Physical Medicine

BlueCross BlueShield Kansas

bcbsks.com

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Rehabilitation Services are covered only if they are expected to result in significant improvement in the member's condition. Blue Cross and Blue Shield of Kansas (BCBSKS) will determine whether significant improvement has, or is likely to occur based on appropriate medical necessity documentation.

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

The information contained here gives guidelines about services that might be performed by an occupational or physical therapist, speech pathologist, and chiropractor. This section is not intended to be comprehensive. If there is a service not addressed and you have specific questions about coverage, please log on to Availity.com to determine coverage of a specific service for a specific patient.

Services performed/billed should be within the scope of the performing provider's license. Submit the appropriate procedure code from the AMA-CPT codebook.

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

I. Acupuncture

Most policies do not cover this service. Please log on to Availity.com 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 + primary code
- 97813
- 97814 + primary code

II. Anodyne Therapy

This service should be coded using 97799 with a description of "anodyne therapy" in the 2400 NTE segment of an electronic submission or box 19 of a CMS-1500 claim form. It should not be confused with Infrared Therapy that is coded 97026.

It is considered experimental/investigational and is a provider write-off unless a Limited Patient Waiver is signed before performance of the service.

Use modifier "GA" to demonstrate waiver on file.

III. Anti-Gravity Lumbar Traction-Reverse (Inversion)

This service should be coded using 97139 with a description of "anti-gravity lumbar traction-reverse (inversion)" in the 2400 NTE segment of an electronic submission or box 19 of a CMS-1500 claim form.

It is considered experimental/investigational and is provider write-off unless a Limited Patient Waiver is signed before performance of the service.

Use modifier "GA" to demonstrate waiver on file.

IV. Aqua Massage Therapy

This service should be coded using 97039 with a description of "aqua massage therapy" in the 2400 NTE segment or box 19. It should not be billed using 97124.

It is considered experimental/investigational and is provider write-off unless a Limited Patient Waiver is signed before performance of the service.

Use modifier "GA" to demonstrate waiver on file.

V. Athletic Trainers

Athletic trainers should use 97169, 97170, and 97171 for an evaluation, and use code 97172 for a re-evaluation.

VI. Audit Red Flags

- High utilization
- Repetitive services
- Misuse of CPT codes
- Billing/use of 97124 and 97140 for the same body part on the same DOS
- # of units / treatment greater than BCBSKS policy allowable
- Billing/use of 97164 for DOS after Jan. 1, 2017 on each DOS billed
- Upcoding (e.g. 97032 instead of 97014)
- Use of unlisted procedure and modality codes
- Billing/use of two or more superficial heating modalities to the same body part – Use of 97010, 97014, 97035 same body part, same session with no documented rationale and objective data to support necessity for **each** modality
- Continued use of modalities for periods greater than 10 treatment sessions with no documented rationale and objective data to support patient improvement and ongoing treatment.
- Lack of treatment plan documented in medical record
- Vague diagnosis codes

VII. Blood-Flow Restriction PT Treatment

It is considered experimental/investigational and is provider write-off unless a Limited Patient Waiver is signed before performance of the service.

VIII. Certified Physical Therapist Assistant (CPTA) or Certified Occupational Therapy Assistant (COTA)

BCBSKS and Federal Employee Program (FEP) will only reimburse the services of a CPTA or COTA if a physical therapist or occupational therapist, respectively, are on site at the time of service.

IX. 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).

Rehabilitation Services are covered only if they are expected to result in significant improvement in the Insured's condition. BCBSKS will determine whether significant improvement has, or is likely to occur.

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 anterior rib cage/costosternal)
- Lumbar
- Sacral
- Pelvic (sacro-iliac joint)

Regions of the Extraspinal (98943)

- Head (including temporomandibular joint, excluding the atlanto-occipital)
- Lower Extremities
- Upper Extremities
- Anterior rib cage costosternal (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

X. Cold Laser Therapy/Soft Laser Therapy/Low-Level Laser Therapy

Cold laser/soft laser therapy should be coded using 97039 with a description of "cold laser therapy/soft laser therapy" in the 2400 NTE segment of an electronic submission or box 19 of a CMS-1500 claim form. It should not be confused with Infrared Therapy that is coded 97026.

Low-level laser therapy should be coded S8948.

All are considered experimental/investigational and is a provider write-off unless a Limited Patient Waiver is signed before performance of the service.

Use modifier "GA" to demonstrate waiver on file.

XI. 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.

XII. Direct Access

Physical therapists can initiate a physical therapy treatment without referral from a licensed health care practitioner.

In instances where treatment of a patient occurs without a referral, the physical therapist is required to obtain a referral from an appropriate referral source to continue treatment if, after 10 patient visits or a period of 15 business days from the initial treatment visit (follows the initial evaluation), the patient is not progressing toward documented treatment goals as demonstrated by objective, measurable, or functional improvement, or any combination of these criteria.

XIII. Dressing Changes

This service should be coded using 97799 with a description of "dressing change" in the 2400 NTE segment of an electronic submission or box 19 of a CMS-1500 claim form.

XIV. Dry Needling

This service should be coded using 20560 or 20561 to include a description of "dry needling" in the 2400 NTE segment of an electronic submission or box 19 of a CMS-1500 claim form.

It is considered non-covered or experimental/investigational depending on member benefits. It is a provider write-off unless a Limited Patient Waiver is signed before performance of the service.

Use modifier "GA" to demonstrate waiver on file.

You may also review the medical policy, Dry Needling of Myofascial Trigger Points, found at https://www.bcbsks.com/providers/medical-policies.

XV. Evaluation and Management (E&M) Codes

BCBSKS uses the CPT definitions for new and established patients. If a provider has treated a patient for any reason within the past three years, the patient is considered an established patient.

Policy Memo No. 2

Established patient E&M codes should not be billed in conjunction with a manipulation. If an established patient E&M is billed in conjunction with the manipulation on the same date of

service, the E&M will deny content of service to the manipulation. Use of modifier 25 will not allow the established patient E&M service to pay.

E&M services can be reported separately on the same date of service as a manipulation if it is for an initial exam of a new patient. Modifier 25 on the E&M is not necessary. The routine use of E&M codes without sufficient documentation is not appropriate billing practice.

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 percent 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.

XVI. Extension/Flexion Joint Devices

Dynamic

- See procedure codes E1800, E1802, E1805, E1810, E1815, E1825, E1830, and E1840.
- Covered for up to three months of rental if:
- Six weeks post-operative or six weeks post-injury and physical therapy has failed to improve ROM.

Bi-directional

- See procedure codes E1801, E1806, E1811, E1816, E1818, and E1841.
- Covered for up to three months of rental if:
- Six weeks post-operative or Six weeks post-injury and physical therapy has failed to improve ROM.

