



Skilled Nursing Facility (SNF) Part B Rehabilitation Services  
Teleconference

December 15, 2008  
1:00 – 2:00 E.S.T.

Agenda

- I. CERT Update
- II. Medical Review Findings
- III. Documentation Requirements for Rehabilitation Services
- IV. Reporting Units of Service for Rehabilitation Services

# Skilled Nursing Facility (SNF) Part B Rehabilitation Services Teleconference

Dial in number: 1-888-276-8689  
Pass code: 454822

December 15, 2008 1:00-2:00 EST



# Agenda

- CERT Update
- Medical Review Findings
- Documentation Requirements for Rehabilitation Services
- Reporting Units of Service for Rehabilitation Services

# Comprehensive Error Rate Testing (CERT) Program



# CERT Program

- Program developed to monitor the accuracy of the payments
- Administered by CMS and its support contractors
- National random sampling of claims
- Requests for medical records
- Timely response is imperative
- Failure to respond prompts refunds

# CERT Reports

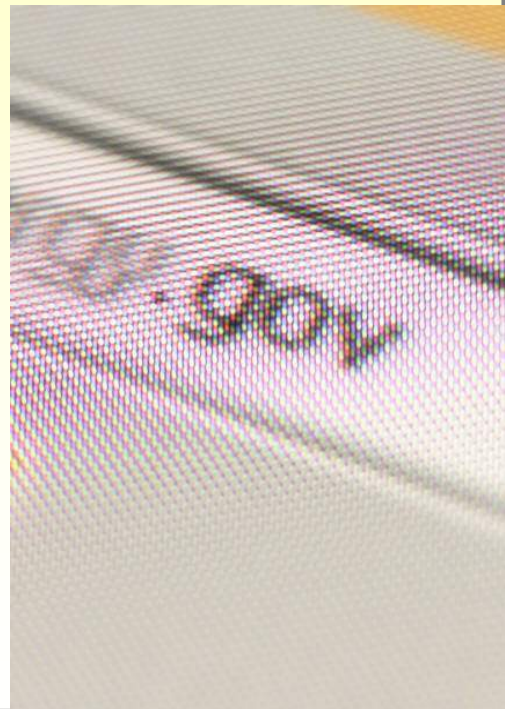
## May 2008 Report

MD/DC	2.6 %
PA	1.2 %
National	1.4 %

## November 2007 Report

MD/DC	1.9 %
PA	.7 %
National	1.5 %

[www.cms.hhs.gov/cert](http://www.cms.hhs.gov/cert)



**HIGHMARK**  
MEDICARE SERVICES  
A CMS CONTRACTOR

# CERT Errors

- Part B Rehabilitation Therapy
  - Insufficient Documentation
  - Services Incorrectly Coded

# CERT Errors

HCPCS	Description
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider
97535	Self-care/home management training e.g. Activities of Daily Living (ADL) and...

## Insufficient Documentation Example

- 97110, therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises
- PT encounter log includes 30 min. of activities with therapist initials only in block for therapeutic activities (billed separately) and no documentation for billed therapeutic exercises.
- Result: Error assessed insufficient documentation to support billed services of 1 unit of therapeutic exercises, line item denied.

## Service Incorrectly Coded Example

- 97150, therapeutic procedure(s), group (2 or more individuals)
- Provider billed therapeutic procedure(s), group 1 unit of service. Documentation submitted supports gait training 1 unit of service was performed.
- Result: Error assessed changed HPCPS code from 97150 to 97116.

## CERT Appeals vs. Claims Adjustments

- Highmark Medicare Services will initiate the adjustments for any necessary denials
- CERT adjustments will appear as an XXH type of bill
- Providers should not cancel or conduct adjustments to medically reviewed claims
- Follow proper appeals process if a correction or addition to the claim is required

## CERT Appeals

- File your Appeal with Highmark Medicare Services
- Submit all evidence that supports coverage
- Utilize the Medicare Part A Redetermination Request Form
- Submit to your designated state address

# Medical Review Findings



## Medical Review Findings

HCPCS	Description
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training
97140	Manual therapy techniques
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider
97532	Development of cognitive skills to improve attention, memory, problem solving.
97535	Self-care/home management training e.g. Activities of Daily Living (ADL) and...
97542	Wheelchair management
97760	Orthotic/s management and training

## Insufficient Documentation Example

- Claim included the following:
  - 97110, 97112, 97140, 97530 and 97535
- Documentation received did not include daily treatment log identifying services rendered and how progress was achieved.
- Result: The claim was denied as insufficient documentation to support services billed.

