Kansas City

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Payment Policy POL-PP-114	
Subject: Timed Therapeutic Procedures	
Effective Date: 10/1/2019	Committee Approval Obtained: 10/1/2019 Last Review: 10/1/2023 Next Review: 10/1/2024
The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://providers.bluekc.com/ContactUs/PaymentPolicies**	
Provider Payment policies are written to provide an overview of coding and payment guidelines as they pertain to claims submitted to Blue KC. These guidelines are not intended to provide billing or coding advice but to serve as a reference for facilities and providers. **Covered services and payment** are based on the member's benefit plan and provider agreement. Providers and their office staff may use our online tools to verify effective dates and member copayments before providing services. Visit our providers page for information on member eligibility and benefits. Member liability may include, but is not limited to, co-payments, deductibles, and co-insurance. Members' costs depend on member benefits. Certain services require prior authorization or referral. **Blue KC reimburses** health care providers based on your contracted rates and member benefits. Claims are subject to payment edits, which Blue KC updates regularly.	
Policy	It is required that time be documented to support the reporting of timed procedure codes. The time reported should reflect direct one-on-one contact time with the patient. Supervised treatment in the absence of skilled intervention is not billable time. Billable time for each service provided should reflect face-to-face time the provider spends with the patient rendering service, not only the time the patient spent receiving supervised procedures in the clinic. When a therapist is working with multiple patients at the one time, CPT code 97150 (group therapy) should be reported. CPT 97150 is not a timed code and should be reported once for each group participant. The specific type of therapy (e.g., 97110) should not be billed in addition to the group therapy code. When more than one service represented by a 15-minute timed code is performed in a single day, the total number of units billed is limited by the total treatment time. If a service represented by a 15-minute timed code is performed in a single day for at least 15 minutes that service shall be billed for at least one unit. If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc. It is not appropriate to count all minutes of treatment in a

	day toward the units for one code if other services were performed for more than 15 minutes. If, on the same day, a 15-minute timed service is performed for 7 minutes or less and another 15-minute timed service was also performed for 7 minutes or less, the total time of the two is 8 minutes or greater, then bill one unit for the service performed for the most minutes. This is correct because the total time is greater than the minimum time for one unit. The same logic is applied when three or more different services are provided for 7 minutes or less. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations may be reviewed. In the same 15-minute (or other specified) period, a therapist may not bill any of the following pairs of CPT codes for outpatient therapy services provided to the same, or to different patients. Examples include: ▪ Any two CPT codes for "therapeutic procedures" requiring direct one-on-one patient contact (CPT codes 97110-97542). ▪ Any two CPT codes for modalities requiring "constant attendance" and direct one-on-one patient contact (CPT codes 97032-97039). ▪ Any two CPT codes requiring either constant attendance or direct one-on-one patient contact-as described in (a) and (b) above. For example: any CPT code for a therapeutic procedure (e.g., 97116-gait training) with any attended modality CPT code (e.g., 97035-ultrasound). ▪ Any CPT code for therapeutic procedures requiring direct one-on-one patient contact (CPT codes 97110-97542) with the group therapy CPT code (97150) requiring constant attendance. For example: group therapy (97150) with neuromuscular reeducation (97112). ▪ Any CPT code for modalities requiring constant attendance (CPT codes 97032-97039) with the group therapy CPT code (97150). For example: group therapy (97150) with ultrasound (97035). ▪ Any untimed evaluation or reevaluation code (CPT codes 97001-97004) with any other timed or untimed CPT codes, including constant attendance modalities (CPT codes 97032-97039), therapeutic procedures (CPT codes 97110-97542) and group therapy (CPT code 97150). In the same 15-minute time period, one therapist may bill for more than one therapy service occurring in the same 15-minute time period where CPT defines "supervised modalities" as untimed and unattended -- not requiring the presence of the therapist (CPT codes 97010-97028). One or more supervised modalities may be billed in the same 15-minute time period with any other CPT code, timed or untimed, requiring constant attendance or direct one-on-one patient contact. However, any actual time the therapist uses to attend one-on-one to a patient receiving a supervised modality cannot be counted for any other service provided by the therapist. **Self-Care/Home Management training** CPT code 97535 (Self-care/home management training (eg, 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, each 15 minutes) should not be used globally for all home instructions. When instructing the patient in a self-management program, use the code that best describes the focus of the self-management activity.

If the instruction given is for exercises to be done at home to improve ROM or strength use 97110; if instructing the patient in balance or coordination activities at home, use 97112; if instructing the patient on using a sock aide for dressing, use 97535; if teaching the patient aquatic exercises to use as an independent program in the community pool, use 97113.

Supportive Documentation Requirements (required at least every 10 visits) for 97535.

- Objective measurements of the patient's activity of daily living (ADL)/instrumental activity of daily living (IADL) impairment to be addressed.

- The specific ADL and/or compensatory training provided, specific safety procedures addressed, specific adaptive equipment/assistive technology utilized, instruction given, and assist required (verbal or physical), and the patient's response to the intervention, to support that the services provided required the skills and expertise of a therapist.

