

APPENDIX B

CHIROPRACTIC GUIDELINES

Acknowledgement: Current Procedural Terminology (CPT®) is copyright 2011 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable – ARS/DFARS Restrictions Apply to Government Use.

NOTE: The revision date appears in the footer of the document. Links within the document are updated as changes occur throughout the year.

Chiropractic Manipulative Treatment (CMT)

BCBSKS expects the specific criteria identified for each code to be met and documented in the medical record when using a particular level of CMT code.

- **All manipulations must be coded separately.**

NOTE: Although a procedure/service has an assigned code that accurately defines the service, it doesn't guarantee the service is covered by BCBSKS.

For the majority of chiropractic office visits, the primary therapeutic procedure rendered is a spinal manipulation/adjustment. Please report manipulations using the appropriate CPT codes 98940-98942 (spinal) and 98943 (extraspinal).

Please note: BCBSKS conducts post payment audits on Evaluation and Management (E&M) visits billed in addition to the CMT procedure codes.

Per CPT, Pre and Post Services are included in CMT Procedure Codes 98940 through 98943.

- **Per CPT, CMT Regions and Procedure Codes**
 - **E&M's are part of the manipulation**
 - **Regions of the Spine (for 98940 through 98942)**
 - ✓ Cervical (includes atlanto-occipital joint)
 - ✓ Thoracic (including costovertebral and costotransverse, excluding rib cage)
 - ✓ Lumbar
 - ✓ Sacral
 - ✓ Pelvic (sacro-iliac joint)
 - **Regions of the Extraspinal (98943)**
 - ✓ Head (including temporomandibular joint, excluding the atlanto-occipital)
 - ✓ Lower Extremities
 - ✓ Upper Extremities
 - ✓ Rib cage (excluding costotransverse and costovertebral)
 - ✓ Abdomen
 - **The procedure codes are**
 - 98940 1 to 2 regions of the spine manipulated
 - 98941 3 to 4 regions of the spine manipulated
 - 98942 5 regions of the spine manipulated
 - 98943 Extraspinal manipulated

Evaluation and Management (E&M) Codes

Chiropractors usually bill the first four levels of new and established office visit codes. BCBSKS uses the CPT definitions for new and established patients. If a provider has treated a patient for any reason within the last three years, the patient is considered an established patient.

[Policy Memo No. 2](#)

As a general rule, E&M codes should not be billed in conjunction with any manipulations. Routine use of E&M codes without sufficient documentation is not an appropriate billing practice.

E&M services can be reported separately in the following circumstances:

- ✓ **Initial exam is for a new patient or a new condition.**
- ✓ **There is an acute exacerbation of symptoms or a significant change in the patient's condition.**
- ✓ **There are distinctly different indications which are unrelated to the manipulation.**

- **Selecting the Correct Level of E&M**

BCBSKS uses AMA-CPT codebook definitions for each level of E&M code as related to type of history, examination, and medical decision-making involved in the office visit. We expect the criteria identified for each code to be met and documented in the medical record when using a particular level of E&M code.

The following should be considered when making a decision as to what E&M procedure code is appropriate for a given date of service: The AMA-CPT book indicates the descriptors for the levels of E&M services recognize *seven* components, *six* of which are used in defining the levels of E&M services. These components are:

- *History*
- *Examination*
- *Medical decision-making*
- *Counseling*
- *Coordination of care*
- *Nature of presenting problem*
- *Time*

The *first three* of these components, history, examination and medical decision making should be considered the **KEY COMPONENTS** in selecting the level of E&M service procedure code.

The *next three* components (counseling, coordination of care, and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter.

The final component is time. Defined as the time the physician spends counseling (50% or more) face-to-face with the patient. The start and stop face-to-face time must be documented.

Coordination of care does not include time spent coordinating care within the physician's own office or clinic. Coordination of care does include time spent coordinating care outside of the physician's own office or clinic (i.e., other physicians, providers, hospitals, etc.)

Muscle and range of motion testing that are more in-depth than the routine tests performed on visit-by-visit basis can be coded separately if they meet the criteria outlined in the AMA-CPT book for each test and all criteria is met in the medical record.

Those tests not meeting the criteria are considered routine and are included in the E&M procedure code or the CMT/OMT procedure code.

E & M and CMT Coding

As stated previously, BCBSKS expects the specific criteria identified for each code to be met and documented in the medical record when using a particular level of CMT code.

- **New Patient**

You may bill a new patient E&M procedure code and a CMT procedure code on the same day.

- **Established Patient**

1. BCBSKS will consider for reimbursement both services when medically necessary and the E&M is a separate and identifiable service.

2. Those services that are considered pre and post service of the CMT cannot be billed as an E&M.
 3. At any time during the treatment plan, if the patient has a new, separately definable injury or complaint, an E&M code can be billed with a modifier "25".
 4. As of 1/1/2012, services billed using the modifier 25 will be reimbursed as follows:
Reimbursement is allowed for the primary service, and the E&M service is allowed at 50 percent, as noted in the 2012 CAP letter.
- **TWO CMTs (98940, 98941, 98942) on the SAME DAY**
 - ✓ Medical records must be submitted with the claim to support the medical necessity.
 - ✓ Use modifier "22" when submitting any claim attachment.

Radiology

Providers must bill diagnostic X-ray services using CPT radiology codes and adhere to the policies described in Policy Memo No. 7.

[Policy Memo No. 7: Radiology and Pathology](#)

Pathology (Labs)

- All anatomic laboratory tests must be billed by the entity that performs the entire exam using CPT codes.

- **PROFESSIONAL SERVICES COORDINATED WITH A NON-CONTRACTING PROVIDER**
When a contracting provider uses a non-contracting provider (either in or out-of-state) to perform a portion of a professional service (e.g., professional component, technical component or other technology utilized in the performance of a service), the contracting provider must bill BCBSKS for all services. If the non-contracting provider bills the member or BCBSKS, the contracting provider will be required to hold the member harmless. [Policy Memo No. 1, Page 11.]

[Policy Memo No. 7: Radiology and Pathology](#)
[2012 Lab Fee Schedule for Professional Providers](#)

Documentation Guidelines

The following information was communicated to Chiropractors via letter dated October, 2009.

In 2006, chiropractors from the state of Kansas who do peer reviews for Blue Cross and Blue Shield of Kansas (BCBSKS) met and concurred that there was need for communication with their peers. The group's stated goals are to see chiropractors obtain appropriate compensation for the services provided and improve the process in performing reviews. A communiqué was sent to Kansas chiropractors, but concerns still remain. The purpose of this follow-up communiqué is to elaborate upon the two areas of concern. The two main concerns are:

- 1) **Documentation of medical necessity**
- 2) **Documentation of services provided**

DOCUMENTATION OF MEDICAL NECESSITY

Before BCBSKS can appropriately reimburse any eligible, professional provider for services, it must be determined if services are documented and can be supported by your records as being medically necessary. Medical necessity is a requirement of good stewardship of member premiums and is a standard of care that is supported by the chiropractic profession as well as all payer sources (see references). In many instances, this requires you to remit all appropriate and **legible** documentation for a claim in question.

When we request records from you, consider what documentation will support the need for the services you provided. Also, keep in mind that your documentation must allow a peer reviewer to discern the medical necessity for each service without knowing your patient as well as you do. Usually, your office must supply more documentation than just the day's chart note in question. For example, if a particular day's service is being considered which is in the midst of a series of treatments, it is necessary to supply the initial date of service notes, history, diagnostic tests, examination and radiology findings, etc. where specific details are documented. If the record

supports the claim's billed services, without additional personal insight or knowledge, it should be adequate for review.

The importance of having the services you perform sufficiently documented cannot be over-emphasized.

DOCUMENTATION STANDARDS

The peer group agrees most travel cards **alone** provide insufficient medical detail from which to determine the medical necessity of care and treatment performed, especially in instances of extended care. The small entries, checkmarks, and commonly illegible notations seldom provide adequate information in a travel card format.

The chiropractic consultants firmly recommend that the content of the daily medical records contain the requirements detailed below. These requirements essentially mirror Kansas Board of healing Arts Regulation Section 100-24-1: Adequacy: minimal requirements.

The following medical record standards are **minimally** required; and if not met, may result in delay or denial of reimbursement as a **provider write-off**:

Records must:

1. Be **legible** in both readability and content. If not readable, reimbursement will be denied.
2. Contain only those terms and abbreviations easily comprehended by peers of similar licensure.
If a legend is needed to review your records, please submit it with your records. If needed and you have not submitted one, BCBSKS may request you provide a legend. If not supplied upon request, reimbursement will be denied.
3. Contain identification of the patient on every page (i.e. front and back). If not recorded, reimbursement may be denied.
4. Indicate the dates any professional service was provided. List start and stop times on all timed codes per CPT nomenclature. If dates of service and/or start/stop time is not recorded, reimbursement will be reduced.
5. Contain pertinent and significant information concerning the patient's presenting condition (**subjective information and history**).
6. Reflect what examination or treatment was performed and physical area(s) treated, vital signs obtained and tests (lab, x-ray, etc.) performed and the findings of each (**objective data**).
7. Indicate the initial diagnosis and the patient's initial reason for seeking the provider's care. The **diagnosis is not just an ICD-9-CM billing code**, but a written interpretation of the patient's condition and physical findings. The diagnosis should be recorded in the record and reflected on the claim form. (**Assessment**)
8. Document the treatment performed (what treatment was done, why was it done, where it was done, and for how long). Treatment goals should be documented. (**Plan of Care**)
9. Document the patient's progress during the course of treatment as it relates to the plan of care and diagnosis.

10. All notes should be **signed** and **dated** by the clinician performing the services. A **legible** first initial and last name is **minimally** required. If not present, reimbursement will be denied. A stamped signature is **not** acceptable. (see *Blue Shield Report*, S-1-09, Jan. 15, 2009)

It is essential for the chiropractor to document clinical findings and justify the medical necessity of care. It is strongly suggested this justification be documented via formal progress note using S.O.A.P. note format, which is considered a medical standard. The following elements should be present on **each initial and subsequent encounter/evaluation** regardless of the note format used.

S-SUBJECTIVE COMPLAINT should include the following:

♦ **Initial Evaluation:**

- Patient's reason for seeking care.
 - History of complaint and/or nature of injury or accident
 - Include history of treatment by previous treators (chiropractic, MD, PT, OT, etc.)
 - Location of complaint
 - How long they've had complaint and what movement or motion aggravates it.
 - Description of pain.
 - * Quality (stabbing, pulling, throbbing, achy, etc.)
 - * Quantity (always there, only there during certain times of the day, certain positions, or while performing certain daily activity tasks)
 - * Severity (use pain scale to have patient describe the severity of the complaint).
 - General health history and thorough systems review (**when clinically appropriate**).
 - Significant illnesses and medical conditions
 - Medication, allergies and adverse reactions
 - Past medical history of serious accidents, operations, hospitalizations, tumors
 - For children and adolescents (18 years and younger) past medical history of prenatal care, birth, operations and childhood illnesses
 - Social history, smoking, drinking, substance abuse, recreational activities as well as occupational history, living arrangements and activities of daily living (ADL).
 - Review of systems.
- ♦ **Subsequent Encounters:**
- Follow-up documentation
 - Patient's perception of progress to date.
 - Perceived improvements in ADL.
 - Perceived improvements in pain quality, quantity and severity (pain scale).

O-OBJECTIVE FINDINGS should include the following:

♦ **Initial Evaluation:**

- Functional and measurable data
 - Vital signs, height, weight, blood pressure, etc.

- Orthopedic and neurological testing, laboratory studies and diagnostic imaging, i.e., x-ray finding, MRI, CT-scan, bone scan, etc. Include radiology or special diagnostic reports in patient record.
- Visual observation
 - Inspection findings
 - Antalgia
 - Postural anomalies
 - Movement pattern deficits
 - Functional deficits
 - ADL deficits
 - Strength deficits, etc.
- Physical examination findings, i.e.:
 - Static and motion palpation findings specific to region and/or specific spinal levels or extremity joints evaluated. May include muscle spasm/tightness, tenderness, trigger points, edema, strength and ROM deficits. Note that subluxations (spinal or extremity) need to be specifically identified objectively. Document the spinal segment or extremity joint involved along with its positional or functional deficit via your palpatory or x-ray analysis. **Example:**
 - * Decreased ROM Cervical right rotation 20° with joint lock at C2-3.
 - * Levorotatory lumbar curvature noted on x-ray. L2-3 fixation evident.
 - * Foraminal compression Cervical spine produces impingement at C5-6 on the right with cervicobrachial pain/paresthesia extending to the tip of the right index finger. Focal joint lock T8-9, L2 and Right ilium.
 - * Right Kemps test produces focal impingement L5-S1 ipsilateral.
- ♦ **Subsequent Encounters:**
 - Follow-up documentation
 - Improvement or decline in functional and measurable data as it relates to:
 - * Range of motion measurement (pre and post treatment)
 - * Strength measurement (pre and post treatment)
 - * Visual observation of movement patterns, palpatory findings, postural anomalies, etc.
 - * ADL's (able to comb hair, reach top cabinets, walk 10' longer without assistive device, etc.)

A-ASSESSMENT should include the following:

- ♦ **Initial Evaluation:**
 - The DIAGNOSIS. The diagnosis is a written interpretation of the patient's condition, physical findings and should correlate with the objective data. **(It is not an ICD-9-CM billing code.)** **Examples:**
 - * Cervical sprain/strain with associated altered biomechanics at C4-5.
 - * Lumbar facet syndrome with associated lumbalgia, lumbar paraspinal myofascitis and subluxations in the lumbar and sacroiliac region.
 - * Right sciatic neuralgia secondary to L5-S1 lateral disc protrusion.
 - * Right rotator cuff sprain/strain, grade 2 with AI luxation of humeral head.

- * Plantar fasciitis secondary to acquired ankle pronation and luxation of the cubo-navicular complex.
- Long and short-term goals and expected functional outcomes. **Examples:**
 - Long-term goals:
 - * Patient able to sleep 8 hours without rising to apply heat or take medicines.
 - * Patient able to play golf in 4 weeks without pain.
 - * Patient able to vacuum house without back pain or rest breaks in 3 weeks, etc.
 - Short-term goals:
 - * Increase ROM cervical spine from 12° to 90°.
 - * Walk 10 ft. without crutches in 2 weeks with stand by assistance.
 - * Increase ROM in R shoulder so patient can wash hair without muscle spasm in trapezius.
- ♦ **Subsequent Encounters:**
 - Follow-up documentation
 - Document appropriate changes in the diagnosis and the provider's evaluation of the patient's overall progress and prognosis with regard to the treatment plan. **Examples:**
 - * Improved ROM cervical spine to 45°, continue at same treatment frequency.
 - * Patient can now vacuum ½ her home without pain, but has low back fatigue. (ADL). Continue with work-hardening exercises at home & maintain treatment frequency at 2/wk to decrease rest breaks to 2.
 - * Patient improved and can play 9 holes of golf without pain. Decrease visits to two times per week and add home exercise program to increase stamina.

P-PLAN should include the following:

- ♦ **Initial Evaluation:**
 - The initial visit would include the treatment plan as it relates to the complaint and diagnosis afforded the patient. The treatment plan should indicate each modality or therapeutic procedure/exercise to be provided, the frequency, duration, to what body area, and future plans for re-examination. Indicate plans for anticipated discharge, prognosis, referral for consultations, and diagnostic testing.
 - Treatment, therapy and procedures performed on the patient are recorded here. The services rendered should correlate with the CPT billing codes submitted for payment.
- Example:**
 - If physiotherapy is used, the type of modality or exercise must be identified as well as the body part treated, the length of time utilized, intensity settings, physiological reason for application and correlation with diagnosis. Medical reasoning for each treatment utilized must be documented when using multiple therapies. **Example:**
 - * To reduce inflammation and edema at patient's cervical sprain area, use pulse ultrasound to C3-6 left facet/paraspinal region for 10 minutes at 50% pulse mode. Daily x3, then reduce to two times per week.
 - * To reduce paraspinal and intercostals muscle spasms, use attended EMS HV therapy to the right thoracic T5-9 and corresponding right intercostal muscles for 15 minutes set at 145 volt tolerance. Daily x5 then reduce to 3 times per week.

- * To reduce inflammation noted over L3-5, place ice pack over lumbar spine wrapped in toweling for 10 minutes to patient tolerance. Daily x3 then have patient do themselves at home.
- * To restore normal biomechanics/juxtaposition, perform CMT to spinal regions C1, C4-5, T7 & L2. Re-evaluate after 10 visits.
- In the case of time-based modality/exercise, list start and stop times for each service provided. Services such as therapeutic procedures, neuromuscular re-education, manual therapy techniques, therapeutic activities, etc., require specific details about the services being performed to determine medical necessity and appropriateness. That detail includes, but is not limited to:
 - Physiological reasoning for **each** service, especially if they are being performed in conjunction with other modalities/exercise procedures. **Each** service should provide a unique physiologic effect if they are to be used together; that effect needs to be documented.
 - What **specific** exercise/procedure is being performed?
 - The area being treated
 - The number of repetitions if applicable
 - * Statements that simply denote completion of activities is **not** adequate.
- ♦ **Subsequent Encounters:**
 - Follow-up documentation:
 - Follow-up visits document any appropriate changes in the diagnosis and/or treatment plan and why.
 - At each patient encounter, a brief post-assessment of the treatment rendered should be performed and recorded. It is intended to evaluate the patient's response to the treatment for that day. This post-assessment is **not** considered a re-exam of the patient. **Example:**
 - * Patient progressing well with home exercises for rotator cuff sprain. Will re-examine shoulder strength quantifiably at next visit. Follow-up 2 weeks.
 - * Patient displays normal and pain-free ROM cervical spine with normal strength and stability displayed. Patient is discharged from care for cervical sprain/strain injury without limitations.
 - * Patient is not responding as expected. Referring for MRI of lumbar spine to R/O underlying pathology.
 - Document any patient instructions such as home care (ice/heat, belts/collars, exercises, work/home restrictions, etc.) or nutritional supplements recommended.
 - Document any complications.
 - * Patient deaf and communication is difficult.
 - * Patient utilizes a walker and retains a forward flexed posture while weight bearing which complicates restoration of normal thoracic kyphosis and is delaying reduction of thoracic paraspinal myospasms.

RESPONSIBILITIES

It is imperative that you and your staff are fully aware of the professional, fiduciary, and legal standards/requirements of complete and thorough documentation. A BCBSKS professional relations representative is readily available to assist you. BCBSKS and chiropractic peer review consultants strive to provide you the information necessary to meet the requirements of

documentation. Please refer to the important resources at the end of this document that will increase the successful and timely adjudication and remittance of payment for the valuable services you provide.

Please contact your BCBSKS professional relations representative should you have questions or require additional information.