## Incorrect Coding Example

- Claim billed 6 units of 97542
- Documentation received indicates treatment time of 75 minutes, which equates 5 units
- Result: HCPCS/CPT code 97542 was down coded to 5 units.

# Documentation Requirements for Rehabilitation Services

## Importance of Documentation

- Documentation needs to be unique, specific, and should accurately reflect the services you are billing
- Services billed should be individualized to the presenting problem(s) on the date in question
- Record everything that is done. No matter how routine it is write it down!

## Documentation Requirements

- Physician's order for evaluation services, initial evaluation and date
- Physician's order for therapeutic services (include type, amount, duration and frequency of services)
- Physician's initial certification, signed and dated
- Physician's recertification, if applicable, to cover billing period, dated and signed
- Clinical documentation of diagnosis for which each therapy is rendered

## Documentation Requirements

- Individualized, dated treatment plan (include long and short term goals, estimated length of services, expected outcome, modalities).
- Treatment log of services (include units and minutes of treatment or start and end times, for each CPT description of specific modalities, region of body being treated, signature and title of individual providing services).
- Progress notes to support medical necessity of services including how the patient is progressing toward meeting goals.
- Documentation to support all other services and / or procedures billed.

# Documentation Requirements

- Documentation is required for every treatment day and every treatment service
  - Daily Notes/Progress Reports
    - Short and long term goals
    - Use standard accepted abbreviations
      - pt. = patient; dx. = diagnosis

## Documentation Requirements

- Evaluation/Re-Evaluation
  - Conditions
  - Complexities
- Where it is not obvious
  - Clearly describe the conditions and complexities for the treatment
- Sample
  - Describe the premorbid function, date of onset, and current function

## Documentation Requirements

- Evaluation/Re-Evaluation Things to Remember
  - Only a clinician may perform an initial exam, evaluation, re-evaluation, assessment, establish a diagnosis or a plan of care
  - Do not summarize objective findings of others
  - Time spent in evaluation shall not also be billed as treatment time

# Documentation Requirements

- Billing Re-Evaluations
  - What kind of patient changes need to occur?
    - Progress toward current goals
    - Professional judgment about continued care
    - Modification of goals
    - Modification of treatment
    - Terminating services
  
  - Providers bill in error for a re-evaluation when they are just re-certifying the ongoing therapy

# Documentation Requirements

- Initial Certification of Plan
  - Must be obtained as soon as possible
  - Applicable to the first interval of 30 calendar days or 1 month of treatment
  - Requires a dated signature indicating approval of the plan
  - Verbal certifications are to be followed within 14 days with the original signed and dated document

## Documentation Requirements

- Re-certifications
  - Required every 90 days
  
  - The care and treatment of the patient must be approved by the Physician or NPP

## Documentation Requirements

- Diagnosis
  - Should be as specific and relevant to the problem to be treated as possible
  - Medical diagnosis (Physician/NPP)
  - Treatment diagnosis (Therapist)
  - Both are appropriate for the claim

## Documentation Tips

- Make sure handwritten notes are legible
  - If the reviewer can't decipher your documentation, they might not be able to allow the service
- When billing for timed codes, make certain your documentation clearly reflects your treatment time

# Local Coverage Determinations (LCD)



## LCD

- ❑ Only contain reasonable and necessary information
- ❑ Can include CPT, HCPCS, ICD-9
- ❑ Gives basis for payment or denial
- ❑ Consistent with statutes, regulations, rulings and NCDs

Medicare Part A  
 (\* = off-site link)

