

Physical Medicine and Rehabilitation Time-Based Services

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Introduction

Workforce Safety & Insurance (WSI) has adopted the HCPCS coding requirements from the Centers for Medicare & Medicaid Services (CMS) for the evaluation of documentation and billing of time-based Physical Medicine and Rehabilitation (PM&R) codes. The purpose of this document is to outline WSI's policy regarding the documentation and billing of PM&R time-based services.

Definitions

Time-Based Physical Medicine and Rehabilitation Codes – CPT® identifies 4 sections of time-based PM&R services. This includes modalities (97032-97039), therapeutic procedures (97110-97542), tests and measurements (97750-97755), and orthotic and prosthetic management (97760-97762). These codes require direct, face-to-face contact with the patient.

Policy

CMS specifies a provider must spend 8 or more minutes in direct, face-to-face contact with the patient to bill for a single 15 minute unit of time-based PM&R services. When a provider performs more than 1 time-based service in a single session, CMS considers the total number of minutes spent with the patient to determine the total number of billable units.

WSI will audit all PM&R services for the following:

- Documentation of specific intervention(s) or technique(s) performed (including the frequency and intensity, when appropriate)
- Documentation of the amount of time spent completing each type of time-based service (therapeutic procedures, modalities, etc.)
- Documentation of timed services provided match the billed units. To determine the number of reimbursable unit(s), WSI will divide the total time-based services documented by 15. If 8 or more minutes remain, an additional unit is reimbursable. See the following chart excerpted from the Centers for Medicare & Medicaid Services (CMS) Medicare Claims Processing Manual to determine the correct number of billable units.

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
8 units	≥ 113 minutes through 127 minutes

Appendix

Time-Based Service Documentation Examples

Physical Medicine and Rehabilitation Time-Based Services (Continued)

WSI will deny reimbursement of any billed services the medical documentation does not support.

For detailed guidance on how to document time based services and determine the correct number of billable units, see [Appendix: Time-Based Service Documentation Examples](#).

Reference

Centers for Medicare & Medicaid Services (CMS) – Medicare Claims Processing Manual Pub. 100-04, Chapter 5, Sec. 20.3

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf>

Appendix

Time-Based Service Documentation Examples

The following examples are excerpted from the Centers for Medicare & Medicaid Services (CMS) Medicare Claims Processing Manual and serve to assist providers in determining how to document time-based services and determine the number of billable units.

Example 1:

24 minutes of neuromuscular reeducation (97112)
23 minutes of therapeutic exercise (97110)
47 minutes of time-based treatment

Appropriate billing for 47 minutes is only 3 times units. Each of the codes is performed for more than 15 minutes, so each shall be billed for at least 1 unit. The correct coding is 2 units of code 97112 and 1 unit of code 97110, assigning more timed units to the service that took the most time.

Example 2:

20 minutes of neuromuscular reeducation (97112)
20 minutes of therapeutic exercise (97110)
40 minutes of time-based treatment

Appropriate billing for 40 minutes is 3 units. Each service was done at least 15 minutes and should be billed for at least 1 unit, but the total allows 3 units. Since the time for each service is the same, choose either code for 2 units and bill the other for 1 unit. Do not bill 3 units for either one of the codes.

Example 3:

33 minutes of therapeutic exercise (97110)
7 minutes of manual therapy (97140)
40 minutes of time-based treatment

Appropriate billing for 40 minutes is for 3 units. Bill 2 units for 97110 and 1 unit of 97140. Count the first 30 minutes of 97110 as 2 full units. Compare the remaining time for 97110 (30-33 = 3 minutes) to the time spent on 97140 (7 minutes) and bill the larger, which is 97140.

Example 4:

18 minutes of therapeutic exercise (97110)
13 minutes of manual therapy (97140)
10 minutes of gait training (97116)
8 minutes of ultrasound (97035)
49 minutes of time-based treatment

Appropriate billing is for 3 units. Bill the procedures you spent the most time providing; 1 unit each of 97110, 97116, and 97140. You are unable to bill for the ultrasound because the total time of timed units that can be billed is constrained by the total timed code treatment minutes (i.e., you may not bill 4 units for less than 53 minutes regardless of how many services were performed). You would still document the ultrasound in the treatment notes.