PHYSICAL MEDICINE AND REHABILITATION GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2021 Edition of the American Medical Association's *Current Procedural Terminology* (CPT®) publication, 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® are preceded by an AZ identifier and numbered in the following format: AZxxx. 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 physical medicine and rehabilitation services. To the extent that a conflict may exist between an adopted portion of the CPT® 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 (Physical Medicine and Rehabilitation) are defined or identified as follows:

A. Physical therapy (PT) evaluation codes (97161-97163) and occupational therapy (OT) evaluation codes (97165-97167) are billed at the initial visit and a re-evaluation code (97164 for PT, 97168 for OT) may be billed once every two calendar weeks following an initial evaluation. Additional billing for PT and OT evaluation services may be allowed when specific additional services are warranted. Approval of the payer must be obtained prior to performing additional services. Criteria to select the appropriate evaluation and re-evaluation codes are outlined in the current CPT® publication.

   NOTE: These limitations do **not** apply to referring healthcare providers or to providers who treat patients once per month.

B. When multiple modalities (untimed 97012-97028 and/or time based 97032-97036) are performed, the first modality (or the first unit of a time-based modality) is reported as listed. The second modality (or the second unit of a time-based modality) is identified by adding modifier -51 to the code number. The second and each subsequent modality (or unit(s) of a time-based modality) should be valued at 50% of its listed value.

First modality reported or first unit of a time-based modality	-100%
Second, third, and additional approved modality or unit(s)	- 50%

   Any more than three modalities or more than three units of a time-based modality per body part being treated must have prior approval from the payer. The time a healthcare provider

bills for a time-based modality (97032-97036) does not count towards the total timed therapeutic procedure maximum of four units or 67 minutes.
NOTE: 97010 is a bundled service and not separately reportable.

Example:
During a visit a patient receives the following services:
45 minutes therapeutic exercise 97110
15 minutes mechanical traction 97012
15 minutes unattended electrical stimulation 97014
10 minutes ultrasound 97035
15 minutes moist heat 97010 while receiving the electric stimulation

Under the multiple modality rule, the healthcare provider would bill:
97110 3 units at 100% of value (therapeutic procedure, timed code)
97012 1 unit at 100% of value (untimed code)
97014 1 unit at 50% of value (untimed code)
97035 1 unit at 50% of value (timed code)
97010 is bundled into the above services and not paid as a separate service

C. CPT® codes describing therapeutic procedures (97110-97150 and 97530-97546) are not subject to the multiple modality rule and shall be paid at 100% of their listed value. When performing therapeutic procedure(s), (excluding work hardening/conditioning, 97545-97546, and physical test or measures for functional capacity evaluation, 97750), a maximum of four units or 67 minutes is allowed each day. Approval must be obtained from the payer prior to performing therapeutic procedures in excess of this maximum (e.g., when multiple body parts are treated in a single visit).

D. The values for the codes in this section include the time and work of the provider, the equipment required to provide the service, and the cost of the healthcare provider's liability insurance. Medications and disposable electrodes used in these procedures should be considered supplies, code 99070, (see Section A in the Medicine Guidelines and Subsection (I)(4) of the Fee Schedule Introduction regarding billing for supplies).

E. Time-Based Physical Medicine and Rehabilitation CPT® codes are billed according to guidance from the Centers for Medicare and Medicaid Services (CMS), as published in the Medicare Claims Processing Manual, Chapter 5, Section 20.2, C. Counting Minutes for Timed Codes in 15 Minute Units.

When only one service is provided in a day, healthcare providers should not bill for services provided for less than 8 minutes. For any single 15-minute timed CPT code in the same day, healthcare providers bill a single 15-minute unit for treatment of greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, two units should be billed. Please refer to the table below, which outlines how to bill for up to four units or 67 minutes, without payer approval.

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

If additional therapeutic procedures are approved by the payer, the pattern for determining time/units is continued.

