

PHYSICAL MEDICINE AND REHABILITATION GUIDELINES

Information regarding publications incorporated by reference is found in the Introduction Section 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 incorporated portion of the CPT® and a code, guideline, identifier, or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control. Codes that are unique to Arizona are preceded by an AZ identifier and numbered in the following format: AZxxx.

General requirements on 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 (2) 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 (3) modalities or more than three (3) units of a time-based modality or any combination of time-based and untimed modalities equaling three (3) billed units 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 (4) units or 67 minutes. However, the time spent performing time-based modalities counts towards the total treatment time and should be used to determine the number of units a provider bills (*see* Section E and Example 5). **The amount of time spent performing each specific procedure or modality provided to the patient is not required to be documented in the treatment notes** (*see* Section G).

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

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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 (modality, untimed code)
97014	1 unit at 50% of value (modality, untimed code)
97035	1 unit at 50% of value (modality, timed code)

97010 is bundled into the above services and not paid as a separate service. The total time spent performing time-based codes (97110 and 97035) is 55 minutes and justifies billing four (4) units of time-based services (*see* Section E).

- 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 (4) 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). Reimbursement for therapeutic procedures in excess of the maximum, without prior approval, shall not affect reimbursement for therapeutic procedures performed within the allowed maximum.
- D. The values for the codes in this section include the time and work of the healthcare 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 and managed in accordance with the HCPCS Section of this Fee Schedule.
- 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 eight (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 eight (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 (2) units should be billed. Please refer to the table below, which outlines how to bill for up to four (4) 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 and/or time-based modalities 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 seven (7) minutes or less on the same day as another service also represented by a 15-minute timed code performed for seven (7) minutes or less, and the total time of these two services is eight (8) minutes or greater, the provider may bill one (1) unit of service that was performed for the most minutes. The same logic is applied if three (3) or more different services are performed on the same day for seven (7) minutes or less.

The expectation, based on the work values assigned to these codes, is that a healthcare 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 healthcare 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 of 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 eight (8) minutes, one (1) unit is billed for 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 (1) unit is appropriate for each. Two (2) 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 (3) units to be billed. Since the time for each service is the same, the healthcare provider can choose which code to bill for two (2) units and which code to bill for one (1) 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 two (2) units. The remaining three (3) minutes is added to the seven (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 (1) 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 (3) units would be billed.

- F. A work hardening program is limited to 6 1/2 hours per day, not to exceed a six (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 (2) 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 unnecessarily 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 is straightforward. Modalities are utilized as a sub-element of the overall 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).

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- Signatures (written or electronic) and professional designation of the qualified healthcare provider who furnished or supervised the services provided.