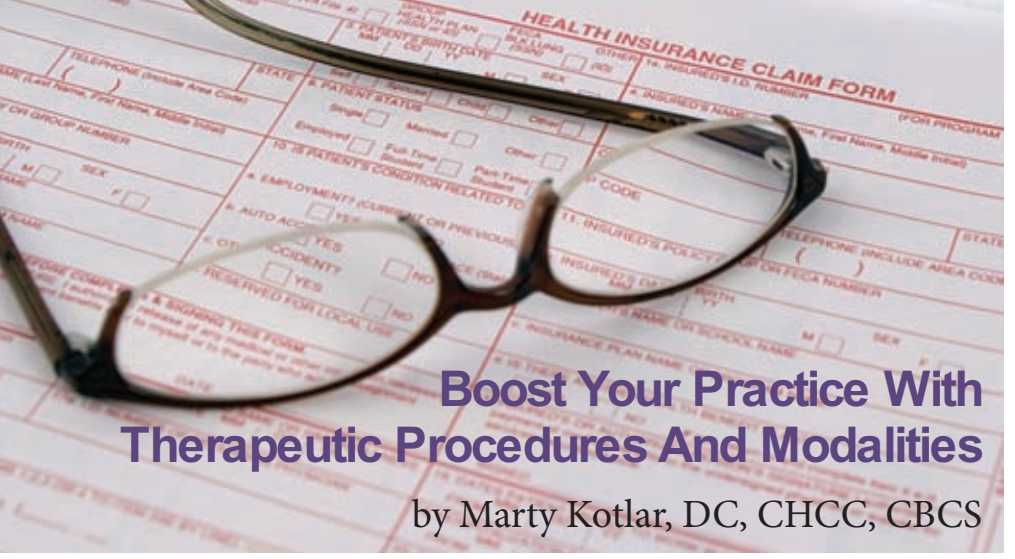

Boost Your Practice With Therapeutic Procedures And Modalities

by Marty Kotlar, DC, CHCC, CBCS

The addition of therapeutic procedures and modalities can be a great adjunct to chiropractic adjustments. Thousands of chiropractors nationwide incorporate therapeutic procedures and modalities, and every state chiropractic scope of practice allows the use of them. Most insurance carriers will reimburse for them (Medicare does not reimburse DCs for therapeutic procedures and modalities) and just about every chiropractic college teaches students how to incorporate therapeutic procedures and modalities.

Medical Necessity

One of the most important items to be aware of as it relates to therapeutic procedures and modalities is establishing "medical necessity." With that in mind, I would like to provide you with the definition of medical necessity according to CMS. "It is a service, treatment, procedure, equipment, drug or supply provided by a hospital, physician, or other health care provider that is required to identify or treat a beneficiary's illness or injury and which is, as determined by the contractor: a) consistent with the symptom(s) or diagnosis and treatment of the beneficiary's illness or injury; b) appropriate under the standards of acceptable medical practice to treat that illness or injury; c) not solely for the convenience of the participant, physician, hospital, or other health care provider; and d) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the beneficiary and accomplishes the desired end result in the most economical manner. The items or services being provided must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

The Diagnosis

The therapeutic procedures and modalities you use and bill to insurance carriers must be supported by your diagnosis codes. In order for your services to be considered reimbursable, many carriers require that your procedure codes link with your diagnosis codes. It is not enough to pick a diagnosis just because it "seems" right. Your diagnoses should have validity and be substantiated by your documentation. The clinical rationale for choosing a diagnosis must be in writing and be entered in the patient chart notes. The diagnoses that you choose represents your patients condition to insurance carriers and should be extremely accurate.

Accuracy is also important when incorporating certain rehabilitation procedures. For example, if you plan on utilizing myofascial release (CPT code 97140) on the shoulder, a soft tissue diagnosis such as 719.51 (shoulder stiffness) would be appropriate. Insurance carriers can look for diagnosis codes that have been truncated. Truncated means shortened or condensed. Many carriers require that your diagnoses be reported to the "highest degree of specificity." That means if the patient presents with a chief complaint that can be reported utilizing a 5-digit diagnosis code, then you should use it.

During the initial patient visit, you may come up with a "probable," "suspected," or "working" diagnosis. Be careful, code to the highest degree of certainty for that patient encounter to include signs, symptoms, subluxation levels, diagnostic test results or other reason for the visit. You may also face a situation where a diagnosis cannot be established at the time of the initial encounter. It is okay to take two or more visits before a diagnosis can be confirmed. You are better off waiting a few visits to submit a claim that has a definitive diagnosis than submitting an incorrect diagnosis code.

