Professional Pricing Policy

Subject: **Guidelines For Reporting Timed Units For Physical Medicine and Rehabilitation Services**	
Policy Number: HLAP-0004	Policy Section: **Medicine**
Last Approval Date: September 1,2020	Effective Date: October 17, 2020

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for allowed amounts for HealthLink members. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

If appropriate coding/billing guidelines are not followed, HealthLink and/or its Payors may:

- *Reject or deny the claim*
- *Recover and/or recoup claim payment*

These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates.

We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or adjust pricing accordingly to the effective date. HealthLink reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to the website. Note: medical claim pricing and processing services provided by HealthLink are available to a payor; however not all payors purchase such services for the benefit plans they sponsor.

Policy

I. Reporting Guidelines

HealthLink requires that the provider maintain direct (one-on-one) visual, verbal, and/or manual contact with the patient throughout the performance of procedures that are reported with 15 minute time-based codes listed under Modalities, Therapeutic Procedures, Tests and Measurements, and Orthotic Management and Prosthetic Management and focuses on Constant Attendance Modalities and Therapeutic Procedures.

A. The time reported should be the time actually spent in the delivery of the modality and/or Therapeutic procedure. This means that pre and post-delivery services should not be counted in determining the treatment time.

B. The time that the patient spends not being treated, due to resting periods or waiting for a piece of equipment to become available, is not considered treatment time.

C. Total treatment time, for each modality, must be recorded in the patient's medical record, along with the note describing the specific modality or procedure.

II. Determining Units

A. A provider should not report a direct treatment service if only one attended modality or therapeutic procedure is provided in a day, and the procedure is performed for less than 8 minutes.

B. A single 15-minute unit of direct treatment service may be billed when the duration of direct treatment is equal to or greater than 8 minutes, and less than 23 minutes. If the duration of a single modality or procedure is between 23 minutes but less than 38 minutes, then two 15-minute units of direct treatment service may be billed.

C. The following table indicates the appropriate protocol for reporting each additional unit:

Number of units billed:	Number of minutes provided in treatment:
1 unit	8 minutes to < 23 minutes
2 units	23 minutes to < 38 minutes
3 units	38 minutes to < 53 minutes
4 units	53 minutes to < 68 minutes
5 units	68 minutes to < 83 minutes
6 units	83 minutes to < 98 minutes
7 units	98 minutes to < 113 minutes
8 units	113 minutes to < 128 minutes*

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

D. HealthLink allows for multiple 15 minute, timed modalities performed on the same day for 7 minutes each, or less. Each timed modality performed at 7 minutes or less, must *total* direct one-on-one treatment time of 8 minutes or greater. The CPT code reported is for the service performed for the most minutes.

For example, if a provider renders:
5 minutes of 97035 (ultrasound),
6 minutes of 97110 (therapeutic procedure), and
7 minutes of 97140 (manual therapy techniques)
18 total minutes of direct treatment

The 18 minutes of direct treatment time for the therapy visit is allowed as one unit and reported under CPT code 97140 since that is the service with the most minutes. The patient's medical record should document that all three modalities and procedures were rendered and include the direct treatment time for each.

Related Coding

Code	Description	Comments
N/A	N/A	Standard correct coding applies.

Exemptions

Definitions

Constant Attendance	Treatment that requires direct (one-on-one) patient contact by the provider.
Modalities	Any physical agent applied to produce therapeutic changes to biologic tissues; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.
Therapeutic Procedures	A manner of effecting change through the application of clinical skills and/or services that attempt to improve function.
General Professional Pricing Policy Definitions	

Related Policies and Materials

References and Research Materials

This policy has been developed through consideration of the following

- CMS
- American Physical Therapy Association (APTA)
- American Medical Association (AMA) Current Procedural Terminology (CPT)

Use of Pricing Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Pricing Policy is constantly evolving and we reserve the right to review and update these policies periodically.