Modalities & Therapeutic Procedure Coding for Chiropractic

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Take Aways

• Know the right diagnosis codes
• Nail the documentation requirements
• Modalities
  o Get the fundamentals and coding rules
  o Document properly for the most common codes
• Therapeutic Procedures
  o Get the fundamentals and coding rules
  o Document properly for the most common codes
References

- **American Medical Association**
  - CPT Assistant articles

- **Centers for Medicare and Medicaid Services**
  - Local Coverage Determination – *Physical Therapy, outpatient (L30009)*, Cahaba
  - Government Benefit Administrators

- **FindACode.com**

- **CMS National Correct Coding Initiative**

- **Private Payer Policies (Optum & Aetna)**
Local Coverage Determination (LCD):
Medicine: Physical Therapy - Outpatient (L30009)

Contractor Information

Contractor Name
Cahaba Government Benefit Administrators®, LLC opens in new window

Contract Number
10101

Contract Type
MAC - Part A

LCD Information

Document Information

LCD ID
L30009

LCD Title
Medicine: Physical Therapy - Outpatient

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Jurisdiction
Alabama

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For services performed on or after 02/01/2014

Revision Ending Date
N/A

Retirement Date
N/A

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CPT® Code Set - 97140

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CPT Chapter/Section Guidelines & Notes

Code Information

97140 - Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes

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Plain English Description

Manual therapy techniques, such as mobilization, manipulation, lymphatic drainage, traction, etc., used on one or more regions.

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Diagnoses

<table>
<thead>
<tr>
<th>13. Diseases of the musculoskeletal system and connective tissue (M00-M99)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M00-M25 Arthropathies (M00-M25)</strong></td>
</tr>
<tr>
<td>M26-M27 Dentofacial anomalies [including malocclusion] and other disorders of jaw (M26-M27)</td>
</tr>
<tr>
<td>M30-M36 Systemic connective tissue disorders (M30-M36)</td>
</tr>
<tr>
<td><strong>M40-M54 Dorsopathies (M40-M54)</strong></td>
</tr>
<tr>
<td><strong>M60-M79 Soft tissue disorders (M60-M79)</strong></td>
</tr>
<tr>
<td>M80-M94 Osteopathies and chondropathies (M80-M94)</td>
</tr>
<tr>
<td>M95 Other disorders of the musculoskeletal system and connective tissue (M95)</td>
</tr>
<tr>
<td>M96 Intraoperative and postprocedural complications and disorders of musculoskeletal system, not elsewhere classified (M96)</td>
</tr>
<tr>
<td>M99 Biomechanical lesions, not elsewhere classified (M99)</td>
</tr>
</tbody>
</table>
Diagnoses

19. Injury, poisoning and certain other consequences of external causes (S00-T88)

- S00-S09 Injuries to the head (S00-S09)
- S10-S19 Injuries to the neck (S10-S19)
- S20-S29 Injuries to the thorax (S20-S29)
- S30-S39 Injuries to the abdomen, lower back, lumbar spine, pelvis and external genitals (S30-S39)
- S40-S49 Injuries to the shoulder and upper arm (S40-S49)
- S50-S59 Injuries to the elbow and forearm (S50-S59)
- S60-S69 Injuries to the wrist, hand and fingers (S60-S69)
- S70-S79 Injuries to the hip and thigh (S70-S79)
- S80-S89 Injuries to the knee and lower leg (S80-S89)
- S90-S99 Injuries to the ankle and foot (S90-S99)
- T07-T88 Injury, poisoning and certain other consequences of external causes (T07-T88)
## Diagnoses

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S40-S49</td>
<td>Injuries to the shoulder and upper arm (S40-S49)</td>
</tr>
<tr>
<td>S40</td>
<td>Superficial injury of shoulder and upper arm</td>
</tr>
<tr>
<td>S41</td>
<td>Open wound of shoulder and upper arm</td>
</tr>
<tr>
<td>S42</td>
<td>Fracture of shoulder and upper arm</td>
</tr>
<tr>
<td>S43</td>
<td>Dislocation and sprain of joints and ligaments of shoulder girdle</td>
</tr>
<tr>
<td>S44</td>
<td>Injury of nerves at shoulder and upper arm level</td>
</tr>
<tr>
<td>S45</td>
<td>Injury of blood vessels at shoulder and upper arm level</td>
</tr>
<tr>
<td>S46</td>
<td>Injury of muscle, fascia and tendon at shoulder and upper arm level</td>
</tr>
<tr>
<td>S47</td>
<td>Crushing injury of shoulder and upper arm</td>
</tr>
<tr>
<td>S48</td>
<td>Traumatic amputation of shoulder and upper arm</td>
</tr>
<tr>
<td>S49</td>
<td>Other and unspecified injuries of shoulder and upper arm</td>
</tr>
</tbody>
</table>
Consider ICD-10 codes from these categories:

- M15-M19 Osteoarthritis (non-spinal)
- M20-M25 Other joint disorders (non-spinal)
- M45–M49 Spondylopathies
- M50–M54 Other Dorsopathies
- M60-M79 Soft tissue disorders
- S13, S23, S33 Sprains of the spine
- S16, S29, S39 Strains of the neck, thorax, and low back
- And all the injuries, such as sprain/strains of extremities in Chapter 19
First visit

- Objective findings which support the correlating diagnosis
- Functional limitations/deficits, if appropriate
- Description of machine settings, or exercise procedures and their purpose (i.e. effect on function)
- Areas treated
- Frequency/duration, goals with outcome expected
Documentation

During typical treatment visits

• Relevant subjective and/or objective changes
• Time
• Any variation from original plan
• Response of patient

At the re-assessment

• Functional progress
• Evaluate whether or not goals were met
• If appropriate, suggest alternate treatment strategies
Modalities vs. Procedures

Modality defined:

“Any **physical agent** applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.” –CPT 4th edition

Code is selected based on the physical agent used to cause the change.
Therapeutic procedures defined: “A manner of effecting change through the application of clinical skills and/or services that attempt to improve function.” -CPT

Modalities vs. Procedures

Code is selected based on the primary therapeutic outcome desired.
Modalities vs. Procedures

Is the service a modality or procedure? Look at what is causing the therapeutic change.

- **A physical agent?**
  - Light, sound, thermal, electrical, mechanical force, etc.

- **The clinical skill of the physician or therapist?**
  - Evidence that clinical direction is necessary to achieve a particular therapeutic result.
Modality Coding for Chiropractic

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Modalities

Most commonly used codes by chiropractors:

1. 97014/G0283 electrical stimulation (unattended)
2. 97012 traction, mechanical
3. 97035 ultrasound, each fifteen minutes
4. 97010 hot or cold packs
5. 97032 electrical stimulation (manual), each fifteen minutes
6. 97026 infrared
7. 97024 diathermy
8. 97039 unlisted modality
9. 97016 vasopneumatic devices
10. 97022 whirlpool
Modalities

Level of contact:

• **Supervised**: does not require direct contact – stay in the building (97010-97028)

• **Constant attendance**: direct (one-on-one) patient contact (97032-97036), time based
  
  o “one-on-one” is defined as “Visual, verbal, and/or manual contact with the patient” – *CPT Assistant July 2004*
  
  o Doesn’t count if you are just lonely. Must be a clinical need to stay with the patient to deliver the service.
Modalities

“Passive modalities are most effective during the acute phase of treatment, as they are typically directed at reducing pain and swelling.”

“They may also be used during the acute phase of an exacerbation or a chronic condition.”

“The optimal duration of a course of passive modalities is a maximum of one to two months, after which their effectiveness diminishes, and patient dependency may develop.”

–CIGNA Chiropractic Coverage Policy 0267
Modalities

• Passive modalities should lead to active procedures.
• After no more lasting physiologic benefit can be attained, modalities are included in the CMT.
• Research indicates that manipulation with active care is most effective.

• “One or more areas” -CPT
  o Each modality may only be billed once per encounter, regardless of number body regions or length of time.
  o No modifier 51 (multiple procedures)
Modalities

• Usually not indicated as the sole treatment, unless patient cannot tolerate exercise or activities
  o If allowed by state scope, then modalities alone should not exceed 2-4 treatments

• Medical necessity limits the number of modalities that can be provided on a single date of service

• Multiple heating modalities should not be used on the same day
97014

Electrical Stimulation
(supervised)

RVU = 0.43

- TENS training for pain, 1-2 visits
- Muscle stimulation (visible contraction), up to 12 visits, transitioning to home use
- IFC for spasm, swelling and/or pain, 6-12 visits
- For acupuncture with e-stim, use 97813, 97814
Electrical Stimulation
(supervised)

- Medicare, along with some private payers, accept the HCPCS code G0283 instead of 97014.
- Two disposable electrodes are included in the RBRVS payment methodology for this code.
- Modalities should lead to active therapeutic procedures
  - If provided as the sole treatment, consider only 2-4 visits
97014
Electrical Stimulation
(supervised)

Indications:
- Spinal pain** (M54.2, M54.5, M54.6)
- Myalgia (M79.1)
- Muscle spasms (M62.83-)
- Inability to contract muscles, weakness or denervation (M62.81)
- Poor muscle coordination
- Peripheral edema** (R60.0)
- Inflammation (M60.88)

**considered investigational by some payers
Electrical Stimulation
(supervised)

Document:

1. As part of care plan:
   - Rationale, type of stimulation, area treated, functional deficits, frequency/duration, goals

2. At each encounter:
   - For muscle weakness: objective strength rating
   - For swelling/edema: location and description
   - For pain: rating, location
     - Variations from treatment plan and response of patient

3. At re-evaluation, show progress towards goals
97012

Traction, mechanical
(supervised)

RVU = 0.44

- Force applied to separate joint surfaces
- Specify whether traction is:
  - Static
  - Intermittent
  - Auto traction (using body’s own weight)
- Roller tables are not considered true mechanical traction by some payers.
- Some payers require FDA cleared devices
97012

Traction, mechanical
(supervised)

• Should be done in conjunction with therapeutic procedures
• 97140 needs the 59 modifier if billed at the same encounter (NCCI edits)
• Flexion-distraction should be billed as CMT
• VAX-D should be billed as S9090
• 3-4 visits max in office, then teach home care
Traction, mechanical (supervised)

Indications:
- cervicalgia (M54.2)
- lumbago (M54.5)
- radiculopathy (M54.1-)
- disc herniation (M50-, M51-)
- sciatica (M54.3-)
- consider also adhesions, stiffness, inflexibility, arthritis, compression
Document:

1. As part of care plan:
   • Rationale, part of the body, force applied, angle, time, frequency/duration, goals

2. At each encounter:
   • Any variation from plan and response of patient

3. At re-evaluation, show progress towards goals
97035

Ultrasound, each 15 minutes
(constant attendance)

RVU = 0.35

• Deep heating modality that produces a sound wave of 0.8 to 3.0 MHz
• Tissues lying immediately next to bone may receive as much as 30% greater dosage of ultrasound than tissue not adjacent to bone.
• Ultrasound is an ideal modality for increasing ROM.
97035

*Ultrasound, each 15 minutes*

*(constant attendance)*

- 52 modifier cannot be used for < 8 minutes
- 6-12 visits is generally sufficient
- If performed with simultaneous e-stim, code only 97035
- “hands free” ultrasound should be reported with 97039
- Should be used with, or transition to, active therapeutic procedures
97035

Ultrasound, each 15 minutes
(constant attendance)

Indications:
• pain (M54-)
• spasm (M62.83-)
• joint stiffness and inflexibility
• soft tissue calcification (M61-)
• Neuromas (G57-, T87-)
97035

Ultrasound, each 15 minutes
(constant attendance)

Document:

1. As part of care plan:
   • Rationale, area treated, US frequency/intensity, time, functional deficits, frequency/duration, goals

2. At each encounter:
   • Subjective findings: pain ratings, location, and effect on function
   • Objective measurements of strength, ROM, and functional limitations
   • Variations from treatment plan and response of patient

3. At re-evaluation, show progress towards goals
97010

*Hot or cold packs*  
*(supervised)*

RVU = 0.16

• Bundled by many payers since skills are not required for its application
• Long term or routine application should be avoided
• Examples: hydro-collator, cryotherapy
Indications:

1. Heat: sub-acute or chronic.
   - scar tissue (L90.5)
   - muscle spasms (M62.83-)
   - inflexibility, poor circulation, nerve damage

2. Cold: acute trauma or severe spasticity
   - inflammation, pain, and swelling
97010

Hot or cold packs
(supervised)

Document:

1. As part of care plan:
   • Areas treated, frequency/duration, goals
2. At each encounter:
   • Any variation from plan and response of patient
3. At re-evaluation, show progress towards goals
97032

Electrical Stimulation, manual, attended, 15 minutes, one or more areas (constant attendance)

RVU = 0.54

• Requires direct contact by the provider or other qualified health care professional
• More than one unit can be billed based on time, but not # of areas treated
97032

**Electrical Stimulation, manual, attended,**
**15 minutes, one or more areas**
**(constant attendance)**

- Attended e-stim is also called manual e-stim
- May be appropriate if the stim must be adjusted and monitored during the course of treatment
- Shooting the breeze about sports while the patient gets passive e-stim, such as IFC is 97014.
Quiz

The provider does interferential e-stim in the lumbar region for twelve minutes, then the left shoulder region for six minutes, and the right shoulder and neck for eight minutes each. The correct code(s) would be

A. 97014
B. 97032 x2
C. 97014-51 x2
D. 97032-52 x2

Hint: -52 means “reduced services”
-51 means “multiple procedures”
97039

Unlisted Modality
(constant attendance)

RVU = none

• Should be used when no accurate code exists
• Not to be used routinely or on a recurring basis
• Not necessarily a timed code
• Only once per day

Requires a “special report”

Description of the nature, extent, and need for the procedure
• Time, effort, and equipment necessary to provide the service.
Document:

1. As part of care plan:
   • Rationale and description of the modality, area treated, functional deficits, frequency/duration, goals

2. At each encounter:
   • Time, if applicable
   • Relevant subjective and objective findings
   • Variations from treatment plan and response of patient

3. At re-evaluation, show progress towards goals
Modalities

What about these?

- Therapeutic Magnetic Resonance Treatment
- Percutaneous Electric Nerve Stimulation
- Class I-II light therapy (LED)
- Class III (cold laser)
- Class IV (hot laser)
- Hands free ultrasound
- E-stim, US combo
- Phonopheresis
- Posture pump
- Vibratory massage/massage chairs
Modalities

- Did you bring about a therapeutic change to biologic tissue?
The ChiroCode DeskBook is available at ChiroCode.com

This presentation is covered in pages 283-288, Chapter 5.2
Therapeutic Procedure Coding for Chiropractic

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Vice President
Therapeutic Procedures

Most commonly used codes by chiropractors:

1. 97140 Manual therapy techniques
2. 97110 Therapeutic exercises
3. 97124 Massage
4. 97112 Neuromuscular reeducation
5. 97530 Therapeutic activities, direct patient contact
6. 97150 Therapeutic procedure(s), group
7. 97139 Unlisted therapeutic procedure
Therapeutic Procedures

“A manner of effecting change through the application of clinical skills and/or services that attempt to improve function.” – CPT manual

“…procedures that attempt to reduce impairments and restore function through the application of clinical skills and/or services.” – CMS LCD
These codes are not limited to any particular specialty group.

Delegation to clinical staff is governed by state licensure, and often a source of contention with payers.

The expectation is that timed services average fifteen minutes, not eight.
CPT editorial approach to time-based services:

• 50% of required time
  - 7.5 minutes or more would be reported as the 1st unit of a fifteen minute service
  - Any less is not reportable, and can’t be bypassed with the 52 modifier (incomplete service)—CPT Assistant March 2014

• Includes all necessary pre, intra, and post service work associated with the service
Therapeutic Procedures

CMS approach to time-based services:

• 8 minute rule
  o 8-22 minutes = 1 fifteen minute unit
  o 23-37 minutes = 2 fifteen minute units
  o 38-52 minutes = 3 fifteen minute units

• Includes only the actual time involved in performance of the service (intra-service time). Pre and post service work does not count. Time should be face-to-face.
CMS approach to time-based services:

• Less than 8 minutes
  - Can’t be billed, but save the time

• Bundling services of the same time
  - Lower value bundles to higher value. Bill the higher value service.

