Medicare 8-Minute Rule Chart

The Medicare 8-Minute Rule is a billing guideline used by therapists to determine the number of billable units for time-based services. This rule requires at least 8 minutes of direct treatment for each billable unit, with each unit occurring in 15-minute increments.

You cannot bill specifically for documentation time after the patient visit. Include documentation done during the visit when it occurs alongside other services.

The 8-Minute Rule applies to outpatient service providers, including PT, OT, and SLP billing.

HOW TO CALCULATE YOUR UNITS

1. **Add total time:** Add together all the time spent on providing timed services.
2. **Separate whole units:** Separate out each whole 15-minute unit by CPT code.
3. **Combine remainder minutes:** If there are any remaining minutes (mixed remainders), combine them with other services to create whole units.
4. **Bill additional unit:** If there are 8 or more remaining minutes left of a service, bill for another single unit.

QUICK REFERENCE CHART

Total Treatment Time	Billable Units
8 – 22 minutes	1 unit
23 – 37 minutes	2 units
38 – 52 minutes	3 units
53 – 67 minutes	4 units
68 – 82 minutes	5 units
83 – 97 minutes	6 units
98 – 112 minutes	7 units
113 – 127 minutes	8 units

BILLING MODIFIERS

- **CQ/CO:** Services performed in part by a therapy assistant (PTA uses CQ, OTA uses CO).
- **GA:** Advanced Beneficiary Notice (ABN) on file for noncoverage of a service.
- **GO:** OT services provided.
- **GN:** SLP services provided.
- **GP:** PT services provided.
- **KX:** Services exceed the Medicare therapy threshold but remain medically necessary.

- **XP:** Service performed by a separate provider.
- **22:** Increased procedural services.
- **52:** Reduced or eliminated scope of a billed service.
- **59:** Services not usually provided together.
- **95:** Services provided through telemedicine.

ADDITIONAL NOTES