[Enter Date]

[Enter Name and Address]

Submitted electronically: [enter email address]

RE: [Enter policy name and number]

Dear [Enter Name]

On behalf of [enter Chapter or Practice Name] is writing to express concern with Policy [enter name and/or number] effective [enter date]. Specifically, [chapter or practice name] urges changes to reflect current practice in the provision of physical therapist services.

As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span, helping individuals improve overall health and prevent the need for avoidable health care services.

**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 CPT code, procedure, or 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 an additional, unnecessary burden with no benefit to patients or utility to [payer name] 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 [payer name] 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.

[Chapter or Practice name] looks forward to modifications to this policy that are consistent with physical therapist practice. Please contact [enter name and contact information] with any follow-up questions.

Sincerely,