Time-Based Coding
A Coder’s Clock Game

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Agenda

• AMA Time Rule
• Physical Medicine Services
• Anesthesia
• Evaluation and Management Services
• Mental Health Services
• 2016 Changes
AMA Time Rule

• AMA CPT Professional defines a unit of time as:
  – “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).”
  • – 2016 AMA CPT Professional pg. xv

Physical Medicine Services

• CPT 97001-97799
• Three Sections
  – Modalities
  – Therapeutic Procedures
  – Tests and Measurements
• Many codes are time-based
• Two methods for counting time
### Physical Therapy Codes (Common)

<table>
<thead>
<tr>
<th>Timed (each 15 minutes)</th>
<th>Non-Timed</th>
<th>Work Hardening</th>
</tr>
</thead>
<tbody>
<tr>
<td>97032</td>
<td>97140</td>
<td></td>
</tr>
<tr>
<td>97033</td>
<td>97530</td>
<td></td>
</tr>
<tr>
<td>97034</td>
<td>97532</td>
<td></td>
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<tr>
<td>97035</td>
<td>97533</td>
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<tr>
<td>97036</td>
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</tr>
<tr>
<td>97110</td>
<td>97537</td>
<td></td>
</tr>
<tr>
<td>97112</td>
<td>97542</td>
<td></td>
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<tr>
<td>97113</td>
<td>97750</td>
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<tr>
<td>97124</td>
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</tr>
</tbody>
</table>

### Time Units

- The table below represents how multiple units are reported based on time for services, excluding work hardening:

<table>
<thead>
<tr>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7 minutes</td>
</tr>
<tr>
<td>8-22 minutes</td>
</tr>
<tr>
<td>23-37 minutes</td>
</tr>
<tr>
<td>38-52 minutes</td>
</tr>
<tr>
<td>53-67 minutes</td>
</tr>
</tbody>
</table>

- To report work hardening at least 61 minutes needs to occur for CPT 97545 to be reported.
2 Time Rules

• AMA:
  – Each time-based code requires time
  – Services based on actual treatment time, not pre- and/or post-service time
  – 8 minutes required before reporting first unit
  – Modifier -52 not allowed with CPT® 97110-97546

• Medicare:
  – Total treatment time for all time-based services
  – Services based on actual treatment time, not pre- and/or post-service time
  – 8 minutes required before reporting first unit
  – Time-based services added together

Commercial Time

• Example #1:
  – 25 min. of exercises (CPT 97110)
  – 20 min. of activities (CPT 97530)
  – 7 min. of manual therapy (CPT 97140)
  – 5 min. of neuromuscular reeducation (CPT 97112)
    • Proper billing: CPT 97110 x 2 units and 97530 x 1 unit

• Example #2:
  – 8 min. of exercises (CPT 97110)
  – 8 min. of activities (CPT 97530)
    • Proper billing: CPT 97110 x 1 unit and 97530 x 1 unit
Commercial Time

• Example #3:
  – 8 min. of exercises (CPT 97110)
  – 7 min. of activities (CPT 97530)
  – 5 min. of manual therapy (CPT 97140)
  – 5 min. of neuromuscular reeducation (CPT 97112)
    • Proper billing: CPT 97110 x 1 unit

Commercial Time

• Example #4:
  – 6 min. of exercises (CPT 97110)
  – 5 min. of activities (CPT 97530)
  – 4 min. of manual therapy (CPT 97140)
    • Proper billing: Nothing is billable
Medicare

• Exception to the Rule:
  – When multiple services are performed on the same date of service, the total time spent on that date would dictate the number of units for all timed services combined, even if some of those services are not individually billable.
    • Centers for Medicare and Medicaid (CMS) and American Academy of Orthopaedic Surgeons (AAOS) from November 2010
  – Total time for time-based services or in/out times for only time-based services would be sufficient to support the charges.