• Bundling services of different times
  - Lower time bundles to higher time. Bill the higher timed service.
Therapeutic Procedures

Suppose you perform the following:

- 97110 10 minutes
- 97140 12 minutes

CPT example:

- 97110 1 unit
- 97140 1 unit

CMS example:

- 22 total minutes
- 97140 1 unit

If 5 minutes of 97035 were also performed, the CPT example would not change, but 1 unit of 97110 would be billable under the CMS example.
Therapeutic Procedures

• One more example:
  • 24 minutes of NMR 97112
  • 23 minutes of exercise 97110
  …would be coded as
  • 2 units of 97112
  • 1 unit of 97110
  …because total time is 47 minutes, which equals 3 units (38-52 minutes)
Therapeutic Procedures

• Physician or other qualified health care professional (i.e. therapist) is required to have direct (one-on-one) patient contact.

• Clinical skill is necessary to achieve the specific therapeutic change and must be applied during the entirety of the service; hence, the direct one-on-one contact requirement.

• Supervision of a previously taught exercise is not covered.

• Exercise using equipment that does not require the intervention/skills of a therapist are not covered.
Therapeutic Procedures

• There is no separate coverage for educational components of treatment or time spent on documentation.

• Improvement of limitations/deficits must be expected in a reasonable and generally predictable period of time.

• Medicare Secondary Payers (MSPs) often require the GP modifier
Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction)

RVU = 0.81

1. Manual traction for cervical radiculopathy
2. Joint mobilization for restricted joint motion *
3. Myofascial release for restricted motion of soft tissue *
4. Manipulation for spasm or restricted motion of soft tissue *
5. Lymphatic drainage for lymphedema
   *Adjunct to 97110, 97112, or 97530
Manual therapy techniques include, but are not limited to:

- soft tissue mobilization
- joint mobilization and manipulation
- manual lymphatic drainage
- manual traction
- myofascial release
- neural gliding techniques
Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction)

- “Manual” therapy requires that providers use their hands
- Number of regions treated is irrelevant
- 3-6 visits typical, 12-18 visits max, 4-6 weeks
- 97140 is not interchangeable with 98940-2 (CMT) or 97124
Modifiers:

- 97124 (massage) in not covered on same visit date unless related to a different area of the body, but NCCI edits say no modifier will bypass the edit.
- 97530 should have 59 or X{EPSU} modifier attached if billed with 97140
- 97140 should have 59 or X{EPSU} modifier attached if billed with 97012 or 97150 or 98940-2
- “Different body region” has different definitions
According to Optum, manual therapy must be performed in a different, *noncontiguous*, body region than CMT.

- **XE Separate Encounter**, a service that is distinct because it occurred during a separate encounter,
- **XS Separate Structure**, a service that is distinct because it was performed on a separate organ/structure,
- **XP Separate Practitioner**, a service that is distinct because it was performed by a different practitioner, and
- **XU Unusual Non-Overlapping Service**, the use of a service that is distinct because it does not overlap usual components of the main service.
According to Optum, when reporting the CPT code 97140 in conjunction with CMT codes, there are six criteria that must be documented to validate the service:

1. Manipulation was not performed to the same anatomic region or a contiguous anatomic region e.g., cervical and thoracic regions are contiguous; cervical and pelvic regions are noncontiguous
2. The clinical rationale for a separate and identifiable service must be documented e.g., contraindication to CMT is present
3. Description of the manual therapy technique(s)
4. Location e.g., spinal region(s), shoulder, thigh, etc.
5. Time i.e., number of minutes spent in performing the services associated with this procedure meets the timed-therapy services requirement
6. CPT code 97140 is appended with the modifier -59 or the appropriate -X modifier
97140

Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction)

Indications:

• Limited range of motion:
  o Adhesive capsulitis, shoulder (M75.0-)
  o Stiffness of joint (M25.6-), tissue adherence
• Muscle spasm (M62.8-)
• Contracted tissue (M62.4- Contracture of muscle)
• Soft tissue swelling, pain (R60.0 localized edema)
• Contracture of joint (M24.5-)
1. As part of care plan:
   - Restricted joint or soft tissue motion, including comparison to unaffected limb, if applicable
   - Areas treated and technique used
   - Functional limitations/deficits, and effect on function
   - Frequency/duration, goals (desired outcome)