Part A

[Print](#)

Latest News & Updates

---> HOT TOPICS : [Orders for Lab/Diagnostic Tests](#) | [POA](#) | [Signature Requirements](#) | [NoPay Bill for Medicare Advantage](#) | [Suspended Claims](#) | [NPI Site](#) <---

Transition Info

J12 MAC LCDs

Medical Policy

Outgoing Contractor LCD Archive (Retired LCDs/Articles)

Reference Library

National Coverage Determinations\* (NCD)

Provider Information

National Coverage Determination Coding Articles

Reimbursement & Settlement

Self-Service Tools

Draft Open Sessions

Outreach & Education

General Policy Info

EDI

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Provider/CMS Links

Search Part A

Select One Option:

- LCDs
- Billing & Coding Articles
- Bulletins/News

is the Medicare Part A intermediary for Pennsylvania, Maryland and Washington, DC. Learn more about us in the [about us](#) below.

**A**

**Customers: New PC-ACE Pro32 Version 1.94 Upgrade Available via Internet Download - UPGRADE**

software program that enables electronic billing for both Medicare Part A and Part B claims in a HIPAA-compliant format. To provide the most up-to-date information within PC-ACE Pro32, the software program is updated regularly. The most recent upgrade, which is PC-ACE Pro32 version 1.94, was released on **July 31, 2008**. The Centers for Medicare & Medicaid Services (CMS) require you to upgrade your software program within 90 day of availability, so please take time now to upgrade immediately.

[read more...](#)

[View all Part A News](#)



**Welcome to the J12 MAC Local Coverage Determination (LCD) transition webpage!**

This page will serve as the J12 "home page" for LCD and LCD related items during the MAC J12 Transition period. Please begin here when you are looking for such information.

**Local Coverage Determinations (LCDs)**

Medicare contractors may establish medical coverage policies, known as Local Coverage Determinations (LCDs), pertinent to their areas of jurisdiction. The primary authority for such determinations is the Social Security Act. The Medicare Program Integrity Manual, CMS Publication IOM 100-08, Chapter 13, gives detailed instructions on LCDs.

Section 522 of the Benefits Improvement and Protection Act (BIPA) created the term "Local Coverage Determination" (LCD). An LCD is a decision by a Medicare contractor whether to cover a particular item or service on a contractor-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the item or service is reasonable and necessary). LCDs are administrative and educational tools to assist providers in submitting correct claims for payment.



LCDs, as opposed to the prior Local Medical Review Policies (LMRPs), are to contain only "reasonable and necessary" information. Other information that the contractor wishes to communicate to providers is to be communicated through an article.

**J12 MAC LCD Final Listing**

As of August 1, 2008, the fifty-seven (57) LCDs and the articles listed below (both LCD-related articles and NCD coding and other related articles) are effective for the following:

DC Part A and DCMA Part B  
Maryland Part A and Maryland Part B  
Pennsylvania Part A  
Delaware Part B

These will become effective for other states when the respective locale cuts over to J12 MAC. [Please see the J12 implementation schedule for details.](#) Until each locale's cutover date, the current outgoing contractor LCDs remain in effect.

MAC Policy Number	MAC Policies	Related MAC Article
<a href="#">L27473</a>	Approved Drugs and Biologicals	<a href="#">A47797</a>
<a href="#">L27474</a>	Blepharoplasty/Blepharoptosis	N/A
<a href="#">L27510</a>	Parathormone (Parathyroid Hormone)	N/A
<a href="#">L27512</a>	Paravertebral Facet Joint Nerve Block and Sacroiliac Joint Injection	N/A
<a href="#">L27513</a>	Physical Medicine and Rehabilitation Services, PT and OT 	N/A
<a href="#">L27514</a>	Psychiatric Therapeutic Procedures	N/A
<a href="#">L27515</a>	Radiation Therapy Services	N/A
<a href="#">L27518</a>	Radiologic Examination of the Chest (CXR)	N/A
<a href="#">L27520</a>	Real-Time, Outpatient Cardiac Monitoring	N/A
<a href="#">L27527</a>	Removal of Benign or Premalignant Skin Lesions	N/A
<a href="#">L27528</a>	Removal of Impacted Cerumen	N/A
<a href="#">L27529</a>	Scanning Computerized Ophthalmic Diagnostic Imaging	N/A
<a href="#">L27530</a>	Sleep Disorders Testing	N/A
<a href="#">L27531</a>	Speech-Language Pathology (SLP) Services: Communication Disorders 	N/A
<a href="#">L27532</a>	Surgical Treatment of Nails	<a href="#">A47803</a>

**Documentation Requirements**

1. All documentation must be maintained in the patient's medical record and available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The record must include the physician or non-physician practitioner responsible for and providing the care of the patient.
3. The submitted medical record should support the use of the selected ICD-9-CM code(s). The submitted CPT/HCPCS code should describe the service performed.
4. Documentation of physical medicine and rehabilitative services includes any entry into a patient's medical record such as a consultation report, initial examination report, patient informed consent notation, progress note, flow sheet/checklist that identifies the care/service that was provided, reexamination report or summation of care.
5. The medical record must identify the physician or non-physician practitioner responsible for the general medical care of the patient and the dates and outcomes of the clinical visits to this provider for continued evaluation during the course of therapy. Please refer to the documentation requirements in the CMS Medicare Benefit Policy Manual (100-02) regarding plan of care requirements (chapter 15, section 220.1.2).
6. Refer to the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy for additional guidelines pertaining to the documentation requirements for the individual treatments/modalities.
7. Procedure codes that require supervision and/or time documentation will be denied if the medical record does not clearly support these services as billed.

**Utilization Guidelines**

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

See the "Indications and Limitations of Coverage and/or Medical Necessity" section of this LCD for specific utilization parameters.

**Sources of Information and Basis for Decision**

American Occupational Therapy Association, Inc. 2003 CPT codes for occupational therapy. [www.aota.org](http://www.aota.org).

American Occupational Therapy Association (2002b), Roles and responsibilities of the occupational therapist and the occupational therapy assistant during the delivery of occupational therapy services. *OT Practice*, 7(15), 9-10.

American Occupational Therapy Association (2002), Occupational therapy practice framework: Domain and process. *American Journal of Occupational Therapy*, 56, 609-639.

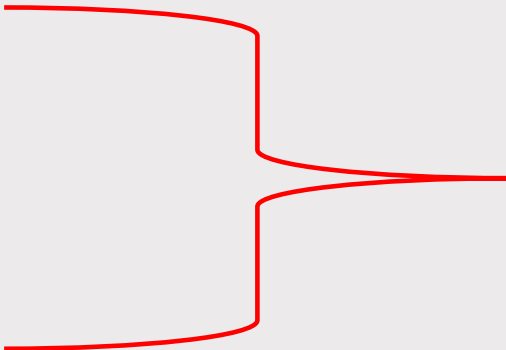
American Occupational therapy Association, Inc. Occupational therapy practice use of CPT codes, 2002. [www.aota.org](http://www.aota.org).

### CPT/HCPCS Codes

Italicized and/or quoted material is excerpted from the American Medical Association, *Current Procedural Terminology (CPT)* codes.

Code 97010 is a status B (bundled) code on the Medicare Fee Schedule Data Base (MFSDB). Separate payment is not allowed for this service.

<a href="#">97001 - 97004</a>	Pt evaluation - Ot re-evaluation
<a href="#">97010 - 97039</a>	Hot or cold packs therapy - Physical therapy treatment
<a href="#">97110 - 97546</a>	Therapeutic exercises - Work hardening add-on
97750	Physical performance test
97755	Assistive technology assess
<a href="#">97760 - 97762</a>	Orthotic mgmt and training - C/o for orthotic/prosth use
97799	Physical medicine procedure
G0283	Elec stim other than wound



### ICD-9 Codes that Support Medical Necessity

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-9-CM code book appropriate to the year in which the service rendered for the claim(s) submitted.

