Eli's Rehab Report

Timed Therapy: Slash Therapy Coding Denials by Following These Simple Tips

Remember: The total treatment time counts.

Traditionally, rehab facilities and their Medicare contractors have struggled with timed therapy billing issues how many units can one bill? The **Centers for Medicare & Medicaid Services'** (CMS') website has answers to some of your pressing questions.

Add Up Your Minutes Before You Bill

In the past, people have assumed that they cannot bill for any time-based modality or therapeutic procedure that they provided for less than eight minutes. This is true to some extent for example, if you do six minutes 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) and the patient suddenly has to go home, you can't bill for it.

"The 8-minute rule applies only to the 15-minute time based CPT® codes," **Rick Gawenda, PT,** President of **Gawenda Seminars & Consulting** tells **Eli.** "In the example below, since all 3 interventions are 15-minute time based CPT® codes, the total timed minutes is 21 minutes that allows the therapist to bill 1 unit. Since the time spent on each code was the same, the therapist would determine which CPT® code to bill for the 1 unit."

CMS offers an interesting example on its website in Transmittal 1019. Suppose you provided 33 minutes of 97110 and seven minutes of manual therapy (97140, Manual therapy techniques [e.g., mobilization/manipulation, manual lymphatic drainage, manual traction], one or more regions, each 15 minutes) you don't want to toss away those seven billable minutes of 97140 just because they're less than eight minutes. Added up, the total time is 40 minutes, which allows you to bill for three units.

How it works: When you perform more than one service in a single day, each represented by a 15-minute timed code, the total number of minutes determines the number of units billed, CMS says. And according to the agency's chart, you may bill three units if your total treatment time is between 38 and 52 minutes.

Caution: If you begin to show a consistent practice of billing less than 15 minutes per unit, "these situations should be highlighted for review," CMS says.

Choose the Highest Time

Now that you know how many units to bill based on total treatment time, the question is: Which codes should you report? To make things simple, start with the codes that had the most time.

In the example above with therapeutic exercise and manual therapy, 97110 had the most time, so you would count the first 30 minutes of 97110 as two full units (15 minutes + 15 minutes). Then, compare the remaining time for 97110 (three minutes) to the time you spent on 97140 (seven minutes), and bill the larger for one unit, which is 97140, CMS says.

Caveat: You may be faced with a situation in which all your code times are the same. In this case, follow CMS' "Example

5" in Transmittal 1019: Suppose you did seven minutes of neuromuscular re-education (97112, ...neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities), seven minutes of therapeutic exercise (97110) and seven minutes of manual therapy (97140). As stated above, add up your total treatment time to determine the number of units to bill. In this case, your total is 21 minutes, which only allows you to bill one unit.

The therapist gets to choose which code to bill. "The qualified professional ... shall select one appropriate CPT® code (97112, 97110, 97140) to bill since each unit was performed for the same amount of time and only one unit is allowed," CMS says.

Good idea: CMS reminds you that your treatment note does not need to include the amount of time for each specific intervention or modality only your total minutes of time-based CPT® codes and total treatment time, which is the summation of time-based and untimed CPT® codes.

Clear Up Untimed Codes

The last part of Transmittal 1019 delves into the issue of billing untimed codes, such as 92506 (Evaluation of speech, language, voice, communication, and/or auditory processing) and 95833 (Muscle testing, manual [separate procedure] with report; total evaluation of body, excluding hands). Unsurprisingly, CMS reiterates that you may not bill more than one unit per day of an untimed code.

And CMS clarifies that you cannot bill two evaluations on the same day. For example, you couldn't do a knee evaluation and a shoulder evaluation on the same day and bill for two evaluations.

Important: The transmittal also notes that when physicians and non-physician practitioners bill "always therapy" codes, these providers must follow the policies of the type of therapy they are providing.

For a list of which codes are "always therapy," see https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html. For details of Transmittal 1019 see www.cms.hhs.gov/Transmittals.