Dynamic Chiropractic

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Recording and Appropriate Billing of Timed Physical Medicine Services

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QUESTION: *UnitedHealthcare recently reviewed my files and recouped payment on several dates of service based on timed therapy services. I do understand the 8-minute rule (or at least I thought I did), and documented massage for 10 minutes and exercise for 10 minutes, billing each for a unit. UHC recouped payments for the massage services, indicating timed therapy documentation did not equal the units billed. What can I do about this and may I appeal?*

Time Spent and Billing Units

There is a common misunderstanding about timed therapy services and although you do have some knowledge of timed service documentation, based on your comment on the 8-minute rule, your understanding is correct, but incomplete.

Physical Medicine and Rehabilitation (PM&R) CPT codes, which make up the timed, skilled, direct, one-on-one component of treatment, have extremely specific requirements for recording the time and subsequently billing those services. Specifically, CPT codes 97110-97140, 97530-97542 and 97750-97762 have this time element. Additionally, there is a time element for "constant attendance modalities" – CPT codes 97032-97036. All of these aforementioned codes have a specific time element of 15 minutes for each unit of service that may be billed.

The 8-minute rule you refer to is based on the interpretation and guidance from the American Physical Therapy Association's *Defensible Documentation for Patient/Client Management* document and the Centers for Medicare and Medicaid Services (CMS) national policy, which define this 8-minute rule. This policy has been adopted by UnitedHealthcare and Optum Health, which is the review arm of UHC.

For a single unit of service, the time spent face-to-face must be a minimum of 8 minutes; however the second unit is not counted for billing until 23 minutes of time has been performed. The following is a chart of units for timed services:

- 1 unit: ≥ 8-22 minutes
- 2 units: ≥ 23-37 minutes
- 3 units: ≥ 38-52 minutes
- 4 units: ≥ 53-67 minutes

The pattern remains the same for treatment times in excess of 1 hour.

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. Based on your question, this appears to be your understanding and is correct for a single service. However, you performed two distinct services; when multiple timed services are performed, the time is considered cumulative for the units billed.

In your question, you noted you performed 10 minutes of 97124 and 10 minutes of 97110. The total time of skilled face-to-face time was 20 minutes. Twenty minutes of skilled face-to-face time is equal to one unit and consequently only one unit may be billed. In your example, you would code for the higher valued service for one unit, which explains why UHC demanded recoupment for the lower-valued massage 97124.

For two units of timed therapy services to be billed, the time must equal 23 minutes or more, even for separate services. If you had performed and documented the time as 12 minutes of exercise 97110 and 11 minutes of massage 97124, the cumulative time of 23 minutes would have allowed you to bill for

two units (one unit of each service).

As is always the case, the documentation must support the service. 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 should reflect the time the provider spent with the patient and not just the time the patient spent performing supervised procedures in the clinic.

The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. Pre, intra- and post-delivery face-to face-time with the patient is counted in determining the total treatment service time.

A Few Examples

Example #1

- 24 minutes of neuromuscular re-education (97112)
- 23 minutes of therapeutic exercise (97110)
- Total timed code treatment time equals 47 minutes
- The 47 minutes falls within the range for three units (38-52 minutes)

Appropriate billing for 47 minutes is only three timed units. Each of the codes is performed for more than 15 minutes, so each should be billed for at least one unit. The correct coding is two units of code 97112 and one unit of code 97110, assigning more timed units to the service that took the most time.

Example #2

- 20 minutes of neuromuscular re-education (97112)
- 20 minutes of therapeutic exercise (97110)
- Total timed code treatment time equals 40 minutes
- As with example #1, the 40 minutes falls within the range for three units.

Each service was performed for at least 15 minutes and should be billed for at least one unit, but the total allows three units. Since the time for each service is the same, choose either code for two units and bill the other for one unit. Do not bill three units for either one of the codes.

Documenting Your Services

So, to answer your question, unfortunately, you do not have grounds for appeal, as you documented only 20 minutes total. I would review your documentation protocol for your office and be sure you are counting the total minutes of skilled, face-to-face contact time including the pre-, intra- and post-service time associated with the therapy.

Note the chiropractic manipulative therapy (CMT) service also has a pre-, intra- and post-component, and that time is not to be included for timed PM&R services. However, the therapies unto themselves have their individual needs of delivery.

The basic rules are as follows: Pre-service time includes assessment and management time – medical record review, physician contact while the patient is present, assessment of the patient's progress since the previous visit, and time required to establish clinical judgment for the treatment session. Pre-service time is not the time required to get the patient ready to receive the treatment.

Intra-service time includes the hands-on treatment time, while post-service time includes the assessment of treatment effectiveness, communication with the patient/caregiver including education/instruction/counseling/advising, professional communications, clinical judgment required for treatment planning for the next treatment session, and documentation while the patient is present.

Be sure that when contact begins face-to-face for a therapy, you record the time, whether by total minutes or from starting to ending time, so your notes accurately reflect the true total time of the service. Often time is recorded as an approximate value or does not include the true pre- to post-time. As a consequence, upon review this oversight could result in recoupment or nonpayment. It is also more likely there is more time spent when the time is accurately recorded and not approximated.

Feel free to submit billing questions to Mr. Collins at sam@hjrossnetwork.com. Your question may be the subject of a future column.

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