BWC Policy Alert

2018 BWC Coding Clarification

Proper Coding of Individual and Group Outpatient Physical Therapy Services

Date: Sept. 1, 2018

Policy Alert # 2018-04

Purpose
This policy alert clarifies correct coding for individual and group outpatient physical therapy services.

Issue
BWC has identified inconsistencies in providers' reporting of codes for outpatient physical therapy procedures provided in a group setting. Some providers are inappropriately reporting group services under an individual therapy code. Additionally, in some cases, the medical documentation does not accurately reflect the services provided.

Discussion
Providers may bill therapeutic physical therapy procedures on an individual or group basis, depending on the specific actions and attention of the qualified provider within the scope of practice of allowed by state law. Qualified providers could include but are not limited to chiropractors, physicians, physical therapists, physical therapy assistants working under the supervision of a qualified therapist, etc.

Unless otherwise noted in rule or policy, BWC follows the American Medical Association *CPT Assistant* and the Centers for Medicare and Medicaid (CMS) and direction for the reporting of individual and group therapy services.

Individual therapy services
A provider must report individual therapy services (i.e., CPTs 97110 through 97140) when in constant attendance with one patient and providing direct one-on-one patient contact. Per *CPT Assistant*, constant attendance involves visual, verbal and/or manual contact with the patient during the provision of the service. There may be other patients in the room or area. However, the provider cannot simultaneously provide services to other patients, including supervision or verbal cueing.

When a provider provides direct one-on-one patient contact, he or she counts the total minutes of service to each patient to determine how many units of service to bill for the timed codes. These direct one-on-one minutes may occur continuously (15 minutes straight) or in notable episodes (10 minutes now, 5 minutes later). Each direct one-on-one episode should be of a sufficient length of time to provide the appropriate skilled treatment in accordance with each patient's plan of care.

Group therapy services
A provider must report group therapy services (i.e., CPT 97150), when performing simultaneous therapeutic procedures in a group setting — two or more patients. The patients may or may not all be doing the same activities. The provider involved in group therapy services must be in constant attendance. However, BWC does not require one-on-one direct patient contact by the provider.

If the provider is dividing attention among the patients, providing only brief, intermittent personal contact or giving the same instructions to two or more patients at the same time, it is appropriate to bill each patient one unit of group therapy. CPT 97150 is not a time-based code. Therefore, you report it per session, regardless of the time involved.

Conclusion
Providers should report correct codes for individual and group therapy services. Documentation of services should clearly and accurately reflect the treatment provided. Managed care organizations may conduct audits, including but not limited to, injured worker surveys, to ensure treatment provided compliance with this policy.

References
2018 CPT Manual
American Medical Association CPT Assistant
Medicare Claims Processing Manual, Chapter 5
Medicare Benefit Policy Manual, Chapter 15
Medicare Part B Billing Scenarios for PTs and OTs (Individual and Group Treatment)