Physical Therapy Max Units Per Day

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

This policy outlines the billing unit standards for physical therapy services provided by Molina Healthcare's network providers. The guidelines are based on the 15-minute timed code system for billing, as defined by the Current Procedural Terminology (CPT) coding standards, and in compliance with guidelines set forth by the Centers for Medicare & Medicaid Services (CMS) and relevant Medicaid Administrative Contractors (MACs). This document provides a comprehensive framework for calculating and billing units based on service duration, highlighting the importance of accurate documentation to substantiate medical necessity and ensure proper reimbursement.

I. Definition of Service:

i. For the purposes of this policy, a 'service' refers to a distinct physical therapy intervention represented by a 15-minute timed CPT code.
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II. Unit Billing Criteria:

i. **Single Service Scenario:**

i. A service performed for at least 15 minutes on a single calendar day shall be billed for one unit.

ii. When a service extends to at least 30 minutes, it shall be billed for two units, and so forth, in 15-minute increments.

ii. Multiple Service Scenario:

i. In instances where multiple services, each represented by 15-minute timed codes, are rendered on a single calendar day, the total number of minutes of service dictates the number of timed units billed.

ii. The aggregate time of all services delivered should not be counted towards the units for a single code if any service was performed for over 15 minutes.

III. Billing Examples:

i. When any 15-minute timed service is performed for 7 minutes or less on the same calendar day as another 15-minute timed service also performed for 7 minutes or less, and the cumulative time of the two services is 8 minutes or more, then one unit should be billed for the service with the longer duration.

ii. The logic extends to scenarios involving three or more different services each rendered for 7 minutes or less on the same calendar day.

IV. ***Provider Expectations***

i. It is anticipated that a provider's direct patient contact time for each unit will average 15 minutes. A consistent practice of billing less than 15 minutes for a unit may trigger a review of billing practices.

V. ***Guidelines for Calculating Number of Units:***

i. Adhere to the following time intervals for determining units billed for therapy modalities performed in a single calendar day, specifying time spent in direct patient contact, as denoted by each 15-minute interval:

Time Interval (minutes)	Units Billed
0-7	0
8-22	1
23-37	2
38-52	3
53-67	4
68-82	5
83-97	6
98-112	7
113-127	8

****Note: The same increment pattern extends for treatments exceeding two hours. ****

It is imperative that exact start and stop times are documented as per Chapter 5, Section 20.2 of the Medicare Claims Processing Manual

Reimbursement Guidelines

I. ***Documentation and Medical Necessity:***

i. Molina Healthcare mandates accurate documentation of medical necessity and valid diagnosis codes for reimbursement of specific procedures. Absence of supporting documentation or incorrect diagnosis codes will result in exclusion from the final claim payment computation.

II. ***Coverage Guidelines and Limitations:***

i. Refer to Chapter 5, Section 20.2 of the Medicare Claims Processing Manual for-coverage guidelines, limitations, and medical necessity criteria.

III. ***Procedure and Diagnosis Code Billing:***

i. Procedure codes must be billed alongside appropriate diagnosis codes to ensure reimbursement.

IV. ***Claims Processing:***

i. Incorrectly billed claims are subject to denial or potential recovery. Reimbursement rates are ascertained based on the pertinent fee schedule or the provider contract agreement.

V. ***Claim Review and Recovery:***

i. Molina Healthcare retains the right to audit all claim payments and recover any amounts identified as overpaid based on contractual rates.

This comprehensive policy aims to standardize the billing practices for physical therapy services across Molina Healthcare's provider network, ensuring consistency, transparency, and compliance with federal and state regulations.

Supplemental Information

Definitions

Term	Definition
CMS	the Centers for Medicare & Medicaid Services. It is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
CPT	Current Procedural Terminology
OT	Occupational Therapy
PT	Physical Therapy

State Exceptions

State	Exception
MI	CMS directives regarding documentation of exact start and stop times for A57067 are not applicable to Michigan.

Documentation History

Type	Date	Action
Effective Date	10/23/2023	New Policy
Revised Date	12/17/2024	Updated Template verified Links
Revised Date	02/25/2025	MI state Exception added

References

State/Agency	Document Name/Description	Link/Document
CGS	Billing and Coding PT (KY, OH)	Article - Billing and Coding: Outpatient Physical and Occupational Therapy Services (A57067)
NGS	Billing and Coding PT (IL, MA, NY, WI,	Article - Billing and Coding: Outpatient Physical and Occupational Therapy Services (A56566)
CMS	Therapy Services	Therapy Services
CMS	Outpatient PT and OT services	Outpatient Physical and Occupational Therapy Services (A57067)
CMS	Billing and Coding PT (IL, MA, NY, WI)	Outpatient Physical and Occupational Therapy Services (A56566)
CMS	Medicare Claims Processing Pub 100-4 - Section C	Medicare Claims Processing (CR7247)
CMS	Claims Manual, Chapter 5, Section 20.2	Medicare Claims Processing Manual