CPT Coding Frequently Asked Questions

1. **Definition of modality terms:**
   - **Supervised = Unattended**
     - The application of a modality that does not require direct (one on one) patient contact by the provider.
   - **Constant = Attended**
     - The application of a modality that requires direct (one on one) patient contact by provider

**Timed CPT codes**
- For any single timed code, providers can bill multiple times depending on the total time the therapist spent with the patient
- 8 minute rule application for the total treatment time provided
- 8 minute rule applies to the whole day for each discipline

**Service Based (Untimed) CPT codes**
- These codes can be billed only one time for the service provided during a single treatment session in one day, no matter how long the therapist treats the patient
- Exception: Untimed codes can be billed BID if:
  - The patient has a BID physician order,
  - All treatment procedures within the plan of care are performed 2x/day, and the amount of time in each treatment session represents the medical complexity of the patient, i.e. at least 30 minutes per session.
  - Patient demonstrates medical necessity and medical and clinical complexity

2. **What is the difference between coding for Medicare A and Medicare B patients?**
   - **Med A**: The CPT codes are used to reflect the treatment that was delivered and coding rules for your time do not apply. You may see odd numbers for your “actual” treatment time spent with the patient. (i.e. 54, 62, 35 minutes, etc). PPS allows for all skillable minutes to be counted toward the MDS for placement of a patient into a rehab RUG category.
   - **Med B**: The delivery for the timed CPT codes is in 15-minute increments and based on the total time spent in treatment, using the 8-minute rule. Rounding of time is not permitted.

3. **How does the 8-minute rule work?**
   When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:

<table>
<thead>
<tr>
<th>Units</th>
<th>Number of Minutes</th>
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<tbody>
<tr>
<td>1 unit</td>
<td>≥ 8 minutes through 22 minutes</td>
</tr>
<tr>
<td>2 units</td>
<td>≥ 23 minutes through 37 minutes</td>
</tr>
<tr>
<td>3 units</td>
<td>≥ 38 minutes through 52 minutes</td>
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<tr>
<td>4 units</td>
<td>≥ 53 minutes through 67 minutes</td>
</tr>
<tr>
<td>5 units</td>
<td>≥ 68 minutes through 82 minutes</td>
</tr>
<tr>
<td>6 units</td>
<td>≥ 83 minutes through 97 minutes</td>
</tr>
<tr>
<td>7 units</td>
<td>≥ 98 minutes through 112 minutes</td>
</tr>
<tr>
<td>8 units</td>
<td>≥ 113 minutes through 127 minutes</td>
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</table>
NOTE: The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the eighth should be excluded from the total count. The total minutes of active treatment counted for all 15 minute timed codes includes all direct treatment time for the timed codes. Total treatment minutes -- including minutes spent providing services represented by untimed codes— are also documented. For documentation in the medical record of the services provided see Pub. 100-02, chapter 15, section 230.3: Documentation, Treatment Notes.

Timed CPT Coding Scenarios:

Scenario # 1:

24 minutes of neuromuscular reeducation, code 97112
23 minutes of therapeutic exercise, code 97110
47 Total timed code treatment time

Appropriate billing for 47 minutes is only 3 timed 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.

Scenario # 2:

20 minutes of neuromuscular reeducation 97112
20 minutes therapeutic exercise 97110
40 Total timed code minutes

Appropriate billing for 40 minutes is 3 units. Each service was done at least 15 minutes and should be coded for at least 1 unit, but the total treatment time allows 3 units. In this scenario POC and FTS will handle this situation differently:

- FTS will assign 1 unit to 97112 and 1 unit to 97110, essentially “dropping” a unit of billing.
- POC will assign 1 unit to 97112 and 1 unit to 97110 automatically, and will assign an extra unit to the code that was entered into the system first.

Therapists should ensure that their time is appropriately assigned to accurately represent the focus of treatment for the date of service.

Scenario # 3:

33 minutes of therapeutic exercise 97110
7 minutes of manual therapy 97140
40 Total timed minutes

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

Appropriate billing is for 3 units. Code the procedures you spent the most time providing. Code 1 unit each of 97110, 97116, and 97140. The facility is 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). Document the ultrasound in the daily treatment note. POC and FTS handle these scenarios differently:

- FTS would code 1 unit of 97110, 1 unit of 97140, 1 unit of 97116 and 1 unit of 97035, essentially “adding” a unit.
- POC will code 1 unit of 97110, 1 unit of 97140 and 1 unit of 97116.

Scenario # 5:

7 minutes of neuromuscular reeducation (97112)
7 minutes therapeutic exercise (97110)
7 minutes manual therapy (97140)
21 Total timed minutes

Appropriate billing is for 1 unit. The qualified professional (See definition in Pub 100-02/15, sec. 220) shall select one appropriate CPT code (97112, 97110, 97140) to bill since each unit was performed for the same amount of time and only 1 unit is allowed. Again, POC and FTS handle this situation differently:

- FTS will not code a unit since none of the services meet the 8-minute standard individually
- POC will add the time together and assign 1 unit to the code that was entered into the system first.

