

DOCUMENTATION AND REPORTING OF TIMED CODES

By Melissa Romanelli

Physical Medicine codes, sometimes called Physical Therapy codes, are generally billed based upon the time spent providing the service to patients. Usually these codes are billed in units based upon 15 minutes in direct contact with the patient.

Medicare policy states that providers should not bill for timed codes if the total time (pre-intra-, and post-service) is less than 15 minutes. You can, however, bill for these services if the claim is submitted with a -52 modifier to indicating a reduced time. Medicare policy further states that if multiple services are provided, and the total time is less than 15 minutes, than the time should be combined. In this instance, the service with the most time should be billed.

You may bill multiple units of many timed procedures. The total time of first unit must be at least 15 minutes. If the time is between 23 minutes (15 minutes for unit one and 8 minutes for unit 2) you may bill a second unit. As a reference:

Less than 8 minutes – bill with -52 modifier

8-22 minutes – 1 unit

23-37 minutes – 2 units

38-52 minutes – 3 units

53 + minutes – 4 units

Medicare policy further states that if multiple services are provided, and the total time is less than 15 minutes, than the time should be combined. In this instance, the service with the most time should be billed. In other words, you should not bill for multiple services using the -52 modifier. Instead, your times should be combined. For example, if you perform 7 minutes of Electric Stim and 8 minutes of mechanical traction, bill one unit of mechanical traction.

In documenting time procedures, you must indicate the start and stop time of each procedure, as well as the lapsed time.

Keep in mind that based upon contractual relationships with some payers, you may need to adhere to more stringent guidelines. Check your provider contract to ensure that you are within the standards set by the insurance carrier.