Coding Secrets in Physical Medicine

Presented by Evan M. Gwilliam, DC CPC CCPC NCICS CCCPC
What will you learn today?

1. Documentation to keep payers happy
2. Outcome assessment tools to establish medical necessity
3. Common modality and therapeutic procedure code details

References: Medicare Local Coverage Determinations:
- L29833 (Outpatient Physical Therapy)
- L24288 (Chiropractic)
Introduction

• BS Accounting - Brigham Young University, 2000
• DC Palmer College of Chiropractic, 2003
  • Valedictorian
• Private practice in Washington and Utah
• Four coding certifications
• ChiroCode Institute - Director of Education, 2012
• Target Coding – guest speaker / consultant
• Coding Instructor - Broadview University, Mountainland Applied Technology College
• ICD10Monitor.com – Editorial Board Member
• Master’s of Business Administration, Broadview University - 2013
Medical Necessity

“No Medicare payment shall be made for expenses incurred for items or services which...are not reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member” – Section 1862(a)(1)(A) of the SSA

There must be an expectation that the patient’s functional status will improve
Diagnosis Coding

- Neurological diagnoses like sciatica (722.0) will carry more weight than DDD (722.4) or other structural diagnoses.
- Soft tissue such as spasm (728.85) or myalgia (729.1) are the least significant.
- Documented persistent symptoms, recurrent episodes, severe pain, anomalies, or pathologies can justify double the recovery time.
Diagnosis Coding

Short term (6-12 treatments)
• 721s Spondylosis
• 723-724s Back Pain

Moderate term (12-18 treatments)
• 353s Root lesions
• 722.9s Unspecified disc disorders
• 724s Stenosis
• 846-7s Sprains

Long term (18-24 treatments)
• 722s Degeneration, displaced discs
CMS-1500 Claim form

• Approved for official use 08/05
• [www.nucc.org](http://www.nucc.org) for official instructions
• Use all CAPS for the OCR
• Use 8 digit dates for DOB
• Don’t use punctuation anywhere
CMS-1500 Claim form

• Box 19 – local use
  • NUCC qualifiers
  • Additional diagnoses

• Box 21 – diagnoses
  • Follow hierarchy
  1. Neurological
  2. Structural
  3. Functional
  4. Soft tissue, complicating factors
Revision 02/12
• Changed to match the electronic format (5010) and accommodate ICD-10 codes
• Adds space for eight more diagnosis codes in box 21.
• June 1st, 2013 - Health plans and clearinghouses must accept the form.
• October 1st, 2013 – Providers must use the new form
**Documentation**

Initial visit should have six elements:

1. **History** (which requires eight elements):
   - Symptoms causing patient to seek treatment;
   - Family history if relevant;
   - Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history);
   - Mechanism of trauma;
   - Quality and character of symptoms/problem;
   - Onset, duration, intensity, frequency, location and radiation of symptoms;
   - Aggravating or relieving factors; and
   - Prior interventions, treatments, medications, secondary complaints.
Initial visit should have six elements:

2. **Description of present illness including:**
   - Mechanism of trauma;
   - Quality and character of symptoms/problem;
   - Onset, duration, intensity, frequency, location, and radiation of symptoms;
   - Aggravating or relieving factors;
   - Prior interventions, treatments, medications, secondary complaints; and
   - Symptoms causing patient to seek treatment.
Documentation

Initial visit should have six elements:

3. **Evaluation** of musculoskeletal/nervous system through physical examination
4. **Diagnosis:** The most severe diagnosis should be listed first
Initial visit should have six elements:

5. Treatment Plan: The treatment plan should include the following:
   - Recommended level of care
     - Acute treatment is shorter duration, higher frequency
     - Chronic treatment is longer duration, but lower frequency
     - Type, amount, duration and frequency of therapy services
   - Specific treatment goals; and
   - Objective measures to evaluate treatment effectiveness

6. Date of the initial treatment
Subsequent visits should have three elements:

1. **History**
   - Review of chief complaint;
   - Changes since last visit;
   - System review if relevant.

2. **Physical Exam**
   - Exam of area of the body involved in diagnosis;
   - Assessment of change in patient condition since last visit;
   - Evaluation of treatment effectiveness.