4. Are service based (untimed) CPT codes included in the total unit calculation?

- Service based codes are not included in the calculation of units. These codes are reported as “1” for each service billed regardless of the amount of time spent delivering the service.
- Service based codes can be billed twice in the same day / BID as long as there is:
  - The patient’s profile reflects medical and clinical complexity
  - The patient has an active BID physician order
  - All treatment procedures within the plan of care are performed 2x/day. The amount of time in each treatment session represents the medical complexity of the patient, i.e., at least 30 minutes per session/code.

5. Are there a minimum number of minutes required for untimed codes?

Medicare has no written policy on minimum minutes for these codes. It is unlikely that many other payers have established such a policy. At least one Medicare Local Coverage Determination notes that, for untimed codes, if treatment time is less than 30 minutes, there
must be documentation in the medical record indicating why it was necessary to render the short session. Bottom line: 30 minutes is a reasonable minimum.

6. **Do SLPs have access to any timed codes?**
   Yes please refer to SLP CPT Code Lists for the current year for accurate coding usage in addition to the summary below:
   - Evaluation of auditory rehab status - 92626 first hour
   - Evaluation of auditory rehab status - following the first hour of 92626 - Each additional 15 minutes - 92627 per 15 min
   - Assessment of aphasia - 96105 per hour
   - Evaluation for use and / or fitting of voice prosthetic device to supplement oral speech - 92597 per hour
   - Standardized cognitive performance testing - 96125 per hour
   - Community/work reintegration training - 97537 per 15 min
   - Sensory integrative techniques - 97533 per 15 min
   - Development of cognitive skills - 97532 per 15 min
   - Evaluation of patient for prescription of speech-generating augmentative and alternative communication device - 92607 first hour
   - Each additional 30 minutes; Evaluation of patient for prescription of speech-generating augmentative and alternative communication device, each additional 30 minutes - 92608 per 30 min

7. **If I am providing untimed estim (G0283) or diathermy (97024) to multiple placements on the patient, how many times can I bill the code for the day?**
   You can only bill the above codes once. Your daily documentation would reflect the sites the modality was applied to the patient for the treatment day.

8. **How do I decide which code to use (timed or untimed) when administering e-stim to a patient?**
   Choose the code(s) that best represents the clinical delivery provided to the patient. If codes are equal from a time perspective, assign more time to the code that represents the highest skill level provided to the patient. For example:
   - 97032 Scenarios:
     - When using a manual probe (Neuroprobe), bill for the whole time the e-stim is applied to the patient
     - 30 minutes of e-stim was administered in water while instructing the patient in ROM and/or fine motor manipulation activities.
       - Code 30 minutes using the e-stim code OR therapeutic activities (97530) OR therapeutic exercise (97110) OR code the set-up time usually 5 minutes to G0283 and 25 minutes to one of the timed codes.
     - 30 minutes of e-stim is applied to the quads while a patient is performing therapeutic exercise with verbal cues
       - Split time between (97032) and (97110) OR code 30 minutes to e-stim (97032) OR code 30 minutes therapeutic exercise (97110) OR code set-up time to (G0283) and the rest of the time to a timed therapeutic procedure code.
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- 30 minutes of e-stim (PENS/neuro re-ed) is applied while observing, instructing and/or providing hand-over-hand guidance with the patient, using PNF movement patterns during motor recruitment cycle of the e-stim
  ➢ Split the time between 97032 and 97112 or code 30 minutes using neuro re-ed code (97112) OR 30 minutes e-stim (97032) OR code set-up time to (G0283) and the rest to another timed therapeutic procedure code (97110 or 97112)

- G0283 Scenarios:
  - Any time you apply estim to a patient and you are not spending one-on-one time with the patient (Pain management)
  - 20 minutes of e-stim (PENS) is applied to a patient’s elbow extensors while the patient is doing sit-to-stand push-ups from the arms of the chair during the extension phase of the e-stim
    ➢ Code the first 5 minutes (set-up time) to (G0283) and 15 minutes to therapeutic exercise (97110)
    ➢ Combo unit application, which includes estim and ultrasound: Split the time between supervised e-stim (G0283) and ultrasound 97035 for the application time (remember 97035 must show at least 8 minutes to be billed).

9. What code should be billed for Vital Stim Therapy?
At this time, 92526 only as the research on VST is currently evolving and until it's efficacy is established fully by research, fiscal intermediaries will recognize it only as a part of the "umbrella code" for swallowing 92526 and not its own entity. Minutes for VST cannot count toward the RUG level for the patient on Medicare A, therefore, when coding the DAR, the minutes spent on VST cannot be added to the DAR for MCA patients. NOTE: Typically and per best practice, VST is performed simultaneously with traditional dysphagia treatment approaches.

10. If I have a group with 4 Med A patient’s for 60 minutes, how should I bill?
Each patient is billed 60 minutes and the group code is used.

