PHYSICAL MEDICINE GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2020 Edition of the American Medical Association's *Physicians' Current Procedural Terminology*, Fourth Edition (CPT®-4), including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule *CPT*® codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in *CPT*®-4 are preceded by an AZ identifier and numbered in the following format: AZ0xx-xxx. Additional information regarding publications adopted by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to the CPT® guidelines and represent additional guidance from the Commission relative to unit values for these services. To the extent that a conflict may exist between an adopted portion of the CPT®-4 and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

General requirements in reporting services are found in the Introduction of the Fee Schedule. In addition to the definitions and commonalities preceding the coded medical procedures, several other requirements unique to this Section on PHYSICAL MEDICINE are defined or identified as follows:

A. During the course of physical medicine treatments, only one evaluation and management billing is allowed per week, except that the following evaluations are allowed once every two calendar weeks: 97164, 97168, and 97172. Additional billing for evaluation and management procedures may be allowed when specific additional services are warranted. Approval of the payer must be obtained prior to performing additional services.

   IT IS IMPORTANT TO NOTE THAT THESE LIMITATIONS DO *NOT* APPLY TO REFERRING HEALTHCARE PROVIDERS OR TO HEALTHCARE PROVIDERS WHO TREAT PATIENTS ONCE PER MONTH.

B. When multiple modalities (97010* through 97039) are performed, the first modality is reported as listed. The second modality is identified by adding modifier "-51" to the code number. The second and each subsequent modality should be valued at 50% of its listed value.

   100% - Full value for the first modality
   50% - For the second and additional modalities

   *97010 is bundled in the payment when a separate Physical Therapy Service is performed.

   Any more than 5 additional modalities or therapeutic procedures must have prior approval of the payer.

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Example: During a visit a patient receives the following care: therapeutic exercise (97110) for 45 minutes, mechanical traction (97012) for 15 minutes, electrical stimulation (97014) for 15 minutes and moist heat (97010) for 15 minutes. Under the multiple procedure rule, you would bill 100% of the total value for (97110) therapeutic exercise ($56.23 x 3), 100% of the total value for (97012) mechanical traction ($27.79 x 1) and 50% of the total value for (97014) electrical stimulation ($26.50 x 50%) and 0% (zero percent) for moist heat (97010), for a total billing of $209.73. Moist heat (97010) is paid at 0% (zero percent) because it is bundled with the physical therapy service (therapeutic exercise, 97110).

C. Codes 97110 – 97150 and 97530 -97546 are not subject to the multiple procedure rule and shall be paid at 100% of their listed value. When performing therapeutic procedure(s), excluding work hardening (97545/97546) and Functional Capacity Evaluation 97750), a maximum of 60 minutes is allowed each day. Approval must be obtained by the payer prior to performing therapeutic procedures in excess of 60 minutes.

D. The values for codes in this section apply to provider's time, expertise and use of equipment. Medications and disposable electrodes used in these procedures should be considered supplies, code 99070, (see item 1, Guidelines for Medicine Section regarding billing for supplies).

E. Time-Based Physical Medicine Services are billed according to guidance provided by the Centers for Medicare and Medicaid Services (CMS). When only one service is provided in a day, healthcare providers should not bill for services performed for less than 8 minutes. For any single timed service provided in a day measured in 15-minute units, healthcare providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. Please refer to the following table which outlines the billing units for each time interval.

Units	Number of Minutes
0	< 8 minutes
1	≥ 8 minutes and ≤ 22 minutes
2	≥ 23 minutes and ≤ 37 minutes
3	≥ 38 minutes and ≤ 52 minutes
4	≥ 53 minutes and ≤ 67 minutes

When more than one service represented by 15-minute timed codes is performed in a single day, the total number of minutes of service (as noted in the chart above) determines the number of timed units billed. If any 15-minute timed service that is performed for 7 minutes or less on the same day as another 15-minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater, then the provider may bill one unit for the service performed for the most minutes. The same logic is applied when three or more different services are provided for 7 minutes or less than 7 minutes. See example below.

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During a visit, a patient receives the following care: therapeutic exercise (97110) for 45 minutes, manual therapy (97140) for 5 minutes, and therapeutic activities (97530) for 7 minutes. The provider would bill 3 units of therapeutic exercise (97110) and 1 unit of therapeutic activities (97530). Since the total time spent on therapeutic activities and manual therapy is greater than 8 minutes (7 minutes + 5 minutes = 12 minutes), one unit should be billed. The unit billed is for therapeutic activities (97530) since the time spent on that time-based service is greater than the time spent on manual therapy (97140).

The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. The healthcare provider is also expected to include the duration (in minutes) for each time-based service in their documentation.

F. A work hardening program is limited to 6 1/2 hours per day, not to exceed a 6 week period of time.

G. The payer has the right to require documentation to establish that a modality or therapeutic procedure was performed. Inasmuch as these Guidelines allow for re-evaluations to be performed every two weeks, it is at that time the healthcare provider should be required to address the success of the treatment protocol, i.e. improvements or lack of improvements regarding stamina, flexibility and strength.

It is not appropriate for the payer on a per billing basis to require a healthcare provider to provide unnecessary detailed documentation to justify payment. A healthcare provider is required to comply with A.R.S. § 23-1062.01 when submitting a bill. For example, the purpose of modalities like hot and cold packs, paraffin baths, and whirlpools are straightforward. Modalities are utilized as a sub-element of the over-all treatment protocol to prepare the injured worker for therapy or to minimize the impact of the therapy on the injured worker. Other than a statement that certain modalities were performed, any additional documentation such as the purpose of the application of modalities, resulting flexibility or comfort is unnecessary. Additionally, listing the amount of weight an individual is lifting, repetitions, and sets is, again, unnecessary. During a re-evaluation visit, the healthcare provider should provide documentation regarding changes in strength, stamina, and flexibility.

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