Coding Policy **Policy and Procedure**		
SUBJECT: Coding Policy 85.0 Documentation Guidelines for Rehabilitation Therapy Services (Physical, Speech, and Occupational Therapy Services)	DEPARTMENT: **Health Care Services**	
ORIGINAL EFFECTIVE DATE: 02/13	DATE(S) REVIEWED/REVISED: 02/13, 01/14, 06/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 01/21, 01/22	
APPROVED BY: Coding Policy Review Committee	NUMBER: **MC 85.0**	PAGE: **1 of 4**

SCOPE:
Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:
Health Plan Providers
All Lines of Business

POLICY:
Therapy services may be time-based or non-time-based. Time-based therapy services are billed based on the total time-code treatment minutes. When a time-based therapy code is reported on the same date as a non-time-based therapy code, the documentation must clearly show distinct time periods for the two services. If two modalities of time-based therapy are rendered simultaneously, only one modality may be reported for that unit of time.

PROCEDURE:
Time-Based Codes: Providers should bill outpatient therapy time-based code units based on the total time-code treatment minutes. If the total time of all time-based codes is less than 8 minutes, no therapy codes should be reported.

Converting Direct Time Spent with Patients to Billable Units for Time-Based Therapy Services	
0 units	Less than 8 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

The expectation remains that a provider's direct treatment time for each unit billed will average 15 minutes, as this is the RVU used for calculating reimbursement rates for time-based CPT codes for therapy.

The medical record should reflect all the services that were rendered. Modifier -59 (distinct procedural service) should be appended to the separate codes to show there were distinct time periods for each service. If two modalities are rendered simultaneously, only one modality may be reported for that unit of time.

Company requires that modifiers GP, GO, and GN also be added to therapy codes as appropriate. **Note: These modifiers do not identify distinct procedural services and thus do not preclude the need for modifier -59 when separate services are provided.**

- GP: Services delivered under an outpatient physical therapy plan of care
- GO: Services delivered under an outpatient occupational therapy plan of care
- GN: Services delivered under an outpatient speech language pathology plan of care

In the calendar year (CY) 2019 PFS final rule (83 FR 59654 through 59660), CMS created 2 new modifiers for services furnished by therapy assistants, as follows:
• CQ Modifier: Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
• CO Modifier: Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

For dates of service on or after January 1, 2022, Company requires these modifiers to be appended to codes for therapy services, along with GP and GO therapy modifiers, for services in which the PTA or OTA performs more than 8 minutes of a 15-minute unit of timed therapy. Presence of these modifiers will not affect payment.

Documentation Requirements:

All of the following documentation is required for each date of service to support therapy services billed:

- Signed and dated daily treatment notes and progress reports.
- Documentation showing total number of minutes for time-based therapy codes.
- Documentation showing total treatment time in minutes, to encompass both the time-based therapy codes and non-time-based therapy codes.
- Documentation showing body areas treated, including specific therapy provided to each body area.
- Legible signature and professional identification of the provider of service.

Group Pool Therapy

When a patient is involved in group pool therapy, code 97150 may be billed once for each patient in the pool. The time spent in one-on-one time with each patient in the pool may not be broken out and billed separately, as there is no time specified for CPT code 97150.

BILLING SCENARIO EXAMPLES:

Example 1

Manual Therapy (CPT 97140) = 20 minutes
Therapeutic Exercises (CPT 97110) = 20 minutes

- Total direct treatment time = 40 minutes.
- Since the treatment minutes for each service are the same, bill two (2) units of one code and one (1) unit of the other code.
- It is inappropriate to bill 3 units of one code only.
- The medical record should reflect all services that were rendered.
- Bill 3 units total:
    - CPT 97140 = 2 units
    - CPT 97110 = 1 unit

    or
    - CPT 97110 = 2 units
    - CPT 97140 = 1 unit

Example 2

Manual Therapy (CPT 97140) = 35 minutes
Ultrasound (CPT 97035) = 7 minutes

- Total direct treatment time = 42 minutes.
- The first 30 minutes spent on CPT 97140 is counted as 2 full units (since the work unit for each CPT code is 15 minutes = 1 unit).
- The remaining time spent on CPT 97140 (5 minutes) is compared to the time spent on CPT 97035 (7 minutes) and the service that took more time is the service that should receive the remaining unit.
- The medical record should reflect all services that were rendered.
- Bill 3 units total:
    - CPT 97140 = 2 units
    - CPT 97035 = 1 unit

Example 3

Therapeutic Exercises (CPT 97110) = 37 minutes
Massage (CPT 97124) = 5 minutes

- Total direct treatment time = 42 minutes.
- The first 30 minutes spent on CPT 97110 is counted as 2 full units (since the work unit for each CPT code is 15 minutes = 1 unit).
- The remaining time spent on CPT 97110 (7 minutes) is compared to the time spent on CPT 97124 (5 minutes) and the service that took more time is the service that should receive the remaining unit.

- In this instance, it would not be appropriate to bill separately for the massage using CPT 97124.
- The medical record should reflect all services that were rendered.
- Bill 3 units total.
    - CPT 97110 = 3 units

Example 4

Therapeutic Exercises (CPT 97110) = 25 minutes
Therapeutic Activities (CPT 97530) = 24 minutes

- Total direct treatment time = 49 minutes.
- In this situation, since only two services have been provided, it is appropriate to bill more units for the service with the most direct treatment time. (25 minutes is greater than 24 minutes.)
- The medical record should reflect all services that were rendered.
- Bill 3 units total.
    - CPT 97110 = 2 units
    - CPT 97530 = 1 unit

Example 5

Manual Therapy (CPT 97140) = 20 minutes
Therapeutic Exercises (CPT 97110) = 10 minutes
Gait Training (CPT 97116) = 10 minutes
Ultrasound (CPT 97035) = 8 minutes

- Total direct treatment time = 48 minutes.
- In this situation, it is not appropriate to bill separately for the ultrasound, as the total units that can be billed are constrained by the total timed code treatment minutes.
- The medical record should reflect all services that were rendered.
- Bill 3 units total.
    - CPT 97140 = 1 unit
    - CPT 97110 = 1 unit
    - CPT 97116 = 1 unit

REFERENCE:

CMS/Medicare Rules and Regulations
Current Procedural Terminology (CPT)
Providence Health Plan Clinical Coding Edits