Commercial Reimbursement Policy

Subject: **Guidelines For Reporting Timed Units For Physical Medicine and Rehabilitation Services – Professional**	
Policy Number: **C-07002**	Policy Section: **Medicine**
Last Approval Date: **09/17/2007**	Effective Date: **04/01/2021**

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Anthem benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Our policies apply to both participating and non-participating professionals and facilities as indicated.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim
- Recover and/or recoup claim payment

These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. Anthem reserves the right to review and revise these policies periodically when necessary. When there is an update we will publish the most current policy to the website.

Policy

I. Reporting Guidelines

Anthem allows reimbursement for the performance of procedures that are reported with 15 minute time-based codes listed under Modalities, Therapeutic Procedures, Tests and Measurements, Orthotic Management and Prosthetic Management, Constant Attendance Modalities and Therapeutic Procedures under the following circumstances:

- The provider must maintain direct (one-on-one) visual, verbal, and/or manual contact with the member
- The time reported should be the time actually spent in the delivery of the modality and/or therapeutic procedure. This means that pre and post-delivery services should not be counted in determining the treatment time.

- The time that the member spends not being treated, due to resting periods or waiting for a piece of equipment to become available, is not considered treatment time.
- Total treatment time, for each modality, must be recorded in the member's medical record, along with the note describing the specific modality or procedure.
- Services must be reported with appropriate modifiers GN, GO and GP to identify therapy type.

II. Determining Units

- A provider should not report a direct treatment service if only one attended modality or therapeutic procedure is provided in a day, and the procedure is performed for less than 8 minutes.
- A single 15-minute unit of direct treatment service may be billed when the duration of direct treatment is equal to or greater than 8 minutes, and less than 23 minutes. If the duration of a single modality or procedure is between 23 minutes but less than 38 minutes, then two 15-minute units of direct treatment service may be billed.
- The following table indicates the appropriate protocol for reporting each additional unit:

Number of units billed:	Number of minutes provided in treatment:
1 unit	8 minutes to < 23 minutes
2 units	23 minutes to < 38 minutes
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 time in excess of 2 hours.

- Anthem allows reimbursement for multiple 15 minute, timed modalities performed on the same day for 7 minutes each, or less. Each timed modality performed at 7 minutes or less, must *total* direct one-on-one treatment time of 8 minutes or greater. The CPT code reported is for the service performed for the most minutes.

Total of direct treatment time for the therapy visit is eligible for reimbursement as one unit and reported under the CPT that is the service with the most minutes. The patient's medical record should document that all three modalities and procedures were rendered and include the direct treatment time for each.

Related Coding

Code	Description	Comments
N/A	N/A	Standard correct coding applies

Policy History

10/08/2020	Biennial review approved and effective 04/01/2021: Minor administrative changes, added language including modifiers GN, GO and GP
06/01/2019	Policy template updated

06/27/2018	Biennial Review: Policy named changed along with removal of language associated with CMS. Removed reimbursement calculations, specific CPT codes and removed “beginning and ending time” language.
11/01/2016	Annual Review: Updated policy header to read “Commercial Reimbursement Policy. Added “This reimbursement policy also applies to Employer Group Retiree Medicare Advantage Programs and included reference to CMS 1500 form.
06/02/2015	Annual Review: No changes
01/07/2014	Annual Review: Updates to footnotes and CPT code 97140 added
01/08/2013	Annual Review: No significant changes
01/10/2012	Annual Review: No significant changes
01/04/2011	Annual Review: No significant changes
12/01/2009	Annual Review: Title changed to “Rule of Eight” – Reporting Guidelines for physical Medicine and Rehabilitation Services
11/25/2009	Language approved by Legal
07/01/2009	Revised with update to policy heading
09/17/2007	Initial approval by Enterprise Professional Reimbursement Committee

References and Research Materials

This policy has been developed through consideration of the following:

- CMS (Centers for Medicaid and Medicare Services)
- APTA (The American Physical Therapy Association)
- American Medical Association (AMA) Current Procedural Terminology (CPT®) 2020

Definitions

Constant Attendance	Treatment that requires direct (one-on-one) patient contact by the provider.
Modalities	Any physical agent applied to produce therapeutic changes to biologic tissues; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.
Therapeutic Procedures	A manner of effecting change through the application of clinical skills and/or services that attempt to improve function.
General Reimbursement Policy Definitions	

Related Policies and Materials

Modifier Rules
Frequency Editing

Use of Reimbursement Policy:

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.