RESOURCES

1. ACA Chiropractic Coding Solutions Manual 2000
2. Coulehan and Block, *The Medical Interview*, 4th Edition, F.A. Davis Company 1997.
3. National Chiropractic Mutual Insurance Company, *List of Some Simple Rules Regarding Responsible Record Keeping*.
4. Medicare documentation standards (<http://www.cms.hhs.gov>)
5. NCQA (national Committee for Quality Assurance) Guidelines.
6. American Chiropractic Association (<http://www.acatoday.org>)
7. BCBSKS *Ad Hoc Therapies-Documentation of Medical Services, Blue Shield Report*, MAC-01-05, pages 2-3.
8. Your BCBSKS contractual agreement
9. Kansas Statutes Annotated (<http://ksbha.org/statutes.html>) and Kansas Board of Healing Arts regulations (<http://ksbha.org/regs.html>)

PROVIDER DOCUMENTATION REFERENCE LIST
By Service Type

Accident related

- ___ Initial evaluation/consultation (with accident description)
 - ___ Test results, including x-rays when obtained
 - ___ Written plan of care
 - ___ Patient's name on each page of record
 - ___ Progress note & therapy note for DOS on claim
 - ___ Record legible
 - ___ Record signed
-

Multiple Modality/Therapy services

- ___ Is **each** service performed documented (where was it done, why was it done, what exercise was done, for how long)
 - ___ Initial evaluation/consultation
 - ___ Applicable test results, including x-rays when obtained
 - ___ Written plan of care
 - ___ Patient's name on each page of record
 - ___ Progress note & therapy note for DOS on claim
 - ___ Record Legible
 - ___ Record signed
-

CMT

- ___ Is **each** spinal segment and/or extremity manipulated documented (segments identified, extremity identified, why was it done)
- ___ Initial evaluation/consultation
- ___ Applicable test results, including x-rays when obtained
- ___ Patient's name on each page of record
- ___ Progress note & therapy note for DOS on claim
- ___ Written plan of care
- ___ Record legible
- ___ Record signed

Tiered Reimbursement

- See Policy Memo No. 1, Section XXIV. Tiered Reimbursement and Provider Number Requirements.

[Policy Memo No. 1](#)

- Tiered reimbursement for chiropractors is defined in the 2012 Competitive Allowance Program (CAP) letter dated July, 2011. Chiropractors are subject to 85 percent of the BCBSKS MAP.

Ineligible Providers

- The following providers are not considered eligible providers as defined in the local BCBSKS member contracts, or for the Federal Employee Program (FEP). Their services cannot be billed incident to an eligible provider if they provide services.

Athletic trainers, massage therapists, exercise physiologists, occupational therapy aides, physical therapy aides and chiropractic assistants.

- Services performed by these specialties are considered patient responsibility and should not be billed to BCBSKS.

Multiple Units of Physical Medicine Modalities and Procedures on Same Date of Service

BCBSKS has guidelines that require we review certain services when the units performed on a given date of service exceed the unit limitation placed on the particular physical medicine modalities and/or procedures, regardless of who performed the service.

These guidelines involve more than 4 physical medicine modalities and/or procedures being billed on one date of service; or the guidelines involve the BCBSKS daily unit limit being exceeded. When multiple providers provide service on the same date of service the limitations are accumulated by procedure code and number of units billed, not by the individual provider, each having a separate limit.

- **Units on Time-Based Physical Medicine Codes**

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers must use a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. Time intervals for 1 through 8 units are as follows:

- 1 unit: > 8 minutes through 22 minutes
- 2 units: > 23 minutes through 37 minutes
- 3 units: > 38 minutes through 52 minutes
- 4 units: > 53 minutes through 67 minutes
- 5 units: > 68 minutes through 82 minutes
- 6 units: > 83 minutes through 97 minutes
- 7 units: > 98 minutes through 112 minutes
- 8 units: > 113 minutes through 127 minutes

At the end of this section there is a chart that outlines the unit limits for selected codes; please refer to that for information of when medical records are required.

Physical Medicine Evaluation, Modalities and Procedures

At the end of this section there is a list of physical medicine evaluation, re-evaluation, modalities and procedures with their related unit limitations and guidelines; please refer to that chart for further information.

- **97010 through 97799**
 - These codes must be billed separately.
 - If you deliver more than one unit of service the number must be recorded in the units field of the CMS 1500 claim form.
 - Medical records supporting medical necessity must accompany the claim (use modifier "22") when:
 - ✓ Two like modalities (i.e., heat) are billed on the same day.
 - ✓ If the unit limit shown on the chart at the end of this section is exceeded.
 - When the same modality is applied to two different locations on the same day, always identify the areas (i.e., right shoulder and left elbow) on claim attachment. Use modifier "22" when submitting any claim attachment.
 - When two modalities are performed by one machine at the same time only one modality may be billed.

Cryotherapy

- This service should be coded as 97010.
- Do not use procedure code 17340, as this is for direct application of chemicals to the skin.

Fluidotherapy

- This service should be coded as 97022.
- Will consider for reimbursement if medically necessary and an integral part of the patient's treatment plan.

Horizontal Therapy

- This service should be coded using 97014.

Hot and Cold Therapies

Certain therapies are considered duplicative services as follows:

- Infrared (97026) and Ultraviolet (97028)
- Microwave (97024) and Infrared (97026)

Ice Massage/Ice Therapy

The use of ice directly on the patient with direct provider attendance. This service is not the same as "cold packs"; which are coded 97010.

- Ice therapy will be denied "content of service" unless it is the only service provided on that date.
- Ice therapy should be coded as 97039 with a description of "ice therapy" in box 19 or the electronic narrative.
- Unit of service is 15 minutes. Indicate units if more than one.
- More than one unit of service on a given date requires medical records.
- Use modifier "22" to indicate attachment to claim.

Magnatherm

- This service should be coded as 97024.
- Magnatherm is considered one unit of service per area.

McConnell Strapping/Taping

- This service should be coded as 97039 with a description of "McConnell strapping" or "McConnell taping" in box 19 or the electronic narrative.
- Includes reimbursement for the tape and the taping procedure.
- A separate charge may be billed for the evaluation or re-evaluation; if performed.

Muscle Testing and Range of Motion Testing

- Performing routine muscle testing and range of motion or muscle testing (i.e., those tests that are an integral part of the assessment performed each visit to determine the patient's status from one visit to the next and to determine the level of care required for the current visit) are considered content of the evaluation or therapy/ies billed that particular day and should not be billed separately.
- Muscle and range of motion testing that are much more in-depth than the routine tests can be coded separately if they meet the criteria outlined in the AMA-CPT book for each test and all criteria is documented in the medical record. Most of the non-routine testing requires an in-depth written report and review with the patient to be considered an independent service.

Nerve Conduction Studies and Related Services

- **Out-of-State Vendors**

It is in violation of your contract with BCBSKS to use the services of an out-of-state vendor to conduct or read nerve conduction studies, diagnostic ultrasound, or any other related service since your contract

indicates you must use the services of a contracting provider when referring services. BCBSKS does not contract with out-of-state vendors for these services.

[Policy Memo No. 1](#)

- **Certification for In-State Providers**

- Reimbursement guidelines are based on the certification of the performing provider.
- For more information see Policy Memo #1.

[Policy Memo No. 1](#)

- **Medical Policy**

To review medical necessity guidelines visit our website and the Medical Policy section.

[Policy Memo No. 1](#)

<h2 style="text-align: center;">Transcutaneous Electrical Nerve Stimulator (TENS) – <u>4</u> Lead</h2>
--

- This service should be coded as E0730.
- *The purchase of E0720 2-Lead is always considered “not medically necessary”. A Policy Memo #1 Limited Patient Waiver must be signed by the patient for the patient to be held financially responsible for the 2-Lead TENS. Use modifier "GA" to indicate waiver on file.*

[Limited Patient Waiver](#)

- *If the patient for this item does not sign a waiver, the contracting provider will be held liable for the charge.*
- Rental of E0730 or E0720 is denied not medically necessary.

- Training the patient to use the equipment is reimbursed in the amount allowed for the equipment. If you have an outside vendor supplying the device, you should look to them for the reimbursement of this service.

Vertebral Axial Decompression Therapy

(i.e., VaxD; IDD; DR 5000; DR 9000; DRX 9000; SpinaSystem; etc.)

- There is a national “S” procedure code assigned to this service. It is as follows:

S9090 Vertebral axial decompression therapy, per session

- All claims for this service must be coded using S9090, with one unit of service per day.
- Based on the lack of scientific evidence (blinded studies, appropriate number participants in studies already conducted, documented long term results) S9090 will be treated as 97012, having the same allowance and unit limitation guidelines.
- This policy will remain in effect until such time that such scientific studies performed within accepted standards are available.
- To ensure correct coding of this service there will be periodic audits performed at random.
- Those claims found to have been coded incorrectly will require appropriate refunds and patients’ credits.

NON-COVERED PROCEDURES

- The following services are non-covered on the majority of policies.
 - Acupuncture
 - Foot Orthotics
 - Vitamins and Nutritional Supplements
- Please verify each specific policy – call the CSC Provider Benefits Only Line (800-432-0272 or 785-291-4183) to determine coverage or the BCBSKS Web site at www.bcbsks.com
- A non-covered service does not need to be submitted to BCBSKS. The patient may be billed direct.
- When covered, you should use the appropriate procedure code from the AMA-CPT codebook.

Acupuncture

- Most policies do not cover this service.
- When covered, you should use the appropriate code from the AMA-CPT code book:
 - 97810
 - 97811 + Add-on code
 - 97813
 - 97814 + Add-on code

Foot Orthotics

- Most policies do not cover this service.
- When covered, you should use the appropriate procedure code from the HCPCS procedure code listing.

Vitamins and Nutritional Supplements

These items are non-covered and should not be billed to BCBSKS. If a patient requires a denial, you may submit vitamins and nutritional supplements with procedure code: A9150 non-prescription drug.

EXPERIMENTAL/INVESTIGATIONAL

- The following procedures are considered experimental/investigational and are a provider write-off unless a Policy Memo #1 Limited Patient Waiver is signed prior to performance of the service.

[Limited Patient Waiver](#)

Use modifier "GA" to demonstrate waiver on file

Anodyne Therapy

- This service should be coded using 97799 with a description of "anodyne therapy" in box 19 or the electronic narrative. It should not be confused with Infrared Therapy that is coded 97026.

Anti-Gravity Lumbar Traction-Reverse (Inversion)

- Use 97139.

Aqua Massage Therapy

- This service should be coded using 97039 with a description of "aqua massage therapy" in box 19 or the electronic narrative. It should not be billed using 97124.

Cold Laser Therapy/Soft Laser Therapy/Low Laser Therapy

- This service should be coded using 97039. It should not be confused with Infrared Therapy that is coded 97026.
- When using an unspecified code (97039) a description of the service must appear in box 19 or a paper claim or in the electronic narrative.

Kinesio Taping

- This service should be coded as 97039 with a description of "Kinesio taping" in box 19 or the electronic narrative.

Posture Pump

- This service should be coded 97139 with a description of "posture pump" in box 19 or the electronic narrative.

Sympathetic Therapy

- This service should be coded using 97799 with a description of "Sympathetic therapy" in box 19 or the electronic narrative.

PLEASE REVIEW THE FOLLOWING GUIDELINES CAREFULLY

Physical Medicine Exams/Modality/Procedure Guidelines

~~More than four (4) modalities or procedures on the same day require medical records~~

Code	Description	Units Allowed Per Day	Special Instructions
97010	HOT OR COLD PACKS Unattended <i>One or more areas is one unit of service</i>	ONE	This code will deny content of service unless it is the only service provided on date of service.
97012	TRACTION (MECHANICAL) Unattended <i>One or more areas is one unit of service</i>	ONE	This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated. Sending in medical records will not change the units reimbursed on this code.
97014	ELECTRICAL STIMULATION , INTERFERENTIAL THERAPY, HORIZONTAL THERAPY Unattended <i>One or more areas is one unit of service</i>	ONE	This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated. Sending in medical records will not change the units reimbursed on this code. Billing of electrodes The electrodes and other supplies used to administer any modality are content of service of the modality. Do not bill them under A4556. That code is for <u>take home supplies</u> dispensed by a home medical equipment supplier.
97016	VASOPNEUMATIC DEVICES Unattended <i>One or more areas is one unit of service</i>	ONE	Covered diagnoses are 457.0, 457.1, and 757.0 only.
97018	PARAFFIN BATH Unattended <i>One or more areas is one unit of service</i>	ONE	This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated. Sending in medical records will not change the units reimbursed on this code.
97022	WHIRLPOOL (FLUIDOTHERAPY) Unattended <i>One or more areas is one unit of service</i>	ONE	By accepted professional definition and by description in the AMA-CPT book the treatment provided by the use of an "aqua massage" unit would be appropriately described as a massage (97124) and not whirlpool. Whirlpool (97022) would not be appropriate as whirlpool is descriptive of a specific apparatus and treatment. If more than one unit of service attach medical records and use a 22 modifier.
97024	DIATHERMY (eg, microwave) Magnatherm Unattended <i>One or more areas is one unit of service</i>	ONE	This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated.
97026	INFRARED Unattended <i>One or more areas is one unit of service</i>	ONE	DO NOT USE this code to bill any of the following: <ul style="list-style-type: none"> • Anodyne Therapy • Cold Laser Therapy • Low Laser Therapy • Soft laser Therapy For information concerning these therapies please refer to information given earlier.

Code	Description	Units Allowed Per Day	Special Instructions
			This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated.
97028	ULTRAVIOLET Unattended <i>One or more areas is one unit of service</i>	ONE	This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated.
97032	ELECTRICAL STIMULATION (MANUAL) Attended One or more areas <i>15 minutes is one unit of service</i>	ONE	This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated. Billing of electrodes The electrodes and other supplies used to administer any modality are content of service of the modality. Do not bill them under A4556. That code is for <u>take home supplies</u> dispensed by a home medical equipment supplier.
97033	IONTOPHORESIS Attended One or more areas <i>15 minutes is one unit of service</i>	TWO	If more than two units (23 through 37 minutes; not areas treated) of service attach medical records. Use modifier 22 when submitting any claim attachment.
97034	CONTRAST BATHS Attended One or more areas <i>15 minutes is one unit of service</i>	ONE	This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated.
97035	ULTRASOUND Attended One or more areas <i>15 minutes is one unit of service</i>	ONE	This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated. ----- Use 97035 for phonophoresis
97036	HUBBARD TANK Attended One or more areas <i>15 minutes is one unit of service</i>	FOUR	If more than four units (61+ minutes; note areas treated) of service attach medical records. Use modifier 22 when submitting any claim attachment.
97039	UNLISTED MODALITY One or more areas <i>15 minutes is one unit of service</i>	TWO	Specify type of modality and time on claim attachment Experimental/Investigational Get Limited Patient Waiver Use "GA" modifier i.e., Aqua Massage, Cold Laser, etc. Attach medical records. Use modifier 22 when submitting any claim attachment.
97110	THERAPEUTIC PROCEDURE Attended One or more areas <i>15 minutes is one unit of service</i>	FOUR	DO NOT USE THIS CODE FOR MASSAGE THERAPY (97124). This code includes: a. General exercise b. Gym equipment c. Open chain bike or treadmill for endurance d. Formulation of or changes to HEP If more than four units (53 through 67 minutes; note areas treated) of service attach medical records. Use modifier 22 when submitting any claim attachment.

Code	Description	Units Allowed Per Day	Special Instructions
97112	NEUROMUSCULAR REEDUCATION Attended One or more areas <i>15 minutes is one unit of service</i>	FOUR	This code includes: a. Closed chain exercise b. BAPS board c. Transitional movement posture training d. Plyometrics e. NDT techniques f. PNF stretches g. Feldenkrais h. Vestibular exercises If more than four units (53 through 67 minutes; note areas treated) of service attach medical records. Use modifier 22 when submitting any claim attachment.
97113	AQUATIC THERAPY Attended One or more areas <i>15 minutes is one unit of service</i>	FOUR	This code includes: a. Back stabilization to increase stabilization with lifting b. Exercise to increase ROM, strength c. Exercise to decrease weight bearing If more than four units (53 through 67 minutes; note areas treated) of service attach medical records. Use modifier 22 when submitting any claim attachment.
97116	GAIT TRAINING Attended <i>15 minutes is one unit of service</i>	TWO	This code includes: a. Gait drills b. Steps c. Crutch training If more than four units (53 through 67 minutes; note areas treated) of service attach medical records. Use modifier 22 when submitting any claim attachment.
97139	UNLISTED THERAPEUTIC PROCEDURE One or more areas <i>15 minutes is one unit of service</i>	ONE	Specify type of therapeutic procedure and time on claim attachment. Attach medical records. Use modifier 22 when submitting any claim attachment. i.e., Anti-Gravity Lumbar Traction-Reverse (Inversion) Posture Pump Use "GA" modifier. Get Limited Patient Waiver.
97140	MANUAL THERAPY TECHNIQUES Attended One or more areas <i>15 minutes is one unit of service</i>	TWO FOUR UNITS WILL BE ALLOWED FOR LYMPHATIC DRAINAGE	<u>MDs, DOs, DCs do not use this code for your manipulations, they must be coded under 98925-98943. 97140 WILL DENY CONTENT TO THE MANIPULATION.</u> DO NOT USE THIS CODE FOR MASSAGE THERAPY (97124). This code includes: a. Lymphatic drainage b. Manual traction c. MFR d. Soft tissue work e. Trigger point therapy f. Joint mobilization If more than two units (23 through 37 minutes; note

Code	Description	Units Allowed Per Day	Special Instructions
			areas treated) of service attach medical records. Use modifier 22 when submitting any claim attachment.
97150	THERAPEUTIC PROCEDURE(S) One or more areas <i>15 minutes is one unit of service</i>		Usually non-covered. Attach medical records. Use modifier 22 when submitting any claim attachment.
97530	THERAPEUTIC ACTIVITIES Attended <i>15 minutes is one unit of service</i>	FOUR	This code includes: a. Body mechanics with functional activities b. Sport related drills c. Dynamic stabilization exercises d. Simulated activities e. Transfers This code should be used for kinetic activity procedure(s). If more than four units (53 through 67 minutes; note areas treated) of service attach medical records. Use modifier 22 when submitting any claim attachment.
97760	ORTHOTICS MANAGEMENT AND TRAINING <i>15 minutes is one unit of service</i>	N/A	Content of original dispensing of orthotic/prosthetic.
97762	CHECKOUT FOR ORTHOTIC/PROSTHETIC USE Established patients <i>15 minutes is one unit of service</i>	N/A	Content of original dispensing of orthotic.
97799	UNLISTED PHYSICAL MEDICINE/REHABILITATION SERVICE OR PROCEDURE		Specify type of service or procedure and time. Attach medical records. Use modifier 22 when submitting any claim attachment. i.e., Anodyne Therapy Use "GA" modifier Specify in Box 19 Get Limited Patient Waiver
97810	ACUPUNCTURE <i>One or more needles; without electrical stimulation</i> <i>INITIAL 15 minutes of personal one-on-one contact with the patient</i>		Usually non-covered. Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).
97811 Add-on code	ACUPUNCTURE <i>One or more needles; without electrical stimulation</i> <i>EACH ADDITIONAL 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)</i>		Usually non-covered. Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).
97813	ACUPUNCTURE <i>One or more needles; with electrical stimulation</i> <i>INITIAL 15 minutes of personal one-on-one contact with the patient</i>		Usually non-covered. Questions about whether a BCBSKS member has this coverage may be directed to: 1-800-432-0272 (Topeka 291-4183).

Code	Description	Units Allowed Per Day	Special Instructions
97814 Add-on code	ACUPUNCTURE <i>One or more needles; with electrical stimulation</i> EACH ADDITIONAL 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)		Usually non-covered. Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).
A9270	NON-COVERED ITEM OR SERVICE	ONE	Use Modifier "22" and attach records. If non-covered, it should not be billed to BCBSKS.
S8948	APPLICATION OF A MODALITY TO ONE OR MORE AREAS Requires constant provider attendance Low level laser Each 15 minutes	ONE	No MAP set, by report
S8950 National S Code	COMPLEX LYMPHEDEMA THERAPY (CLT) Each 15 minutes	FOUR	Attach medical records if providing more than 4 units (53 through 67 minutes; note areas treated). Use modifier 22 when submitting any claim attachment.
S9090 National S Code	VERTEBRAL AXIAL DECOMPRESSION THERAPY Per session This service is provided on mechanical traction machines, with provider intervention as appropriate. Some of the brand names for these machines are: VaxD; IDD; DR 5000; DR 9000; DRX 9000; SpinaSystem	ONE	This code is per session, regardless of time spent or areas treated. Submitting medical records will not change the unit limit for this code.

REVISIONS

01/01/2011	Changed revision date to "January 2011" from "August 3, 2010."
	Updated all references to the copyright date of <i>Current Procedural Terminology</i> . Changed from "© 2009" to "© 2010."
	Page B-12 Added a first bullet under "Ice Massage/Ice Therapy:" <ul style="list-style-type: none"> • Ice therapy will be denied "content of service" unless it is the only service provided on that date."
	Page B-20 Changed BOEING provider from Washington State Health Insurance to BCBS of Illinois.
	Page B-22 Removed the first bulleted item under "Medical records . . ." <ul style="list-style-type: none"> ✓ More than 4 modalities/procedures are billed on the same day.
05/10/2011	Page B-20 Added a link to <i>Blue Shield Report S-7-10</i> dated December 6, 2010, which provides complete contact information for the Boeing Company.
	Page B-23 Under 90901 <ul style="list-style-type: none"> • In "Units Allowed Per Day" column, removed "ONE."
	Page B-23 Under 90911 <ul style="list-style-type: none"> • In "Units Allowed Per Day" column, removed "ONE."
	Page B-23 Under 95992 <ul style="list-style-type: none"> • Removed "Per visit one" from "Description" column • In "Description" column, added "PROCEDURE(S)" • In "Description" column, added "(e.g., Epley maneuver, Semont maneuver), per day" • In "Units Allowed Per Day" column, changed "TWO" to "ONE."
	Page B-27 Under 97032 – Replaced language in "Special Instructions" column. Language did read: <p style="margin-left: 40px;">If more than one unit (16+ minutes; note areas treated) of service; attach medical records.</p> <p style="margin-left: 40px;">Use modifier 22 when submitting any claim attachment.</p> <p>Billing of electrodes The electrodes and other supplies used to administer any modality are content of service of the modality.</p> <p style="margin-left: 40px;">Do not bill them under A4556.</p> <p style="margin-left: 40px;">That code is for <u>take home supplies</u> dispensed by a home medical equipment supplier.</p>
	Page B-27 Under 97033 – Under "Special Instructions" column, changed "31+" to "23 through 37."
	Page B-27 Under 97034 – Replaced language in "Special Instructions" column. Language did read: <p style="margin-left: 40px;">If more than one unit (16+ minutes; not areas treated) of service attach medical records.</p> <p style="margin-left: 40px;">Use modifier 22 when submitting any claim attachment.</p>

REVISIONS

5/10/2011, continued	Page B-27 Under 97035 – Under “Special Instructions” column, replaced language above wavy lines. Language did read:
	If more than one unit (16+ minutes; note areas treated) of service attach medical records.
	Use modifier 22 when submitting any claim attachment.
	Page B-28 Under 97110 – Under “Special Instructions” column, changed number of minutes from “61+” to “53 through 67.”
	Page B-28 Under 97112 – Under “Special Instructions” column, changed number of minutes from “61+” to “53 through 67.”
	Page B-29 Under 97113 – Under “Special Instructions” column, changed number of minutes from “61+” to “53 through 67.”
	Page B-29 Under 97116 – Under “Special Instructions” column, changed number of minutes from “61+” to “53 through 67.”
	Page B-29 Under 97139 –Under “Special Instructions” column, changed “GET” to “Get” on last line.
	Page B-30 Under 97140 – Under “Special Instructions” column, changed number of minutes from “31+” to “23 through 37.”
	Page B-30 Under 97530 – Under “Special Instructions” column, changed number of minutes from “61+” to “53 through 67.”
	Page B-30 Under 97532 – Under “Units Allowed Per Day” column, deleted “FOUR.”
	Page B-31 Under 97750 – Under “Special Instructions” column, changed number of minutes from “61+” to “53 through 67.”
	Page B-32 Under 97799 –Under “Special Instructions” column, changed “GET” to “Get” on last line.
	Page B-32 Under 97810 – Under “Units Allowed Per Day” column, deleted “ONE.”
	Page B-32 Under 97813 – Under “Units Allowed Per Day” column, deleted “ONE.”
	Page B-33 Under S8950 – Under “Special Instructions” column, changed number of minutes from “61+” to “53 through 67.”
	Page B-33 Under S9090 – Under “Units Allowed Per Day” column, added “ONE.”
6/17/2011	Changed revision date in the footer to “June, 2011” from “May, 2011.”
	Page B-30 Under 97150 – Under “Special Instructions” column, deleted “Specify type and time on claim attachment.”
	Page B-30 Under 97533 – Under “Special Instructions” column, deleted “Specify time,” and deleted the words “containing pertinent information for review” from the sentence beginning “Attach medical records.”
	Page B-30 Under 97535 – Under “Special Instructions” column, deleted “Denied Content of Service,” and added the current verbiage.

REVISIONS

7/15/2011	<p>Changed revision date in the footer to “July, 2011” from “June, 2011.”</p> <p>Page B-15 Added section on “McConnell Strapping/Taping.”</p>
1/01/2012	<p>Changed revision date in the footer to “January, 2012” from “July, 2011.”</p> <p>Replaced all references to “E and M” with “E&M” throughout the appendix.</p> <p>Page B-1 Copyright date in Acknowledgement section changed to 2011 for <i>Current Procedural Terminology</i>. The date was also changed to 2011 in the footer on each page.</p> <p>Page B-1 Added manipulation bullet, NOTE, explanation paragraph and “Please note:” paragraph.</p> <p>Page B-1 Deleted the following verbiage from B-1 – B-4 under Chiropractic Manipulative Treatment (CMT)</p> <ul style="list-style-type: none"> ● Pre and Post Service Included in CMT Procedure Codes (98940 through 98943) <p>The following services are included in the CMT procedure codes and should not be billed as E&M services:</p> <ul style="list-style-type: none"> ▪ CMT Pre-Service (Before Face-To-Face) <ul style="list-style-type: none"> ✓ Review of previously gathered clinical data: <ul style="list-style-type: none"> ➤ Initial or interim history ➤ Objective findings ➤ Response to prior care ➤ Problem list ➤ Pertinent correspondence or reports ✓ Review of imaging and other test results ✓ Test interpretation ✓ Care planning ▪ CMT Intra-Service (Face-To-Face) <ul style="list-style-type: none"> ✓ Interactive patient reassessment: <ul style="list-style-type: none"> ➤ Determine current status ➤ Determine indicators/contraindications ➤ Assess change in condition since last encounter ➤ Evaluate any newly developing complaints ➤ Mechanical assessment ➤ Correlate physical findings <ul style="list-style-type: none"> ◆ With subjective status ◆ Original diagnosis ◆ Diagnosis at previous encounter ◆ Appropriate revision of current diagnosis ✓ Coordinate & modify current treatment plan ✓ Patient preparation <ul style="list-style-type: none"> ➤ Assure that the patient understands the nature of the procedure selected and implies consent of application ➤ Determine appropriateness of patient for pre-selected equipment ➤ Prepare or adjust equipment settings for specific patient characteristics

REVISIONS

1/01/2012,
continued

- Determine the need for any pre-adjustment treatment
- Assure patient is properly prepared
- Position patient appropriately on equipment to ensure optimal mechanical advantage, comfort, etc.

