Eli's Rehab Report

Therapists Assessment of Patient Counts for Timed Codes

PM&R codes are unique in that most of those listed in the physical medicine section of CPT Codes are billed in 15-minute increments. Various theories abound in the PM&R billing community, however, regarding what parts of the therapist's care should count toward the 15-minute interval, and how the practitioner should bill when a session is more or less than 15 minutes. The following guidelines will help PM&R coders more accurately assign time units to their therapy codes.

Factor Time Spent in Assessment

According to **Pauline Watts, MS, PT,** co-founder of Encompass Education Inc., a rehabilitation education and consulting firm in Palm Harbor, Fla., many therapists are selling their practices short by billing only for the time spent performing the actual modality. "The therapy skill is not just the 'hands-on skill,' " Watts says. "The American Physical Therapy Association says that the skilled care you perform from the moment you start with the patient is included in the therapy code. You are doing skilled care when you are asking the patient how they've been doing, assessing their condition and educating them on new exercises to do at home."

However, Watts says, if the patient then leaves the room and changes into a different outfit during therapy, that is not included in the time, even if an aide is helping him or her. Once the patient returns and the therapist resumes the question and answer period, "looking for signs of trouble on the skin surface or problems with the gait, that counts toward the skilled treatment again. Skilled care includes education and assessment skills," Watts says.

Not included toward the 15-minute increments is time that the therapist spends writing in the record, documenting the visit, talking to physicians, etc. "This is not counted because it has already been factored into the amount set for the reimbursement for these codes," Watts says. "So when therapists say that they don't get paid for writing in the record, they are getting paid because that extra work has been included in the reimbursement set for the codes."

Watts says that if the therapist happens to be assessing the patient while writing in the record, "they can count that as part of the time because they're getting paid for the assessment, not the documentation, but you have to be very careful to count only the time you're performing assessment."

The following example demonstrates how the time period should be broken down. Billable times are italicized, while unbillable periods are not italicized:

The therapist greets a patient who is receiving therapy to correct gait abnormalities.

The therapist talks to the patient for five minutes about his activities at home, asking questions about how many stairs he has to climb each day, the height of his bathtub, whether he walks his dog, etc.

The patient spends five minutes changing into a more appropriate outfit in which to perform therapy.

The patient performs 25 minutes of gait training and 25 minutes of therapeutic exercise.

The therapist spends five minutes teaching the patient how to perform specialized exercises at home to practice before his next therapy session.

The patient leaves the room to get changed again while the therapist spends 10 minutes documenting the visit in her records.

The total billable time spent on the therapy session is 60 minutes. The five minutes prior to the session during which the therapist asks the patient questions about stair climbing, etc., should be added to the gait training time, totaling 30 minutes of gait training. Therefore, two units of 97116 (Therapeutic procedure, one or more areas, each 15 minutes; gait training) would be billed.

The five minutes instructing the patient to perform exercises at home would be added to the therapeutic exercise code, totaling 30 minutes. Therefore, two units of 97110 (... therapeutic exercises to develop strength and endurance, range in motion and flexibility) would be billed.

When Therapy Does Not Total 15 Minutes

Billing the PM&R codes would be much easier if therapists' patient sessions always totaled 15 minutes (or increments thereof), but in the real world of treating patients, more or less time is often necessary to provide the best care. Unfortunately, many practices are writing off sessions lasting less than 15 minutes when, in actuality, any therapy session lasting eight minutes or more can be billed.

According to the CMS Program Memorandum AB-00-14, released in March 2000, the above chart breakdown applies to practitioners billing the PM&R codes:

The program memorandum states that any service lasting less than eight minutes should not be billed. And, says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS,** consultant and CPC trainer for A+ Medical Management and Education in Absecon, N.J., "this is a CMS guideline, so the various carriers may use their own interpretation of it." Therefore, practices should confirm that their payers are using the same scale to determine time units billed.

Example One: A patient suffered a motor vehicle accident and required a cast on his left arm. After the cast was removed, the patient experienced atrophy of the left arm, requiring considerable therapy to strengthen it to resume prior functional status. The physical therapist begins the patient's session with a hot pack on the patient's left arm for six minutes, after which the patient complains of pain, and the therapist removes the pack. The therapist then leads the patient as he performs 27 minutes of therapeutic exercises, 22 minutes of gait training and 12 minutes of whirlpool.

Jandroep recommends coding this session as follows:

27 minutes of upper-extremity strengthening totals two units of 97110 (Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility)

22 minutes of gait training totals one unit of 97116 (gait training [includes stair climbing])

12 minutes of whirlpool totals one unit of 97022 (Application of a modality to one or more areas; whirlpool)

Total time is 61 minutes, totaling four units billed.

Jandroep says that the six minutes of hot-pack application cannot be reported because it lasted less than eight minutes.

Example Two: A 78-year-old female patient who suffered a stroke is seeing an occupational therapist who will help her prepare to move back into her apartment. They work on upper-body exercises for 18 minutes, lower-body exercises for 13 minutes and activities of daily living (ADL) training for 39 minutes.

Jandroep recommends reporting this session as follows:

18 minutes of upper-extremity exercises totals one unit of 97110

13 minutes of lower-extremity exercises totals one unit of 97110

39 minutes of ADL training totals three units of 97535 (Self-care/home management training [e.g., 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)

Total time is 70 minutes, resulting in five units total.

Total Treatment Time Determines Number of Units

"The only caveat to the CMS regulation is that the total number of units billed per day is constrained by the total treatment time," Jandroep says. For example, if the therapist provides 24 minutes of manual therapy (97140) and 23 minutes of aquatic therapy (97113), his or her initial inclination would be to bill two units of each. However, because the total time spent determines the number of units billed, and in this case the total time is 47 minutes, only three units can be billed. The correct way to code this scenario is with two units of 97140 and one unit of 97113 because the manual therapy took longer.