CPT Coding 2009

Current Procedural Terminology

Making Sense of Coding

Peoplefirst Rehabilitation Clinical Services Team
Medicare A versus Medicare B Billing

**Medicare A**
- PPS - Prospective Payment System
- Reimbursement based on time and frequency of visits, and type of codes (groups and evals) during an assessment reference period.
- EXACT minutes for CPT codes

**Medicare B**
- Fee for service
- Reimbursed based on value of CPT codes utilized
- CMS expectation:
  - 15 minutes = 1 unit when using time based, 1:1 code
- “Rounding Rule” or the 8-minute rule applies
- Times vs untimed
Value of a Code

1. Work value
   - Technical skill
   - Mental effort and judgment
   - Stress associated with the concern of the risk to the patient
   - Time to perform the service (considered least important)

2. Practice expense

3. Professional liability
Timed vs. Untimed

**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 applies to the total treatment time provided in one 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.
- Can be billed more than once if the patient has a BID order; if pt demonstrates medical necessity.
Three Types of Codes

• Evaluations

• Modalities

• Therapeutic Procedures
Evaluation/ Re-evaluation

• When value was established for evaluation codes, the reimbursement was based on skill, mental effort and an average time for assessment of approximately 30 minutes.

• Re-evaluation code should be used when there is a change in the plan of treatment resulting from a significant change.

• If a 90-day recertification is required and there are no changes to the plan of care then we would not bill the Re-eval code.

• No separate re-evaluation code for SLP.
Modalities

• Any physical agent applied to produce therapeutic changes to biological tissue.

• Includes but not limited to:
  – thermal
  – acoustic
  – light
  – mechanical
  – electrical energy
Definition of Modality Terms

• **Supervised = Unattended** (e.g. diathermy, e-stimulation)
  – The application of a modality that does not require direct (one on one) patient contact by the provider.
  – Can only be billed once a day unless BID orders were obtained or indicated in the Plan of Care.

• **Constant = Attended** (e.g. ultrasound, ionto, PENS)
  – The application of a modality that requires direct (one on one) patient contact by provider.
  – Can be billed more than once if orders were obtained or indicated in the Plan of Care
Billing for Supervised Modalities

**Medicare A**

PPS allows for all *skilled* minutes to be counted toward the MDS for placement of a patient into a rehab RUG category.

**Medicare Part B**

One or more supervised modalities may be billed in the same 15-minute time period with any other CPT code.

*All minutes that a patient spends participating in a supervised modality can be billed regardless of payer source.*
Therapeutic Procedures

• A manner of effecting change through the application of clinical skills and/or services that attempt to improve function.

• Therapist required to have direct (one on one) patient contact.
Group Therapeutic Procedures

• 97150 Therapeutic procedure(s), group (2 or more individuals)
  (Group therapy procedures involve constant attendance of the therapist, but by definition do not require one-on-one patient contact by the therapist.)
• Documentation must support skilled nature of group as it applies to each patient.

*Please see link below for complete information*

Coding Challenges with Procedures

- No Specific codes for “Training”. Use code that best represents your training.

- All procedures do not have named codes (e.g., Bed Mobility, transfers)

- Be sure your documentation supports the codes you use. Utilize your CPT code list for 2008 to reflect the skilled nature of your services (e.g. discuss strength/ROM deficits).
Unit Calculation for Medicare B

- Calculate the total amount of time spent on time based codes.
- Divide the total amount of time by 15 minutes.
- Apply the 8 minute rule to the remainder. If the remainder after the calculation is greater than or equal to eight minutes, you can “round” up and add an additional unit.
# 8 Minute Rule – Medicare B

<table>
<thead>
<tr>
<th>Total Treatment time</th>
<th>Number of Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 to 22 Minutes</td>
<td>1 CPT Code</td>
</tr>
<tr>
<td>23 to 37 Minutes</td>
<td>2 CPT Codes</td>
</tr>
<tr>
<td>38 to 52 Minutes</td>
<td>3 CPT Codes</td>
</tr>
<tr>
<td>53 to 67 Minutes</td>
<td>4 CPT Codes</td>
</tr>
<tr>
<td>68 to 83 Minutes</td>
<td>5 CPT Codes</td>
</tr>
<tr>
<td>84 to 97 Minutes</td>
<td>6 CPT Codes</td>
</tr>
<tr>
<td>98 to 112 Minutes</td>
<td>7 CPT Codes</td>
</tr>
<tr>
<td>113 to 127 Minutes</td>
<td>8 CPT Codes</td>
</tr>
</tbody>
</table>
Unit Calculation and the DAR