Content of service procedures – Procedure codes E1820 and E1821 are content of service of the device itself and may not be billed separately.

XVII. 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.

XVIII. Foot Orthotics

Most policies do not cover this service.

Please log on to Availity.com to determine coverage for a specific patient.

When covered, use the appropriate procedure code from the HCPCS procedure code listing.

XIX. Functional Electrical Stimulation (FES)

See Medical Policy, Electrical Stimulation Devices for Home Use, found at https://www.bcbsks.com/providers/medical-policies.

XX. Habilitative Services

Habilitative services are health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Appropriate billing of habilitative services will include appending the modifier "SZ" to CPT for the habilitative service that is being provided.

XXI. Heat Therapies

This service will be denied content of service unless it is the only service provided on that date.

Certain therapies are considered duplicative services as follows:

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

XXII. Horizontal Therapy

This service should be coded using 97014.

The unit of service is limited to one, regardless of the time spent or the number of areas treated.

When electrical stimulation 97014 and ultrasound 97035 are performed at the same time, using the same machine, only one modality should be billed.

The electrodes and other supplies used to administer any modality are content of service of the modality.

XXIII. 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 the date of service.

Ice therapy should be coded as 97039 with a description of "ice therapy" in the 2400 NTE segment or box 19 of a CMS-1500 claim form.

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.

XXIV. Ineligible Providers

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

- Chiropractic assistants
- Exercise physiologists
- Interns
- Massage therapists
- Occupational therapy aides
- Physical therapy aides
- Physical therapy technician

Services performed by these specialties or other office staff are considered patient responsibility and should not be billed to BCBSKS.

XXV. Kinesio Taping

This service should be coded using 97039 with a description of "kinesio taping" in the 2400 NTE segment of an electronic submission or box 19 of a CMS-1500 claim form.

It is considered experimental/investigational and is a provider write-off unless a Limited Patient Waiver is signed before performance of the service.

Use modifier "GA" to demonstrate waiver on file.

XXVI. Magnatherm

This service should be coded as 97024.

Magnatherm is considered one unit of service per area.

XXVII. Maintenance Care

BCBSKS considers Maintenance Care not medically reasonable or necessary, is NOT payable, and will be denied not medically necessary. Ongoing physical medicine treatment after a condition has stabilized or reached a clinical plateau (maximum medical improvement) does not qualify as medically necessary, and would be considered "Maintenance Care." If a provider renders Maintenance Care, a conversation should take place with the patient before services are provided. This will allow the patient to decide if they want to assume financial responsibility. This includes patient directed care as well.

Maintenance Care is a provider write-off unless a Limited Patient Waiver is signed before performance of the service. The patient has the choice to choose to file the claim with BCBSKS by choosing option 1 or to not file these services by choosing option 2.

Use modifier "GA" to demonstrate waiver on file.

XXVIII. 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 that 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 PT or OT
- Performed by a PTA or COTA under the direct supervision (on-site) of the physical or occupational therapist respectively.

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. Processing of claims received without this information may be delayed until such information is provided.
- Refunds will be required if services were performed by someone other than the licensed eligible provider.

XXIX. McConnell Strapping/Taping

This service should be coded as 97039 with a description of "McConnell strapping" or "McConnell taping" in the 2400 NTE segment or box 19 of the CMS-1500 claim form.

Includes reimbursement for the tape and the taping procedure.

A separate charge may be billed for the evaluation, re-evaluation; or physical modalities, if performed.

Codes 29200 – 29280 and 29520 – 29550 will deny as content of service to codes 97161-97168 and may not be billed separately.

XXX. Microcurrent Stimulation Therapy

- Microcurrent stimulation therapy, for all applications and all indications, is experimental/investigational. This includes but is not limited to: microcurrent electrical nerve stimulation, frequency specific microcurrent, microelectrical therapy, microcurrent therapy, electro therapeutic point stimulation, microcurrent point stimulation, microcurrent therapy, and concentrated micro-stimulation.
- Microcurrent stimulation should be billed using 97039 with a description of “microcurrent therapy” submitted in the 2400 NTE segment or box 19 of the claim form.
- This service should not be billed using 97014 or 97032.

XXXI. Multiple Therapies

If electrical stimulation, unattended (97014), electrical stimulation, attended (97032) and ultrasound (97035) are provided to the same area at the same session, attach medical records. If medical records are not attached, only 97032 (since it has the highest MAP) will be allowed.

If infrared (97026) and ultraviolet (97028) are provided to the same area at the same session, attach medical records. If medical records are not attached, only 97028 (since it has the highest MAP) will be allowed.

If diathermy, e.g., microwave (97024) and infrared (97026) are provided to the same area at the same session, attach medical records. If medical records are not attached, only 97024 (since it has the highest MAP) will be allowed.

If infrared (97026) and electrical stimulation, attended (97032) are provided to the same area at the same session, attach medical records. If medical records are not attached, only 97032 (since it has the highest MAP) will be allowed.

XXXII. 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 four physical medicine modalities and/or procedures being billed on one date of service, or the guidelines involve the BCBSKS daily unit limit being exceeded.

Units on Time-Based Physical Medicine Codes

All CPT time-based codes require start and stop times or total time documented in the medical record.

When only one service is provided in a day, providers should not bill for services performed for less than eight 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 eight minutes through and including 22 minutes. Time intervals for one through eight 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

Note – If billing for more than one modality/therapy, time should not be combined to report units. Each unit for the modality/therapy is reported separately by code.

XXXIII. 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.

XXXIV. 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. See Policy Memo No. 1 for more information.

Certification for In-State Providers — Reimbursement guidelines are based on the certification of the performing provider. See Policy Memo No. 1 for more information.

Medical Policy — To review medical necessity guidelines, visit the Medical Policy section of the BCBSKS website. See Policy Memo No. 1 for more information.

XXXV. 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 visit 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.

XXXVI. Not Medically Necessary

Roller bed Services (code 97012) are considered not medically necessary. When billing for this service, have the patient sign the Limited Patient Waiver and use modifier "GA" to demonstrate waiver on file.

XXXVII. Occupational Therapists

Occupational therapists should use 97165, 97166, and 97167 for an evaluation, and use code 97168 for a re-evaluation.

XXXVIII. Pathology (Labs)

- All clinical 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, Section XIV, Page 13.)

Policy Memo No. 7: Radiology and Pathology

Referring provider information should be submitted in the 2310A and/or 2420F loop.

Ordering provider information should be submitted in the 2420E loop

When filing on paper the information is reported in box 17B.