11. What code should be used for SLP and swallowing group treatment?
The code 92508 encompasses group treatment for speech, language, voice, communication, and/or auditory processing disorders only. In addition, the code 97150 for group therapeutic procedures is not available for SLP use; physical medicine codes are not approved for Speech Pathologists.

At this time, there is not a code that specifically represents Dysphagia group services. The dysphagia treatment code 92526 reflects a reimbursement amount appropriate for comprehensive 1:1 focused intervention and is the only code that defines dysphagia treatment. **Under the CPT payment system, only individual dysphagia treatment is recognized and reimbursed. This direction impacts all patients with Medicare B coverage.**

Therefore, dysphagia therapists should not provide care in group setting for Medicare A and other payer and Medicare B patients as the only code available 92508 does not reflect dysphagia services. Therefore, dysphagia services cannot be tracked. Please refer to...
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Peoplefirst Policy and Procedure 2.06 for Concurrent / Dovetail Treatment for detailed directions.

<table>
<thead>
<tr>
<th>DYSPHAGIA SERVICE DELIVERY</th>
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<tr>
<td><strong>INSURANCE</strong></td>
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<tr>
<td>Medicare A and Other Payers</td>
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<tr>
<td>Medicare B</td>
</tr>
</tbody>
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12. What Codes are NOT available for SLP use?
- 97110 - Therapeutic exercises
- 97112 - Neuromuscular re-education
- 92630 - Auditory rehabilitation; pre-lingual hearing loss; to report, use 92507 only for all auditory rehab treatment procedures
- 92633 - Auditory rehabilitation; post-lingual hearing loss; to report, use 92507 only for all auditory rehab treatment procedures

13. What code should be used for a cognitive - linguistic or cognitive - functional evaluation and how does it relate to the SLP (92506) and OT (97003) comprehensive eval codes?
CPT Code 96125 should be used for cognitive – linguistic and cognitive – functional evaluations via SLP and/or OT.

96125 Description = Standardized cognitive performance testing (e.g. Ross Information Processing Assessment, other formal cognitive test); per hour of face to face healthcare professionals time, both face to face time interpreting these test results and preparing the report.

BEST PRACTICE NOTE: To develop a functional communication outcome from an SLP perspective and a functional ADL outcome from an OT perspective, we should INITIALLY complete a comprehensive SLP (92506) and / or OT (97003) evaluation with follow up on specific cognitive skills assessment (96125) thereafter. For example, we need to determine how language and motor planning relate to cognition for each individual; this is accomplished through initial completion of the comprehensive SLP / OT evaluation followed up with a detailed cognitive evaluation. Therefore, SLPs and OTs should bill 92506 or 97003 BEFORE billing 96125.

14. What is the appropriate use of code 96125 related to insurance and time?
- It is a time based code – available for both OT and SLP, intended to be reported per hour
- For MCA and 96125: We bill time spent with the patient, therefore non face-to-face time to prepare the report should not be included in the minutes for 96125
- For MCB and 96125: We bill per the description of the code so non face-to-face time to prepare the report can be billed without the patient as this is part of the code description
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• At this time, 96125 should be billed 1x per day only per our fiscal intermediary's guidance.
• If an SLP or OT has an eval that extends beyond 60 minutes, it can be continued and billed with 96125 the next day.
• 96125 can be billed on the same day as any other SLP or OT code except 96105 (Assessment of Aphasia).

15. What code should be billed for cognitive-linguistic treatment?
   97532 or 92507 depending on the primary focus of treatment - cognition or communication.

16. Can codes 97532 (Development of Cognitive Skills) and 92507 (Treatment of Speech-Language Communication) be billed in the same day for the same patient?
   Yes, the 2 codes are part of Table 1 NCCI Edits which represents codes where the modifier – 59 code is allowed when two or more “timed” service codes were delivered to the same patient, on the same day during different treatment sessions and/or distinctly different time intervals, during the same patient treatment session.
   When providing 92507 and 97532 to the same patient on the same day, an SLP must:
   • Document on the DAR separate in and out times for both codes
   • 92507, per best practice, should be a minimum of 30 minutes and 97532 should be in 15 minute increments

17. Billing Clarifications - Augmentative / Alternative Communication
   • Augmentative and Alternative Communication Devices (AAC) - Speech-Generating Devices (SGD) – Use 92607, 92608, and 92609 for eval and treatment respectively
   • Augmentative and Alternative Communication Devices (AAC) - Non-Speech-Generating Devices (NSGD) – Use 92506 and 92507 for eval and treatment respectively

18. How should SLPs bill assessment of aphasia?
   • 96105 - Assessment of aphasia, only specific initial aphasia evaluation was conducted
   • 96105 cannot be used on the same day as 92506 or 96125
   • 92506 should be used, if a more comprehensive evaluation is warranted
   • 92506 should be used if other clinical areas were assessed in addition to language and aphasia

19. What codes should be used for aural rehab evaluation?
   • 92626 - Evaluation of auditory rehabilitation status, first hour
   • 92627 - Each additional 15 minutes, Evaluation of auditory rehabilitation status

References: