

## APPENDIX B

# CHIROPRACTIC GUIDELINES

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**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.

- **Pre and Post Service Included in CMT Procedure Codes (98940 through 98943)**

The following services are included in the CMT procedure codes and should not be billed as E and M services:

- ***CMT Pre-Service (Before Face-To-Face)***
  - ✓ **Review of previously gathered clinical data:**
    - 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)***
  - ✓ **Interactive patient reassessment:**
    - Determine current status
    - Determine indicators/contraindications
    - Assess change in condition since last encounter
    - Evaluate any newly developing complaints
    - Mechanical assessment
    - Correlate physical findings
      - ◆ With subjective status
      - ◆ Original diagnosis
      - ◆ Diagnosis at previous encounter
      - ◆ Appropriate revision of current diagnosis
  
  - ✓ **Coordinate and modify current treatment plan**
  
  - ✓ **Patient preparation**
    - 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
    - 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**
  - Access immediate patient response to treatment
  - Access 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)

- **CMT Regions and Procedure Codes**
  - **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

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

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

BCBSKS uses AMA-CPT codebook definitions for each level of E and 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 and M code.

The following should be considered when making a decision as to what E and M procedure code is appropriate for a given date of service: The AMA-CPT book indicates the descriptors for the levels of E and M

services recognize *seven* components, *six* of which are used in defining the levels of E and 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 and 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.)

## • **Consultations**

Consultations are services rendered to give advice or an opinion to a requesting physician about a patient's condition and/or management. Medical records must contain documentation of the actual request, the evaluation, and include a copy of the report that is sent to the physician who requested the consultation. Consultations by the same specialty or within the same group are subject to the medical review process. To use the consultation codes, three guidelines apply:

- The request for the consultation must be documented in the patient's medical record.
- The service must be for advice or opinion. While diagnostic work-up or therapy may be ordered and initiated by the consultant, this information must be documented in the record and included in the report to the referring physician.
- A report of the findings and advice must be sent to the referring physician.

When a consultant assumes responsibility for patient care (begins treating the patient, schedules follow-up care, etc.) the additional services are coded as office visits using the appropriate level of Evaluation and Management service for an established patient or the CMT code for the visit.

- **X-ray review for atypical situation**
  - ✓ These services should be coded with the appropriate code from the x-ray section of AMA-CPT.
- **X-ray routine review**
  - ✓ These services are included in the professional component of the x-ray procedure itself.

***Please Note:*** Counseling a patient on an x-ray report or performing routine range of motion or muscle testing, in and of themselves, DO NOT justify the use of a higher level of E and M code.

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 and M procedure code or the CMT/OMT procedure code.

## E and 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**

1. You may bill a new patient E and M procedure code and a CMT procedure code on the same day.
2. The E and M code should have modifier "25" directly following it (i.e., 9920325).
3. New patient visits are those patients that have never been seen before or that have not been seen by someone in the clinic of the same specialty within three years.
4. Other levels of E and M new patient visit codes (99201, 99202, 99203, 99204, 99205) may be used; the medical records must clearly identify each criteria being met for the particular code used.
5. E and M code 99205 would rarely be used.

- **Established Patient**

1. You may bill an E and M procedure code for established patient when there is a separate and identifiable service performed. The E and 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 and 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.
- **Established Patient**
  - ✓ BCBSKS will consider for reimbursement both services when medically necessary and the E & M is a separate and identifiable service.
  - ✓ *Those services that are considered pre and post service of the CMT cannot be billed as an E & M.*
  - ✓ 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".
- **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.

## Acupuncture

- Most policies do not cover this service.
- Please call the CSC Provider Benefits Only Line (800-432-0272 or 785-291-4183) to determine coverage by a specific patient's contract.
- When covered you should use the appropriate procedure code from the AMA-CPT codebook:
  - 97810
  - 97811 + Add-on code
  - 97813
  - 97814 + Add-on code

## 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.

## 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.

### [Limited Patient Waiver](#)

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

## 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.

## **Assistants: Chiropractic Assistants (CA)**

- Services provided by a chiropractic assistant (CA)

BCBSKS will only reimburse the above services if a chiropractor is on site at the time of service.