XXXIX. Physical Medicine Evaluation, Modalities and Therapeutic 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 97546; 97760 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.
- 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.
- When two modalities are performed by one machine at the same time only one modality may be billed.

XL. Physical Therapists

Physical therapists should use 97161, 97162, and 97163 for an evaluation, and use code 97164 for a re-evaluation.

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.
- Medical records supporting medical necessity must accompany the claim when two like modalities (i.e. heat) are billed on the same day.
- If the unit limit, that is 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) in the 2400 NTE segment of an electronic submission or box 19 of a CMS-1500 claim form.
- When two modalities are performed by one machine at the same time only one modality may be billed.

XLI. Posture Pump

This service should be coded using 97139 with a description of "posture pump" in the 2400 NTE segment of an electronic submission or box 19 of a CMS-1500 claim form.

It is considered not medically necessary and is a provider write-off unless a Limited Patient Waiver is signed before performance of the service.

Use modifier "GA" to demonstrate waiver on file.

XLII. Radiology

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

Referring provider information should be submitted in the 2310A and/or 2420F loop.

Ordering provider information should be submitted in the 2420E loop.

When filing on paper the information is reported in box 17B.

Refer to page 13 of the 2020 Annual CAP Report for QBRP incentives for Low-Back Pain imaging.

XLIII. Speech Therapy

Speech Therapy is limited to one service per day and a maximum of 60 days per episode per member.

Maximum benefit limitations are determined by member benefits.

Use the appropriate CPT procedure code. One session is equivalent to one unit.

XLIV. Sympathetic Therapy

This service should be coded using 97799 with a description of "sympathetic therapy" in the 2400 NTE segment of an electronic submission or box 19 of a CMS-1500 claim form.

It is considered experimental/investigational and is a provider write-off unless a Limited Patient Waiver is signed before performance of the service.

Use modifier "GA" to demonstrate waiver on file.

XLV. Therapy Student Guidelines

Only the services of the therapist can be billed and paid under BCBSKS. However, a student may participate in the delivery of the services if the therapist is directing the service, making the judgment, responsible for the treatment and present in the room guiding the student in service delivery.

Therapists may bill and be paid for the provision of services in the following scenarios:

- The qualified practitioner is present and in the room for the entire session.
- The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.

The qualified practitioner is responsible for the services and as such, signs all documentation. (A student may, of course, also sign but it is not necessary since the payment is for the clinician's service, not for the student's services).

XLVI. Tiered Reimbursement

- See Policy Memo No. 1, Section XXV. Tiered Reimbursement and Provider Number Requirements.
- Tiered reimbursement for chiropractors is defined in the 2016 Competitive Allowance Program (CAP) letter dated July 2015. Chiropractors are subject to 85 percent of the BCBSKS MAP.

XLVII. Transcutaneous Electrical Nerve Stimulator (TENS) – 4 Lead

This service should be coded as E0730.

Rental and purchase of E0720 is denied not medically necessary.

A Limited Patient Waiver must be signed by the patient for the patient to be held financially responsible for the 2-Lead TENS.

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.

XLVIII. Vasopneumatic Devices

This service should be coded 97016.

This service will be denied content of service unless it is billed with one of the following diagnoses: postmastectomy lymphedema syndrome, other lymphedema, or hereditary edema of legs.

XLIX. Vertebral Axial Decompression Therapy (i.e., VaxD, IDD, DR 5000, DR 9000, SpinaSystem, etc.)

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 of participants in studies already conducted, documented long-term results) S9090 will be allowed based on the 97012 allowance and unit limitation guidelines.

This policy will remain in effect until such time that 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.

L. Wound Debridement Billed with Evaluation

BCBSKS will not cover both services on the same date; unless there is a separate and identifiable service for the evaluation other than wound assessment.

Medical records should be submitted for separate and identifiable services.

Please Review the following Guidelines Carefully

Physical Medicine Exams/Modality/Procedure Guidelines

More than four modalities or procedures on the same day require medical records

Code	Description	Units allowed per day	Special Instructions
A4556	**ELECTRODES,** 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. Multiple units required in the 2400 SV104 segment or box 24G if more than one pair 2 pairs = 002 units of service 4 electrodes = 002 units of service
A4557	**LEAD WIRES, per pair**	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. 2 pairs = 002 units of service 4 lead wires = 002 units of service
A4630	**Replacement Batteries**		
20560	**DRY NEEDLING, needle insertion**	1 UNIT	1 or 2 muscles without injection.
20561	**DRY NEEDLING, needle insertion**	1 UNIT	3 or more muscles without injection.
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 Availity.com.
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 Availity.com.
92507	**TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESS DISORDER** - individual	1 UNIT	
92508	**TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESS DISORDER** – group	1 UNIT	
92521	**EVALUATION OF SPEECH FLUENCY**	1 UNIT	

Code	Description	Units allowed per day	Special Instructions
92522	**EVALUATION OF SPEECH SOUND PRODUCTION**	1 UNIT	
92523	**EVALUATION OF SPEECH SOUND PRODUCTION** with language comprehension and expression	1 UNIT	
92524	**BEHAVIORAL AND QUALITATIVE ANALYSIS OF VOICE AND RESONANCE**	1 UNIT	
95831-95857	**MUSCLE TESTING AND REANGE OF MOTION TESTING**		Perform routine muscle testing and range of motion or muscle testing (i.e. tests that are an integral part of the assessment performed each visit to determine the patient's status for one visit to the next and to determine the level of care required for the current visit) are considered content of service of the evaluation or therapy billed that particular day and should not be billed separately.
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. This code is per session, regardless of time spent or areas treated. Submitting medical records will not change the unit limit for this code.
97010	**CRYOTHERAPY**		Do not use procedure code 17340, as this is for direct application of chemicals to the skin. This code will deny content of service unless it is the only service provided on the date of service.
97010	**HOT OR COLD PACKS Unattended** ***One or more areas is one unit of service*** 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.	ONE	This code will be denied content of service unless it is the only service provided on that date. 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.
97012	**TRACTION (MECHANICAL) Unattended** ***One or more areas is one unit of service*** 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.	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. Roller bed is considered not medically necessary and should not be billed separately.

Code	Description	Units allowed per day	Special Instructions
97014	**ELECTRICAL STIMULATION, INTERFERENTIAL THERAPY, HORIZONTAL THERAPY** **Unattended** ***One or more areas is one unit of service*** 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.	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 take home supplies dispensed by a home medical equipment supplier.
97016	**VASOPNEUMATIC DEVICES** **Unattended** ***One or more areas is one unit of service*** 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.	ONE	This code will be denied content of service unless it is billed with one of the following diagnoses: postmastectomy lymphedema syndrome, other lymphedema, or hereditary edema of legs. 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.
97018	**PARAFFIN BATH** **Unattended** ***One or more areas is one unit of service*** 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.	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.

