

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

Providers are responsible for submission of accurate claims requests. This reimbursement policy is intended to ensure that you are reimbursed based on the code that correctly describes the procedure performed. This and other reimbursement policies may use CPT, CMS or other coding methodologies from time to time. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

Coding methodology, clinical rationale, industry-standard reimbursement logic, regulatory issues, business issues and other input is considered in developing reimbursement policy.

This information is intended to serve as a resource regarding the reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly we may use reasonable discretion in interpreting and applying this policy to services being delivered in a particular case. Further, the policy does not cover all issues related to reimbursement for services rendered to enrollees as legislative mandates, the provider contract documents, and the enrollee's benefit coverage documents, may supplement or in some cases supersede this policy. Finally, systems logic or set up may prevent the loading of this policy onto different claims platforms in exactly the same way; however, we strive to minimize these variations.

ACN Group Inc. (OptumHealth Physical Health), may modify this policy from time to time by publishing a new version of the policy on its Website; however, the information presented in this policy is believed to be accurate and current as of the date of publication.

Documentation Requirements for Timed Therapeutic Procedures

Type	Reimbursement	
Number	0049	
Approved by		Approval Date
Reimbursement and Technology Committee Quality Improvement Committee		November 15, 2007 January 17, 2008
Description		
This policy describes OptumHealth Physical Health documentation requirements for reimbursement of the Physical Medicine and Rehabilitation (PM&R) CPT codes which make up the timed, skilled, direct one-on-one component of treatment. Specifically CPT codes, 97110-97140, 97530-97542, 97750-97762.		
Audience		
Targeted Population	This policy applies to all products, all network and non-network rehabilitation providers. This includes non-network authorized, percent of charge contract.* <i>*Fee schedule/provider contract/client contract may supersede.</i>	
Policy		

<p>Policy Statement</p>	<p>Documentation Requirements – Timed Therapeutic Intervention OptumHealth Physical Health will align timed therapeutic treatment documentation requirements with the American Physical Therapy Association’s Defensible Documentation for Patient/Client Management document and Centers for Medicare and Medicaid Services (CMS) National Policy.</p>
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Edit Sources

OptumHealth Physical Health sources its Physical Medicine and Rehabilitation and Chiropractic CPT code payment policy methodology to methodologies used and recognized by third party authorities. The sources used to determine if a CPT code is reimbursable are:

Current Procedural Terminology book (CPT) from the American Medical Association (AMA)

Centers for Medicare and Medicaid (CMS) National Coverage Policy and current Centers for Medicare and Medicaid (CMS) Policy Manual(s) <http://www.cms.hhs.gov>

ChiroCode DeskBook, 18th ed., 2010. <http://www.chirocode.com>

Background Summary

The CPT section devoted to “therapeutic procedures” contains many of the CPT codes utilized by rehabilitation providers to describe the skilled, direct one-on-one component of treatment. These codes describe the bulk of hands-on, skilled care typically provided by rehabilitation providers.

- CPT defines Therapeutic Procedures 97110-97140, 97530-97542, 97750-97762 as follows:
- *A manner of effecting change through the application of clinical skills and/or services that attempt to improve function.*
 - *Physician or therapist required to have direct (one-on-one) patient contact.*
 - *Therapeutic procedure, one or more areas, each 15 minutes;*

Additionally, the definition of CPT codes 97750-97755, Therapeutic Procedures, Tests and Measurement includes, “*with written report, each 15 minutes.*”

In the case of the timed therapeutic CPT codes, documentation should reflect the thought process and skilled decision making of the licensed therapy provider. As such, documentation of patient/client care needs to be more than a litany of procedures related to a date of service. Documentation must include evidence of knowledge and skill related to the procedures performed. It also should provide verification of professional judgment. This concept of clinical decision making can be incorporated into clinical documentation.

Documentation Requirements

General Guidelines

In addition to the documentation requirements referenced in OptumHealth Physical Health Guideline for Record Keeping policy, there are specific requirements that must be evident in the patient medical record for reimbursement of certain time-based therapeutic procedure interventions. Documentation of certain timed-based procedures should be recorded on the day of the patient visit and include both of the following:

- A. Substantiation that the skilled services of a licensed therapy provider or physician were required.
- B. Substantiation that services met the one-on-one timed-based requirement.

A. Skilled Intervention

1. Documentation to support skilled intervention is required. Demonstration of skilled care requires documentation of the type and level of skilled assistance given to the patient, clinical decision making or problem solving, and continued analysis of patient progress. This may be documented by recording both the type and amount of manual, visual, and/or verbal cues used by the licensed therapy provider to assist the patient in completing the exercise/activity completely and correctly. Skilled care may also be documented through explanation regarding rationale for choosing the interventions and/or the rationale for the continued use of the intervention. Another way of documenting skilled care may be to provide documented observation regarding responses before, during, and after an intervention as well as the patient's specific response to the intervention.
2. Services related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute skilled physical medicine and rehabilitation services. Services provided by practitioners/staff who are not qualified licensed therapy providers are not skilled intervention services. Unskilled services are palliative procedures that are repetitive or reinforce previously learned skills, or maintain function after a maintenance program has been developed.
3. The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a licensed therapy provider. Services that do not require the skill of a licensed therapy provider are not considered skilled services, even if they are performed or supervised by a qualified professional.
4. While a patient's particular medical condition is a valid factor in deciding if skilled physical medicine and rehabilitation services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a licensed therapy provider are needed to treat the illness or injury, or whether the services can be carried out by unskilled personnel.

