Fact Sheet

Guidelines for Timed Codes

CMS and the AMA have developed guidelines concerning timed codes. There is often confusion around timed coding rules because the AMA Current Procedural Terminology (CPT) Coding guidelines and descriptions include the language, "each 15 minutes." Several years ago, CMS clarified a process known as the "8-minute Timed Coding Rule"; only recently has further explanation about how the two intersect been provided by coding authorities. Many third-party payers have adopted these guidelines as their own. It's important to check each carrier's medical review policy for these therapy services to make sure you understand the carrier's specific timed coding requirements.

Physical Medicine modalities and procedures are a significant source of revenue for most chiropractic offices; being well-versed in proper billing and documentation of timed codes is essential. Often more than one therapy service is provided in a single visit, and each service has its own code. Accurately coding, modifying, and billing for these services can result in increased reimbursements and reduced risk for the practice.

Billing and Coding Guidelines

There are three general levels of Physical Medicine and Rehabilitation modalities and procedures, and each has its own rules and guidelines.

- Supervised Modalities (97010-97028) are generally called "per encounter codes." This means that although it's important to document the treatment time for each, the billing for each code is not time-dependent. Each service is billed one time per patient encounter. For example, if the patient received Electric Muscle Stimulation (billed as 97014) for 10 minutes on the upper thoracic musculature and for another 10 minutes on the lumbar paraspinal musculature, the service is billed only once for that patient encounter, regardless of time spent.
- Constant Attendance Modalities (97032-97039) are modalities that require one-on-one attendance and are billed in 15-minute increments. The total time spent on the modality is documented and billed. Billing for each timed unit of service is clarified later in this document.
- Therapeutic Procedures (97110-97546) are services that require one-on-one attendance and are billed in 15-minute increments. Each procedure is documented and billed for the total time. Proper billing for each timed unit of service is clarified later in this document.

The Merger of the 8-Minute and 15-Minute Rules

In order to seek reimbursement for a unit of service for a constant attendance modality or a therapeutic procedure, the provider must spend at least **eight minutes** (just past the halfway point of 15 minutes) providing that service to the patient. According to CMS (Medicare) guidelines[1], if the service is performed for less than eight minutes, do not bill for the code. The 8-Minute Rule further dictates that in order to bill for additional time-based units, you must spend at least eight minutes providing one-on-one service to the patient to warrant the additional code. For any single timed CPT code on the same day, measured in 15-minute units, providers must bill a single 15-minute unit for treatment greater than or equal to 8 minutes through (and including) 22 minutes. If the duration of any single modality or procedure completed in a day is greater than or equal to 23 minutes (through and including 37 minutes) then 2 units are billed.

[1] *Medicare Claims Processing Manual, 100-4, Chapter 5, Sections 10, 20, 30, 40, 100 Medicare Benefit Policy Manual, 100-2, Chapter 15, sections 220 and 230*

The units per number of minutes are calculated as follows:

Units	Time Window
1	Greater than or equal to 8 minutes through 22 minutes
2	Greater than or equal to 23 minutes through 37 minutes
3	Greater than or equal to 38 minutes through 52 minutes
4	Greater than or equal to 53 minutes through 67 minutes

If multiple time-based services are performed on the same day in increments of 7 minutes or less and the **total time** is 8 minutes or greater, bill one unit for the service performed for the most minutes. This is allowed because the total time for all services was greater than the minimum time for one unit.

Note: only direct, one-on-one time with the patient is considered for timed codes.

Another easy calculation for billing multiple timed codes performed during the same visit is:

$$\frac{\textbf{Total time spent on all services}}{\textbf{15}} = \textbf{Total Billable Units}$$

If 8 minutes or more are leftover, bill one additional unit. If 7 minutes or less are leftover, **do not** bill an additional unit.

Common Chiropractic Examples

Scenario	Proper Billing/Coding
Patient receives 6 minutes of therapeutic exercise	Do not bill any CPT code. You have not met the threshold of at least 8 minutes. Document the file and include the service performed and the outcome. **6 minutes = 6 minutes (0 units)**
Patient receives 21 minutes of therapeutic exercise	Bill CPT code 97110 for one unit. According to the 8-Minute Rule, the chiropractor has not met the requirement (23 minutes) for a second unit. **15 minutes + 6 minutes = 21 minutes (1 unit)**
Patient receives 28 minutes of therapeutic exercise	Bill CPT code 97110 for two units. **15 minutes + 13 minutes = 28 minutes (2 units)**
Patient receives 26 minutes of neuromuscular re-education and 25 minutes of therapeutic exercises	Bill CPT code 97112 for two units and bill CPT code 97110 for one unit. You've performed a total of 51 minutes. 97112 is assigned two units because it took the most time. Document the exact number of minutes performed for each therapy in the patient health record. **26 minutes + 25 minutes = 51 minutes (3 units)**
Patient receives 5 minutes of ultrasound, 5 minutes of manual therapy, and **10 minutes** of therapeutic exercise	Bill CPT code 97110 for one unit. The total time for the service was 20 minutes. The ultrasound and manual therapy time were both less than the therapeutic exercise time, so bill for the service that took the most time (the therapeutic exercise time). Because the three services **did not** total 23 minutes, you **cannot** bill for a second unit. Document the exact number of minutes performed for each therapy in the patient health record. (i.e., **5 minutes + 5 minutes + 10 minutes = 20 minutes (1 unit)**