**These ICD-9-CM codes apply to all CPT/HCPCS codes listed above EXCEPT 97026:**

<a href="#">013.00 - 013.96*</a>	TUBERCULOUS MENINGITIS UNSPECIFIED EXAMINATION - UNSPECIFIED TUBERCULOSIS OF CENTRAL NERVOUS SYSTEM TUBERCLE BACILLI NOT FOUND BY BACTERIOLOGICAL OR HISTOLOGICAL EXAMINATION BUT TUBERCULOSIS CONFIRMED BY OTHER METHODS (INOCULATION OF ANIMALS)
<a href="#">036.0 - 036.3*</a>	MENINGOCOCCAL MENINGITIS - WATERHOUSE-FRIDERICHSEN SYNDROME MENINGOCOCCAL
<a href="#">038.0 - 038.9*</a>	STREPTOCOCCAL SEPTICEMIA - UNSPECIFIED SEPTICEMIA
<a href="#">041.00 - 041.19*</a>	STREPTOCOCCUS INFECTION IN CONDITIONS CLASSIFIED ELSEWHERE AND OF UNSPECIFIED SITE STREPTOCOCCUS UNSPECIFIED - STAPHYLOCOCCUS INFECTION IN CONDITIONS CLASSIFIED ELSEWHERE AND OF UNSPECIFIED SITE OTHER STAPHYLOCOCCUS
<a href="#">041.81 - 041.9*</a>	OTHER SPECIFIED BACTERIAL INFECTIONS IN CONDITIONS CLASSIFIED ELSEWHERE AND OF UNSPECIFIED SITE MYCOPLASMA - BACTERIAL INFECTION UNSPECIFIED IN CONDITIONS CLASSIFIED ELSEWHERE AND OF UNSPECIFIED SITE
042*	HUMAN IMMUNODEFICIENCY VIRUS (HIV) DISEASE

<a href="#">996.80 - 996.89*</a>	COMPLICATIONS OF UNSPECIFIED TRANSPLANTED ORGAN - COMPLICATIONS OF OTHER SPECIFIED TRANSPLANTED ORGAN
<a href="#">996.90 - 996.99</a>	COMPLICATIONS OF UNSPECIFIED REATTACHED EXTREMITY - COMPLICATION OF OTHER SPECIFIED REATTACHED BODY PART
997.01	CENTRAL NERVOUS SYSTEM COMPLICATION
<a href="#">997.60 - 997.61</a>	UNSPECIFIED LATE COMPLICATION OF AMPUTATION STUMP - NEUROMA OF AMPUTATION STUMP
<a href="#">V43.60 - V43.7</a>	UNSPECIFIED JOINT REPLACEMENT - LIMB REPLACED BY OTHER MEANS
V45.4	POSTSURGICAL ARTHRODESIS STATUS
<a href="#">V48.2 - V48.5</a>	MECHANICAL AND MOTOR PROBLEMS WITH HEAD - SENSORY PROBLEM WITH NECK AND TRUNK
<a href="#">V49.0 - V49.77</a>	DEFICIENCIES OF LIMBS - HIP AMPUTATION STATUS
V52.0	FITTING AND ADJUSTMENT OF ARTIFICIAL ARM (COMPLETE) (PARTIAL)
V52.1	FITTING AND ADJUSTMENT OF ARTIFICIAL LEG (COMPLETE) (PARTIAL)
V52.8	FITTING AND ADJUSTMENT OF OTHER SPECIFIED PROSTHETIC DEVICE
V53.7	FITTING AND ADJUSTMENT OF ORTHOPEDIC DEVICES
V53.8	FITTING AND ADJUSTMENT OF WHEELCHAIR
V53.90	FITTING AND ADJUSTMENT OF UNSPECIFIED DEVICE
V54.01	ENCOUNTER FOR REMOVAL OF INTERNAL FIXATION DEVICE
V54.09	OTHER AFTERCARE INVOLVING INTERNAL FIXATION DEVICE
<a href="#">V54.81 - V54.89</a>	AFTERCARE FOLLOWING JOINT REPLACEMENT - OTHER ORTHOPEDIC AFTERCARE
V57.1*	CARE INVOLVING OTHER PHYSICAL THERAPY
V57.21	CARE INVOLVING OCCUPATIONAL THERAPY
V57.81	CARE INVOLVING ORTHOTIC TRAINING
V57.89*	CARE INVOLVING OTHER SPECIFIED REHABILITATION PROCEDURE
*Use additional code to clarify the reason / diagnosis for PM&R services.	

