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Coding Guidance

Timed Codes: Constant Attendance Modalities and Therapeutic Procedures

Introduction:

This paper is designed to explain the proper use of constant attendance modality codes, supervised modalities, and therapeutic procedures. In general they are meant to produce therapeutic changes and improve function. They can be billed as direct one-on-one interventions or simply supervised.

Definition:

Constant Attendance Modality Codes

Constant Attendance Modality codes (97032 – 97039) are used to report various physical agents applied to the patient for the purpose of producing therapeutic changes to biological tissue. The codes require direct one-on-one contact throughout the procedure during which the provider is required to maintain visual, verbal, and/or manual contact with the patient. Codes 97010-97028 identify supervised modalities, which do not require this type of contact.

These time-based codes include the time required to perform all aspects of the service itself, including pre-, intra-, and post-service effort. The language in the constant attendance modality codes indicates that these codes are reported once for each 15 minutes of service. For example, if manual electrical stimulation is applied to four areas for a total of 30 minutes, CPT® code 97032 is reported for two units, once for each 15-minute interval. If a substantial portion of a 15-minute interval is not provided, then the service should not be billed. Note that the requirement to not bill for services lasting less than 8 minutes applies to constant attendance modalities (97032-97039).

- 97032 Electrical Stimulation (manual)
- 97033 Iontophoresis
- 97034 Contrast baths
- 97035 Ultrasound
- 97036 Hubbard Tank
- 97039 Unlisted modality (specify type and time in constant attendance)

Therapeutic Procedures

Therapeutic Procedures (codes 97110-97150, 97530-97546) were added to CPT® in 1995 to clarify the differences between Therapeutic Procedures, Modalities, and Tests and Measurements. A Therapeutic Procedure is defined as “a manner of effecting change through the application of clinical skills and/or services that attempt to improve function.” These procedures require direct one-on-one patient contact by a physician or therapist. The descriptions for most of these codes reflect 15-minute intervals.

Common components included as part of Therapeutic Procedures include chart reviews for treatment, setup of activities and the equipment area, and review of previous documentation as needed. Subsequent to providing the therapeutic service, the treatment is recorded, and the patient’s progress is documented. The patient health record should list the duration of the procedure time.



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Therapeutic Procedures are intended to be performed with one-on-one patient contact. If a provider is performing Therapeutic Procedures in a group of two or more individuals, CPT® code 97150 should be reported. Time and/or the number of Therapeutic Procedures are not specified in this code so it should only be billed once per patient per visit.

Application:

Question: *A practitioner spends 10 minutes working with patient X on therapeutic exercises to develop strength and endurance. The practitioner instructs patient X to continue the exercises for 5 or more minutes and attends to another patient, patient Y, during this time, while continuing to supervise patient X. The practitioner returns to patient X and spends another 5 minutes directly working with him, and once again instructs patient X to continue an exercise for 5 minutes. The practitioner again attends to patient Y during this time, and then returns to patient X to work directly with him for another 5 minutes. Should code 97150 be reported, or should code 97110 be reported twice?*

Comment: From a CPT coding perspective, code 97110 requires the practitioner to maintain direct patient contact (i.e., visual, verbal, and/or manual contact) during provision of the service, so 97110 should only be reported when the practitioner is providing therapy to one patient alone. When the practitioner is working with several patients at the same time, then CPT code 97150 should be reported.

Question: *When reporting CPT code 97150, Therapeutic procedure(s), group (2 or more individuals), should another code(s) be reported in addition to the group code to specify the type of therapy?*

AMA Comment: Group therapeutic procedures include CPT codes 97110-97139. If any of these procedures are performed with two or more individuals, then only report 97150. Do not code the specific type of therapy in addition to the group therapy code.

Question: *When a patient receives a therapeutic procedure (eg, 97110-97139) in a group setting, is it appropriate to report code 97150, Therapeutic procedure(s), group (2 or more individuals), in addition to the code for the individual therapeutic procedure?*

AMA Comment: Code 97150 is intended to report supervised group activities (ie, two or more individuals) of therapeutic procedures. CPT codes 97110-97139 describe therapeutic procedures performed with a single individual. If the therapeutic procedure described by codes 97110-97139 are performed in a group setting (ie, two or more individuals), then only code 97150 would be reported. The specific type of therapy is not reported in conjunction with code 97150. CPT code 97150 is not a time-based code, as are codes 97110-97139; therefore, code 97150 is reported per session, regardless of the time involved. Code 97150 may be reported for each individual receiving group therapy.