## **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.

## 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.

## Foot Orthotics

- Most policies do not cover this service.
- Please call the CSC Provider Benefits Only Line (800-432-0272 or 785-291-4183) to determine coverage for a specific patient.
- When covered, you should use the appropriate procedure code from the HCPCS procedure code listing.

## 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 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.

## 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
  - Ordered by a physician or chiropractor
  - Contracting with a massage therapist to perform massage therapy does not constitute employment.
    - ✓ Employment is demonstrated by withholding and paying payroll taxes such as Social Security for the massage therapist.
    - ✓ When services are rendered by a massage therapist, the employing chiropractor must be on site.
    - ✓ Services by an independent massage therapist, even under contract, are non-covered and should not be billed by you or the massage therapist. (Refunds are required on claims' payment when performing person is not a licensed provider or an employee of a licensed provider.)
- **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 and information concerning the performing person. (See below for specific instructions.)
      - ✓ Claims paying with one unit of service will be subject to audit procedures to validate who performed the service and whether the billing provider employed the performing person. (Refunds will be required if services were performed by someone other than the licensed provider or an employee of the licensed provider.)

- Making someone an employee after the fact is not acceptable. Refunds will be required if payment is made for services performed by a non-employee.
- **More than One Unit of Massage on a Date of Service**  
*All claims for more than one unit of massage therapy 97124 must have the following information:*
  - ✓ Medical records to support the medical necessity of the multiple units of massage.
  - ✓ Who performed the service.
  - ✓ Employment if service performed by someone other than the licensed billing provider.
  - ✓ The above information must be submitted on a claim attachment (see form at end of this section)
    - The first form included is a blank form for you to copy for your use.
    - The last two forms are completed examples for your review.
  - ✓ Processing of claims received without this information may be delayed until such information is provided.
  - ✓ Use modifier "22" when submitting any claim attachment.

## **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](#)

## 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.

## Transcutaneous Electrical Nerve Stimulator (TENS) – 4 Lead

- 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.)

- This service should be coded using S9090.
- 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.

## **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.

# BOEING

**For current information please refer to [www.wa.regence.com](http://www.wa.regence.com)**

**[Washington State Health Insurance](#)**

## **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 each code; 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 complete 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:
    - ✓ More than 4 modalities/procedures are billed on the same day.
    - ✓ 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.

**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~~

<b>Code</b>	<b>Description</b>	<b>Units Allowed Per Day</b>	<b>Special Instructions</b>
<b>A4556</b>	ELECTRODES, (e.g., apnea monitor), per pair		<p><b>NOTE: Do not bill in-office use of electrodes under this code. Those electrodes are content of the modality being performed.</b></p> <p>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</p>
<b>A9150</b>	NON-PRESCRIPTION DRUG		<p><b>VITAMINS and NUTRITIONAL SUPPLEMENTS</b> <b>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.</b></p>
<b>64550</b>	APPLICATION OF SURFACE (TRANSCUTANEOUS) NEUROSTIMULATOR		<p>Included in the equipment reimbursement.</p> <p>If using an outside vendor you should look to them for reimbursement of this service.</p>
<b>90901</b>	BIOFEEDBACK training by any modality	ONE	<p>Usually non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).</p>
<b>90911</b>	BIOFEEDBACK training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry by any modality	ONE	<p>Usually non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).</p>
<b>95992</b>	CANOLITH REPOSITIONING Per visit one	TWO	<p>If the diagnosis is other than benign paroxysmal positional vertigo submit office records.</p> <p>Use modifier 22 when submitting any claim attachment.</p> <p>This code is per session, regardless of time spent or areas treated.</p> <p>Submitting medical records will not change the unit limit for this code.</p>
<b>97001</b>	PHYSICAL THERAPY EVALUATION	ONE	<p><b>MDs, DOs, DCs please use the appropriate E and M procedure code.</b></p> <p>To be used only by Licensed Physical Therapists.</p> <p>Initial visit considered for coverage.</p> <p>One initial visit per patient, unless patient has not been seen in office in last three years.</p>

