OHIO STATE CHIROPRACTIC ASSOCIATION

BWC TIMED SERVICE CODES CHEAT SHEET

APPLICABILITY

This policy applies to all BWC identified timed procedure codes and services used in BWC fee schedules, including CPT or HCPCS code description which reflects a unit of service that is counted in minutes or hours. (e.g. each 15 minutes; or 11–20 minutes of medical discussion). This policy is applicable to bills with dates of service on or after April 1, 2019.

There are three scenarios described in greater detail below:

1. When only one service is performed and it is a timed code,
2. When multiple services are performed and at least one is a timed code,

POLICY

A. Only one service is performed and it is a timed code. When a provider performs a single timed procedure in a treatment session and no other services, documentation shall include the start and stop time of the service.

> **Example 1:** 97110 performed for 20 minutes, starting at 9:20am and ending at 9:40am
> **Documentation must include:** 9:20am to 9:40am

B. Multiple services are performed and at least one is a timed code. When a provider performs two or more procedures in a treatment session (timed or un-timed), documentation for the timed service shall include:

1. **Total treatment time** (i.e. total session time), documented as start and stop times, and;
2. **Total accumulated time** for all timed services, documented in number of minutes; and
3. **Total time for each individual timed procedure**, documented in number of minutes.

Example:

1. Total treatment/session time from 12 noon to 1pm;
2. Total time for all timed services: 30 minutes;
3. By procedure code:
   10 minutes gait training;
   20 minutes manual therapy.

C. Time Override is used to Determine E/M level

When a provider chooses to bill an E&M service as a timed service.

1. The extent of counseling and/or coordination of care must be documented in the medical record, including:
   a. The minutes spent in face-to-face counseling or coordinating care; and
   b. A description of the counseling and/or activities to coordinate care; and
2. Documentation requirements IV. A, B and E also apply.

D. Billing for vocational rehab timed service codes

For timed service codes on the vocational rehabilitation fee schedule, the following documentation requirements apply only when the provider is performing in-person (i.e. face-to-face) services:

1. When billing for travel, the documentation shall be reported as the start and stop time of the meeting associated with the travel; or
2. When billing for all other timed vocational rehabilitation services, documentation shall follow requirements in section IV.A, B and E.

E. **General Requirements that apply to timed service codes.** Time Documentation Requirements for all timed services – Required documentation shall:

1. Be legibly noted in the medical record (e.g. therapy notes, psychological treatment summaries, etc.); and
2. Be system generated (e.g. minutes calculated by EMR software); or
3. Notated in free text fields recorded by the provider or in handwritten notes; and
4. Not be routinely noted on medical bills.

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Q & A

Q: If I am billing for codes that are non-timed codes only, do I still need to record start and end time?

A: No, you only need to record start and end time if you services include at least ONE timed service code.

Example:

1. 99203 (not Time Override) and 98941 – neither code is a timed code so document as you normally would
2. 98940 and 98943 – neither code is a timed code so document as you normally would

Q: What if I am billing multiple codes, some are timed codes and some are not?

Example: Patient has an appointment with you at 9am. Their treatment starts at 9am and ends at 9:50am. They receive 98941, one unit of 97110, one unit of 97124, and one unit of 97014.

A: This is a multiple procedure visit that includes timed codes, so scenario B from the policy section applies. Your documentation would need to include the following to verify the time component:

1. Total treatment/session time from 9am – 9:50am;
2. Total time for all timed services: 30 minutes;
3. By procedure code:
   15 minutes therapeutic exercises
   15 minutes massage therapy

In this scenario, you have 20 minutes that are unaccounted for. This is when the patient received the services reflected by a non-timed code, in this case, 98941 and 97014.

Keep in mind this policy represents the documentation requirement to support the time only. All other required documentation that you would normally provide to support the service are still also required.

Based on the 2019 Chirocode Desk Book: The following Supervised Modalities do not have a time component:

97010	97012	97014	G0283
97016	97018	97022	97024
97026	97028		

The following Constant Attendance Modalities do have a time component of 15 minutes/unit:

97032	97033	97034	97035
97036	97039		

The following Therapeutic Procedures do have a time component, 15 minutes/unit:

97110	97112	97113	97116
97124	97139	97140	97150
97530	97533	97535	
97537			

DEFINITIONS

Timed services – nationally recognized or BWC local level procedure codes which, per their definitions are classified as time-based (or "timed") codes and require a time-based factor to be met.

Timed Evaluation and Management (E&M) service – when counseling and/or coordination of care dominates (more than 50%) of an injured worker E&M service encounter.

Timed service for vocational rehabilitation – BWC local level vocational rehabilitation procedure code which has a unit of service of 6 minutes or greater.

Non-timed services – nationally recognized or BWC local level procedure codes with definitions that include typical time spent on the service are not considered timed services for the purposes of this policy.

Total treatment time – time the injured worker spent in the session or encounter with the provider. Also known as total session time.