3. **Documentation of treatment given**
Bad records are:
• Most common cause of state board action in US
• Most common reason for claim payment denial
• Most common source of administrative heartburn
• Largest source of miscommunication between payers and the providers
Documentation

- Subjective
- Objective
- Assessment
- Plan

- Only 1/6 of a Problem Oriented Medical Record (POMR)
Documentation

Problem Oriented Medical Record
1. Complete problem list
2. Diagnoses for each problem
3. Treatment goals for each problem
4. Written treatment plan for each problem
5. SOAP notes for ongoing treatment of each problem
6. Date of resolution or referral for each problem
Complicating factors can increase the time required for recovery:

- symptoms more than 8 days \(1.5X\)
- 4 to 7 previous episodes \(2X\)
- anomaly or structural pathology \(2X\)
- severe pain \(2X\)
- superimposed injury \(2X\)

Be sure to document these if they are present.
Outcome assessment tools (OATs)

Patient

Provider ↔ Payer
Blue Cross determines whether services, drugs, supplies or equipment provided by a hospital or other covered provider are:
  o Appropriate to prevent, diagnose or treat your condition, illness or injury
  o Consistent with standards of good medical practice in the United States
  o Not primarily for the personal comfort or convenience of the patient, the family or the provider
  o Not part of or associated with scholastic education or vocational training of the patient
  o In the case of inpatient care, cannot be provided safely on an outpatient basis

The fact that one of our covered providers has prescribed, recommended or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.

http://www.fepblue.org/about/glossary/term-glossary.jsp#m
Medicare definition of medical necessity under Title XVIII of the Social Security Act, section 1862 (a)(1)(a):

Notwithstanding any other provisions of this title, no payment may be made under Part A or Part B for any expenses incurred for items or services, which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
Outcomes in clinical practice provide the mechanism by which the health care provider, the patient, the public, and the payer are able to assess the end results of care and its effect upon the health of the patient and society.”

Outcome assessment tools (OATs)

According to Medicare, you must have:
1. Subjective complaint*
2. Objective findings
3. A plan to get it better**
4. Demonstrable progress**

*OATs are traditionally based on #1 only. SONOMA also uses #2

**OATs help to shape and report #3 and #4.
Outcome assessment tools (OATs)

• Support medical necessity by quantifying patient functional loss.
• They “objectify the subjective”
• They measure a change in health status after exposure to a health care delivery system.
• Which is more useful?:
  o “Patient says she feels better” OR
  o “Functional outcome assessment score has improved by 30%”
Outcome assessment tools (OATs)

• Functional Status
  o Oswestry
  o Roland-Morris
  o Neck Disability

• Pain Assessment
  o Visual analog scale
  o Pain drawing
  o McGill Pain Questionnaire
### Outcome assessment tools (OATs)

#### THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

**SECTION 1 - Pain Intensity**

- A  The pain comes and goes and is very mild.
- B  The pain is mild and does not vary much.
- C  The pain comes and goes and is moderate.
- D  The pain is moderate and does not vary much.
- E  The pain comes and goes and is severe.
- F  The pain is severe and does not vary much.

**SECTION 6 - Standing**

- A  I can stand as long as I want without pain.
- B  I have some pain on standing but it does not increase with time.
- C  I cannot stand for longer than one hour without increasing pain.
- D  I cannot stand for longer than 1/2 hour without increasing pain.
- E  I cannot stand for longer than 10 minutes without increasing pain.
- F  I avoid standing because it increases the pain immediately.

The questionnaire that the patient completes during the re-exam now looks like this:

#### THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

**SECTION 1 - Pain Intensity**

- A  The pain comes and goes and is very mild.
- B  The pain is mild and does not vary much.
- C  The pain comes and goes and is moderate.
- D  The pain is moderate and does not vary much.
- E  The pain comes and goes and is severe.
- F  The pain is severe and does not vary much.
Outcome assessment tools (OATs)

- What do you do if...
  - The score improves
  - The score is unchanged
  - The score worsens

- 30% change is clinically significant (Spine, 2008).
- What does this mean for the three “P’s”?
Procedure Coding

Procedure codes are also known as the "what" codes. They fill in box 24, column D of the CMS-1500.