Code	Description	Units Allowed Per Day	Special Instructions
97002	PHYSICAL THERAPY RE-EVALUATION	ONE	<p><b>MDs, DOs, DCs please use the appropriate E and M procedure code.</b></p> <p>To be used only by Licensed Physical Therapists. A re-evaluation is allowed once every thirty days.</p> <p>If an additional re-evaluation is submitted within thirty days, medical records must be submitted with the second re-evaluation.</p> <p>Use modifier 22 when submitting any claim attachment.</p>
97003	OCCUPATIONAL THERAPY EVALUATION	ONE	<p><b>MDs, DOs, DCs please use the appropriate E and M procedure code.</b></p> <p>To be used only by Licensed Occupational Therapists.</p> <p>Initial visit considered for coverage.</p> <p>One initial visit per patient, unless patient has not been seen in office in last three years.</p>
97004	OCCUPATIONAL THERAPY RE-EVALUATION	ONE	<p><b>MDs, DOs, DCs please use the appropriate E and M procedure code.</b></p> <p>To be used only by Licensed Occupational Therapists.</p> <p>A re-evaluation is allowed once every thirty days.</p> <p>If an additional re-evaluation is submitted within thirty days, medical records must be submitted with the second re-evaluation.</p> <p>Use modifier 22 when submitting any claim attachment.</p>
97005	ATHLETIC TRAINING EVALUATION		NON-COVERED
97006	ATHLETIC TRAINING RE-EVALUATION		NON-COVERED
97010	<p><b>HOT OR COLD PACKS</b>  <b>Unattended</b>  <i>One or more areas is one unit of service</i>  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>	ONE	This code will deny content of service unless it is the only service provided on date of service.
97012	<p><b>TRACTION (MECHANICAL)</b>  <b>Unattended</b>  <i>One or more areas is one unit of service</i>  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>	ONE	<p>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.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p>

Code	Description	Units Allowed Per Day	Special Instructions
97014	<p><b>ELECTRICAL STIMULATION , INTERVERENTAL THERAPY, HORIZONTAL THERAPY</b></p> <p><b>Unattended</b>  <i>One or more areas is one unit of service</i>            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>	ONE	<p>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.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p> <p><b>Billing of electrodes</b>            The electrodes and other supplies used to administer any modality are content of service of the modality.</p> <p>Do not bill them under A4556.</p> <p>That code is for <u>take home supplies</u> dispensed by a home medical equipment supplier.</p>
97016	<p><b>VASOPNEUMATIC DEVICES</b></p> <p><b>Unattended</b>  <i>One or more areas is one unit of service</i>            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>	ONE	Covered diagnoses are 457.0, 457.1, and 757.0 only.
97018	<p><b>PARAFFIN BATH</b></p> <p><b>Unattended</b>  <i>One or more areas is one unit of service</i>            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>	ONE	<p>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.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p>
97022	<p><b>WHIRLPOOL (FLUIDOTHERAPY)</b></p> <p><b>Unattended</b>  <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>A key component of whirlpool is immersion of the body part in the water.</u></p> <p>By the following descriptions, whirlpools would not correctly describe the use of an aqua massage table.</p> <ol style="list-style-type: none"> <li>1. The clinician utilizes whirlpool to provide superficial heat in an environment that facilitates tissue debridement, wound cleaning, and/or exercise.</li> </ol> <p><b>Warm whirlpool</b>  <i>Equipment needed:</i></p> <ol style="list-style-type: none"> <li>a. Towels- these are to be used for padding and drying off.</li> <li>b. Chair- Padding-this is to be placed on the side of the whirlpool.</li> </ol>

