[Month DD, YYYY]

[Enter Name and Address]

Submitted electronically: [enter email address]

RE: Guidelines for Reporting Timed Units for Physical Medicine and Rehabilitation Services - Professional, Policy number C-07002

Dear [Enter Name],

[Enter Chapter or Practice Name] is writing to express concern with Policy Number C-07002 revised effective December 11, 2024. Specifically, [Chapter or Practice Name] urges changes to the Reporting Guidelines and the Determining Units sections of the policy to reflect current practice in the provision of physical therapist services. We are also requesting a meeting with you to discuss the implications and impact of the policy revisions.

**Reporting Guidelines – Section I**

[Chapter or Practice Name] requests that Anthem revise the language of the fourth bullet as edited below under this section as follows:

• Total treatment time in minutes, and total timed code minutes for each modality, must be recorded in the member’s medical record, along with the note describing the specific modality or procedure.

If for some reason, Anthem feels greater detail is necessary, the standard should in no event exceed the following: “Total treatment time, for each modality, must be recorded in the member’s medical record, along with the note describing the specific modality or procedure.” Any expectation beyond this is unnecessarily and unreasonably burdensome.

**Rationale**

The Reporting Guidelines which require the provider to document “total treatment time, including the beginning and ending time of the direct treatment for each modality” are unfeasible and entirely inconsistent with the evidence-based and safe practice of physical therapy. A physical therapist establishes a plan of care based on the patient’s chief complaint(s), diagnoses, the findings of a patient examination, the clinical presentation of the patient, as well as the patient’s goals and values. That plan of care is dynamic. Each visit is based on the patient’s status on that day and their response to interventions during the session. Physical therapist interventions are not provided sequentially with a start and end time for each procedure except for a limited number of physical agent modalities. A physical therapist engages with a patient during a treatment session based on the patient’s needs, goals, and tolerance.

To that end, a therapist typically must move between procedures rather than fully completing one procedure before starting another. Therapists either record start and stop times for the entire session or document the total time spent delivering timed codes and the total treatment time to support the billing. As an example, a physical therapist may engage a patient in therapeutic exercise, neuromuscular re-education, and gait training in a single session. However, the different interventions that support each of these codes may be provided in an alternating fashion based on the patient’s response and on accepted clinical guidelines.

At the end of a session the therapist documents the skilled interventions provided and based on that documentation - as well as the total treatment time and the combination of service based and timed codes - determines the appropriate number of units to bill and the CPT codes that best represent the distribution of those units. The need to determine if the appropriate number of units and the appropriate CPT codes are billed is satisfied by the documentation of total treatment time as well as the total time spent delivering timed codes. This is in line with Medicare requirements.

The expectation that a therapist would document a start and stop time for each procedure brings no added value to the documentation, serves no purpose in determining appropriate billing, and adds an onerous level of burden for the provider and unnecessary disruptions for the patient. A physical therapist would need to be watching the clock during an entire session and stopping treatment to record times when moving from one intervention to another.

Imposing additional unnecessary burden with no benefit to patients or utility to Anthem renders the policy in its current state indefensible. That no electronic documentation and billing systems used by physical therapists accommodate this requirement makes it even more impracticable. This level of detail is entirely inappropriate and interferes with the therapist’s ability to transition between appropriate interventions to provide the most clinically appropriate care. The policy in its current state then seemingly serves no purpose other than a reason to deny a claim for medically necessary and appropriately delivered services provided to Anthem members in good faith.

Finally, Chapter 15 of the Medicare Benefit Policy Manual 220.3 E adopts total treatment time as indicated below.

“Documentation of each treatment shall include total timed code treatment minutes and total treatment time in minutes. Total treatment time includes the minutes for timed code treatment and untimed code treatment.”

CMS recognizes that the delivery of procedures and modalities during a therapy session is not necessarily linear and that a therapist often alternates between procedures during a treatment session based on patient needs and/or the goals of treatment.

Determining Units – Section II

[Chapter or Practice Name] requests the following modifications to this section for purposes of clarification, consistency with CPT coding, and ability to administer the policy.

• The addition of a new bullet stating the following:

* Consistent with the AMA CPT midpoint rule , a unit of time is attained when the mid-point is passed. A single 15-minute unit of direct treatment service for each procedure may be billed when the duration of direct treatment is greater than or equal to 8 minutes. If the duration of one procedure is greater than or equal to 8 minutes and the duration of a different procedure is greater than or equal to 8 minutes, one unit of each procedure may be billed.

• Change in the title of the second column of the table to from “Number of minutes provided in treatment” to “Number of minutes provided for a single procedure or modality.” Additionally, the clarifying statement beneath the table should be changed from “The pattern remains the same for treatment time in excess of 2 hours” to “The pattern remains the same for single procedure time in excess of 2 hours.”

• Deletion of the last two bullets of this section arrayed below.

* 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.

**Rationale**

The current language represents a hybrid of the AMA CPT Midpoint rule and the CMS 8-minute rule that cannot be accommodated by any electronic documentation and billing system and does not represent standard CPT reporting.

[Chapter or Section Name} looks forward to the modifications outlined above to best serve Anthem members. Please contact [enter name and contact information] to discuss this issue further.

Sincerely,

[Sender’s Name]

[Sender’s Title]