Code	Description	Units allowed per day	Special Instructions
97022	**WHIRLPOOL (FLUIDOTHERAPY) Unattended** ***One or more areas is one unit of service*** 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.	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 (97039) and not whirlpool. Whirlpool (97022) would not be appropriate as whirlpool is descriptive of a specific apparatus and treatment. *A key component of whirlpool is immersion of the body part in the water.* By the following descriptions, whirlpools would not correctly describe the use of an aqua massage table. 1. The clinician utilizes whirlpool to provide superficial heat in an environment that facilitates tissue debridement, would cleaning, and/or exercise. **Warm whirlpool** *Equipment needed*: a. Towels- these are to be used for padding and drying off. b. Chair- Padding-this is to be placed on the side of the whirlpool. *Treatment:* a. The patient should be positioned comfortable, allowing the injured part to be immersed in the whirlpool. b. Direct flow should be 6 to 8 inches from the body segment. c. 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). d. Time of application should be 15 to 20 minutes. *Considerations:* a. Patient positioning should allow for exercise of the injured part. b. The size of the body segment to be treated will determine whether an upper extremity, lower extremity, or full body whirlpool should be used. c. Frequency. The above is from "Therapeutic Modalities in Sports Medicine, Third Edition, Mosby-Year Book Inc., 1994. If more than one unit of service attach medical records.
97024	**DIATHERMY (eg, microwave) Magnatherm Unattended** ***One or more areas is one unit of service*** 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.	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.

Code	Description	Units allowed per day	Special Instructions
97026	**INFRARED** **Unattended** ***One or more areas is one unit of service*** 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.	ONE	DO NOT USE this code to bill any of the following: • Anodyne Therapy • Cold Laser Therapy • Low Laser Therapy • Soft Laser Therapy For information concerning these therapies please refer to information given earlier. 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.
97028	**ULTRAVIOLET** **Unattended** ***One or more areas is one unit of service*** The clinician applies ultra light to treat dermatological problems. Once applied and safety instructions have been provided, the treatment is supervised.	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.
97032	**ELECTRICAL STIMULATION (MANUAL) Attended** **One or more areas** ***15 minutes is one unit of service*** 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	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 take home supplies dispensed by a home medical equipment supplier.
97033	**IONTOPHORESIS** **Attended** **One or more areas** ***15 minutes is one unit of service*** 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 (23 through 37 minutes; not areas treated) of service attach medical records. 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
97034	**CONTRAST BATHS** **Attended** **One or more areas** ***15 minutes is one unit of service*** 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	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
97035	**ULTRASOUND** **Attended** **One or more areas** ***15 minutes is one unit of service*** 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	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 ~~~~~~ **Use 97035 for phonophoresis.** 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.
97036	**HUBBARD TANK** **Attended** **One or more areas** ***15 minutes is one unit of service*** 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.
97039	**MCCONNELL STRAPPING/TAPING**	TWO	A description of "McConnell strapping" or McConnell taping" needs to be indicated in the 2400 NTE segment or box 19 Includes reimbursement for the tape and the taping procedure. A separate charge may be billed for the evaluation or re-evaluation, if performed.
97039	**MICROCURRENT STIMULATION THERAPY**		Considered experimental and investigational.

Code	Description	Units allowed per day	Special Instructions
97110	**THERAPEUTIC PROCEDURE Attended** **One or more areas** ***15 minutes is one unit of service*** 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	**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.
97112	**NEUROMUSCULAR REEDUCATION Attended** **One or more areas** ***15 minutes is one unit of service*** 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 (53 through 67 minutes; note areas treated) of service attach medical records.
97113	**AQUATIC THERAPY Attended** **One or more areas** ***15 minutes is one unit of service*** 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 (53 through 67 minutes; note areas treated) of service attach medical records. Use modifier 22 when submitting any claim attachment.
97116	**GAIT TRAINING Attended** ***15 minutes is one unit of service*** 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.	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.

Code	Description	Units allowed per day	Special Instructions
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	This code will be denied content of service unless it is the only service provided on that date. **General Guidelines:** 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.**
97139	**UNLISTED THERAPEUTIC PROCEDURE** **One or more areas** ***15 minutes is one unit of service*** This code is used if the clinician performs a therapeutic procedure to one or more areas that is not listed under the current codes.	ONE	Specify type of therapeutic procedure and time on claim attachment. Attach medical records. i.e., Anti-Gravity Lumbar Traction-reverse (Inversion) Posture Pump Cupping Therapy Use "GA" modifier Get Limited Patient Waiver
97140	**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. **APPLIED KINESIOLOGY**	TWO FOUR UNITS WILL BE ALLOWED FOR LYMPHATIC DRAINAGE	***MDs, DOs, DCs do not use this code for your manipulations, they must be coded under 98925-98943*** **DO NOT USE THIS CODE FOR MASSAGE THERAPY (97124)** **97140 WILL DENY CONTENT TO THE MANIPULATION** 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 areas treated) of service attach medical records. May be medically justified with appropriate documentation.

Code	Description	Units allowed per day	Special Instructions
97150	**THERAPEUTIC PROCEDURE(S)** **One or more areas** ***15 minutes is one unit of service*** 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.		Not medically necessary.
97161	**PHYSICAL THERAPY EVALUATION** **Low complexity**	ONE	Use for dates of service January 1, 2017 and after. Refer to CPT for required components.
97162	**PHYSICAL THERAPY EVALUATION** **Moderate complexity**	ONE	Use for dates of service January 1, 2017 and after. Refer to CPT for required components.
97163	**PHYSICAL THERAPY EVALUATION** **High complexity**	ONE	Use for dates of service January 1, 2017 and after. Refer to CPT for required components.
97164	**PHYSICAL THERAPY RE-EVALUATION**	ONE	Use for dates of service January 1, 2017 and after. Refer to CPT for required components.
97165	**OCCUPATIONAL THERAPY EVALUATION** **Low complexity**	ONE	Use for dates of service January 1, 2017 and after. Refer to CPT for required components.
97166	**OCCUPATIONAL THERAPY EVALUATION** **Moderate complexity**	ONE	Use for dates of service January 1, 2017 and after. Refer to CPT for required components.
97167	**OCCUPATIONAL THERAPY EVALUATION** **High complexity**	ONE	Use for dates of service January 1, 2017 and after. Refer to CPT for required components.
97168	**OCCUPATIONAL THERAPY RE-EVALUATION**	ONE	Use for dates of service January 1, 2017 and after. Refer to CPT for required components.
97169	**ATHLETIC TRAINING EVALUATION** **Low complexity**		Use for dates of service January 1, 2017 and after.
97170	**ATHLETIC TRAINING EVALUATION** **Moderate complexity**		Use for dates of service January 1, 2017 and after.
97171	**ATHLETIC TRAINING EVALUATION** **High complexity**		Use for dates of service January 1, 2017 and after.
97172	**ATHLETIC TRAINING RE-EVALUATION**		Use for dates of service January 1, 2017 and after.

Code	Description	Units allowed per day	Special Instructions
97530	**THERAPEUTIC ACTIVITIES** **Attended** ***15 minutes is one unit of service*** 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.	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.
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 Availity.com.
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.
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., *activities of daily living* 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.

Code	Description	Units allowed per day	Special Instructions
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 Availity.com. ***MDs, DOs, DCs do not use this code unless you are truly performing the services listed.*** 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.
97542	**WHEELCHAIR MANAGEMENT/PROPULSION TRAINING** ***15 minutes is one unit of service*** The clinician instructs and trains the patient in proper wheelchair skills (e.g., propulsion, safety techniques). This service requires direct contact by the clinician.		By Report. Specify time. Attach medical records containing pertinent information for review.
97545	**WORK HARDENING/CONDITIONING** ***Initial 2 hours*** This code is used for a procedure where the injured worker is put through a series of conditioning exercises and job simulation tasks in preparation for return to work. Endurance, strength, and proper body mechanics are emphasized. The patient is also educated in problem solving skills related to job task performance and employing correct lifting and positioning techniques.		Usually non-covered. Questions about whether a BCBSKS member has this coverage may be directed to Availity.com.

Code	Description	Units allowed per day	Special Instructions
97546 **Add on code**	**WORK HARDENING AND CONDITIONING** ***Each additional hour*** This code is used for a procedure where the injured worker is put through a series of conditioning exercises and job simulation tasks in preparation for return to work. Endurance, strength, and proper body mechanics are emphasized. The patient is also educated in problem solving skills related to job task performance and employing correct lifting and positioning techniques**.**		Usually non-covered. Questions about whether a BCBSKS member has this coverage may be directed to Availity.com.
97597	**DEBRIDEMENT** (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less.		
97598 **Add on code**	**DEBRIDEMENT** (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure).		

Code	Description	Units allowed per day	Special Instructions
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.
97605	**NEGATIVE PRESSURE WOUND THERAPY** (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters.		See Medical Policy, Vacuum Assisted Wound Closure (VAC), found at https://www.bcbsks.com/providers/medical-policies.
97606	**NEGATIVE PRESSURE WOUND THERAPY** (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters.		See Medical Policy, Vacuum Assisted Wound Closure (VAC), found at https://www.bcbsks.com/providers/medical-policies.
97607	**NEGATIVE PRESSURE WOUND THERAPY** (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters.		See Medical Policy, Vacuum Assisted Wound Closure (VAC), found at https://www.bcbsks.com/providers/medical-policies.

Code	Description	Units allowed per day	Special Instructions
97608	**NEGATIVE PRESSURE WOUND THERAPY** (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters.		See Medical Policy, Vacuum Assisted Wound Closure (VAC), found at https://www.bcbsks.com/providers/medical-policies.
97610	**LOW FREQUENCY, NON-CONTACT, NON-THERMAL ULTRASOUND** including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day.		Experimental/Investigational
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.
97755	**ASSISTIVE TECHNOLOGY ASSESSMENT** (e.g., to restore, augment or compensate for existing function, optimize functional task and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes.		Usually non-covered Questions about whether a BCBSKS member has this coverage may be directed to Availity.com.
97760	**ORTHOTICS MANAGEMENT AND TRAINING** ***15 minutes is one unit of service*** 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.	N/A	Content of original dispensing of orthotic/prosthetic.

Code	Description	Units allowed per day	Special Instructions
97761	**PROSTHETIC TRAINING** ***15 minutes is one unit of service*** The clinician fits and/or trains the patient in use of a prosthetic device for one or more body parts. This does not include fabrication time, if appropriate, or cost of the materials.	TWO	Content of original dispensing of orthotic/prosthetic. Covered when billed by different provider from the one supplying orthotic/prosthetic. If more than two units (23 through 37 minutes; note areas treated) of service attach medical records.
97762	**CHECKOUT FOR ORTHOTIC/PROSTHETIC USE** **Established patients** ***15 minutes is one unit of service*** The clinician evaluates the effectiveness of an existing orthotic or prosthetic device and makes necessary recommendations for changes, as appropriate.	N/A	Content of original dispensing of orthotic.
97799	**UNLISTED PHYSICAL MEDICINE/REHABILITATION SERVICE OR PROCEDURE** 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.		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** ***One or more needles;* without *electrical stimulation*** ***INITIAL 15 minutes of personal one-on-one contact with the patient*** 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.		Usually non-covered. Questions about whether a BCBSKS member has this coverage may be directed to Availity.com.

Code	Description	Units allowed per day	Special Instructions
97811 **Add-on code**	**ACUPUNCTURE** ***One or more needles;* without *electrical stimulation*** ***EACH ADDITIONAL 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)*** 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.		Usually non-covered. Questions about whether a BCBSKS member has this coverage may be directed to Availity.com.
97813	**ACUPUNCTURE** ***One or more needles;* with *electrical stimulation*** ***INITIAL 15 minutes of personal one-on-one contact with the patient*** 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.		Usually non-covered. Questions about whether a BCBSKS member has this coverage may be directed to: Availity.com.
97814 **Add-on code**	**ACUPUNCTURE** ***One or more needles;* with *electrical stimulation*** ***EACH ADDITIONAL 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)*** 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.		Usually non-covered. Questions about whether a BCBSKS member has this coverage may be directed to Availity.com.
98925, 98926, 98927, 98928, 98929	**OSTEOPATHIC MANIPULATIVE TREATMENT (OMT)**		Only allowed if billed by a DO or MD.

Code	Description	Units allowed per day	Special Instructions
98940	**CHIROPRACTIC MANIPULATIVE TREATMENT, SPINAL** ***One to two regions***	1	
98941	**CHIROPRACTIC MANIPULATIVE TREATMENT, SPINAL** ***Three to four regions***	1	
98942	**CHIROPRACTIC MANIPULATIVE TREATMENT, SPINAL** ***Five regions***	1	
98943	**CHIROPRACTIC MANIPULATIVE TREATMENT, EXTRASPINAL** ***One or more regions***	1	
S3900	**SURFACE EMG (SEMG)**		Experimental/Investigational
S8948	**APPLICATION OF A MODALITY TO ONE OR MORE AREAS** **Requires constant provider attendance** **Lower level laser** **Each 15 minutes**		Experimental/Investigational
S8950 **National S Code**	**COMPLEX LYMPHEDEMA THERAPY (CLT)** ***Each 15 minutes*** 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 (53 through 67 minutes; note areas treated).
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; 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.