Question: *What is considered a unit of time when reporting time-based codes?*

Comment: According to CPT® Assistant - A Review of Reporting Time-Based Codes: "According to the codebook's instruction, a unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes) When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used (CPT 2014; page xv). Therefore ...based on the time guidelines provided in the CPT code set, it is not appropriate to append modifier 52, Reduced Services, to codes 97110-97546. Services of less than eight minutes would not be reported. To illustrate further, when reporting Physical Medicine and



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Rehabilitation code 97110, a time-based code can be reported for each 15-minute unit. Multiple units can be reported on a date of service for one or more procedures based on the aggregate amount of time spent by a qualified health care professional in direct contact with the patient. As with any 15-minute time-based code, it is important to recognize that a substantial portion of the 15 minutes must be spent in performing the pre-, intra-, and post service work in order to report the time-based code. If only five minutes are spent performing the physical medicine service, the code should not be reported. A minimum of eight minutes of therapeutic exercises is required to report code 97110.” *Emphasis added.¹

Question: *What standards are used when measuring and reporting multiple time-based CPT codes?*

Comment: Per CPT® Assistant -Frequently Asked Questions: Medicine: Physical Medicine and Rehabilitation: "For the purpose of determining the total time of a service, incremental intervals of treatment at the same visit may be accumulated," how would the following scenario be reported: At 8 am, the therapist provides seven minutes of treatment described by code 97110; at 8:15 am, the therapist provides 23 minutes of treatment described by code 97112; and at 8:45 am, another eight minutes of treatment described by code 97110 was provided?

Multiple units may be reported on a date of service for one or more procedures based on the aggregate amount of time spent by a qualified health care professional in direct (one-on-one) contact with the patient. Therefore, for the scenario described in your question, it is appropriate to report one unit of code 97110 for the 15 minutes of aggregate time the services were performed. It is also appropriate to report two units of code 97112, Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities, because 23 minutes is greater than the midpoint between 15 minutes and 30 minutes, which qualifies the procedures for two units of code 97112.”²

Medicare Guidelines for Timed Codes:

Medicare guidelines are different from the above in that providers should report the code for the time actually spent in delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as “intraservice care” begins when the therapist, physician, or assistant under the supervision of a physician, is delivering treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment.

The time counted is the time the patient is treated. For example, if gait training for a patient with a recent stroke requires both a therapist and an assistant, or even two therapists to manage the patient on the parallel bars, each 15 minutes the patient is being treated counts as one unit of 97116. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.

¹ CPT Assistant, March 2020, page 15

² CPT Assistant, August 2020, page 5



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For any single CPT® code, providers would bill Medicare a single 15-minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes, then 2 units should be billed. Time intervals for larger numbers of units are as follows:

3 units > 38 minutes to < 53 minutes

4 units > 53 minutes to < 68 minutes

5 units > 68 minutes to < 83 minutes

6 units > 83 minutes to < 98 minutes

7 units > 98 minutes to < 113 minutes

8 units > 113 minutes to < 128 minutes

The pattern remains the same for treatment times in excess of 2 hours. Providers should not bill for services performed for less than 8 minutes. The expectation (based on the work values for these codes), is that a provider's time for each unit will average 15 minutes in length. If a provider has a practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

The above schedule of times is intended to aid in rounding time into 15-minute increments. It does not imply that any minute until the 8th should be excluded from the total count as the timing of active treatment counted includes all time.

It is advisable that the beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment and patient's progress. If more than one 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, see examples below.

Example 1: If 24 minutes of 97112 and 23 minutes of 97110 were furnished, then the total treatment time was 47 minutes, so only 3 units can be billed for the treatment. The correct coding is 2 units of 97112 and one unit of 97110, assigning more units to the service that took more time.

Example 2: If a therapist delivers 5 minutes of 97035 (ultrasound), 6 minutes of 97140 (manual techniques), and 10 minutes of 97110 (therapeutic exercise), then the total minutes are 21 and only one unit can be paid. Bill one unit of 97110 (the service with the longest time) and the clinical record will serve as documentation that the other two services were also performed.³

ACA highly recommends that providers:

³ <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf>



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- check with their licensing board to determine if the procedure is within their state scope of practice;
- closely scrutinize their payer contracts and contact the payer directly for coverage details since policies regarding physical therapy services are often being revised;
- and take advantage of ACA's Benefits Verification Form, a helpful resource

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