Supervised Modalities

Supervised modalities include the application of a modality to one or more areas that does not require direct patient contact by the provider. Supervised modalities examples include mechanical traction (CPT code 97012), and electrical stimulation, unattended (CPT codes 97014/G0283).

Constant Attendance Modalities

Constant attendance modalities include the application of a modality to one or more areas that does require direct patient contact by the provider. Constant attendance modalities examples include the following: electrical stimulation, attended (CPT code 97032), and ultrasound (CPT code 97035).

Therapeutic Procedures

Therapeutic procedures are a manner of effecting change through the application of clinical skills and/or services that attempt to improve function. The physician or therapist is required to have direct (one-on-one) patient contact. Modalities are generally coded and billed based on the device that is used. Therapeutic procedures are generally coded and billed on the basis of the intended outcome, not on a device or piece of equipment. When billing and coding for therapeutic procedures, it is

very important to document the intended clinical outcome as well as how the procedure is performed. The relationship to a functional activity is important to document in the treatment plan. An example might be to increase flexibility of the quadratus lumborum muscles while activating and stretching the hamstring muscles to improve the patient's capacity for walking and standing. Therapeutic procedure examples include therapeutic exercises (CPT code 97110), neuromuscular reeducation (CPT code 97112), gait training (CPT code 97116), massage therapy (CPT code 97124), manual therapy techniques (CPT code 97140), and therapeutic activities (CPT code 97530).

The overall goal should be to get the patient to return to the highest level of function realistically attainable and within the context of the presenting problem. The plan of treatment should address specific therapeutic goals for which modalities and procedures are outlined in terms of type, frequency and duration. There must be an expectation that the condition will improve significantly in a reasonable and generally predictable period of time based on the assessment of the patient's rehabilitation potential. Therapeutic procedures and modalities are not covered by insurance when the documentation indicates that the patient has attained the therapy goals or has reached the point where no further significant practical improvement can be expected.

Billing For Units

For any single timed CPT code in the same day measured in 15-minute units, providers should bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed.

If a service represented by a 15 minute timed code is performed in a single day for at least 15 minutes that service shall be billed for at least one unit. If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc. It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes. When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service determines the number of timed units billed.

If any 15 minute timed service that is performed for 7 minutes or less than 7 minutes on the same day as another 15 minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater than 8 minutes, then bill one unit for the service performed for the most minutes. The same logic is applied when three or more different services are provided for 7 minutes or less than 7 minutes.

The expectation is that a provider's direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations could be highlighted for review. If more than one 15 minute timed CPT code is billed during a single calendar day, then the total number of timed units that can be billed is constrained by the total treatment minutes for that day.

Unlisted Modalities

Getting paid for unlisted procedures can be complicated. However, there are several things you can do to increase your chances of reimbursement. To begin with, call the carrier and ask them if they cover the procedure you are about to perform. If they consider it a non-covered service, make sure the patient is made aware of this. Give the name and phone number of the person you spoke to at the insurance company to the patient. Tell the patient to ask the carrier for their policy on unlisted and non-covered services. Even if the carrier does not pay for the unlisted procedure, I recommend that you bill the carrier anyway. This will help the carrier see that you are providing the service and the EOB will hopefully show a "patient responsibility" remark code. Oftentimes the carrier will deny the unlisted procedure due to "lack of medical necessity." If this is the case, get the carrier to define "medical necessity." You may be able to send in a "pre-authorization" letter in the future. If you have clinical trials and research conducted by recognized bodies of physicians for the unlisted procedure, make sure you include that information in your pre-authorization letter. Describe the condition of the patient, how much they are suffering and what the impact of this pain is on that patient's life. Include a lay-term description of the procedure in your letter so that anybody who reads it can understand. Try to relate the procedure performed to an existing CPT code as support for reimbursement. Explain how your procedure differs to show why you did not choose an existing code.

Additionally, ensure the carrier understands the anticipated cost of the care with and without the unlisted procedure. Insurance carriers are always looking to save money. You should tell them how much money you anticipate saving them by minimizing the risk of future, more expensive procedures.

Ultimately, you should always adhere to the AMA official coding guidelines unless your contract with a carrier stipulates otherwise. If you have had difficulty with a carrier processing any unlisted procedure code, then you may address the issue with the provider relations rep who may, in writing, allow you to report a CPT code not following the AMA CPT guidelines.

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