Documentation Guidelines – Chiropractic

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 or total time on all timed codes per CPT nomenclature. If dates of service and/or start/stop time are 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-10-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. Signature Requirements -- In the content of health records, each entry must be authenticated by the author. Authentication is the process of providing proof of the authorship signifying knowledge, approval, acceptance or obligation of the documentation in the health record, whether maintained in a paper or electronic format accomplished with a handwritten or electronic signature. Individuals providing care for the patient are responsible for documenting the care. The documentation must reflect who performed the service.
    a. The handwritten signature must be legible and contain at least the first initial and full last name along with credentials and date. A typed or printed name must be accompanied by a handwritten signature or initials with credentials and date.
    b. An electronic signature is a unique personal identifier such as a unique code, biometric, or password entered by the author of the electronic medical record (EMR) or electronic health record (EHR) via electronic means, and is automatically and permanently attached to the document when created including the author’s first and last name, with credentials, with automatic dating and time stamping of the entry. After the entry is electronically signed, the text-editing feature should not be available for amending documentation. Example of an electronically signed signature: “Electronically signed by John Doe, M.D. on MM/DD/YYYY at XX:XX A.M.”
    c. A digital signature is a digitized version of a handwritten signature on a pen pad and automatically converted to a digital signature that is affixed to the electronic document. The digital signature must be legible and contain the first and last name, credentials, and date.
    d. Rubber stamp signatures are not permissible. This provision does not affect stamped signatures on claims, which remain permissible.

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 (Chief Complaint)
- History of complaint and/or nature of injury or accident
  - Onset of complaint (including mechanism of injury)
  - Include history of treatment by previous providers (chiropractic, MD, PT, OT, etc.)
  - Location of complaint
  - How long they've had complaint and what movements or motions aggravates it, including functional loss and how those movements affect the patient's activities of daily living
  - Description of pain, including:
    - 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 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 ADLs (able to comb hair, reach top cabinets, walk 10 feet longer without assistive device, etc.)
  - 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, temperature, pulse, 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 20º with joint restrictions at C2-3.
    - Levorotatory lumbar curvature noted on x-ray. L2-3 fixation evident.
    - Foraminal compression Cervical spine produces pain and tenderness at C5-6 on the right that produces cervicobrachial pain/paresthesia extending to the tip of the right index finger. Focal joint restrictions noted at 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:
    - Orthopedic or neurological improvement of positive test (pre- and post-treatment)
    - Range of motion measurement (pre- and post-treatment)
    - Strength measurement (pre- and post-treatment)
    - Visual observation of movement patterns, palpation findings, postural anomalies, etc.
    - Indication for x-rays or other imaging, including imaging reports

<u>A-ASSESSMENT</u> 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 should include the ICD-10-CM code with the explanation for each code used. **(It is not JUST an ICD-10-CM billing code.)**

<u>P-PLAN</u> 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.
  For 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, and correlation

with diagnosis. Medical reasoning for each treatment utilized must be documented when using multiple therapies. **For 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 apply ice 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 total direct patient-doctor times for each service provided. Services such as therapeutic procedures, 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:
  - What specific exercise/procedure is being performed?
  - The area being treated
  - The number of repetitions if applicable
    - Statements that simply denote completion of activities are not adequate.
- Long- and short-term goals and expected functional outcomes. **For example:**
  - 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^{o} to 90^{o}.
    - 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:
  - 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/released from active 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, 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. BCBSKS contractual agreement, BCBSKS Policy Memo No. 1, XI, page 10
9. Kansas Statutes Annotated and Kansas Board of Healing Arts regulations (http://www.ksbha.org/statsandregs.shtml)

Chiropractic Documentation Checklist

NOTE – This form is intended to be used as an education tool and does not guarantee payment or coverage.

IDENTIFICATION
Patient's Name on Each Page
Patient DOB or Unique ID #
Provider Name, Address, and Phone Number
Date of Visit
Signature (Including Credentials). Electronic signature should contain name, credentials, date, and time for authentication.

SUBJECTIVE INITIAL EVALUATION OR RE-EVALUATION
Patient's Chief Complaint
Pertinent History/History of Present Illness
Onset/Aggravating or Relieving Factors/Trauma (including Mechanism of Injury)
Pain Location with Functional Loss and Effect on Activities of Daily Living (ADLs)
Frequency/Interval Changes
Quality/Radiation/Severity
Timing/Duration/Intensity
Review of Systems (Pertinent to Complaints)

OBJECTIVE/FINDINGS
Asymmetry/Misalignment (Inspection/Posture)
Palpation (Spasm or Hypertonicity)
Range of Motion
Orthopedic/Neurologic Tests
Indication for X-rays (if applicable) and Imaging Documentation/Report

ASSESSMENT/DIAGNOSIS
Initial or Updated Diagnoses (Diagnoses must be consistent with Subjective and Objective Findings

PLAN (each visit) TREATMENT, MODALITIES, and PROCEDURES
Modalities – Location/Duration/Intensity
CMT (Segmental Levels)
Recommended Frequency of Visits and Duration of Treatment
Specific Measurable Treatment Goals (baseline functional loss and ADLs)
Objective Measures to Evaluate Treatment Effectiveness
Home Exercise Program/Care Instructions/Counseling

NOTE – Blue Cross considers Maintenance Care not medically reasonable or necessary, NOT payable, and will be denied not medically necessary. Ongoing physical medicine treatment after a condition has stabilized or reached a clinical plateau (maximum medical improvement) does not qualify as medically necessary and would be considered "maintenance care."

NOTE – Chiropractors must perform all services.

Documentation Guidelines – Occupational and Physical Therapists

Medical Necessity Documentation

Before BCBSKS can appropriately reimburse you for services, it must be determined if services are documented and can be supported by your records as being medically necessary. Medical necessity is required as a fiduciary steward and is a standard of care that is supported by your profession. In many instances, this requires that you remit all appropriate and legible documentation for the claim in question.

