

Physical Medicine



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Rehabilitation Services are covered only if they are expected to result in significant improvement in a 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](https://www.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.

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NOTE — The revision date appears in the footer of the document.

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
- 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), including the Federal Employee Health Benefit (FEHB) and Postal Services Health Benefit (PSHB), 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 Extrapinal (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 — Extrapinal 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. Cupping Therapy

This service should be coded using 97139 with a description of "cupping 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.

XIII. Direct Access

Physical therapists can initiate 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.

XIV. 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.

XV. 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.

If 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 www.bcbsks.com/providers/medical-policies.

XVI. Epley Maneuver/Canolith Repositioning Procedures

This service should be coded using 95992. 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.

Note: Submitting medical records will not change the unit limit for this code.

XVII. 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.

When a patient makes an appointment, a reason for the encounter needs to be established. Per AMA CPT®, a “concise statement describing the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter, usually stated in the patient’s words.”

At this point a diagnosis is established for the encounter. The reason for the encounter will be assigned an ICD-10 code to correlate with the AMA CPT® code. An ICD-10 code defines what prompted the encounter and the AMA CPT® code defines what service was performed during the encounter.

The different levels of office visits are determined by medical decision making (MDM) or time as outlined in the AMA CPT® guidelines. These guidelines do not establish documentation requirements of standards of care. History and examination should still be completed and documented, as medically appropriate.

XVIII. 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.

Static Progressive/Bi-directional

- See procedure codes E1801, E1806, E1811, E1816, E1818 and E1841.
- Considered experimental and investigational.
 - This service is considered experimental and 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.

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

XIX. 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.

XX. 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.

XXI. Functional Electrical Stimulation (FES)

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

XXII. 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.

XXIII. 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)

XXIV. HIVAMAT

This service is considered experimental and investigational and is a provider write-off unless a Limited Patient Waiver is signed before performance of the service. Use modifier “GA” to demonstrate a waiver on file.

XXV. 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.

XXVI. 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.

XXVII. Ineligible Providers

The following providers are not considered eligible providers as defined in the local BCBSKS member contracts, or for FEP, including the Federal Health Benefit (FEHB) and Postal Services Health Benefit (PSHB). 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.

XXVIII. 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.

XXIX. Magnatherm

This service should be coded as 97024.

Magnatherm is considered one unit of service per area.

XXX. 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 must 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 rendering the service.

Use modifier "GA" to demonstrate waiver on file.

XXXI. 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.

XXXII. 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.

XXXIII. 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, micro-electrical 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.

XXXIV. 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.

XXXV. 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.

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

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.

Units on Time-Based Physical Medicine Codes

When only one service is provided in a day, providers should not bill for services performed for less than 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.

XXXVI. 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.

XXXVII. 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.

Certification for In-State Providers — Reimbursement guidelines are based on the certification of the performing provider.

Medical Policy — To review medical necessity guidelines, visit the Medical Policy section of the BCBSKS website.

See Policy Memo No. 1 for more information.

XXXVIII. Occupational Therapists

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

XXXIX. Pathology (Labs)/Radiology

All clinical laboratory tests must be billed by the entity that performs the entire exam using CPT codes. See Policy Memo No. 1 for coordinating services with a non-contracting provider.

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.

For more information on radiology and pathology services, see Policy Memo No. 7.

- 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 the Annual CAP Report for QBRP incentives for Low-Back Pain imaging.

XL. 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.

XLI. Physical Therapists

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

Telehealth/Telemedicine services are not a covered service.

XLII. 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.

XLIII. Roller Bed Services

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.

XLIV. Speech Therapy

Speech Therapy is the treatment of speech and communication disorders. It may include physical exercises to strengthen the muscles used in speech (oral motor work), speech drills to improve clarity, or sound production practice to improve articulation.

Maximum benefit limitations are determined by member benefits.

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

XLV. 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.

XLVI. 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).

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

This service should be coded as E0730.

Rental and purchase of E0720 (2 lead) 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.

You can review the medical policy Electrical Stimulation Devices for Home and Provider Use on our website, www.bcbsks.com/providers/medical-policies.

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.