Entering services when Timed and Untimed codes are used

*Example: Patient seen for 45 minutes total (0900-0945).*

**Treatment consisted of:**

- 45 minute unattended estim. treatment G0283
- 40 minutes of Therapeutic exercise while receiving estim

*DAR should be entered as:* 0900-0905 (5min estim G0283); 0905-0945 (40 min therex)

*This will bill correctly 45 minutes (Total time) and 4 CPT codes (3 Therex, and 1 Estim)*
Currently this is what might happen . . . . . 

Example: Pt treated from 9:00 - 10:00 consisted of...

- Neuromuscular re-education 97112 20 minutes = 1 Unit
- Therapeutic exercises 97110 20 minutes = 1 Unit
- Therapeutic activities 97530 20 minutes = 1 Unit

Total time 60 minutes = 3 Units

Pt seen for 60 minutes but only billed 3 (15min units) = 45 Code Minutes

Instead Consider..............................................
Thinking About Total Time

*Example:* Pt treated from 9:00 - 10:00 consisted of...

- Neuromuscular Re-education 97112 20 minutes
- Therapeutic exercises 97110 10 minutes
- Therapeutic Activities 97530 30 minutes

Total time 60 minutes

*Determine the codes that best reflect the treatment.*

- 1 unit of 97112 delivered
- 1 unit of 97110 delivered
- 2 units of 97530 delivered
- 4 units - 60 minutes
Code Selection

- Whenever a code must be selected:
  - Choose the codes that best represent the clinical delivery.
  - Assign the billing codes on the basis of services that require the highest level of clinician skill to deliver.
  - Remember to list the primary code in the first column on the DAR

- POC performs unit calculations after all data entry is completed to ensure the appropriate number of codes have been billed.
National Corrective Coding Initiatives (NCCI edits)

Applies only to Medicare Part B patients.

• Congress initiative to curb fraud and abuse for Medicare Part B claims by curtailing improper “unbundling” of services for Medicare Part B claims.

• Updated quarterly by Center of Medicare and Medicaid Services (CMS)
National Correct Coding Initiative

- The Resource Tables ensure appropriate utilization of the –59 modifier
  - Table 1: Column One / Column Two Edits
    - Codes may be used together with modifier 59
  - Table 2: Column One / Column Two Edits
    - Modifier 59 is not allowed
  - Table 3: Mutually Exclusive Codes
    - Codes may be used together with modifier 59
  - Table 4: Mutually Exclusive Codes
    - Modifier 59 is not allowed
59 Modifier -Distinct Procedural Service

• In response to prior objections to CCI edits, CMS clarified that the -59 modifier may be used to indicate that services were performed in distinctly separate time intervals.

• CMS will accept use of the modifier if billing the edits together is clinically appropriate.
59 Modifier - Distinct Procedural Service

Example of how to use the modifier -59

• If a provider performs a re-evaluation during the same visit as a therapeutic procedure, the provider may bill for both services by appending the -59 modifier to the Column 2 code.

• The re-evaluation must be medically necessary and distinctly separate from the therapeutic procedure. This must be clearly indicated in the documentation. Use separate in/out times for services on DAR.
NCCI / CCI Edits

• What does this mean to you and your DAR?
• How does this affect your choice of codes?
• What does your RM do to ensure accurate billing?
Rehab/Billing Office Responsibilities

• It is important that the billing office manager understands that there are times when these codes may be appropriately used and by using the modifier can be submitted for successful payment.

• Timely communication ensures billing accuracy.

• It is imperative that communication occur between the RM and Business Office on a planned and regular basis.
2009 CPT Updates

• There are NO new, revised or deleted CPT codes related to PT, OT, and SLP services for 2009

• Any ‘new’ codes without an assigned work value are not available for use at this time