Code	Description	Units Allowed Per Day	Special Instructions
			<p><i>Treatment:</i></p> <ol style="list-style-type: none"> <li>The patient should be positioned comfortable, allowing the injured part to be immersed in the whirlpool.</li> <li>Direct flow should be 6 to 8 inches from the body segment.</li> <li>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).</li> <li>Time of application should be 15 to 20 minutes.</li> </ol> <p><i>Considerations:</i></p> <ol style="list-style-type: none"> <li>Patient positioning should allow for exercise of the injured part.</li> <li>The size of the body segment to be treated will determine whether an upper extremity, lower extremity, or full body whirlpool should be used.</li> <li>Frequency.</li> </ol> <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>
97024	<p><b>DIATHERMY (eg, microwave) Magnatherm Unattended</b>  <b>One or more areas is one unit of service</b>  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>	ONE	<p>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.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p>
97026	<p><b>INFRARED Unattended</b>  <b>One or more areas is one unit of service</b>  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>	ONE	<p>DO NOT USE this code to bill any of the following:</p> <ul style="list-style-type: none"> <li>• Anodyne Therapy</li> <li>• Cold Laser Therapy</li> <li>• Low Laser Therapy</li> <li>• Soft laser Therapy</li> </ul> <p>For information concerning these therapies please refer to information given earlier.</p> <p>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.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p>
97028	<p><b>ULTRAVIOLET Unattended</b>  <b>One or more areas is one unit of service</b>  The clinician applies ultra light to treat dermatological problems. Once applied and safety instructions have been provided, the treatment is supervised.</p>	ONE	<p>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.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p>

Code	Description	Units Allowed Per Day	Special Instructions
97032	<b>ELECTRICAL STIMULATION (MANUAL)</b> <b>Attended</b> <b>One or more areas</b> <b>15 minutes is one unit of service</b> 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.	ONE	If more than one unit (16+ minutes; note areas treated) of service; attach medical records.  Use modifier 22 when submitting any claim attachment.  <b>Billing of electrodes</b> 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	<b>IONTOPHORESIS</b> <b>Attended</b> <b>One or more areas</b> <b>15 minutes is one unit of service</b> 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.	TWO	If more than two units (31+ minutes; not areas treated) of service attach medical records.  Use modifier 22 when submitting any claim attachment.  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	<b>CONTRAST BATHS</b> <b>Attended</b> <b>One or more areas</b> <b>15 minutes is one unit of service</b> 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.	ONE	If more than one unit (16+ minutes; not areas treated) of service attach medical records.  Use modifier 22 when submitting any claim attachment.
97035	<b>ULTRASOUND</b> <b>Attended</b> <b>One or more areas</b> <b>15 minutes is one unit of service</b> 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 corticosteroid medication via ultrasound is called phonophoresis. This service requires constant attendance of the clinician.	ONE	If more than one unit (16+ minutes; note areas treated) of service attach medical records.  Use modifier 22 when submitting any claim attachment.  ----- <b>Use 97035 for phonophoresis</b>  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.