**97140**

Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction)
2. At each encounter:
   • Objective and subjective measurements of joint/soft tissue restrictions
   • Activities performed and amount of assistance required
   • Any variation from plan and response of patient

3. At re-evaluation, show functional progress and/or alternative txt strategy

Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction)
RVU = 0.88

• Examples include treadmill (endurance), isokinetic exercise (ROM), lumbar stabilization exercise (flexibility), and gymnastic ball (stretch/strengthen)
• Use 97112 to rehabilitate movement, coordination, or balance
• 3-6 visits typical, 12-18 visits max, 4-6 weeks, transition to Home Exercise Program (HEP)
• If passive, then 2-4 visits
• 97110 should have 59 modifier attached if billed with 97150
Indications:
• Loss or restriction of joint motion, strength, flexibility, functional capacity or mobility from a specific disease or injury.
• If used for pain, include pain rating, location of pain, and effect of pain on function.
• Not covered for exercises to promote overall fitness, flexibility, endurance enhancing, aerobic conditioning, and weight reduction.
• Not covered for maintenance of ROM or strength unless a skilled therapist is needed.
1. As part of care plan:
   - Objective loss of joint motion (degrees, with comparison to unaffected limb), strength (grades), mobility (levels of assistance)
   - Specific exercises and purpose
   - Why a skilled therapist is needed
   - Functional limitations/deficits, and effect on function
   - Frequency/duration, goals (desired outcome)
Document:

2. At each encounter:
   • Objective measurements of strength, ROM, and mobility
   • Exercises performed
   • Any variation from plan and response of patient

3. At re-evaluation, show functional progress and/or alternative txt strategy
97124
Massage, including effleurage, petrissage and/or tapotement
(stroking, compression, percussion)

RVU = 0.72

- Adjunctive to another therapeutic procedure on same day
- Must be performed by hand, not with a device
- May not be covered as an isolated treatment, or for more than 30 minutes
- 97140 not covered on same visit unless related to a different area of the body
- Maximum 6-8 visits generally
- Maximum of 1-2 units is easiest to defend as medically necessary
97124

Massage, including effleurage, petrissage and/or tapotement
(stroking, compression, percussion)

Modifiers:

• 97124 should have 59 modifier attached if billed with 97150 or 98940-2

• 97124 (massage) is not covered on same visit date as 97140 unless related to a different area of the body, but NCCI edits say no modifier will bypass the edit.
97124
Massage, including effleurage, petrissage and/or tapotement
(stroking, compression, percussion)

Indications:
- Restore muscle function
- Relieve muscle spasm (M62.8-)
- Improve joint motion, mobilize stiff or scarred tissue (M62.4-)
- Reduce edema, (R60.0 localized edema) increase blood flow
Document:

1. As part of care plan:
   - Area being treated and technique used
   - Rationale for use of procedure
   - Frequency/duration, goals (desired outcome)

2. At each encounter:
   - Area treated and technique used
   - Any variation from plan and response of patient

3. At re-evaluation, show progress towards goals and/or alternative txt strategy

97124
Massage, including effleurage, petrissage and/or tapotement
(stroking, compression, percussion)
97112

Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

RVU: 0.9

- Examples include PNF, Feldenkrais, Bobath, BAP’s boards, and desensitization techniques
- Use 97110 for strength, ROM, and flexibility
- Max 12-18 visits within 4-6 weeks
- 97112 should have 59 modifier attached if billed with 97150 or 98940-2
This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, and/or proprioception to a person who has had muscle paralysis and is undergoing recovery or regeneration. Goal is to develop conscious control of individual muscles and awareness of position of extremities. The procedure may be considered medically necessary for impairments which affect the body’s neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, hypo/hypertonicity) that may result from disease or injury such as severe trauma to nervous system, cerebral vascular accident and systemic neurological disease. [Aetna policy 0325 - Emphasis Added]
97112

Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

Indications:
• Loss of DTRs and vibration sense accompanied by paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers
• Nerve palsy (i.e. foot drop)
• Nerve injury or disease leading to muscle weakness or flaccidity
• Inability to sit or stand unassisted
• Loss of gross and fine motor coordination
• Hypo/hypertonicity
97112

Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

Document:

