Codify
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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Don't Sell Yourself Short In Timed Therapy Coding

Tip: Focus on the total treatment time

With our expert interpretation of the latest directions from CMS, you can cut your therapy coding denials in half by following a few simple rules.

Traditionally, physician offices and their Medicare contractors have struggled with timed therapy billing issues--how many units can you bill? In response, CMS released Transmittal 1019 (Change Request 5253). Filled with straightforward examples, this transmittal answers your pressing questions.

Count Every Minute

In the past, people have assumed that they cannot bill for any time-based modality 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, then you can't bill for it, explains **Rick Gawenda, PT**, director of physical medicine and rehabilitation for **Detroit Receiving Hospital.**

But check out the following example from 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 those seven billable minutes of 97140 away just because they-re less than eight minutes, Gawenda says.

-Added up, the total time is 40 minutes, which allows you to bill for three units,- Gawenda points out.

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 you can bill, CMS says. And according to the agency's chart in the transmittal, you may bill three units if your total treatment time is between 38 and 52 minutes. For a quick cheat sheet on numbers of units you may bill per total treatment time, see the clip n- save on the following page.

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 warns.

Code To The Highest Time

Now that you know how many units to bill based on total treatment time, the question is which codes do 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 when all your code times are the same. In this case, follow CMS- -Example 5- in the transmittal: Suppose you did seven minutes of neuromuscular reeducation (97112,   [- neuromuscular re-education 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.

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As far as which code to bill, the therapist gets to choose. -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 instructs.

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 treatment time. On the other hand, -I would have some mechanism to show how I-ve decided to bill each unit,- suggests **Marvel Hammer, RN, CPC, CHCO**, of **MJH Consulting**, a healthcare reimbursement consulting firm in Denver.

-It never would hurt to put it in your treatment notes, and if not there, I would at least have accessible in a grid or flow chart how you spent your total minutes and how you justified your coding choice,- she adds.

Get A Straight Answer On 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 disorder; individual) 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.

You-ll also notice that CMS clarifies you cannot bill two muscle evaluations in 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,- Gawenda says.

Important: The transmittal also notes that when physicians and nonphysician practitioners bill -always therapy- codes, these providers must follow the policies of the type of therapy they are providing. In other words, they must use a plan of care and bill with the appropriate therapy modifier (GP, GO or GN), Hammer says. For a list of which codes are -always therapy,- see pages 10-12 in the document at the following Web site: www.cms.hhs.gov/Transmittals/Downloads/R805CP.PDF.

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