

11 Part B Billing Scenarios for PTs and OTs

This page is designed to clarify existing therapy policy and to provide guidance on current Part B billing issues relevant to physical therapists (PTs), occupational therapists (OTs) and speech-language pathologists (SLPs) and to the services they provide. Because we have received numerous requests to restore the previously published 11 Frequently Asked Questions (FAQs) resulting from the 9/13/02 Open Door Forum on Group Therapy, we have chosen to reformat these FAQs into "billing scenarios" to appear below. As a result, the 11 Part B Billing Scenarios are specific to PTs and OTs. We will update this Web Page to reflect changes in policy (for example, CCI edits, new codes, new coverage determinations) that impact therapy billing and/or to provide clarification on billing policy for PTs, OTs and/or SLPs.

Check the manuals first.

Therapy Manual References

- Medicare Claims Processing Manual, 100-4, Chapter 5, Sections 10, 20, 30, 40, 100
- Medicare Benefit Policy Manual, 100-2, Chapter 15, sections 220 and 230

The Medicare contractor who pays your claims is the best source of answers to specific Medicare questions. Contractors are carriers, intermediaries or Program Safeguard Contractors who interpret Medicare laws, develop local policies and educate providers. Contractor websites list local policies. You may also contact your Medicare Regional Office for assistance.

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The following billing scenarios formerly appeared on the Frequently Asked Questions (FAQ) website and on the Therapy Medlearn website as "11 FAQs" - posted 9/13/02 Open Door on Group Therapy.

CMS Assumptions

The following CMS assumptions were used in constructing the following billing scenarios regarding Part B therapy services. These represent requirements that are necessary pre-conditions to the information that follows and are part of the service delivery framework that CMS assumes is in place when Part B therapy services are delivered:

- Physical and Occupational Therapists (PTs and OTs) and their therapy assistants - physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) meet Medicare personnel qualifications.
- All therapy provided consists of skilled and medically necessary services and is appropriate to each patient's plan of care.

- Therapists can enroll in Medicare as providers of PT or OT services, but therapy assistants cannot. The services of the therapy assistant are billed through the enrolled therapist, or other therapy provider.
- The therapist reports the time the therapy assistant provides care, whether it is one-on-one care or delivered via the untimed codes, such as supervised modalities or group therapy.
- All Medicare rules are met with respect to supervision requirements for therapy assistants in their respective settings. For example: (1) direct ("in the office suite") supervision in private practice PT or OT therapy settings and (2) general supervision in the following settings: OPSS, SNF, CORF, Rehab Agency and the HHA.
- Each therapist's supervision of therapy assistant(s) is in compliance with all State laws and regulations and with local medical review policies.

References

The following references are used throughout the billing scenarios that follow:

1. Definitions of qualified therapy personnel: 42 C.F.R. 485.705, 484.4
2. Reasonable and necessary: Program Integrity Manual Chapter 13, Section 5.1
3. Skilled therapy: Benefits Policy Manual, 100-02, Chapter 15, Sections 220 and 230
4. CPT Definitions: CPT 2004, American Medical Association Press
5. Counting of timed codes: Claims Processing Manual, 100-04, Chapter 5, Section 20.3, and Program Memorandum AB-01-68 (May 1, 2001)
6. SNF Therapy: Federal Register, 66 Fed. Reg. 39567 (July 31, 2002)
7. Correct Coding Initiative websites:
 - o Physician Fee Schedule
 - o Hospital Outpatient PPS
8. User's Manual for the Minimum Data Set (MDS) Version 2.0, Revised December 2002, Revised Long Term Care Resident Assessment Instrument:

1. Billing - CPT Codes: Not Permitted

In the same 15-minute (or other) time period, a therapist cannot bill any of the following pairs of CPT codes for outpatient therapy services provided to the same, or to different patients. Examples include:

- a. Any two CPT codes for "therapeutic procedures" requiring direct one-on-one patient contact (CPT codes 97110-97542);
- b. Any two CPT codes for modalities requiring "constant attendance" and direct one-on-one patient contact (CPT codes 97032 - 97039);
- c. Any two CPT codes requiring either constant attendance or direct one-on-one patient contact - as described in (a) and (b) above -- (CPT codes 97032- 97542). For example: any CPT code for a therapeutic procedure (eg. 97116-gait training) with any attended modality CPT code (eg. 97035-ultrasound);
- d. 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);

- e. 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);
- f. 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)

See reference numbers 4. and 5. above.