- ✓ **Manipulation**
 - Instruct/assist patient in positioning for procedure
 - Identify (and mark if appropriate) precise patient contact points for application of adjustment
 - Identify physician's position and precise contact
 - Determine mechanical considerations for thrust
 - ◆ Directional vector, leverage points; stabilization points; and, velocity considerations
 - Instruct patient in anticipated adjustment behaviors
 - ◆ Appropriate relaxations, sensations, etc.
 - ◆ Apply adjustment procedure
 - ◆ Assist return to post-adjustment position

- ✓ **Post-adjustment assessment**
 - Assess immediate patient response to treatment
 - Assess clinical effect of procedure
 - ◆ Function; symptomatic state
 - Assess need for re-application of procedure
 - Assess need for appropriateness of adjustment to other body region
 - Instruct patient for repositioning for next procedure, as appropriate
 - Take appropriate measures in the case of a reaction to a procedure
 - Post-adjustment instruction to patient
 - ◆ Instruct on likely post-adjustment effects
 - ◆ Instruct on appropriate interim activities and exercise
 - ◆ Instruct on home self-care techniques
 - ◆ Prescribe any follow-up evaluation or care, as appropriate

- **CMT post-service (After Face-To-Face)**
 - ✓ **Chart entry and documentation**
 - Documentation of subjective and objective assessments
 - Procedural components of the patient visit

 - ✓ **Communication and coordination**
 - Referral to other health care providers
 - Referral to imaging center/testing
 - Communication
 - ◆ Family; health care provider; employers/case managers
 - Care planning
 - ◆ Updating diagnosis impressions
 - ◆ Modification of the treatment plan
 - Review appropriate literature (when necessary)

Page B-2 Added verbiage "Per CPT, Pre and Post Services are included in CMT Procedure Codes 98940 through 98943" as the first two lines on the page.

Page B-2 Added "Per CPT," to the beginning verbiage of the first bullet.

Page B-2 Added bullet about E&M's under "CMT Regions and Procedure Codes" bullet.

REVISIONS

1/01/2012,
continued

Page B-2 Changed section title to “Evaluation and Management (E&M) Codes”. Deleted title:

E&M with Chiropractic Manipulative Therapy (CMT) Code Selection and Use Guidelines

Page B-5 Deleted Established Patient and CMT bullets, as well as How to Bill for E&M And CMT on the Same Day bullet with related New Patient sub-bullet.

1. You may bill an E&M procedure code for established patient when there is a separate and identifiable service performed. The E&M should have a modifier "25" immediately following it (i.e., 9921325).
2. The time involved in the office visit is rarely used as a factor in the decision of which level of code to use.

- **CMT**
All manipulations must be coded separately.

Please note: BCBSKS conducts post payment audits on E&M visits billed in addition to the CMT procedure codes.

- **How to Bill for E & M And CMT on the Same Day**

- **New Patient**
 - ✓ BCBSKS will consider for reimbursement both services when medically necessary.
 - ✓ You should bill each service with a modifier "25" on the E & M code.

Page B-5 The bullets under the Established Patient sub-bullet are now the numbered bullets under the higher-level bullet, Established Patient. Also, a fourth bullet was added to clarify modifier 25 reimbursement.

Page B-5 Inserted Radiology section.

Page B-5 Inserted Pathology (Labs) section.

Page B-6 Inserted Chiropractic Guidelines.

Page B-14 Deleted second bullet under Acupuncture. Moved section to page B-21 under “Non-Covered Procedures”.

Deleted verbiage includes:

- Please call the CSC Provider Benefits Only Line (800-432-0272 or 785-291-4183) to determine coverage by a specific patient's contract.

Page B-14 Combined all Experimental/Investigational codes (Anodyne Therapy, Anti-Gravity Lumbar Traction-Reverse (Inversion), Aqua Massage Therapy, Cold Laser Therapy/Soft Laser Therapy/Low Laser Therapy, Kinesio Taping, Posture Pump, and Sympathetic Therapy), now appearing beginning on page B-22. See notes under page B-17 through B-20 for deleted verbiage under each section.

Page B-14 Moved the following sections to the beginning of the topical sections: Tiered Reimbursement, Ineligible Providers, Multiple Units of Physical Medicine Modalities and Procedures on Same Date of Service, and Physical Medicine Evaluation, Modalities and Procedures.

REVISIONS

1/01/2012,
continued

Page B-14 Deleted provider types other than chiropractor from second bullet under Tiered Reimbursement. Changed date from 2011 CAP letter dated July, 2010 to 2012 CAP letter dated July, 2011.

Deleted verbiage is as follows:

“, physical therapists, occupational therapists, CPTAs, and COTAs”

Page B-15 Last paragraph before “Physical Medicine Evaluation, Modalities and Procedures” section, changed “each code” to “selected codes.”

Page B-15 Deleted the word “complete” from the first line of the first paragraph under “Physical Medicine Evaluation, Modalities and Procedures.”

As the first line did appear:

At the end of this section there is a complete list of physical medicine . . .

Page B-16 Moved the “Anodyne Therapy” section under the “Experimental/Investigational” section beginning on B-22. The second and third bullets are now combined under the main “Experimental/Investigational” header.

As the section did appear:

Anodyne Therapy

- This service should be coded using 97799 with a description of "anodyne therapy" in box 19 or the electronic narrative. It should not be confused with Infrared Therapy that is coded 97026.
- It is considered experimental/investigational and is provider write-off unless a Policy Memo #1 Limited Patient Waiver is signed prior to performance of the service.

[Limited Patient Waiver](#)
- Use modifier "GA" to demonstrate waiver on file.

Page B-16 Moved the “Anti-Gravity Lumbar Traction-Reverse (Inversion)” section under the “Experimental/Investigational” section beginning on B-22. The second and third bullets are now combined under the main “Experimental/Investigational” header.

As the section did appear:

Anti-Gravity Lumbar Traction-Reverse (Inversion)

- Use 97139.
- It is considered experimental/investigational and is provider write-off unless a Policy Memo #1 Limited Patient Waiver is signed prior to performance of the service.

REVISIONS

1/01/2012,
continued

Limited Patient Waiver

- Use modifier "GA" to demonstrate waiver on file.

Page B-16 Moved the "Aqua Massage Therapy" section under the "Experimental/Investigational" section beginning on B-22. The second and third bullets are now combined under the main "Experimental/Investigational" header.

As the section did appear:

Aqua Massage Therapy

- This service should be coded using 97039 with a description of "aqua massage therapy" in box 19 or the electronic narrative. It should not be billed using 97124.
- It is considered experimental/investigational and is provider write-off unless a Policy Memo #1 Limited Patient Waiver is signed prior to performance of the service.

Limited Patient Waiver

- Use modifier "GA" to demonstrate waiver on file.
site at the time of service.

Page B-16 Moved the "Cold Laser Therapy/Soft Laser Therapy/Low Laser Therapy" section under the "Experimental/Investigational" section beginning on B-22. The second and fourth bullets are now combined under the main "Experimental/Investigational" header.

As the section did appear:

Cold Laser Therapy/Soft Laser Therapy/ Low Laser Therapy

- This service should be coded using 97039. It should not be confused with Infrared Therapy that is coded 97026.
- It is considered experimental/investigational and is provider write-off unless a Policy Memo #1 Limited Patient Waiver is signed prior to performance of the service.

Limited Patient Waiver

- When using an unspecified code (97039) a description of the service must appear in box 19 or a paper claim or in the electronic narrative.
- Use modifier "GA" to demonstrate waiver on file.

Page B-17 Deleted second bullet under Foot Orthotics. Moved section to page B-21 under "Non-Covered Procedures".

Deleted verbiage includes: (However, this information is now included in the second bullet under "Non-Covered Procedures".

- Please call the CSC Provider Benefits Only Line (800-432-0272 or 785-291-4183) to determine coverage for a specific patient.

REVISIONS

1/01/2012,
continued

Page B-17 Moved the “Kinesio Taping” section under the “Experimental/Investigational” section beginning on B-22. The second and third bullets are now combined under the main “Experimental/Investigational” header.

As the section did appear:

Kinesio Taping

- This service should be coded as 97039 with a description of "Kinesio taping" in box 19 or the electronic narrative.
- It is considered experimental/investigational, and is provider write-off unless a Policy Memo No. 1 Limited Patient Waiver is signed prior to performance of the service.

[Limited Patient Waiver](#)
- Use modifier "GA" to demonstrate waiver on file.

Page B-18 Deleted the “Massage” section.

Massage

- This service must be coded as 97124, regardless of delivery.
- This will be denied content of service unless it is the only service provided on date of service.
- **Coverage Criteria**
BCBSKS will consider massage therapy for possible coverage if the following are met.

The massage must be:
 - Medical in nature
 - Medically necessary
 - An integral part of the treatment plan
 - Performed by a MD, DO, DC, PA, ARNP, PT, OT
- **Limitation of Units of Massage Therapy per Date of Service**
 - Massage therapy 97124 is coded by 15-minute increments.
 - ✓ One unit of service per date of service will be considered for coverage without medical records.
 - ✓ If more than one unit of massage is performed on any given date you must attach medical records to support the care.
 - ✓ Claims paying with one unit of service will be subject to audit procedures.
 - ✓ Processing of claims received without this information may be delayed until such information is provided.
 - ✓ Use modifier "22" when submitting any claim attachment.
 - ✓ Refunds will be required if services were performed by someone other than the licensed eligible provider.

REVISIONS

1/01/2012,
continued

Page B-19 Moved the "Posture Pump" section under the "Experimental/Investigational" section beginning on B-22. The second and third bullets are now combined under the main "Experimental/Investigational" header.

As the section did appear:

Posture Pump

- This service should be coded 97139 with a description of "posture pump" in box 19 or the electronic narrative.
- This service is considered not medically necessary and is a provider write-off unless the Policy Memo No. 1 Limited Patient Waiver is signed prior to performance of the service.
[Limited Patient Waiver](#)
- Use modifier "GA" to demonstrate waiver on file.

