all timed CPT code minutes that determines how many units you can bill.

Watch Out for Supervised Modalities

You treat a 77-year-old male who had a rotator cuff surgically repaired seven weeks ago. Treatment today consists of the following:

• 10 minutes of the upper-body ergometer (UBE) for warm-up
• 15 minutes of strengthening exercises using a red Thera-Band
• 15 minutes of joint mobilization to increase shoulder active range of motion
• 20 minutes of interferential current (IFC) with cold pack at the conclusion of treatment for pain reduction.

Answer: The total of time-based skilled interventions provided in this scenario is 30 minutes. The time-based therapeutic procedures include the manual therapy for the joint mobilization and the strengthening exercises. The 10 minutes spent on the upper-body ergometer does not count toward the time-based skilled interventions because warm-up activities are not skilled therapy.

Caution: You would not include the 20 minutes spent providing IFC in the time-based therapeutic procedures because IFC is an unattended form of electrical stimulation and is a service-based supervised modality and therefore untimed.

You would automatically bill one unit of G0283 (Electrical stimulation [unattended], to one or more areas for indication[s] other than wound care, as part of a therapy plan of care) regardless of the amount of time the PT spent providing the IFC. The correct billing in this scenario then is one unit of G0283, one unit of 97110 and one unit of 97140.

Bonus: If you would like a more detailed explanation of Medicare's eight-minute rule, e-mail the editor at suzannel@eliresearch.com.

Codify
BY AAPC