"Inclusion of a descriptor...in the CPT codebook is based on whether the procedure is consistent with contemporary medical practice and is performed by many practitioners in clinical practice in multiple locations. Inclusion in the CPT codebook does not represent endorsement by the AMA... or imply any health insurance coverage or reimbursement policy.” CPT 2012, by the AMA
Procedure Coding

• Physical therapy services are those services provided within the scope of practice of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in physical function and health status.

• **No -51 on 97001-97755**
95831 Muscle testing (manual) with report
95851 ROM measurements & report

- Not time based, but RVUs imply 16-22 minutes
- Should not be routine
- Includes a written report, identifying specific body areas and their grades
- “Separate procedure”, which means not typically billable with E/M (-25), but could be.
- Requires written documentation of medical necessity
97550 Physical performance test with written report, each 15 minutes

- Includes functional capacity testing, computerized muscle testing, dynamic gait index, etc.
- Time to analyze and interpret data is included
- Document total contact time, time performing the protocol, and time providing post test instructions.
- Report must include test protocol, data collected, and the impact on the patient outcome/care plan
- It is “atypical” to code with E/M or PT eval, but can be done
- Can’t report 98531 or 95851 with 97550
- Can be used for SONOMA tool
Procedure Coding

• 97001 & 97002 Physical Therapy Evaluation and Re-evaluation
  o Includes history, ROS, physical assessment, and tests.
  o Reevaluation is necessary only if patient shows significant change
  o Routine assessments are not covered typically
  o Based upon a functional diagnosis, prognosis, and positive prognostic indicators
Procedure Coding

- 97001 documentation should include
  - Treatment requested
  - Diagnosis and onset date
  - Medical history and co-morbidities
  - Subjective complaint and mechanism of injury
  - Prior testing, therapy history, and level of function
  - Baseline evaluation data
  - Reason for skilled care
Procedure Coding

- 97001 treatment plan should include
  - Treatment strategies
  - Areas treated
  - Treatment frequency and duration
  - Patient home instruction
  - Measurable, dated short term goals
  - Measurable, dated long term goals
  - Rehabilitation potential
  - Signature and credentials
Procedure Coding Modalities

- Defined as “any physical agent applied to produce a therapeutic change to biologic tissue”
- Includes “thermal, acoustic, light, mechanical, or electric energy.”
- Two types:
  1. **Supervised** - in the building
  2. **Constant attendance** - visual, verbal, and/or manual contact with the patient (CPT Assistant, July 2004)

**No modifier -51 (multiple procedures)**

CPT is a registered trademark of the American Medical Association
Procedure Coding Modalities

• Usually not indicated as the sole treatment, unless patient cannot tolerate exercise or activities
• If so, then modalities should not exceed 2-4 treatments
• Two modalities maximum on each date of service
Supervised

- 97010 hot or cold packs
- 97012 traction, mechanical
- 97014 elec stim (unattended) [G0283]
- 97018 paraffin bath
- 97022 whirlpool
- 97024 diathermy
- 97026 infrared

**All say "1 or more areas"

**None are time-based
97010 hot or cold packs

- To provide analgesia, relieve muscle spasm, reduce inflammation/edema
- Cold for acute, heat for subacute/chronic
- Does not require clinical skill, therefore not considered reasonable and necessary by most payers
97012 traction, mechanical

- Typically cervical or lumbar spine
- Good for radiculopathy, disc herniation, and sciatica (724.3)
- Mutually exclusive to 97140 according to NCCI, but may be billable with -59
- Roller tables and VAX-D not covered
- 3-4 visits maximum
Supervised - 97012 traction, mechanical

- Documentation should include:
  - Body part
  - Force applied and angle
  - Time
  - Response of patient
  - Functional progress
97014/ G0283 electrical stim, unattended

• TENS training for pain, 1-2 visits
• Muscle spasm 2-4 visits without therapeutic procedures
• Swelling and pain, 6 visits, maybe 12
• Muscle retraining up to 12 visits

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Quiz:

- The provider does e-stim in the lumbar region for twelve minutes, then the left shoulder region for twelve minutes. The correct code(s) would be
  A. 97014
  B. 97014 X2
  C. 97014-52 X2
Procedure Coding Modalities

