Eli's Rehab Report

Follow HCFAs Coding Guidance to Expedite Pay Up

Nugget: Regardless of the number of therapists and assistants it may take to perform a treatment, the timed therapy codes are used to bill only the time the patient actually is being treated.

Coding for physical medicine and outpatient rehabilitation, never simple, gets more confusing if more than one site is involved or more than one person is giving treatment. The new Health Care Financing Administration (HCFA) guidelines may help clear up some of the confusion.

On March 13, HCFA issued transmittal AB-00-14, which answers frequently asked questions regarding the prospective payment system (PPS) for outpatient rehabilitation services, and provides guidance for physical medicine **CPT Codes** . Below are some of the highlights from the memorandum.

Outpatient Rehabilitation Services Coding

HCFAs memorandum states that 97504 (orthotics fitting and training, upper and/or lower extremities, each 15 minutes) and **CPT 97116** (gait training, includes stair climbing) should not be billed together unless the 97504 is performed on an upper extremity, in which case both codes can be billed with modifier -59 (distinct procedural service) to denote separate anatomic sites.

According to **Susan Callaway-Stradley, CPC, CCS-P**, independent coding consultant, N. Augusta, S.C., Correct use of the -59 modifier is very important, because it allows payment for services that typically are bundled. If practices choose to use this modifier, they need to be sure they understand the correct scenarios for payment and document those scenarios appropriately.

The new HCPCS code G0169 (removal of devitalized tissue, without use of anesthesia [conscious sedation, local, regional, general]) is defined to describe the type of active debridement performed by therapists and is intended to replace 10040 and 97799. HCFAs memo clarifies that this code can be used to describe active debridement, whether performed with a scissor, scalpel or waterjet regardless of the depth of the tissue involved. There is no global period on this code, and the code includes dressings placed on the wound after debridement.

Clarifying the difference between unlisted physical medicine codes, HCFA states that CPT 97139 (unlisted therapeutic procedure) applies to services that effect change throughout the application of clinical skills or services that attempt to improve function in one or more areas and requires that a physician or therapist have direct patient contact throughout each 15 minute session. Code 97799 (unlisted physical medicine/rehabilitation service or procedure) includes all other physical medicine and rehabilitation services and procedures, including tests and measurements.

These rules are outlined for intermediaries and carriers:

Medicare pays for speech re-evaluation services when medically necessary and appropriate, which should be billed using 92506 (evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status).

Coders should use 92525 (evaluation of swallowing and oral function for feeding) to bill for a modified barium swallow to evaluate swallowing ability.

For cognitive speech therapy training, billers should use either code 92507 (treatment of speech, language, voice, communication and/or auditory processing disorder; individual) or 97770 (development of cognitive skills to improve attention, memory, problem solving, includes compensatory training and/or sensory integrative activities, direct patient

contact by the provider, each 15 minutes), but never both codes for the same treatment.

Occupational therapists providing splints (97504) should report revenue code 430.

Physical Medicine CPT Coding Guidance

HCFA reports that it is frequently asked for guidance regarding billing the 15 minute timed therapy codes (97032-97036, 97110-97124, 97140, 97504-97542, and 97703-97770). The memo states that providers should report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. Despite the number of people involved in performing the therapy, only the time the patient is treated counts toward the total billable time.

For example, If gait training for a patient with a recent stroke requires both a therapist and an assistant (or even two therapists) to manage the patient on the parallel bars, each 15 minutes the patient is being treated can count only as one unit of 97116. Time that the patient spends resting or waiting to use a piece of equipment should not be billed.

For guidance on billing for times under and over the 15-minute intervals, HCFA states, For any single CPT code, providers bill a single 15 minute unit for treatment greater than or equal to eight minutes and less than 23 minutes. Services lasting less than eight minutes should not be billed. The following chart should help coders bill the appropriate time units (in 15-minute increments) for therapeutic services:

1 unit = between 8 and 23 minutes of treatment
2 units = between 23 and 38 minutes
3 units = between 38 and 53 minutes
4 units = between 53 and 68 minutes
5 units = between 68 and 83 minutes
6 units = between 83 and 98 minutes
7 units = between 98 and 113 minutes
8 units = between 113 and 128 minutes

HCFA notes that the patients medical record should state the beginning and ending time of the treatment clearly, and should include a note describing the treatment. Callaway-Stradley says, This directive puts the time requirements for these services in line with all other timed services. HCFA has always required that timed services exceed the halfway point of the second and subsequent units before those units can be billed.

If more than one CPT code is billed during a calendar day, HCFA affirms that the total number of units that can be billed is constrained by the total treatment time. For example, if 24 minutes of 97112 and 23 minutes of 97110 are furnished, the total treatment time is 47 minutes, which would total three units. The coder would bill two units of 97112 and one unit of 97110, assigning more units to the service that took more time.

This program memorandum can be viewed in its entirety by referencing transmittal AB-00-14 at the HCFA Web site, www.hcfa.gov.