For therapy modalities performed on any calendar day that specify time spent in direct patient contact, i.e., each 15 minutes, use the following guidelines to calculate the number of units that should be reported.

TIME INTERVAL	UNITS BILLED
0-7 minutes	0
8-22 minutes	1
23-37 minutes	2
38-52 minutes	3
53-67 minutes	4
68-82 minutes	5
83-97 minutes	6
98-112 minutes	7

The pattern remains the same for treatment in excess of two hours.

The following medical record standards (not all inclusive) are required; and if not met, may result in delay or denial of payment:

1. Documented referral from appropriate referral source

2. Documented name (on each page of the record) and birth date of beneficiary

3. Legible handwriting (if it is not readable, it will be denied)

4. Avoidance of abbreviations (use only standard abbreviations well known to your peers)

5. Each CPT code submitted for payment must have the appropriate documentation to support the service rendered. Clearly document what you performed to differentiate between each service utilized.

	6. Initial evaluation that includes: a. Diagnosis (medical and physical therapy) b. Complete history and thorough systems review (patient stated problems, co-morbidities, medications, review of past-present care) c. Objective, functional, measurable data (at a minimum): ▪ ROM (relate to function deficits and symptom) ▪ Neuro (relate to function deficits and symptom) ▪ Tissue integrity (trigger pts, pain patterns, spasms, relate to function deficits and symptom) ▪ ▪ Movement pattern deficits (relate to function deficits and symptom) ▪ Functional deficits (relate to symptom) ▪ Posture (relate to function deficits and symptom) ▪ Strength (relate to function deficits and symptom) ▪ ▪ Specific Tests (relate to function deficits and symptom) d. Clearly defined, measurable, time-framed goals that relate to function ▪ Description of movement or activity ▪ Connect to specific function deficit or symptom ▪ Measurable & time framed (What does patient need to be doing before DC?) ▪ Identify who will accomplish the goal e. Clearly stated plan of care defining what will be provided, at what frequency and duration f. Clearly stated medical reason and rationale for each modality utilized, especially when utilizing more than one modality to the same area and same session 7. Daily Notes that include: a. Statements that demonstrate the skill required by the physical therapist or physical therapist assistant, under the supervision and direction of a physical therapist, not just statements of completion of activities (this can be seen on the flow sheet). Why can't patients perform their own exercises at home? b. Statements that demonstrate co-founding factors that delay progress.

c. Time in and time out

d. Time for each CPT code billed

Examples

- Subjective complaints / descriptive / numerical pain / percentage of improvement
- Complicating factors
- Flow sheet (show progression and skill)
- Observation of movement / measurements / function gain – loss / skill need / education of patient
- Factors that modify frequency / intensity / progression
- Statement of clinical decision and problem solving
- Plan for next visit = intervention and objective

8. Progress notes (or re-eval) completed every 10 treatment sessions or every 30 days (whichever is less) that include:

a. Statements of pertinent subjective nature

b. Comparison of objective, functional, measurable data (at a minimum as indicated ROM, Strength, Neuro, Ambulation, Special tests, etc.)

c. Distinctly defined and updated measurable, time-framed goals that relate to function (i.e., what does the patient need to be doing before discharge from therapy?)

d. Distinctly stated updated plan of care delineating what will be provided, frequency and duration

e. Clear medical reason and rationale for continuance of each service utilized

- Evaluate status and modify plan. May simply mean continue current plan, but state why.
- Billing 97164 – Re-Eval
  * Unanticipated change
  * Failure to respond
  * New direction or plan
- Compare similar data points.
- Goals addressed, updated.
- Reasons for lack of progress, changes needed.

9. Flow sheets that include:

a. Date of service, area being treated, and name of professional providing services.

b. Clearly defined CPT Code

	c. Activity completed for each CPT code including name of activity, repetitions, weights, resistance, etc. d. Modalities (parameters, period of time, and specific location(s) treated) Manual therapy techniques (i.e., CPT 97140) when performed on the same date, and in the same region(s) as spinal manipulation (98941-98943) will not be paid separately if the same practitioner performs both services. The following applies to manual therapy techniques when performed in regions other than those regions manipulated: ▪ Modifier 59 may be appropriate to append to code 97140 if the documentation supports its use ▪ The CPT code 97140 for manual therapy techniques is a timed code and therefore the documentation must include time ▪ Code 97140-59 will be limited to one unit per date of service **Non-Covered Services** There will be no additional reimbursement for: • Hot/cold pack therapy • Massage therapy
History	Approval Date: 10/1/2020 Effective Date: 10/1/2020
Review	10/1/2021 Annual Update, removed CPT code table 8/23/2022 added Manual therapy techniques (i.e., CPT 97140) when performed on the same date, and in the same region(s) as spinal manipulation (98941-98943) will not be paid separately when the same practitioner performs both services." 10/1/2022 – Annual review, there were no updates made. 10/1/2023 – Annual review, there were no updates made.
References and Research Materials	CMS NCCI Policy Manual
Related Policies	N/A