Constant attendance

- 97032 e-stim (attended)
- 97033 iontophoresis
- 97034 contrast baths
- 97035 ultrasound
- 97036 Hubbard tank
- 97039 unlisted modality

**All are time based, 1 or more areas.**
Time dependent code rules (CMS):

- First unit is 15 (8-22) minutes
- Second unit is 30 (23-37) minutes
- Have patient use egg timers and initial in chart
- Two services must exceed 22 minutes to bill 2 units, even if different codes
Procedure Coding

Time

Document

• 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.
• Total treatment time does not include time for services that are not billable (e.g., rest periods).
• For Medicare purposes, it is not required that unbilled services that are not part of the total treatment minutes be recorded, although they may be included voluntarily to provide an accurate description of the treatment, show consistency with the plan, or comply with state or local policies.
Quiz:

- The provider does attended e-stim in the lumbar region for twelve minutes, then the left shoulder region for twelve minutes. The correct code(s) would be
  A. 97032
  B. 97032 X2
  C. 97032-52 X2
97035 ultrasound
• Reasonable and necessary for reduction of pain, spasm, joint stiffness, and inflexibility
• Should be used with therapeutic procedures
• 6-12 visits is generally sufficient
• Document tightened structures that limit joint motion, frequency and intensity of treatment
Therapeutic Procedures

- Defined as the application of clinical skills that attempt to improve function.
- All require direct (one-on-one) contact from a physician or therapist.
- Most are time-based and say “one or more areas”.
- -59 modifier may be required.

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NCCI Code Bundling Edits: electronically identify inappropriate bundling of codes

1. Component edits: when one code is part of a more comprehensive code
   - Example: 95851 ROM testing usually can't be billed along with 97750
   - some can be billed with a modifier (-59 or -25)

2. Mutually exclusive edits: codes that cannot reasonably be performed in the same session
   - Example: 97001 Initial PT Eval and 97002 PT re-eval

www.cms.hhs.gov/NationalCorrectCodInitEd
**Procedure Coding Therapies**

- 97110 Therapeutic exercises
- 97112 Neuromuscular re-education
- 97113 Aquatic therapy
- 97116 Gait training
- 97124 Massage
- 97139 Unlisted therapeutic procedures
- 97140 Manual therapy
- 97150 Therapeutic procedures, group
- 97530 Therapeutic activities

**All say "1 or more areas" and are time-based**

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97110 Therapeutic exercises

- Fifth most commonly submitted code to Medicare
- Used to restore strength, aerobic capacity, endurance, range of motion and flexibility where loss or restriction is a result of a specific injury and has resulted in a functional limitation.
- Not typically covered:
  - Once patient no longer needs clinical skill to perform exercise. i.e. they can do it on their own.
  - Exercises to maintain ROM or strength
97110 Therapeutic exercises

- Documentation should include:
  - Measurable functional loss and ADL limitations
  - How the procedure improves function
  - Metrics (such as ROM) that are functionally meaningful
  - Changes to the procedures and progress towards a “home exercises program” (HEP)

- Number of visits
  - 12-18 typically
  - 2-4 if the exercise is passive

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97112 Neuromuscular reeducation

- For the purpose of restoring balance, coordination, kinesthetic sense, posture, and proprioception for sitting or standing activities
- Reasonable and necessary for:
  - Loss of DTRs and vibration sense
  - Nerve palsy, spinal cord trauma
  - Postural abnormalities
  - Loss of motor coordination
97112 Neuromuscular reeducation

- Generally covered for 12-18 visits
- Not covered when it is just to remind patient of certain cues that could be taught to a caregiver
- Document
  - Objective loss of ADL, mobility, balance, coordination deficits, hypo/hypermobility, posture, and effect on function
  - Specific exercises, purpose as it relates to function, instructions given, and support that the skills of a therapist were required
Procedure Coding Therapies

97124 Massage
- Efflurage, petrissage, tapotement
- Adjunctive to another treatment – typically not covered as an isolated treatment
- Good treatment goals to consider:
  - Reduce edema
  - Improve joint motion
  - Relieve muscle spasm
- Not covered:
  - Massage chairs, aquamassage tables, roller beds
  - When performed on the same visit as 97140 (NCCI edits)
97124 Massage