Documentation Standards

The following medical record standards (not all inclusive) are required; and if not met, may result in delay or denial of payment:

- Documented referral from appropriate referral source
- Documented name (on each page of the record) and birth date of patient
- **Legible** handwriting (if it is not readable, it will be denied)
- Avoidance of abbreviations (use only standard abbreviations well known to your peers)
- Each CPT code submitted for payment must have the appropriate documentation to support the service rendered. Clearly document what you performed to differentiate between each service utilized.
- Initial evaluation that includes:
  - Diagnosis
  - Complete history and thorough systems review (patient stated problems, co-morbidities, medications, review of past-present care)
  - Objective, functional, measurable data (at a minimum):
    - ROM (relate to function deficits and symptoms)
    - Neuro (relate to function deficits and symptoms)
    - Tissue integrity (trigger pts, pain patterns, spasms, relate to function deficits and symptoms)
    - Movement pattern deficits (relate to function deficits and symptoms)
    - Functional deficits (relate to symptoms)
    - Posture (relate to function deficits and symptoms)
    - Strength (relate to function deficits and symptoms)
    - Specific Tests (relate to function deficits and symptoms)
  - Clearly delineated, measurable, time-framed goals that relate to **function**
    - Description of movement or activity
    - Connect to specific function deficit or symptoms
    - Measurable & Time-framed (What does patient need to be doing before discharge?)
    - Identify who will accomplish the goal
    - Examples:
      - *Pt. Improve shldr flex to 160 to reach into cupboards at home 3 wks*
      - *Pt. Reduce and control pain to 2 / 10 to enable pain free sleeping 2 wks*
      - *Pt. Safely walk inside home no external assistance 2 wks*

        - *Pt. Increase mid scapular strength 4+ / 5 to reduce pain to 1 / 10 and sit at computer all day for work 4 wks*
    - Clearly stated plan of care delineating what will be provided, at what frequency and duration.
    - Examples:
        - *Gt train walker, 100', indep, no falls or stumbles for goal #3*
        - *T Ex isotonic, closed chain, progress no weight to 3 lbs, related to goal #4*
        - *US, 1.5w/cm@ X 8 minutes Left trap and levator, decrease spasms, trigger pts, increase circulation, pain modulation for goal #2*
        - *Discharge to Specialty Exercise Program*
    - Clearly stated **medical reason and rationale** for **each** modality utilized, especially when utilizing more than one modality to the same area and same session
- Daily Notes that include:
    - Statements that demonstrate the skill required by the OT, PT, OTA or PTA, under the supervision and
    - Direction of an OT or PT, not just statements of completion of activities (this can be seen on the flow sheet). Why can't patient perform their own exercises at home?
    - Statements that demonstrate co-founding factors that delay progress
    - Time In and Time Out or Total Time
    - Time for each CPT code billed.
    - Examples:
        - *Subjective complaints / descriptive / numerical pain / percentage of improvement*
        - *Complicating factors*
        - *Flow sheet (show progression and skill)*
        - *Observation of movement / measurements / function gain – loss / skill need / education of patient*
        - *Type and amount of manual, visual, verbal cues*
        - *Why needed*
        - *Constant verbal and tactile cues for shldr flex without substitution. Ther ex resulted increase shldr flx to 120 to comb hair, still unable to reach into cupboards at home.*
    - *Factors that modify frequency/intensity/progression*
        - *Performing shldr flex and abd ex incorrectly resulting increased impingement.*
        - *Painted bedroom with repeated overhead mvts increased pain.*
        - *Computer station ergonomic corrections not made, enhances poor posture and muscle imbalances aggravating sx.*
    - *Statement of clinical decision and problem solving*
        - *Poor control and contraction transverse ab muscles resulting in continued compression and sheering lumbar with pain and radicular sx requires neuro-ed ex and educ.*
        - *Poor blood sugar control resulting fatigue and avoidance of exercise. Speak to MD or DO.*
        - *Quad control in open chain good, transition into controlled functional closed chain in preparation for running.*

        - *Plan for next visit = intervention and objective*
- Progress notes (or re-eval) completed every 10 treatment sessions or every 30 days (whichever is less) that include:
    - Statements of pertinent subjective nature
    - Comparison of **objective, functional, measurable data** (at a minimum as indicated ROM, strength, neuro, ambulation, special tests, etc.)
    - Clearly delineated and **updated** measurable, time-framed goals that relate to **function** (i.e., what does the patient need to be doing before discharge from therapy?)
    - Clearly stated, **updated** plan of care delineating what will be provided, frequency and duration
    - Clear stated medical **reason and rationale** for continuance of **each** service utilized
        - *Evaluate status and modify plan. May simply mean continue current goals but state why*
        - *Billing 97164 or 97168 – Re-Eval*
            - *Unanticipated change*
            - *Failure to respond*
            - *New direction or plan*
        - *Compare similar data points*
        - *Goals addressed, updated*
        - *Reasons for lack of progress, changes needed*
- Flow sheets that include:
    - Date of service, area being treated, and name of OT, PT, OTA, or PTA providing services
    - Clearly delineated CPT Code
    - **Activity** completed for each CPT code including name of activity, repetitions, weights, resistance, etc.
    - Modalities (parameters, time frame, and specific location(s) treated)

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. 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.

Resources

- Medicare documentation standards: https://www.cms.gov/
- BCBSKS policies and procedures: https://www.bcbsks.com/providers/professional/publications
- Your BCBSKS contractual agreements
- Kansas statutes and rules/regulations: http://www.ksbha.org/statsandregs.shtml
- Kansas Physical Therapy Association
- Kansas Occupation Therapy Association
- Kansas Speech and Hearing Association

Signature Requirements

In the content of health records, each entry must be authenticated by the author. Authentication is the process of providing proof of the authorship signifying knowledge, approval, acceptance or obligation of the documentation in the health record, whether maintained in a paper or electronic format accomplished with a handwritten or electronic signature. Individuals providing care for the patient are responsible for documenting the care. The documentation must reflect who performed the service.

- The handwritten signature must be legible and contain at least the first initial and full last name along with credentials and date. A typed or printed name must be accompanied by a handwritten signature or initials with credentials and date.
- An electronic signature is a unique personal identifier such as a unique code, biometric, or password entered by the author of the electronic medical record (EMR) or electronic health record (EHR) via electronic means, and is automatically and permanently attached to the document when created including the author's first and last name, with credentials, with automatic dating and time stamping of the entry. After the entry is electronically signed, the text-editing feature should not be available for amending documentation. Example of an electronically signed signature: "Electronically signed by John Doe, M.D. on MM/DD/YYYY at XX:XX A.M."
- A digital signature is a digitized version of a handwritten signature on a pen pad and automatically converted to a digital signature that is affixed to the electronic document. The digital signature must be legible and contain the first and last name, credentials, and date.
- Rubber stamp signatures are not permissible. This provision does not affect stamped signatures on claims, which remain permissible.