Medicare Time

• Example #1:
  – 25 min. of exercises (CPT 97110)
  – 20 min. of activities (CPT 97530)
  – 7 min. of manual therapy (CPT 97140)
  – 5 min. of neuromuscular reeducation (CPT 97112)
  – Total minutes for all services: 57 (Max of 4 units)
    • Proper billing: CPT 97110 x 2 units, 95730 x 1 unit, and 97140 x 1 unit (4 units total)
    • Bill for the largest timed code
Medicare Time

• Example #2:
  – 8 min. of exercises (CPT 97110)
  – 8 min. of activities (CPT 97530)
  – Total minutes for all services: 16 (Max of 1 unit)
    • Proper billing: CPT 97110 x 1 unit OR CPT 95730 x 1 unit
    • Bill for the service with the highest allowed amount

Medicare Time

• Example #3:
  – 8 min. of exercises (CPT 97110)
  – 7 min. of activities (CPT 97530)
  – 5 min. of manual therapy (CPT 97140)
  – 5 min. of neuromuscular reeducation (CPT 97112)
  – Total minutes for all services: 25 (Max of 2 units)
    • Proper billing: CPT 97110 x 1 unit and 95730 x 1 unit (Max of 2 units)
    • Bill for the largest timed code
Medicare Time

• Example #4:
  – 6 min. of exercises (CPT 97110)
  – 5 min. of activities (CPT 97530)
  – 4 min. of manual therapy (CPT 97140)
  – Total minutes for all services: 15 (Max of 1 unit)
    • Proper billing: CPT 97110 x 1 unit
    • Bill for the largest timed code

Physical Medicine Services

• Check with payer on payment policy for time
• Documentation stating the definition of a code or simply the number of units does not meet the time rule requirements
• Report services only supported by the documentation and appropriate time policy
• Identify in records or company policy, which time policy is used for reporting
• Communicate information
Physical Medicine Services

- Document the regions or areas treated for all physical therapy services
- Ensure total treatment time is documented for all time-based codes
- Ensure treatment time for each time-based code is documented
- Provide sufficient details regarding the services performed to differentiate between the physical therapy codes

Anesthesia

- Multiple types:
  - General / Monitored Anesthesia Care (MAC)
  - Conscious Sedation
  - Regional
  - Local
  - Topical
- Time focus on general anesthesia / MAC
Anesthesia

- 3 Time Rules
  - Round Down
  - Round Up
  - Nearest Tenths Place

Anesthesia

- Billing Requirements for CMS-1500
  - Changed with the effective date of the HIPAA 5010 transaction set
  - Do not convert time to units
  - Report the number of minutes in the units field
  - Report all appropriate modifiers
Anesthesia

• Number of Units
  – Time Units +
  – Base Units +
  – Physical Status Modifier Units

=Total Units

Anesthesia

• Time Rule
  – Only affects time units
  – Industry standard is 15 minute intervals

<table>
<thead>
<tr>
<th>Time Units</th>
<th>Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>2</td>
<td>30</td>
</tr>
<tr>
<td>3</td>
<td>45</td>
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<tr>
<td>4</td>
<td>60</td>
</tr>
<tr>
<td>5</td>
<td>75</td>
</tr>
<tr>
<td>6</td>
<td>90</td>
</tr>
</tbody>
</table>
Anesthesia

• Time Rule #1
  – Least used
  – Time units are rounded down
  – Example:
    • Anesthesia Start Time: 07:00
    • Anesthesia Stop Time: 09:23
    • Transfer of Care from Anesthesia: 09:35
    • Total minutes = 155
    • Time units = 155 / 15 = 10.33
    • Processed units = 10

• Time Rule #2
  – Old Standard
  – Time units are rounded up
  – Example:
    • Anesthesia Start Time: 07:00
    • Anesthesia Stop Time: 09:23
    • Transfer of Care from Anesthesia: 09:35
    • Total minutes = 155
    • Time units = 155 / 15 = 10.33
    • Processed units = 11
Anesthesia

• Time Rule #3
  – Emerging Standard
  – Time units are rounded to the tenths place
  – Example:
    • Anesthesia Start Time: 07:00
    • Anesthesia Stop Time: 09:23
    • Transfer of Care from Anesthesia: 09:35
    • Total minutes = 155
    • Time units = 155 / 15 = 10.33
    • Processed units = 10.3

Anesthesia

• Verify with payers their time unit standard for calculating reimbursement
• Report all time in minutes on CMS-1500 do not convert to units
• Verify reimbursement split for services billed for the CRNA and the Anesthesiologist
• Communicate information
Evaluation and Management Services

• Code family determined by place where services were rendered and type of patient (e.g., new patient, office)
• Level determined by history, exam, and/or medical decision making, unless service is based on time.
• Determining level of the evaluation and management service (E/M) based on time should be the exception and not the rule.