B. Timed Intervention

1. Documentation to support the reporting of timed procedure codes is required. The time reported should reflect direct one-on-one contact time with the patient. Supervised treatment in the absence of skilled intervention is not billable time. Billable time should reflect the time that the provider spent with the patient and not just the time the patient spent performing supervised procedures in the clinic.
2. The amount of billable one-on-one units that can be charged per day is partly dependent on the number of hours per day that a licensed therapy provider works. A licensed therapy provider can not be one-on-one with more than one patient at any given time.
3. The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. **Pre, intra, and post-delivery face to face time with the patient are counted in determining the total treatment service time.** If more than one 15 minute timed CPT code is billed during a single calendar day, then the total number of timed units that can be billed is constrained by the total treatment minutes for that day.

4. When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service determines the number of units billed.
5. **If any 15 minute timed service is performed for 7 minutes or less on the same day as another 15 minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater, then bill one unit for the service performed for the most minutes.** This is correct because the total time is greater than the minimum time for one unit. The same logic is applied when three or more different services are provided for 7 minutes or less. The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review. If more than one 15 minute timed CPT code is billed during a single calendar day, then the total number of timed units that can be billed is constrained by the total treatment minutes for that day.

Counting Time as a Function of Work

Pre-service time includes assessment and management time - medical record review, physician contact while the patient is present, assessment of the patient's progress since the previous visit, and time required to establish clinical judgment for the treatment session. Pre-service time is not the time required to get the patient ready to receive the treatment.

Intra-service time includes the hands-on treatment time.

Post-service time includes the assessment of treatment effectiveness, communication with the patient/caregiver to include education/instruction/counseling/advising, professional communications, clinical judgment required for treatment planning for the next treatment session, and documentation while the patient is present.

Counting Minutes for Timed Codes in 15 Minute Units

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:

Units Number of Minutes

1 unit: ≥ 8 minutes through 22 minutes

2 units: ≥ 23 minutes through 37 minutes

3 units: ≥ 38 minutes through 52 minutes

4 units: ≥ 53 minutes through 67 minutes

5 units: ≥ 68 minutes through 82 minutes

6 units: ≥ 83 minutes through 97 minutes

7 units: ≥ 98 minutes through 112 minutes

8 units: ≥ 113 minutes through 127 minutes

The pattern remains the same for treatment times in excess of 2 hours.

Example 1 -

24 minutes of neuromuscular reeducation, code 97112,

23 minutes of therapeutic exercise, code 97110,

Total timed code treatment time was 47 minutes.

See the chart above. The 47 minutes falls within the range for 3 units = 38 to 52 minutes.

Appropriate billing for 47 minutes is only 3 timed units. Each of the codes is performed for more than 15 minutes, so each shall be billed for at least 1 unit. The correct coding is 2 units of code 97112 and one unit of code 97110, assigning more timed units to the service that took the most time.

Example 2 -

20 minutes of neuromuscular reeducation (97112)

20 minutes therapeutic exercise (97110),

40 Total timed code minutes.

Appropriate billing for 40 minutes is 3 units. Each service was done at least 15 minutes and should be billed for at least one unit, but the total allows 3 units. Since the time for each service is the same, choose either code for 2 units and bill the other for 1 unit. Do not bill 3 units for either one of the codes.

Definitions

Direct	Characterized by a close, logical, causal, or consequential relationship.
One-on-One	Involving a direct encounter between one person and another.

Coding

CPT Code Section

97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction) one or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97532	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training) direct (one-on-one) patient contact by the provider, each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes

97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes
97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes

References and Resources

References

1. American Medical Association, *Current Procedural Terminology (CPT), Professional Edition 2010*
2. Centers for Medicare and Medicaid Services (CMS), *Medicare Benefit Policy Manual, Chapter 15* <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>
2. Centers for Medicare and Medicaid Services (CMS), *Medicare Claims Processing Manual, Chapter 5* <http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf>
3. American Physical Therapy Association (APTA) *Defensible Documentation for Patient/Client Management* document.
4. American Physical Therapy Association (APTA) *Coding, Compliance, and Reimbursement for Physical Therapists*, 2006.
5. American Physical Therapy Association (APTA) *Issues and Insights: CPT Coding Transcript*, 2004.
6. Merriam-Webster Online <http://www.m-w.com/>

History/Updates

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