Code	Description	Units Allowed Per Day	Special Instructions
97036	<b>HUBBARD TANK Attended</b> <b>One or more areas</b> <b>15 minutes is one unit of service</b> 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.	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	<b>UNLISTED MODALITY</b> <b>One or more areas</b> <b>15 minutes is one unit of service</b> This code is used if the clinician performs a modality to one or more areas that is not listed under the current codes.	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	<b>THERAPEUTIC PROCEDURE Attended</b> <b>One or more areas</b> <b>15 minutes is one unit of service</b> 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.	FOUR	<b>DO NOT USE THIS CODE FOR MASSAGE THERAPY (97124).</b>  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 (61+ minutes; note areas treated) of service attach medical records.  Use modifier 22 when submitting any claim attachment.
97112	<b>NEUROMUSCULAR REEDUCATION Attended</b> <b>One or more areas</b> <b>15 minutes is one unit of service</b> 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.	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 (61+ minutes; note areas treated) of service attach medical records.  Use modifier 22 when submitting any claim attachment.
97113	<b>AQUATIC THERAPY Attended</b> <b>One or more areas</b> <b>15 minutes is one unit of service</b> 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.	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 (61+ 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
97150	<p><b>THERAPEUTIC PROCEDURE(S)</b>  <b>One or more areas</b>  <b>15 minutes is one unit of service</b>            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>Usually non-covered.</p> <p>Specify type and time on claim attachment.</p> <p>Attach medical records.</p> <p>Use modifier 22 when submitting any claim attachment.</p>
97530	<p><b>THERAPEUTIC ACTIVITIES</b>  <b>Attended</b>  <b>15 minutes is one unit of service</b>            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>	FOUR	<p>This code includes:</p> <ul style="list-style-type: none"> <li>a. Body mechanics with functional activities</li> <li>b. Sport related drills</li> <li>c. Dynamic stabilization exercises</li> <li>d. Simulated activities</li> <li>e. Transfers</li> </ul> <p>This code should be used for kinetic activity procedure(s).</p> <p>If more than four units (61+ minutes; note areas treated) of service attach medical records.</p> <p>Use modifier 22 when submitting any claim attachment.</p>
97532	<p><b>DEVELOPMENT OF COGNITIVE SKILLS</b>  <b>Attended</b>  <b>15 minutes is one unit of service</b>            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.</p>	FOUR	<p>Usually non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).</p>
97533	<p><b>SENSORY INTEGRATIVE TECHNIQUES</b>  <b>15 minutes is one unit of service</b>            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.</p>	FOUR	<p>By Report. Specify time.</p> <p>Attach medical records containing pertinent information for review.</p> <p>Use modifier 22 when submitting any claim attachment.</p>
97535	<p><b>SELF CARE/HOME MANAGEMENT TRAINING</b>  <b>15 minutes is one unit of service</b>            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.</p>		Denied Content of Service.

Code	Description	Units Allowed Per Day	Special Instructions
97537	<p><b>COMMUNITY/WORK REINTEGRATION TRAINING</b>  <b>15 minutes is one unit of service</b>  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.</p>		<p>Usually non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).</p> <p><b><u>MDs, DOs, DCs do not use this code unless you are truly performing the services listed.</u></b></p> <p>This code includes:</p> <ul style="list-style-type: none"> <li>a. Shopping</li> <li>b. Transportation</li> <li>c. Money management</li> <li>d. A vocational activity or work environment/modification analysis</li> <li>e. Work task analysis</li> </ul> <p>If more than one unit (16+ minutes; note areas treated) of service attach medical records.</p> <p>Use modifier 22 when submitting any claim attachment.</p>
97602	<p><b>REMOVAL OF DEVITALIZED TISSUE NON-SELECTIVE</b>  <b>Per session</b>  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.</p>	ONE	<p>This code is per session, regardless of time spent or areas treated.</p> <p>Submitting medical records will not change the unit limit for this code.</p>
97750	<p><b>PHYSICAL PERFORMANCE TEST OR MEASUREMENT WITH WRITTEN REPORT</b>  <b>15 minutes is one unit of service</b>  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.</p>	FOUR	<p>This code includes:</p> <ul style="list-style-type: none"> <li>a. Biodex</li> <li>b. KT1000 tests</li> </ul> <p>If more than four units (61+ minutes; note areas tested) of service attach medical records.</p> <p>Use modifier 22 when submitting any claim attachment.</p>
97760	<p><b>ORTHOTICS MANAGEMENT AND TRAINING</b>  <b>15 minutes is one unit of service</b>  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>	TWO	Content of original dispensing of orthotic/prosthetic.
97762	<p><b>CHECKOUT FOR ORTHOTIC/PROSTHETIC USE</b>  <b>Established patients</b>  <b>15 minutes is one unit of service</b>  The clinician evaluates the effectiveness of an existing orthotic or prosthetic device and makes necessary recommendations for changes, as appropriate.</p>	N/A	Content of original dispensing of orthotic.