Evaluation and Management Services

• Determining the E/M based on time
  – Identify the code family by place where services were rendered and type of patient
  – Document total time spent with the patient
  – Document that time spent performing counseling and coordination of care. At least 50% of the time must be spent performing counseling and coordination of care.
  – Describe the extent of the counseling and/or coordination of care.
Evaluation and Management Services

• Determining the E/M based on time
  – Not all E/Ms have a time component associated with them, such as:
    • Emergency Room services (99281-99285)
    • Observation codes (99218-99220; 99234-99236)
    • Preventive medicine (99381-99397)
  – Critical care (99291) requires a minimum of 30 minutes to be reported, but the documentation must indicate an immediate threat to life or physiologic function

– A second unit of critical care (99292) requires a minimum of 75 minutes to be reported with the documentation indicating an immediate threat to life or physiologic function
  • This reflects the first 60 minutes to meet the requirements of 99291, with a minimum of 15 minutes needed for the second unit
Evaluation and Management Services

• Prolonged Services:
  – If the base E/M code is based on counseling and/or coordination of care for time, the time associated with the highest level E/M must first be met before time can be considered for prolonged physician services.
  – If the base E/M code is not based on time, then the elements for that base code must be met before time can be considered for the prolonged services for that base code.

Example #1:
  • Greater than 50% of a 60-minute office visit spent counseling the established patient on his diabetes, including compliance with medication and proper diet. Documentation supported the elements of a 99213.
  • Since time is the controlling factor in the scenario above, the service would be reported only be reported as 99215.
  • 99215 is typically 40 minutes per CPT.
  • The remaining 20 minutes does not meet the 30 minute minimum criteria for the prolonged services.
Evaluation and Management Services

• Example #2:
  – Patient arrived for her pre-operative clearance for knee replacement surgery. 100 minutes was spent performing the pre-operative exam and evaluation. Documentation supported the elements associated with a 99214.
  – Since time is not the controlling factor in the scenario, the service would be reported as 99214 with 99354 and 99355 for the prolonged service.
  – 99214 is typically 25 minutes per CPT
  – 75 minutes is needed for the first unit of 99355

Evaluation and Management Services

• Documentation and Business Practices:
  – Verify with payers coverage limitations for prolonged services and other E/M limitations
  – Ensure E/Ms follow the coding guidelines set forth by the AMA and utilize 1995 and/or 1997 Documentation Guidelines to accurately code the level of service
  – Ensure documentation meets the criteria for reporting on time since time is not the only documentation element for the service
Mental Health Services

• The Range Factor
  – Prior to 2013, psychotherapy was reported for 20-30 minutes, 45-50 minutes, or 75-80 minutes
  – Since 2013, services are reported on range and the time rule
  – Prolonged Visits greater than 90 minutes of psychotherapy (90837) reported with 99354-99357

Mental Health Services

• Time Rule for Standard Psychotherapy
  – 0-15 minutes = not reported
  – 16-37 minutes = 90832 w/o E/M or 90833 w/ E/M
  – 38-52 minutes = 90834 w/o E/M or 90836 w/ E/M
  – 53+ minutes = 90837 w/o E/M or 90838 w/ E/M
Mental Health Services

- **Time Rule for Crisis**
  - 0-29 minutes = not reported
  - 30-74 minutes = 90839
  - 75-104 minutes = 90839 + 90840 x 1
  - 105-135 minutes = 90839 + 90840 x 2

2016 Code Changes

- **Prolonged E/M Services:**
  - “Time spent performing separately reportable services other than the E/M or psychotherapy service is not counted toward the prolonged services time.”
    - 2016 CPT Professional pg. 32
  - CPT 99354 or 99356 is limited to once per date
  - CPT 99415 and 99416 are new
  - CPT 99354 and 99356 cannot be reported with either 99415 or 99416
2016 Code Changes

• 99415 and 99416:
  – Used to report prolonged clinical staff services with physician/other qualified health care professional supervision
  – 99415 is for the first hour of prolonged services
  – 99415 does not follow the traditional time rule:
    • First 45 minutes required to report or 75% of the time for the code
    • Less than 45 minutes not reported.
    • 99416 follows time rule of greater than 50%
    • 99416 requires 75 to 104 minutes to report first unit

Summary

• Verify with payers on payment guidelines for time rules
• Report anesthesia in minutes
• Document time in the medical record
• Document all requirements for the code besides time
References

- Centers for Medicare and Medicaid Services (CMS)
- American Society of Anesthesiologists (ASA)
- CPT Manual

Questions??
Thank You!

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