CAC/IAC Distribution: 04/01/2008

**Start Date of Comment Period**

04/01/2008

**End Date of Comment Period:**

05/15/2008

**Start Date of Notice Period**

05/23/2008

**Revision History**

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**Revision History**

**Revision History Number**

L27513

**Revision History Explanation**

Date	Policy #	Description
08/01/2008	L27513	LCD effective 08/01/2008 for DC Part A, Maryland Part A, and Pennsylvania Part A. LCD is now effective for DC Part A and DCMA Part B, Maryland Part A and Maryland Part B, Pennsylvania Part A; and Delaware Part B.
05/23/2008	L27513	Original LCD posted for notice. LCD to become effective 07/11/2008 for Maryland Part B, DCMA Part B and Delaware Part B.
04/01/2008	Draft J12-D36	Original LCD posted for comment.

**Last Reviewed On**

07/31/2008

**Related Documents**

This LCD has no Related Documents.

**LCD Attachments**

There are no attachments for this LCD.

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# Reporting Units of Service for Rehabilitation Services

## Reporting Units of Service for Rehabilitation Services

- Units:
  - Number of times the service/procedure reported according to the HCPCS/CPT code definition
  - Incorrect reporting of units can result in under or over payment
  
- 15 Minute Timed Units
  - Do not bill for less than 8 minutes
  - Total number of units billed equals total treatment time
  - The total number of timed minutes or the beginning and ending time must be documented

## Counting Minutes for Timed Codes

Units	Number of Minutes
1	≥ 8 minutes through 22 minutes
2	≥ 23 minutes through 37 minutes
3	≥ 38 minutes through 52 minutes
4	≥ 53 minutes through 67 minutes
5	≥ 68 minutes through 82 minutes
6	≥ 83 minutes through 97 minutes
7	≥ 98 minutes through 112 minutes
8	≥ 113 minutes through 127 minutes

## Counting Minutes Example

- 18 minutes of therapeutic exercises (97110)
- 13 minutes of manual therapy (97140)
- 10 minutes of gait training (97116)
- 8 minutes of ultrasound (97035)
- **49 Total timed minutes**
  
- **Total billable units = 3**
  - 97110 = 1
  - 97116 = 1
  - 97140 = 1

## How to prevent insufficient documentation errors?

- When responding to CERT or Medicare record requests, submit any and all documentation to substantiate the service billed



*It is the responsibility of the provider who billed the service to submit all requested documentation*

## How to prevent incorrect coding errors?

- Code service at appropriate level performed / time increments
- Ensure the service performed is clearly substantiated in the medical record

## Summary

- CERT Update
- Medical Review Findings
- Reminder of the documentation requirements for Part B rehabilitation therapies
  - Ensure services rendered are clearly documented in the medical record
- Review treatment time minutes and how to convert to billable units
  - Ensure billed units accurately reflect total treatment time

Need help? Contact .....

Provider Contact Center

1-877-235-8048

Interactive Voice  
Response (IVR) System

Thank you!



Thank you for your participation.  
Please complete the evaluation form and fax  
it to number that appears at the bottom of  
the form.





### **Counting Minutes for Timed Codes in 15 Minute Units**

(CMS Pub. 100-04, Chapter 5, section 20.2C - [www.cms.hhs.gov/manuals/downloads/clm104c05.pdf](http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf))

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure, in a day, is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed.