1. As part of care plan:
   • Objective measurements/ratings of loss of
     o Motion (degrees), strength (grades), balance (assistance required), coordination (deficits), mobility
   • Specific exercises to be performed, functional purpose, and instruction given
   • Documentation to support that the skills of a therapist are needed
   • Functional limitations/deficits as result of the neuromuscular impairment
   • Frequency/duration, goals (desired outcome)
2. At each encounter:
   • Objective measurements of strength, ROM (compared to uninvolved side) and mobility, balance, and coordination deficits
   • Exercises performed
   • Any variation from plan and response of patient
3. At re-evaluation, show functional progress and/or alternative txt strategy
RVU = 0.94

- Dynamic activities include the use of **multiple parameters**, such as balance, strength, and range of motion, for a functional activity.
- Procedure involves the use of functional activities (e.g. bending, lifting, carrying, reaching, catching, transfers, and overhead activities) to restore functional performance in a progressive manner.
97530

Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes

- 97110 focuses on a single parameter via exercise, 97530 focuses on multiple parameters via activities.
- 97530 requires the skill of the therapist to design the activities to address a specific functional need and instruct the patient.
- If more than 12 visits, documentation must support need.
- 97530 should have 59 modifier attached if billed with 97140 or 97150
97530
Therapeutic activities, direct (one-on-one) patient contact
(use of dynamic activities to improve functional performance), each 15 minutes

Indications:

- Loss or restriction of mobility, strength, balance, or coordination

1. Patient must have a condition for which 97530 will improve function
2. Exercise must correlate with patient’s condition
3. Patient must be unable to perform the activities without the skilled intervention of the therapist
Document:

1. As part of care plan:
   • Objective measurements of balance, strength, coordination, mobility, etc.
   • Specific activities to be performed and amount of assistance required
   • Documentation to support that the skills and expertise of a therapist are needed
   • Functional limitations addressed
   • Frequency/duration, goals (desired outcome)
2. At each encounter:
   - Objective measurements of balance, strength, coordination, mobility, etc.
   - Activities performed and amount of assistance required
   - Any variation from plan and response of patient

3. At re-evaluation, show functional progress and/or alternative txt strategy
RVU = 0.48

- If 97110-97139 are performed with two or more individuals, 97150 is reported instead. Do not code the specific type of therapy in addition to 97150.

- Group therapy procedures involve constant attendance of the physician or other qualified health care professional [ie, therapist], but by definition do not require one-on-one patient contact by the same physician or other qualified health care professional.
97150
Therapeutic procedure(s), group (2 or more individuals)

• Patients may or may not be doing the same activity
• 97150 is not time based, therefore it is reported once per session, regardless of the time involved
• 97150 is reported for each individual receiving group therapy
• 97110-97530 need modifier 59 or X{ESPU} when performed one-on-one separate in time from the group.
Group therapy is typically only billable once per patient per day.
Groups should not exceed 4 individuals.
Supervising patients who are exercising independently or on exercise equipment is not a skilled service and may not be billable as group or individual therapeutic procedures.
Indications:
- Functional loss (same as for 97110-97530)

Document:
1. As part of care plan:
   - Specific skilled treatments used
   - Functional loss, frequency/duration, goals
2. At each encounter:
   - Size of group
   - Any variation from plan and response of patient
3. At re-evaluation, show progress towards goals
RVU = none

- Should be used when no accurate code exists
- Direct one on one contact is required
- May be a timed code
- Only once per day
- Requires a “special report”
  - Description of the nature, extent, and need for the procedure
  - Time, effort, and equipment necessary to provide the service
97139
Unlisted therapeutic procedure
(constant attendance)

Document:

1. As part of care plan:
   • Rationale and description of the procedure, area treated, functional deficits, frequency/duration, goals

2. At each encounter:
   • Time, if applicable
   • Relevant subjective and objective findings
   • Variations from treatment plan and response of patient

3. At reassessment, show functional progress
The *ChiroCode DeskBook* is available at ChiroCode.com

This presentation is covered in Chapter 5.2
Take Away

• Know the right diagnosis codes
• Nail the documentation requirements
• Modalities
  o Get the fundamentals and coding rules
  o Document properly for the most common codes
• Therapeutic Procedures
  o Get the fundamentals and coding rules
  o Document properly for the most common codes