- Document:
  - Area being treated
  - ROM measurements, muscle spasms and effect on function
  - Subjective findings: pain location, rating and effect on function
- Some payers pay less for subsequent units after first 15 minutes
- Typically covered for 6-8 visits
- Difficult to establish medical necessity for more than 30 minutes
97140 Manual therapy techniques

- Manual traction for cervical pain and radiculopathy
- Joint mobilization with therapeutic exercise for loss of articular motion and flexibility
- Myofascial release (like ART or trigger point) for restricted motion of soft tissues
- Manipulation- high-velocity, low-amplitude thrust for painful spasm or restricted motion
- Manual lymphatic drainage for lymphedema
- Not covered on same visit as 97124 massage
97140 Manual therapy techniques

- Document
  1. location
  2. technique used
  3. Findings: ROM, capsular end-feel, pain descriptions
  4. Effect on function

- NCCI edits – needs modifier when billed with 97002, 97018, 97530, 97750
97530 Therapeutic activities

- Use of dynamic activities to improve functional performance
- Rehabilitative techniques that involve movement
  - Bending, lifting, carrying, reaching, catching, pushing, pinching, grasping, transfers, bed mobility, and overhead activities
- Indicated for loss of mobility, strength, balance, or coordination
- Typically covered for 10-12 visits
- Document
  - Objective measures and their effect on function
  - Activities performed and reason it required a skilled therapist
Quiz

The provider performs 10 minutes of the percussion “thumper”. What is the correct code?

A. 97124
B. 97140
C. 97012
D. 97039
Quiz

Manual therapy is performed for 19 minutes and ultrasound is performed for 5 minutes. What is/are the correct code(s)?

A. 97035-52, 97140
B. 97140 X2
C. 97035, 97140 X2
• These identify an encounter that has been altered
• Some will increase the value of a service
• Some will decrease the value of a service
• Some are simply required by the payer, and do not affect value
• All are two characters, four fit on the CMS-1500
-59 Distinct procedural service
  • It tells the payer that this service is not included in some other service billed that day
  • Only use when required by the payer (in writing) or for NCCI edits

-22 Increased Procedural Services
  • Document words like “prolonged”, “difficult”, “extended” (ex: obesity or language barrier)
  • Almost always reviewed by payer
Procedure Coding Modifiers

-52 Reduced services
  - Reserve for clinic fires. Send cover letter

-76 Repeat procedure by same provider
  - Could be used for a service done twice in one day

-77 Repeat procedure by different provider
Recommended Resources

OIG.hhs.gov
FindACode.com
  Membership and extensive coding references
  Replaces the CPT and ICD-9 and ICD-10
The Clinical Application of Outcomes Assessment
  By Steven G. Yoemans, DC
ChiroCode.com
SONOMA
  By B. Timothy Harcourt, DC FACO 239-278-3344
Medical Billing Codes

Simple search, Fast results, and Always up to date.

Enter a code or keywords... Search

Enter a code or keywords from the code description, article, or document.

Find-A-Code News & Updates: "Medicare Fee Fix Signed into Law"

Read more news...

Code Sets
- Diagnosis (Dx)
  - ICD-9-CM - Volumes 1 & 2
  - ICD-10-CM - New for 2013!
  - DRG - Diagnosis Related Groups
- Procedure (Tx)

Coding Information
- Helps & Guides
  - Find-A-Code™ Tutorials
  - CMS1500 Guide - NUCC & Medicare Instr.
  - ICD-9-CM Official Guidelines
  - AMA's E&M Guidelines (Green Pages)
  - Interactive NBR into E/M

Coding Tools
- Find-A-Code™ Search - Simple search!
- Click-A-Dex™ - Fast index searching.
- Cross-A-Code™ ICD 9/10 GEMs
What did you learn today?

1. Documentation to keep payers happy
2. Outcome assessment tools to establish medical necessity
3. Common modality and therapeutic procedure code details
The End

• Feel free to contact me for one free question during the two weeks that follow this seminar

• DrG@ChiroCode.com

Thanks!