Codify
BY AAPC

Eli's Rehab Report

Reader Question: Translating PT Services Into CPT Codes

Question: How do I bill when the medical record reads as follows: mass. to L-leg 8 min., upper back 8 min. and lower back 8 min. to decrease muscle spasms.
ES to L-leg 10 min. and lower back 10 min. to reduce pain. Ther. exerc. to back 8 min. and L-leg 10 min. to increase flexibility. Neuro-reed 5 min. to improve balance and posture?

Texas Subscriber

Answer: The first entry indicates that the therapist performed eight-minute massages to the left leg, upper back and lower back, totaling 24 minutes of massage. Because massage is billed in 15-minute increments, you would code this portion of the claim as one unit of 97124 (therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement [stroking, compression, percussion]). Medicare guidelines state that any period between eight and 24 minutes should be billed as one 15-minute unit. To bill two units, the total massage time must exceed 24 minutes.

The second entry indicates that the therapist gave the patient electrical stimulation for 10 minutes each to the left leg and lower back, totaling 30 minutes. Electrical stimulation is billed as 97014 (application of a modality to one or more areas; electrical stimulation) if its unattended, or 97032 (application of a modality to one or more areas; electrical stimulation [manual], each 15 minutes) if direct one-on-one patient contact was provided. Because these codes are also billed in 15-minute increments, you would bill two units of the appropriate electrical stimulation code for the 30 minutes of care provided.

The third entry is for therapeutic exercise, which is coded as 97110 (therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility). Because the therapist performed therapeutic exercises for only 18 minutes, only one unit of the code would be billed.

Finally, the therapist performed neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture and/or proprioception, which is coded as 97112 (therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception). This was performed for only five minutes, therefore you cannot bill for it. Medicare says services performed for less than eight minutes should not be billed. The only exception is if two or more services under eight minutes each are provided, then the sum of the minutes spent can be added, to equal a total time. This amount should be billed with the service on which the therapist spent the most time. For example, five minutes of therapeutic exercise and seven minutes of gait training would be billed as one unit of gait training (97116) for a total of 12 minutes.

Because no national Correct Coding Initiative edits bar you from billing these codes together, they can all be billed for the same patient on the same date of service. Be sure to check your local carriers guidelines to ensure they are following the above rules outlined by Medicare; otherwise, ask for a copy of their guidelines for billing time-based therapy services.

Advice for Reader Questions was provided by **Laureen Jandroep, OTR, CPC, CCS-P,** owner of A+ Medical Management and Education, a coding and reimbursement consulting firm and a national CPC training curriculum site in Egg Harbor City, N.J.; and **Patricia Niccoli,** a chiropractic coding expert from ElectroAge Billing, a physician billing service that specializes in chiropractic reimbursement in Phoenix.

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