2. Billing - CPT Codes: Permitted

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 "supervised modalities" are defined by CPT 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.

See reference numbers 4. and 5. above.

3. Group Therapy-vs- Individual Therapy:

The following is provided to assist you in determining whether to bill for group therapy (97150) or individual therapy (defined by the timed CPT codes for therapeutic procedures requiring direct one-on-one patient contact), when treating two patients during the same time period.

When direct one-on-one patient contact is provided, the therapist bills for individual therapy, and counts the total minutes of service to each patient in order to determine how many units of service to bill each patient for the timed codes. These direct one-on-one minutes may occur continuously (15 minutes straight), or in notable episodes (for example, 10 minutes now, 5 minutes later). Each direct one-on-one episode, however, should be of a sufficient length of time to provide the appropriate skilled treatment in accordance with each patient's plan of care. Also, the manner of practice should clearly distinguish it from care provided simultaneously to two or more patients.

Group therapy consists of simultaneous treatment to two or more patients who may or may not be doing the same activities. If the therapist is dividing attention among the patients, providing only brief, intermittent personal contact, or giving the same instructions to two or more patients at the same time, it is appropriate to bill each patient one unit of group therapy, 97150 (untimed).

- a. **One-on-One Example:** In a 45-minute period, a therapist works with 3 patients - A, B, and C - providing therapeutic exercises to each patient with direct one-

on-one contact in the following sequence: Patient A receives 8 minutes, patient B receives 8 minutes and patient C receives 8 minutes. After this initial 24-minute period, the therapist returns to work with patient A for 10 more minutes (18 minutes total), then patient B for 5 more minutes (13 minutes total), and finally patient C for 6 additional minutes (14 minutes total). During the times the patients are not receiving direct one-on-one contact with the therapist, they are each exercising independently. The therapist appropriately bills each patient one 15 minute unit of therapeutic exercise (97110) corresponding to the time of the skilled intervention with each patient.

- b. **Group Example:** In a 25-minute period, a therapist works with two patients, A and B, and divides his/her time between two patients. The therapist moves back and forth between the two patients, spending a minute or two at a time, and provides occasional assistance and modifications to patient A's exercise program and offers verbal cues for patient B's gait training and balance activities in the parallel bars. The therapist does not track continuous or notable, identifiable episodes of direct one-on-one contact with either patient and would bill each patient one unit of group therapy (97150) corresponding to the time of the skilled intervention with each patient.

See reference numbers 4. and 5. above.

4. Team Therapy:

Therapists, or therapy assistants, working together as a "team" to treat one or more patients **cannot** each bill separately for the same or different service provided at the same time to the same patient.

CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same patient(s). Where a physical and occupational therapist both provide services to one patient at the same time, only one therapist can bill for the entire service or the PT and OT can divide the service units. For example, a PT and an OT work together for 30 minutes with one patient on transfer activities. The PT and OT could each bill one unit of 97530. Alternatively, the 2 units of 97530 could be billed by either the PT or the OT, but not both. Similarly, if two therapy assistants provide services to the same patient at the same time, only the service of one therapy assistant can be billed by the supervising therapist or the service units can be split between the two therapy assistants and billed by the supervising therapist(s).

See reference numbers 4. and 5. above.

5. Counting Minutes of Service Units

Billing of six units over a 60-minute period by providing direct one-on-one treatments to six patients for 10 minutes each:

If more than one timed CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time. Medicare's

expectation (based on the work values for these CPT codes) is that a therapist's direct one-on-one patient contact time will average 15 minutes in length, for each unit. Therapy sessions should not be structured to consistently provide less than an average of 15 minutes treatment for each timed unit. Routine billing of the above-described practice (10-minute treatment sessions) results in an average workload that exceeds the expected time frames and would likely cause the contractor to question whether the services were reasonable and necessary.

In the case of group therapy, an untimed code, Medicare expects that skilled, medically necessary services will be provided as appropriate to each patient's plan of care. Therefore, group therapy sessions should be of sufficient length to address the needs of each of the patients in the group.

See reference number 5. above.

6. Group and Individual CPT Codes Billed on Same Day:

Billing for both individual (one-on-one) and group services provided to the same patient in the same day:

This is allowed, provided the CPT and CMS rules for one-on-one and group therapy are both met. However, the group therapy session must be clearly distinct or independent from other services and billed using a -59 modifier.