Page B-19 Moved the "Sympathetic Therapy" section under the "Experimental/Investigational" section beginning on B-22. The second and third bullets are now combined under the main "Experimental/Investigational" header.

As the section did appear:

Sympathetic Therapy

- This service should be coded using 97799 with a description of "Sympathetic therapy" in box 19 or the electronic narrative.
- This service is considered experimental/investigational and is provider write-off unless a Policy Memo #1 Limited Patient Waiver is signed prior to performance of the service.
[Limited Patient Waiver](#)
- Use modifier "GA" to demonstrate waiver on file.

Page B-20 Moved "Vitamins and Nutritional Supplements" to B-21 under "Non-Covered Procedures".

Page B-20 Deleted first bullet under "Vertebral Axial Decompression Therapy."

- This service should be coded using S9090.

Page B-21 Deleted the "Boeing" section.

BOEING

For current information please refer to

[Blue Shield Report S-7-10 dated December 6, 2010](#)

Blue Cross and Blue Shield of Illinois (BCBSIL) is the new benefits administrator for The Boeing Company, previously administered by Regence BlueShield of Washington.

BCBS of Illinois
Benefits Administrator
Eligibility and Benefits
1-800-676-2583

REVISIONS

1/01/2012, continued	Page B-21 Added a new section entitled “Non-Covered Procedures”. Combined common bullet information from the sub-topics.
	Page B-22 Added a new section entitled “Experimental/Investigational”. Combined common bullet information from the sub-topics.
	Page B-24ff Deleted codes A4556, A4557, A9150, 64550, 90901, 90911, 95992, 97001, 97002, 97003, 97004, 97005, 97006, 97124, 97532, 97533, 97535, 97537, 97602, and 97750.
	Deleted codes in table format are shown below separate from this table. (Revision section will resume following the table.)

Deleted Codes

A4556	ELECTRODES , (e.g., apnea monitor), per pair	2 PAIRS PER 30 DAYS	NOTE: Do not bill in-office use of electrodes under this code. Those electrodes are content of the modality being performed. Content of service of rental of equipment Covered if equipment purchased for home use. Submit date purchased and by whom on claim attachment. Use modifier 22 when submitting any claim attachment. Multiple units required in Box 24G if more than one pair 2 pairs = 002 units of service 4 electrodes = 002 units of service
A4557	LEAD WIRES	2 PAIRS EVERY 6 Months	NOTE: Do not bill in-office use of lead wires under this code. Those lead wires are content of the modality being performed. Content of service of rental of equipment Covered if equipment purchased for home use. Submit date purchased and by whom on claim attachment. Use modifier 22 when submitting any claim attachment. 2 pairs = 002 units of service 4 lead wires = 002 units of service
A9150	NON-PRESCRIPTION DRUG		VITAMINS and NUTRITIONAL SUPPLEMENTS These items are non-covered and should not be billed to BCBSKS. If a patient requires a denial you may submit vitamins and nutritional supplements with procedure code A9150.
64550	APPLICATION OF SURFACE (TRANSCUTANEOUS) NEUROSTIMULATOR		Included in the equipment reimbursement. If using an outside vendor you should look to them for reimbursement of this service.
90901	BIOFEEDBACK training by any modality		Usually non-covered. Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).
90911	BIOFEEDBACK training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry by any modality		Usually non-covered. Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).
95992	CANOLITH REPOSITIONING PROCEDURE(S) (e.g., Epley maneuver, Semont maneuver), per day	ONE	If the diagnosis is other than benign paroxysmal positional vertigo submit office records.

			Use modifier 22 when submitting any claim attachment. This code is per session, regardless of time spent or areas treated. Submitting medical records will not change the unit limit for this code.
97001	PHYSICAL THERAPY EVALUATION	ONE	<i>MDs, DOs, DCs please use the appropriate E&M procedure code.</i> To be used only by Licensed Physical Therapists. Initial visit considered for coverage. One initial visit per patient, unless patient has not been seen in office in last three years.
97002	PHYSICAL THERAPY RE-EVALUATION	ONE	<i>MDs, DOs, DCs please use the appropriate E&M procedure code.</i> To be used only by Licensed Physical Therapists. A re-evaluation is allowed once every thirty days. If an additional re-evaluation is submitted within thirty days, medical records must be submitted with the second re-evaluation. Use modifier 22 when submitting any claim attachment.
97003	OCCUPATIONAL THERAPY EVALUATION	ONE	<i>MDs, DOs, DCs please use the appropriate E&M procedure code.</i> To be used only by Licensed Occupational Therapists. Initial visit considered for coverage. One initial visit per patient, unless patient has not been seen in office in last three years.
97004	OCCUPATIONAL THERAPY RE-EVALUATION	ONE	<i>MDs, DOs, DCs please use the appropriate E&M procedure code.</i> To be used only by Licensed Occupational Therapists. A re-evaluation is allowed once every thirty days. If an additional re-evaluation is submitted within thirty days, medical records must be submitted with the second re-evaluation. Use modifier 22 when submitting any claim attachment.
97005	ATHLETIC TRAINING EVALUATION		NON-COVERED
97006	ATHLETIC TRAINING RE-EVALUATION		NON-COVERED
97124	MASSAGE Attended One or more areas 15 minutes is one unit of service The clinician uses massage to provide muscle relaxation, increase localized circulation, soften scar tissue or mobilize mucous secretions in the lung via tapotement and/or percussion. This service requires direct contact of the clinician.	ONE	General Guidelines: This code will deny content of service unless it is the only service provided on date of service. This code includes: a. Stroking b. Compression for pain relief or muscle spasm c. Percussion for pain relief or muscle spasm See previously in this manual a section on massage and the guidelines that are applied.

			Use modifier 22 when submitting any claim attachment.
97532	DEVELOPMENT OF COGNITIVE SKILLS Attended 15 minutes is one unit of service The clinician uses procedures to improve attention, memory, problem solving, (includes compensatory training). This service requires direct (one on one) patient contact by the clinician.		Usually non-covered. Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).
97533	SENSORY INTEGRATIVE TECHNIQUES 15 minutes is one unit of service The clinician uses procedures to enhance sensory processing and promote adaptive responses to environmental demands. This service requires direct (one on one) patient contact by the clinician.	FOUR	By Report. Attach medical records. Use modifier 22 when submitting any claim attachment.
97535	SELF CARE/HOME MANAGEMENT TRAINING 15 minutes is one unit of service The clinician instructs and trains the patients in self-care and home management activities (e.g., <i>activities of daily living</i> and use of adaptive equipment in the kitchen, bath and/or car). This service requires direct contact of the clinician.		By Report. May be denied Content of Service. Attach medical records. Use modifier 22 when submitting any claim attachment.
97537	COMMUNITY/WORK REINTEGRATION TRAINING 15 minutes is one unit of service The clinician instructs and trains the patient in community re-integration activities (e.g., work task analysis and modification, safe accessing of transportation, money management, vocation activities). This service requires direct supervision by the clinician.		Usually non-covered. Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183). <u>MDs, DOs, DCs do not use this code unless you are truly performing the services listed.</u> This code includes: a. Shopping b. Transportation c. Money management d. A vocational activity or work environment/modification analysis e. Work task analysis If more than one unit (16+ minutes; note areas treated) of service attach medical records. Use modifier 22 when submitting any claim attachment.
97602	REMOVAL OF DEVITALIZED TISSUE NON-SELECTIVE Per session The clinician performs non-selective debridement, without anesthesia, (e.g., wet to moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for on going care.	ONE	This code is per session, regardless of time spent or areas treated. Submitting medical records will not change the unit limit for this code.
97750	PHYSICAL PERFORMANCE TEST OR MEASUREMENT WITH WRITTEN REPORT 15 minutes is one unit of service The clinician performs a test of physical performance evaluating function of one or more body areas and evaluates musculoskeletal functional capacity. A written report must be included in this service.	FOUR	This code includes: a. Biodex b. KT1000 tests If more than four units (53 through 67 minutes; note areas tested) of service attach medical records. Use modifier 22 when submitting any claim attachment.

