Commercial Reimbursement Policy

Subject: **Guidelines for Reporting Timed Units for Physical Medicine and Rehabilitation Services - Professional**	
Policy Number: **C-07002**	Policy Section: **Medicine**
Last Approval Date: **12/11/2024**	Effective Date: **12/11/2024**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem Blue Cross and Blue Shield (Anthem) member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

I. Reporting Guidelines

The Health Plan allows reimbursement for the performance of procedures that are reported with 15-minute time-based codes listed under Modalities, Therapeutic Procedures, Tests and Measurements, Orthotic Management and Prosthetic Management, Constant Attendance Modalities and Therapeutic Procedures, unless provider, state, or federal contracts and/or requirements indicate otherwise.

Reimbursement is based on the following circumstances:

- The provider must maintain direct (one-on-one) visual, verbal, and/or manual contact with the member.
- The time reported should be the time spent in the delivery of the modality and/or therapeutic procedure. This means that pre- and post-delivery services should not be counted in determining the treatment time.
- The time that the member spends not being treated, due to resting periods or waiting for a piece of equipment to become available, is not considered treatment time.
- Total treatment time, including the beginning and ending time of the direct treatment for each modality, must be recorded in the member's medical record, along with the note describing the specific modality or procedure.
- Services with CMS "Always Therapy" services must be reported with appropriate modifiers GN, GO, and GP to identify therapy type.

II. Determining Units

- A provider should not report a direct treatment service if only one attended modality or therapeutic procedure is provided in a day, and the procedure is performed for less than 8 minutes.
- A single 15-minute unit of direct treatment service may be billed when the duration of direct treatment is greater than or equal to 8 minutes, and up to 22 minutes. If the duration of a single modality or procedure is between 23 minutes and up to 37 minutes, then two 15-minute units of direct treatment service may be billed.
- The following table indicates the appropriate protocol for reporting each additional unit:

Number of units billed:	Number of minutes provided in treatment:
1 unit	≥8 minutes to 22 minutes
2 units	≥23 minutes to 37 minutes
3 units	≥38 minutes to 52 minutes
4 units	≥53 minutes to 67minutes

Number of units billed:	Number of minutes provided in treatment:
5 units	≥68 minutes to 82 minutes
6 units	≥83 minutes to 97minutes
7 units	≥98 minutes to 112 minutes
8 units	≥113 minutes to 127 minutes*

*The pattern remains the same for treatment time in excess of 2 hours.

- The Health Plan allows reimbursement for multiple 15-minute, timed modalities performed on the same day for 7 minutes each, or less. Each timed modality performed at 7 minutes or less, must total direct one-on-one treatment time of 8 minutes or greater.
- Total of direct treatment time for the therapy visit is eligible for reimbursement as one unit and reported under the CPT service with the most minutes. The patient's medical record should document that all modalities and procedures were rendered and include the direct treatment time for each.

Related Coding

Standard correct coding applies

Exemptions

Connecticut	Anthem Blue Cross and Blue Shield does not require the beginning and ending times of direct treatment to be included in the medical record for reimbursement.

Policy History

02/13/2025	Review approved and effective: added Connecticut exemption
12/11/2024	Review approved and effective: updated language by adding back beginning and ending times of direct treatment in the medical record
10/07/2021	Review approved and effective: updated language to state Services with CMS "Always Therapy" must be reported with appropriate modifiers GN, GO and GP to identify therapy type
10/08/2020	Review approved 10/08/2020 and effective 04/01/2021: minor administrative changes; added language including modifiers GN, GO and GP
06/01/2019	Review approved: updated policy template

06/27/2018	Review approved: updated policy title; removed language associated with CMS; removed reimbursement calculations and specific CPT codes; removed *beginning and ending time* language
11/01/2016	Review approved: updated policy header to Commercial Reimbursement Policy; added This reimbursement policy also applies to Employer Group Retiree Medicare Advantage Programs; included reference to CMS 1500 form
06/02/2015	Review approved: no changes
01/07/2014	Review approved: added footnotes and CPT code 97140
01/08/2013	Review approved: no changes
01/10/2012	Review approved: no changes
01/04/2011	Review approved: no changes
12/01/2009	Review approved: updated policy title to “Rule of Eight” – Reporting Guidelines for physical Medicine and Rehabilitation Services
11/25/2009	Review approved: language approved by Legal
07/01/2009	Review approved: updated policy heading
09/17/2007	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- The American Physical Therapy Association (APTA)

Definitions

Constant Attendance	Treatment that requires direct (one-on-one) patient contact by the provider.
Modalities	Any physical agent applied to produce therapeutic changes to biologic tissues includes but not limited to thermal, acoustic, light, mechanical, or electric energy.
Therapeutic Procedures	The process of effecting change through the application of clinical skills and/or services that attempt to improve function.
General Reimbursement Policy Definitions	

Related Policies and Materials

Frequency Editing - Professional
Modifier Usage - Professional

Use of Reimbursement Policy
This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.