Time intervals for 1 through 8 units are as follows:

Units	Number of Minutes
1	≥ 8 minutes through 22 minutes
2	≥ 23 minutes through 37 minutes
3	≥ 38 minutes through 52 minutes
4	≥ 53 minutes through 67 minutes
5	≥ 68 minutes through 82 minutes
6	≥ 83 minutes through 97 minutes
7	≥ 98 minutes through 112 minutes
8	≥ 113 minutes through 127 minutes

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

If more than one 15 minute timed CPT code is billed during a single calendar day, then the total number of timed units that can be billed is constrained by the total treatment minutes for that day.

Examples: How to count the number of units for the total therapy minutes provided.

Example 1 -

24 minutes of neuromuscular reeducation (97112)

23 minutes of therapeutic exercise (97110)

47 Total timed code minutes

Appropriate billing for 47 minutes is only 3 timed units. Each of the codes is performed for more than 15 minutes, so each shall be billed for at least 1 unit. The correct coding is 2 units of code 97112 and one unit of code 97110, assigning more timed units to the service that took the most time.

Example 2 -

20 minutes of neuromuscular reeducation (97112)

20 minutes therapeutic exercise (97110)

40 Total timed code minutes

Appropriate billing for 40 minutes is 3 units. Each service was done at least 15 minutes and should be billed for at least one unit, but the total allows 3 units. Since the time for each service is the same, choose either code for 2 units and bill the other for 1 unit. Do not bill 3 units for either one of the codes.

Example 3

33 minutes of therapeutic exercise (97110)

7 minutes of manual therapy (97140)

40 Total timed minutes

Appropriate billing for 40 minutes is for 3 units. Bill 2 units of 97110 and 1 unit of 97140. Count the first 30 minutes of 97110 as two full units. Compare the remaining time for 97110 (33-30 = 3 minutes) to the time spent on 97140 (7 minutes) and bill the larger, which is 97140.

Example 4 –

18 minutes of therapeutic exercise (97110)

13 minutes of manual therapy (97140)

10 minutes of gait training (97116)

8 minutes of ultrasound (97035)

49 Total timed minutes

Appropriate billing is for 3 units. Bill the procedures you spent the most time providing. Bill 1 unit each of 97110, 97116, and 97140. You are unable to bill for the ultrasound because the total time of timed units that can be billed is constrained by the total timed code treatment minutes (i.e., you may not bill 4 units for less than 53 minutes regardless of how many services were performed). You would still document the ultrasound in the treatment notes.

Example 5 –

7 minutes of neuromuscular reeducation (97112)

7 minutes therapeutic exercise (97110)

7 minutes manual therapy (97140)

21 Total timed minutes

Appropriate billing is for one unit. The qualified professional (See definition in Pub 100-02/15, sec. 220) shall select one appropriate CPT code (97112, 97110, 97140) to bill since each unit was performed for the same amount of time and only one unit is allowed.

**NOTE:** The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the eighth should be excluded from the total count. The total minutes of active treatment counted for all 15 minute timed codes includes all direct treatment time for the timed codes. Total treatment minutes-- including minutes spent providing services represented by untimed codes— are also documented. For documentation in the medical record of the services provided see Pub. 100-02, chapter 15, section 230.3: Documentation, Treatment Notes.



### **SNF Resources**

CMS Pub. 100-04, Chapter 5, Part B Outpatient Rehabilitation and CORF/OPT Services, §20.2 & 20.3

[www.cms.hhs.gov/manuals/downloads/clm104c05.pdf](http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf)

CMS Pub. 100-04, Chapter 7, SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule)

[www.cms.hhs.gov/manuals/downloads/clm104c07.pdf](http://www.cms.hhs.gov/manuals/downloads/clm104c07.pdf)

LCD L27513, Physical Medicine and Rehabilitation Services, PT and OT

[www.highmarkmedicare.com/transition/j12/lcd.html](http://www.highmarkmedicare.com/transition/j12/lcd.html)

LCD L27531, Speech-Language Pathology (SLP) Services: Communication Disorders

[www.highmarkmedicare.com/transition/j12/lcd.html](http://www.highmarkmedicare.com/transition/j12/lcd.html)

### **Highmark Medicare Services Resources**

Highmark Medicare Services [www.highmarkmedicare.com/](http://www.highmarkmedicare.com/)