Code	Description	Units Allowed Per Day	Special Instructions
97799	<p><b>UNLISTED PHYSICAL MEDICINE/REHABILITATION SERVICE OR PROCEDURE</b></p> <p>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>Specify type of service or procedure and time.</p> <p>Attach medical records.</p> <p>Use modifier 22 when submitting any claim attachment.</p> <p>i.e., Anodyne Therapy Use "GA" modifier Specify in Box 19 GET Limited Patient Waiver</p>
97810	<p><b>ACUPUNCTURE</b> <i>One or more needles; without electrical stimulation</i> <b>INITIAL 15 minutes of personal one-on-one contact with the patient</b></p> <p>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>	ONE	<p>Usually non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).</p>
97811  Add-on code	<p><b>ACUPUNCTURE</b> <i>One or more needles; without electrical stimulation</i> <b>EACH ADDITIONAL 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)</b></p> <p>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>Usually non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).</p>
97813	<p><b>ACUPUNCTURE</b> <i>One or more needles; with electrical stimulation</i> <b>INITIAL 15 minutes of personal one-on-one contact with the patient</b></p> <p>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>	ONE	<p>Usually non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to: 1-800-432-0272 (Topeka 291-4183).</p>
97814  Add-on code	<p><b>ACUPUNCTURE</b> <i>One or more needles; with electrical stimulation</i> <b>EACH ADDITIONAL 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)</b></p> <p>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>Usually non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).</p>

Code	Description	Units Allowed Per Day	Special Instructions
<b>S8950</b> National S Code	<b>COMPLEX LYMPHEDEMA THERAPY (CLT)</b> <i>Each 15 minutes</i> 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.	FOUR	Attach medical records if providing more than 4 units (61+ minutes; note areas treated).  Use modifier 22 when submitting any claim attachment.
<b>S9090</b> National S Code	<b>VERTEBRAL AXIAL DECOMPRESSION THERAPY</b> <i>Per session</i> 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		This code is per session, regardless of time spent or areas treated.  Submitting medical records will not change the unit limit for this code.



**EXAMPLE of LICENSED PROVIDER and EMPLOYED  
MASSAGE THERAPIST**

**Blue Cross and Blue Shield of Kansas**  
Independent Licensees of the Blue Cross and Blue Shield Association

**Massage Therapy Services**

*With More Than One 15-Minute Unit on a Given Date of Service*

**This form and medical records must be submitted when a claim contains more than one unit of massage therapy 97124 on a given date.**

**Use modifier 22 when submitting any claim attachment**

Patient Name	Patient ID#	Provider number(s) Individual/group	Date of service	Massage therapy performed by	Credentials or title	Employer
Jane Doe- Smith	XSA5114209J4	xxxxxx/yyyyyy	2-13-09	Shirley Myers	DO	Self
			2-16-09	Larrie Jones	MT	Dr. Shirley Myers
			1-18-09	Larie Jones	MT	Dr. Shirley Myers
			1-20-09	Shirley Myers	DO	Self

Ruth Davis, Clinic Manager  
I certify the above to be correct Name and Title

Date 2-21-09

(785) 291-7XXX  
Telephone number including area code

**EXAMPLE of CONTRACTED MASSAGE THERAPIST**

**Blue Cross and Blue Shield of Kansas**

Independent Licensees of the Blue Cross and Blue Shield Association

**Massage Therapy Services**

*With More Than One 15-Minute Unit on a Given Date of Service*

**This form and medical records must be submitted when a claim contains more than one unit of massage therapy 97124 on a given date.**

**Use modifier 22 when submitting any claim attachment**

Patient Name	Patient ID#	Provider number(s) Individual/group	Date of service	Massage therapy performed by	Credentials or title	Employer
John Doe	XSA51142P954	zzzzzz/ssssss	12-12-09	Mully Evan	MT	Self/Contracted
			12-19-09	Mully Evan	MT	Self/Contracted

Edward Corne, Office Manager  
I certify the above to be correct Name and Title

12-22-09  
Date

(785) 290-6XXX  
Telephone number including area code