Eli's Rehab Report

Use Caution When Billing Group Therapy and Theraputic Exercise Together

Nugget: Confusion about billing the group therapy code and the therapeutic code together stem from the fact the therapeutic exercise code is used on a one-on-one basis.

Physical medicine and rehabilitation (PM&R) coders who are billing the group therapy code 97150 (therapeutic procedure[s], group, [2 or more individuals]) with the therapeutic exercise **CPT 97110** (therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength, endurance, range of motion and flexibility) for the same patient, on the same day are likely to receive denials from Medicare and other providers, says **Bill Davies**, owner of Medical Insurance Transmissions, a billing firm in Alpharetta, Ga. But understanding what documentation needs to accompany these codes can help with ethical reimbursement for physiatrists offices and clinics.

Many physiatrists and physical or occupational therapists use group therapy and therapeutic exercise on the same treatment day, but at different times. For example: The physical therapist works on range-of-motion exercises with patient #1 from 1:00 p.m. to 1:15 p.m. (which would be billed as one unit of 97110). The therapist then does flexibility exercises with patients #1 and #2 from 1:15 to 1:45 (97150, the group therapy code). Unfortunately, a Correct Coding Initiative (CCI) edit prohibits the use of these two codes together, so the therapist would not receive full reimbursement for patient #1.

The group code is extremely confusing, says **Diane McCauley**, who handles the billing at Northstar Physical Therapy in Ironwood, Mich. Its hard to know when to use a modifier and when to just schedule the visits separately.

There has been some controversy about billing the group code, and what to bill it with and how to bill it, says **Lisa Marie Moran**, staff liaison of the payer relations committee for the private practice section of the American Physical Therapy Association. Not only is it controversial nationwide, but among the states, there are varying interpretations of the group code.

The Problem With Billing the Codes Together

The dilemma stems from the fact that the therapeutic exercise code (97110) falls under the CPTs Therapeutic Procedures heading, which, according to the Medicare Part B Billing Manual for Physical Therapy Services, dictates that use of the therapeutic procedures requires that the practitioner have direct (one-on-one) patient contact. The group therapy codes, however, involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact by the physician or therapist, according to the CPT 2000 guidelines.

The therapeutic exercise code (97110) is used on a one-on-one basis, so it cant be billed with a group code, says Davies. For the most part, its not allowable to bill Medicare for both the therapeutic exercise and group therapy codes on the same day, even if the procedures occur at different times. The only exception, depending on the insurance company youre dealing with, is if, for example, youre working on a workers compensation case. You might be able to get it approved by the insurance company beforehand, and then you could bill both codes with the -59 modifier (distinct procedural service).

Include Documentation With the Claim

The difficulty in billing these codes together is further aggravated by the fact that they already require backup documentation, even when submitting them alone. The Medicare Part B Billing Manual for Physical Therapy states that

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claims for therapeutic exercise (97110) must include documentation showing objective loss of joint motion, strength, or mobility, e.g., degrees of motion, strength grades, levels of assistance.

Under the group therapy code (97150), the manual dictates that attached documentation detail:

the specific treatment techniques used in the
group;

how the techniques will restore function;

the frequency and duration of the group setting;

the treatment goal in the individualized plan; and

the number of persons in the group.

Many state Medicare providers, including Alabama, Arizona and Georgia, determine the coverage of the group therapy on a case-by-case basis since many group procedures do not require the professional skills of a provider, according to the Medicare Part B Billing Manual. This has led many practices to stop utilizing group therapy.

We just avoid the use of the group therapy code, says **Greg Saxton, PT**, a practicing physical therapist at Healthsouth Sports Medicine and Rehabilitation Center in Chapel Hill, N.C. We dont use group therapy at all. We do all individualized therapy.

CPT 2000 does not dictate the number of patients allowable in a group setting. It only states that the group must include two or more individuals. **Ted N. Layne, PT, ATC**, president of Flatirons Practice Management LLC, a billing firm in Boulder, Colo., says there is no set limit on the number of people who can be in the group. But as a rule, we try not to do more than six patients at a time, he adds.

The therapeutic exercise code (97110) also sparks confusion when used in conjunction with the manual therapy code (97140, manual therapy techniques, e.g., mobilization/manipulation, manual lymphatic drainage, manual traction; one or more regions, each 15 minutes).

The manual therapy code is a nightmare, says McCauley. Medicare started rejecting claims when we billed manual therapy with therapeutic exercise. HCFA [the Health Care Financing Administration] later rescinded that edit, but were rebilling it constantly.

The Rescinded Edits

In April 1999, Medicare instituted CCI edits that disallowed the use of 97140 with 97110, or the use of 97140 with any of the other following codes: 97112 (neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture and proprioception), 97113 (aquatic therapy with therapeutic exercises), and 97116 (gait training).

At that point, says **Beth Smith**, biller at Lakefront Billing Service in Milwaukee, Wis., the only way Medicare would recognize billing 97140 and 97110 together was if we used the modifier -59. But shortly thereafter, Medicare said they no longer required the modifier.

That decision came in July 1999, when those CCI edits were officially removed. Therefore, it is not necessary to use the modifier -59 when billing 97140 with 97110, 97112, 97113 and 97116, HCFA says. However, many billers may not be aware of this edit reversal and still might be using the modifier -59 to bill the codes together.

You can bill the 97140 with the 97110 without the
-59 modifier, and you can use as many units as you need to, says Smith.

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Be sure and check your states rules on time limits for therapy services. For example, in Colorado, says Layne, workers compensation limits therapy to one hour worth of codes without prior approval.

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