BCBSKS Policies

While this is not a totally exhaustive listing, these are more common policies that apply to Occupational Therapy and Physical Therapy (as well as other providers):

- **When Physical Therapy Assistants (PTA) and Occupational Therapy Assistants (OTA) provide service, it is required that they bill under their own NPI and not the Physical/Occupational Therapist's NPI.**
- Vertebral Axial Decompression therapy must be billed using HCPCS code S9090. (*Blue Shield Report* May 28, 2003)
- VaxD, IDD, DR 5000, DR 9000, SpinaSystem, and similar vertebral axial decompression therapy are subject to this billing policy
- **ALLOW ONE** (1) unit per day based on documented medical necessity
- Accident Related Documentation – Payment for services related to an accident is NOT the same as those services for general medical coverage. In the event the services are being rendered as related to an accident, it is imperative that your documentation is clear and concise about:
- The details of the accident (simple statements like "they fell on 4-10-09" are insufficient)
- The objective, functional, measurable data that supports the medical problems that are a direct result of the accident and need for occupational/physical therapy services.

Physical and Occupational Therapy Documentation Checklist for Submission of Records – ACCIDENT

____ **Details of accident**

____ **Initial evaluation that includes:**

- Diagnosis (medical and occupational/physical therapy)
- History, patient stated problems, co-morbidities, medications review of past-present care
- Objective functional, measurable data (at a minimum as indicated ROM, strength, neuro, ambulation, special tests, etc.)
- Clearly delineated, measurable, time-framed goals that relate to function
- Clearly stated plan of care delineating what will be provided, frequency and duration
- Clearly stated medical reason and rationale for each modality utilized

____ **Daily Notes that include:**

- Statements that demonstrate the skill required by the OT, PT, OTA, or PTA under the supervision and direction of an OT or PT
- Statements that demonstrate co-founding factors that delay progress
- Time In and Time Out or Total Time
- Time for each CPT code billed

____ **Progress notes completed every 10 treatment sessions or every 30 days (whichever is less) that include:**

- Statements of pertinent subjective nature
- Comparison of objective, functional, measurable data (at a minimum as indicated ROM, strength, neuro, ambulation, special tests, etc.)
- Clearly delineated and updated measurable, time-framed goals that relate to function
- Clearly stated, updated plan of care delineating what will be provided, frequency and duration and why continued care is medically necessary.
- Clearly stated medical reason and rationale for continuance of each modality utilized

____ **Flow sheets that include:**

- Date of each service
- Clearly delineated CPT code
- Activity completed for each CPT code including name of activity, repetitions, weights, resistance, etc.
- Modalities (parameters, time frame, and specific location(s) treated)

____ **Patient's name on each page of the records**

____ **Record legible?**

____ **Does the record reflect why more than the allowable number of units per CPT code were utilized?**

Physical and Occupational Therapy Documentation Checklist for Submission of Records – NON-ACCIDENT

____ **Initial evaluation that includes:**

- Diagnosis (medical and occupational/physical therapy)
- History, patient stated problems, co-morbidities, medications, review of past-present care.
- Objective, functional, measurable data (at a minimum as indicated ROM, strength, neuro, ambulation, special tests, etc.)
- Clearly delineated, measurable, time-framed goals that relate to function
- Clearly stated plan of care delineating what will be provided, frequency and duration
- Clearly stated medical reason and rationale for each modality utilized

____ **Daily Notes that include:**

- Statements that demonstrate the skill required by the OT, PT, OTA or PTA under the supervision and direction of an OT or PT
- Statements that demonstrate co-founding factors that delay progress
- Time In and Time Out or Total Time
- Time for each CPT code billed

____ **Progress notes completed every 10 treatment sessions or every 30 days (whichever is less) that include:**

- Statements of pertinent subjective nature
- Comparison of objective, functional, measurable data (at a minimum as indicated ROM, strength, neuro, ambulation, special tests, etc.)
- Clearly delineated and updated measurable, time-framed goals that relate to function
- Clearly stated updated plan of care delineating what will be provided, frequency and duration and why continued care is medically necessary
- Clearly stated medical reason and rationale for continuance of each modality utilized

____ **Flow sheets that include:**

- Date of each service
- Clearly delineated CPT code
- Activity completed for each CPT code including name of activity, repetitions, weights, resistance, etc.
- Modalities (parameters, time frame, and specific location(s) treated)

____ **Patient's name on each page of the records**

____ **Record legible?**

____ **Does the record reflect why more than the allowable number of units per CPT code were utilized?**

Limited Patient Waiver

BlueCross BlueShield of Kansas

Section 1 – Patient Information

Clear Data

First Name | MI | Provider Name

Last Name | Suffix | Provider Address

Identification Number | City

Provider NPI | State | ZIP Code | +4

The provider must document in the patient record the discussion with the patient regarding the following service(s):

Section 2 – Notice of Personal Financial Obligation (Please read before signing)

I have been informed and do understand that the charge(s) for _____
Nomenclature/Procedure Code/Appliance

provided to me on ____ ____ _____ **will not be covered** because Blue Cross and Blue Shield of Kansas (BCBSKS) considers this service to be:

- ☐ Not medically necessary
- ☐ Deluxe features (applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract) – the allowance for standard item(s) will be applied to the deluxe item(s)
- ☐ Patient-requested services
- ☐ Utilization denials
- ☐ Experimental or investigational

It is my wish to have this service(s) performed even though it will not be paid by BCBSKS.

I understand that I will be held personally responsible for approximately $_____. This amount is an approximation only, based on the service(s) scheduled to be provided.

Options: Check only one box. We cannot choose for you.

- ☐ **Option 1:** I want the service listed above. I also want the provider to bill my insurance for the service provided so that a determination of coverage can be made by my carrier.
- ☐ **Option 2:** I want the service listed above, but do not want the provider to bill my insurance. I understand that I am responsible for the charge and have no appeal rights if the claim is not processed through my insurance.

Acknowledgment of personal financial obligation applies to charge(s) for service(s) specified above when performed by this or another provider(s).

I further understand any additional service(s) could affect the amount of my financial responsibility.

Your signature required

Patient (Signature of parent/guardian if other than patient) | Date Signed

I, _____ (witness name), did personally observe and do certify the person who signed above did read this notice and did affix their signature in my presence.

Your signature required

Witness | Date Signed

Revisions

01/01/2020	Combined Chiropractic and Rehabilitation manuals into Physical Medicine manual.
01/01/2021	Page 8 – Updated Dry Needling section
	Page 49/50 – Updated header for checklists
01/01/2022	Page 8 – Updated verbiage of Dry Needling denial reason
	Page 8 – Clarified E&M billing
	Page 11 – Added Interns under Ineligible Providers section
	Page 12 – Added information on patient directed care and removed applicable codes under Maintenance Care section
	Page 17 – Clarified coverage of E0730 and E0720
	Page 20 – Added A4630 to table

BlueCross BlueShield
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