The group therapy CPT code (97150) and the direct one-on-one 15-minute CPT Codes for therapeutic procedures (97110 - 97542) are subject to Medicare's Correct Coding Initiative (CCI). The CCI edits require the group therapy and the one-on-one therapy to occur in different sessions, timeframes, or separate encounters that are distinct or independent from each other when billed on the same day. The therapist would use the -59 modifier to bill for both group therapy and individual therapy CPT codes to distinguish that the two coded services represent different sessions or separate encounters on the same day. Without the -59 modifier, payment would be made for the lower-priced group therapy CPT Code, in accordance with CPT/CCI rules. The CCI edits are based upon interpretation of coding rules.

The National Correct Coding Initiative website contains a section titled "How To Obtain Assistance With Questions Related to CCI Edits" that may be helpful. In addition to the group therapy edits, CCI edits are applied to certain other pairs of CPT codes used by physical and occupational therapists. The CCI website contains a link to the National Technical Information Service (NTIS) website for information on obtaining the CCI Edits Manual and now lists current CCI edits.

See reference number 7. above.

7. Supervision:

The services of a therapist or therapy assistant **cannot** be billed for supervising a patient who is independently performing a therapeutic exercise program.

Medicare pays only for skilled, medically necessary services delivered by qualified individuals, including therapists or appropriately supervised therapy assistants. Supervising patients who are exercising independently is not a skilled service.

See reference numbers 1. and 3. above.

8. Qualified Personnel:

You **cannot** bill Medicare for the services of an aide that is supervised by the therapist or therapy assistant.

Medicare Part B does not pay for the services provided by aides regardless of the level of supervision. Medicare pays only for skilled, medically necessary services delivered by qualified individuals, including therapists and appropriately supervised therapy assistants.

See reference numbers 1. and 3. above.

9. Group Frequency:

In private practice settings for physical and occupational therapists and in physician offices where therapy services are provided incident to the physician, Medicare expects the group therapy code (97150) to be billed only once each day per patient. In the facility/institutional therapy settings, the group therapy code could be applied more than once. However, the occasional situation where group therapy is billed more than once each day would require sufficient documentation to support its medical necessity and clinical appropriateness of providing more than one separate session of group therapy.

See reference number 4. above.

10. Documentation:

Records need to be maintained in order to demonstrate that billing for individual therapy or group therapy was proper:

CMS provides guidance on the reporting of service units that includes documentation instructions. A therapist or therapy assistant should record the total treatment time (or the actual beginning and ending time of treatment) for services described by timed codes, untimed codes and unattended (billed and unbilled) activities. **The total number of timed 15-minute units that can be billed by the therapist (whether performed by the therapist or therapy assistant) for each patient is constrained by the total time of the skilled therapeutic one-on-one intervention by the therapist or therapy assistant.** For the untimed codes, including "supervised" modalities, group therapy, and the evaluation codes, documenting the session time can help to justify the appropriateness of the services provided.

Alternatively, in cases where recording the total treatment time may not be sufficient

to describe the extent of the therapeutic procedures or where certain practice policies require it, the time spent delivering each service described by either a timed or untimed CPT code could be recorded. In these cases, the therapist could document (a) the total time or the beginning and ending time for each session defined by a timed code and/or (b) the total time (or segments of time) in which the patient is involved in services defined by untimed codes and unattended codes.

See reference number 5. above.

11. SNF Part B Billing:

In a SNF, when a therapist is working simultaneously with two or more residents - at least one each from Part A and Part B - providing the same or different activities, the regulations for each payer source must be followed. Examples of possible billing scenarios follow:

- A therapist treats one Part A resident and one Part B resident during the same 30-minute session, providing different activities to each, and does not track identifiable one-on-one episodes of direct care with either patient. The therapist would bill one unit of 97150 (group) for the Part B resident, and code the total time, 30 minutes, toward the MDS as individual treatment time for the Part A resident.
- A therapist treats one Part A resident and one Part B resident during the same 30-minute session, providing the same or similar activities to each, and not tracking identifiable one-on-one episodes of care with either patient. The therapist would bill one unit of 97150 (group) for the Part B resident and code the total time, 30 minutes, toward the MDS as group treatment time for the Part A resident.

Note: Part A therapy is different from Part B:

- In order to be considered group therapy under Part A, the SNF residents perform similar activities whereas, under Part B, the therapeutic interventions can be similar or different; and,
- SNF therapy services are paid as part of the bundled PPS rate and not reimbursed under the physician fee schedule as they are under Part B.

See reference numbers 6. and 8. above.

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