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

The expectation, based on the work values assigned to these codes, is that a provider's direct patient contact time for each unit will average 15 minutes in length. If more than one 15-minute timed CPT® code is billed during a single calendar day, the total number of units billed is constrained by the total treatment time for that day.

When documenting to support the billing of timed CPT® codes, the provider should **document the total number of timed minutes and the total time of the treatment provided that day.** Total treatment time includes the minutes for timed code treatment and untimed code treatment. Total treatment time does not include time for services that are not billable (e.g., rest periods). **The amount of time for each specific intervention/modality provided to the patient is not required to be documented in the treatment note.**

It is important that the total number of timed treatment minutes support the billing of units on the invoice and that the total treatment time also reflects the services billed as untimed codes. The billing and the total timed code treatment minutes documented must be consistent. Additional guidance for documentation of timed codes is found in the CMS Benefit Policy Manual, Chapter 15, 220.3, E. Treatment Note

Examples on how to count the appropriate number of minutes for the total therapy minutes provided:

Example 1
During a visit, the patient receives the following services:
45 minutes therapeutic exercise 97110
5 minutes manual therapy 97140
7 minutes therapeutic activities 97530
Total Timed Codes – 57 minutes

The healthcare provider would bill: 4 units
97110 3 units
97530 1 unit

Since the total time spent providing manual therapy and therapeutic exercises is greater than 8 minutes, one unit is billed of the service which was performed for more time.

Example 2
During a visit, the patient receives the following services:
24 minutes neuromuscular reeducation 97112
23 minutes therapeutic exercise 97110
Total Timed Codes: 47 minutes

The healthcare provider would bill: 3 units
97112 2 units
97110 1 unit

Each service is provided for more than 15 minutes, so at least one unit is appropriate for each. Two units are billed for Neuromuscular reeducation since that service was performed for more time.

Example 3
During a visit, the patient receives the following services:
20 minutes therapeutic activities 97530
20 minutes therapeutic exercise 97110
Total Timed Codes: 40 minutes

The healthcare provider would bill: 3 units
97530 2 units
97110 1 unit
OR
97110 2 units
97530 1 unit

Each service was provided for 20 minutes, which would allow for one unit for each service. However, the total time of 40 minutes allows for three units to be billed. Since the time for each service is the same, the provider can choose which code to bill for two units and which code to bill for one unit.

Example 4
During a visit, the patient receives the following services:
33 minutes therapeutic exercise 97110
7 minutes manual therapy 97140
Total Timed Codes: 40 minutes

The healthcare provider would bill: 3 units
97110 2 units
97140 1 unit

The first 30 minutes of therapeutic exercise is 2 units. The remaining 3 minutes is added to the 7 minutes of manual therapy and then is billed for one unit of manual therapy. The time for manual therapy is greater than the remaining time from the therapeutic exercise.

Example 5
During a visit, the patient receives the following services:
18 minutes therapeutic exercise 97110
13 minutes manual therapy 97140
10 minutes gait training 97116
8 minutes ultrasound 97035
Total Timed Codes: 49 minutes

The healthcare provider would bill: 3 units
97110 1 unit
97140 1 unit
97116 1 unit

Bill the procedures that the most time was spent performing. One unit each of 97110, 97140, and 97116. Although the ultrasound should be documented, it cannot be billed, as the healthcare provider is constrained by the total timed codes minutes. Since the total for the timed codes is 49 minutes, only three units would be billed.

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 address and document the status of the treatment protocol.

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.

Documentation of each treatment shall include the following elements:

- Date of treatment.
- Identification of each specific intervention/modality provided and billed, both timed and untimed services in a manner that it can be compared with the billing record to verify correct coding.
- Total timed code treatment minutes and total treatment time in minutes (the amount of time for each specific intervention/modality provided is not required).
- Signatures (written or electronic) and professional designation of the qualified healthcare provider who furnished or supervised the services provided.