Customer Contact Center/IVR  
1-877-235-8048

Mailing List [www.highmarkmedicare.com/maillinglists.html](http://www.highmarkmedicare.com/maillinglists.html)

Calendar of Events [www.highmarkmedicare.com/calendar/parta/index.html](http://www.highmarkmedicare.com/calendar/parta/index.html)

Provider Bulletins [www.highmarkmedicare.com/bulletins/parta/bulletins.html](http://www.highmarkmedicare.com/bulletins/parta/bulletins.html)

Don't access to the Internet? Request hardcopy bulletins thru the Customer Contact Center

On Line Training Modules [www.highmarkmedicare.com/parta/outreach/cds-modules.html](http://www.highmarkmedicare.com/parta/outreach/cds-modules.html)

### **CERT Resources**

CERT Documentation Call Center [www.certprovider.org](http://www.certprovider.org)

- (301) 957-2380
- (240) 568-6222 (FAX)

CMS CERT website [www.cms.hhs.gov/cert/](http://www.cms.hhs.gov/cert/)

CERT Alert [www.highmarkmedicareservices.com/cert](http://www.highmarkmedicareservices.com/cert)

CERT Questions [questCERT@highmark.com](mailto:questCERT@highmark.com)

- (888) 779-7477, select option 1

CMS' CERT Webpage [www.cms.hhs.gov/cert/](http://www.cms.hhs.gov/cert/)

Establish/update your CERT address/point of contact [www.certprovider.org](http://www.certprovider.org)

Highmark Medicare Services CERT Coordinator [QuestCERT@highmark.com](mailto:QuestCERT@highmark.com)

Highmark Medicare Services' CERT Webpage

[www.highmarkmedicareservices.com/partb/professionals/mr/cert.html](http://www.highmarkmedicareservices.com/partb/professionals/mr/cert.html)

### **CMS Resources**

CMS website [www.cms.hhs.gov](http://www.cms.hhs.gov)

CMS Mailing List [www.cms.hhs.gov/MLNProducts/downloads/MailingLists\\_FactSheet.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf)

Quarterly Provider Update [www.cms.hhs.gov/QuarterlyProviderUpdates/](http://www.cms.hhs.gov/QuarterlyProviderUpdates/)

MLN Matters [www.cms.hhs.gov/MLNMattersArticles/](http://www.cms.hhs.gov/MLNMattersArticles/)

Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers and Billers

[www.cms.hhs.gov/MLNProducts/downloads/RA\\_Guide\\_Full\\_03-22-06.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf)

Preventive Services [www.cms.hhs.gov/MLNProducts/35\\_PreventiveServices.asp](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp)

## **Skilled Nursing Facility (SNF) Part B Rehabilitation Services Teleconference**

Your assessment of this program is very important to us. By completing this evaluation form, you will help us measure the effectiveness of this program and prepare for future webinars. Thank you for your cooperation.

Date: December 15, 2008

Medicare Speaker Name(s): Cathy MacKenzie

Your Name/Telephone Number: \_\_\_\_\_

(Optional) \_\_\_\_\_

Medicare Provider Number: \_\_\_\_\_

Using the rating system of **(1) Poor, (2) Fair, (3) Good, (4) Very Good, (5) Excellent**, please circle the number that best expresses your rating of each of the following:

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. The webinar was informative.                                     | 1 | 2 | 3 | 4 | 5 |
| 2. The visual aids/handouts were beneficial.                        | 1 | 2 | 3 | 4 | 5 |
| 3. The Speaker(s) was knowledgeable of the subject matter.          | 1 | 2 | 3 | 4 | 5 |
| 4. The Speaker(s) presented the subject matter clearly.             | 1 | 2 | 3 | 4 | 5 |
| 5. The Speaker(s) provided clear and complete answers to questions. | 1 | 2 | 3 | 4 | 5 |
| 6. Overall, how would you rate this webinar?                        | 1 | 2 | 3 | 4 | 5 |

What additional comments do you have for changing/improving this program to better meet your needs?

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Please fax the completed form to 717-302-3658.