REVISIONS

1/01/2012, continued	<p>Page B-24 In the “Description” column of the table, deleted the explanation for each of the following codes: (The code appears below with the deleted verbiage.)</p> <p>97010 - The clinician applies heat (dry or moist) or cold to one or more body parts with appropriate padding to prevent skin irritation. The patient is given necessary safety instructions. The treatment requires supervision only.</p> <p>97012 - The clinician applies sustained or intermittent mechanical traction to the cervical and/or lumbar spine. The mechanical force produces distraction between the vertebrae thereby relieving pain and increasing tissue flexibility. Once applied, the treatment requires supervision.</p> <p>97014 - The clinician applies electrical stimulation to one or more areas in order to stimulate muscle function, enhance healing, and alleviate pain and/or edema. The clinician chooses which type of electrical stimulation is appropriate. The treatment is supervised after the electrodes are applied.</p> <p>97016 - The clinician applies a vasopneumatic device to treat extremity edema (usually lymphedema.) A pressurized sleeve is applied. Girth measurements are taken pre and post treatment. Supervision is required.</p> <p>97018 -The clinician uses a paraffin bath to apply superficial heat to a hand or foot. The part is repeatedly dipped into the paraffin forming a "glove." Use of paraffin facilitates treatment of arthritis and other conditions that cause limitations in joint flexibility. Once the paraffin is applied and the patient instructions provided, the procedure requires supervision</p> <p>97022 - The clinician uses a whirlpool to provide superficial heat in an environment that facilitates tissue debridement, wound cleaning and/or exercise. The clinician decides the appropriate water temperature, provides safety instruction and supervises the treatment.</p> <p>97024 - The clinician uses diathermy as a form of superficial heat for one or more body areas. After application and safety instructions have been provided, the clinician supervises the treatment.</p> <p>97026 - The clinician uses infrared light as a form of superficial heat that will increase circulation to one or more localized areas. Once applied and safety instructions have been provided, the treatment is supervised.</p> <p>Page B-24 Verbiage has been revised for 97022. Previous version appears beginning on B-43.</p> <p>Page B-24 – Under “Special Instructions” column, the following verbiage has been deleted for codes 97024 and 97026.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p> <p>Page B-25 In the “Description” column of the table, deleted the explanation for each of the following codes: (The code appears below with the deleted verbiage.)</p> <p>97028 - The clinician applies ultra light to treat dermatological problems. Once applied and safety instructions have been provided, the treatment is supervised.</p> <p>97032 - The clinician applies electrical stimulation to one or more areas to promote muscle function, wound healing edema and/or pain control. This treatment requires direct contact by the provider</p> <p>97033 - The clinician uses electrical current to administer medication to one or more areas. Iontophoresis is usually prescribed for soft tissue inflammatory conditions and pain control. This service requires constant attendance by the clinician.</p> <p>97034 - The clinician uses hot and cold baths in a repeated alternating fashion to stimulate the vasomotor response of a localized body part. This service requires constant attendance of the clinician.</p> <p>97035 - The clinician applies ultrasound to increase circulation to one or more areas. A water bath or some form of ultrasound lotion must be used as coupling agent to facilitate the procedure. The delivery of</p>
-------------------------	---

REVISIONS

1/01/2012,
continued

corticosteroid medication via ultrasound is called phonophoresis. This service requires constant attendance of the clinician.

97036 - The Hubbard tank is used when it is necessary to immerse the full body into water. Care of wounds and burns may require use of the Hubbard tank to facilitate tissue cleansing and debridement. This service requires constant attendance of the clinician.

97039 - This code is used if the clinician performs a modality to one or more areas that is not listed under the current codes.

97110 - The clinician and/or the patient perform(s) therapeutic exercises to one or more body areas to develop strength, endurance, and flexibility. This service requires direct contact of the clinician.

Page B-25 Deleted the following verbiage under "Special Instructions" column for the following codes:

97028 and 97032 - Sending in medical records will not change the units reimbursed on this code.

97033 - Medication may be billed separately, give NDC number, dosage and use the appropriate J procedure code, if within your licensure to dispense prescription drugs.

If it is not within your scope of licensure to dispense prescription drugs the patient must obtain the drug from their physician or pharmacy and provide it for use with this procedure.

DO NOT use supply code(s) for the medication.

97034 - Sending in medical records will not change the units reimbursed on this code.

97035 - Sending in medical records will not change the units reimbursed on this code.

Medication may be billed separately, give NDC number, dosage and use the appropriate J procedure code, if within your licensure to dispense prescription drugs.

If it is not within your scope of licensure to dispense prescription drugs the patient must obtain the drug from their physician or pharmacy and provide it for use with this procedure.

Page B-26 In the "Description" column of the table, deleted the explanation for each of the following codes: (The code appears below with the deleted verbiage.)

97112 - The clinician and/or the patient perform(s) activities to one or more body areas that facilitate reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception. This service requires direct contact of the clinician.

97113 - The clinician directs and/or performs therapeutic exercises with the patient in the aquatic environment. This code requires skilled intervention by the clinician and documentation must support medical necessity of the aquatic environment.

97116 - The clinician instructs the patient in specific activities that will facilitate ambulation and stair climbing with or without an assistive device. Proper sequencing and safety instructions are included when appropriate. This service requires direct contact of the clinician.

97139 - This code is used if the clinician performs a therapeutic procedure to one or more areas that is not listed under the current codes.

Page B-26 Verbiage has been revised for 97140. Previous version appears on B-44.

Page B-27 In the "Description" column of the table, deleted the explanation for each of the following codes: (The code appears below with the deleted verbiage.)

REVISIONS

1/01/2012, continued	<p>97150 - The clinician supervises the GROUP activities (two or more patients) of therapeutic procedures on land or the aquatic environment. The patients do not have to be performing the same activity simultaneously; however, the need for skilled intervention must be documented.</p> <p>97530 - The clinician uses dynamic therapeutic activities designed to achieve improved functional performance (e.g., lifting, pulling, bending). This service requires direct contact of the clinician.</p> <p>97760 - The clinician fits and/or trains the patient in use of an orthotic device for one or more body parts. This does not include fabrication time, if appropriate, or cost of the materials.</p> <p>97762 - The clinician evaluates the effectiveness of an existing orthotic or prosthetic device & makes necessary recommendations for changes, as appropriate.</p> <p>97799 - This code is used if the clinician performs a physical medicine/rehabilitation service or procedure to one or more areas that is not listed under the current codes.</p> <p>97810 - The physician applies acupuncture using one or more needles. The physician inserts a fine needle as dictated by acupuncture meridians to relieve pain. More than one needle may be used as needed. The needles may be twirled or manipulated.</p> <p>97811 - The physician applies acupuncture using one or more needles. The physician inserts a fine needle as dictated by acupuncture meridians to relieve pain. More than one needle may be used as needed.</p> <p>97813 - The physician applies acupuncture using one or more needles. The physician inserts a fine needle as dictated by acupuncture meridians to relieve pain. More than one needle may be used as needed. Electrical stimulation is employed by energizing the needles with micro-current.</p> <p>Page B-28 In the "Description" column of the table, deleted the explanation for each of the following codes: (The code appears below with the deleted verbiage.)</p> <p>97814 - The physician applies acupuncture using one or more needles. The physician inserts a fine needle as dictated by acupuncture meridians to relieve pain. More than one needle may be used as needed. Electrical stimulation is employed by energizing the needles with micro-current.</p> <p>S8950 - CLT consists of lymphatic drainage, compression bandaging, skin care, and patient specific physical therapy exercises. The basic concept of CLT is to maximize central lymphatic drainage. This is accomplished by opening collateral vessels to channel peripheral lymph into normally functioning lymphotomes. The correct application of this technique requires extensive training.</p>
	NOTE: Revision section will resume following the table.

Previous verbiage for 97022 and 97140

97022	<p>WHIRLPOOL (FLUIDOTHERAPY) Unattended <i>One or more areas is one unit of service</i> The clinician uses a whirlpool to provide superficial heat in an environment that facilitates tissue debridement, wound cleaning and/or exercise. The clinician decides the appropriate water temperature, provides safety instruction and supervises the treatment.</p>	ONE	<p>By accepted professional definition and by description in the AMA-CPT book the treatment provided by the use of an "aqua massage" unit would be appropriately described as a massage (97124) and not whirlpool.</p> <p>Whirlpool (97022) would not be appropriate as whirlpool is descriptive of a specific apparatus and treatment.</p> <p><u><i>A key component of whirlpool is immersion of the body part in the water.</i></u></p> <p>By the following descriptions, whirlpools would not correctly describe the use of an aqua massage table.</p> <p>1. The clinician utilizes whirlpool to provide</p>
--------------	---	-----	---

			<p>superficial heat in an environment that facilitates tissue debridement, would cleaning, and/or exercise.</p> <p>Warm whirlpool <i>Equipment needed:</i></p> <ol style="list-style-type: none"> Towels- these are to be used for padding and drying off. Chair- Padding-this is to be placed on the side of the whirlpool. <p><i>Treatment:</i></p> <ol style="list-style-type: none"> The patient should be positioned comfortable, allowing the injured part to be immersed in the whirlpool. Direct flow should be 6 to 8 inches from the body segment. Temperature should be 98 to 110 degrees F (37 to 45 degrees C) for treatment of the arm and hand. For treatment of the leg, the temperature should be 98 to 104 degrees F (37 to 40 degrees C), and for full body treatment, the temperature should be 98 to 102 degrees F (37 to 39 degrees C). Time of application should be 15 to 20 minutes. <p><i>Considerations:</i></p> <ol style="list-style-type: none"> Patient positioning should allow for exercise of the injured part. The size of the body segment to be treated will determine whether an upper extremity, lower extremity, or full body whirlpool should be used. Frequency. <p>The above is from "Therapeutic Modalities in Sports Medicine, Third Edition, Mosby-Year Book Inc., 1994.</p> <p>If more than one unit of service attach medical records.</p> <p>Use modifier 22 when submitting any claim attachment.</p>
<p>97140</p>	<p>MANUAL THERAPY TECHNIQUES Attended One or more areas 15 minutes is one unit of service The clinician performs manual therapy techniques including soft tissue and joint mobilization, manual traction and/or manual lymphatic drainage to one or more areas. This service requires direct contact of the clinician.</p>	<p>TWO</p> <p>FOUR UNITS WILL BE ALLOWED FOR LYMPHATIC DRAINAGE</p>	<p><u>MDs, DOs, DCs do not use this code for your manipulations, they must be coded under 98925-98943. 97140 WILL DENY CONTENT TO THE MANIPULATION.</u></p> <p>DO NOT USE THIS CODE FOR MASSAGE THERAPY (97124). This code includes:</p> <ol style="list-style-type: none"> Lymphatic drainage Manual traction MFR Soft tissue work Trigger point therapy Joint mobilization <p>If more than two units (23 through 37 minutes; note areas treated) of service attach medical records.</p> <p>Use modifier 22 when submitting any claim attachment.</p>

REVISIONS

1/01/2012, continued	Page B-30 Added two codes near the end of the table: A9270 and S8948.