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	<p>NOTE – Do not bill in-office use of electrodes under this code. Those electrodes are content of the modality being performed.</p> <p>Content of service of rental of equipment. Covered if equipment purchased for home use. Submit date purchased and by whom on claim attachment. 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</p>
A4557	LEAD WIRES, per pair	2 PAIRS EVERY 6 Months	<p>NOTE: Do not bill in-office use of lead wires under this code. Those lead wires are content of the modality being performed.</p> <p>Content of service of rental of equipment. Covered if equipment purchased for home use. Submit date purchased and by whom on claim attachment. 2 pairs = 002 units of service 4 lead wires = 002 units of service</p>
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		<p>Included in the equipment reimbursement.</p> <p>If using an outside vendor, you should look to them for reimbursement of this service.</p>
90901	BIOFEEDBACK training by any modality		<p>Usually, non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to Availity.com.</p>
90911	BIOFEEDBACK training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry by any modality		<p>Usually, non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to Availity.com.</p>
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 <i>One or more areas is one unit of service</i> The clinician applies heat (dry or moist) or cold to one or more body parts with appropriate padding to prevent skin irritation. The patient is given necessary safety instructions. The treatment requires supervision only.	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 <i>One or more areas is one unit of service</i> The clinician applies sustained or intermittent mechanical traction to the cervical and/or lumbar spine. The mechanical force produces distraction between the vertebrae thereby relieving pain and increasing tissue flexibility. Once applied, the treatment requires supervision.	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	<p>ELECTRICAL STIMULATION, INTERFERENTIAL THERAPY, HORIZONTAL THERAPY</p> <p>Unattended <i>One or more areas is one unit of service</i> The clinician applies electrical stimulation to one or more areas in order to stimulate muscle function, enhance healing, and alleviate pain and/or edema. The clinician chooses which type of electrical stimulation is appropriate. The treatment is supervised after the electrodes are applied.</p>	ONE	<p>This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p> <p>Billing of electrodes The electrodes and other supplies used to administer any modality are content of service of the modality.</p> <p>Do not bill them under A4556.</p> <p>That code is for <u>take home supplies</u> dispensed by a home medical equipment supplier.</p>
97016	<p>VASOPNEUMATIC DEVICES Unattended <i>One or more areas is one unit of service</i> The clinician applies a vasopneumatic device to treat extremity edema (usually lymphedema.) A pressurized sleeve is applied. Girth measurements are taken pre and post treatment. Supervision is required.</p>	ONE	<p>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.</p> <p>This code is one or more areas, so the unit of service is limited to one regardless of the time spent or the number of areas treated.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p>
97018	<p>PARAFFIN BATH Unattended <i>One or more areas is one unit of service</i> The clinician uses a paraffin bath to apply superficial heat to a hand or foot. The part is repeatedly dipped into the paraffin forming a "glove." Use of paraffin facilitates treatment of arthritis and other conditions that cause limitations in joint flexibility. Once the paraffin is applied and the patient instructions are provided, the procedure requires supervision.</p>	ONE	<p>This code is one or more areas, so the unit of service is limited to one regardless of the time spent or the number of areas treated.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p>

Code	Description	Units allowed per day	Special Instructions
97022	<p>WHIRLPOOL (FLUIDOTHERAPY) Unattended <i>One or more areas is one unit of service</i></p> <p>The clinician uses a whirlpool to provide superficial heat in an environment that facilitates tissue debridement, wound cleaning and/or exercise. The clinician decides the appropriate water temperature, provides safety instruction and supervises the treatment.</p>	ONE	<p>By accepted professional definition and by description in the AMA-CPT book the treatment provided by the use of an “aqua massage” unit would be appropriately described as a massage (97039) and not whirlpool.</p> <p>Whirlpool (97022) would not be appropriate as whirlpool is descriptive of a specific apparatus and treatment.</p> <p><u><i>A key component of whirlpool is immersion of the body part in the water.</i></u></p> <p>By the following descriptions, whirlpools would not correctly describe the use of an aqua massage table.</p> <ol style="list-style-type: none"> 1. The clinician utilizes whirlpool to provide superficial heat in an environment that facilitates tissue debridement, would cleaning and/or exercise. <p>Warm whirlpool <i>Equipment needed:</i></p> <ol style="list-style-type: none"> 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. <p><i>Treatment:</i></p> <ol style="list-style-type: none"> a. The patient should be positioned comfortably, 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. <p><i>Considerations:</i></p> <ol style="list-style-type: none"> 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. <p>The above is from “Therapeutic Modalities in Sports Medicine, Third Edition, Mosby-Yearbook Inc., 1994.</p> <p>If more than one unit of service attach medical records.</p>
97024	<p>DIATHERMY (eg, microwave) Magnatherm Unattended <i>One or more areas is one unit of service</i></p> <p>The clinician uses diathermy as a form of superficial heat for one or more body areas. After application and safety instructions have been provided, the clinician supervises the treatment.</p>	ONE	<p>This code is one or more areas, so the unit of service is limited to one regardless of the time spent or the number of areas treated.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p>

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: <ul style="list-style-type: none"> • Anodyne Therapy • Cold Laser Therapy • Low Laser Therapy • Soft Laser Therapy For information concerning these therapies please refer to information given earlier. 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 <u>take home supplies</u> 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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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	<p>MASSAGE Attended One or more areas 15 minutes is one unit of service</p> <p>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 from the clinician.</p>	ONE	<p>This code will be denied content of service unless it is the only service provided on that date.</p> <p>General Guidelines: This code includes:</p> <ul style="list-style-type: none"> a. Stroking b. Compression for pain relief or muscle spasm c. Percussion for pain relief or muscle spasm <p>See previously in this manual a section on massage and the guidelines that are applied.</p>
97139	<p>UNLISTED THERAPEUTIC PROCEDURE One or more areas 15 minutes is one unit of service</p> <p>This code is used if the clinician performs a therapeutic procedure to one or more areas that is not listed under the current codes.</p>	ONE	<p>Specify type of therapeutic procedure and time on claim attachment.</p> <p>Attach medical records.</p> <p>i.e., Anti-Gravity Lumbar Traction-reverse (Inversion) Posture Pump Cupping Therapy Use "GA" modifier Get Limited Patient Waiver</p>
97140	<p>MANUAL THERAPY TECHNIQUES Attended One or more areas 15 minutes is one unit of service</p> <p>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 from the clinician.</p> <p>APPLIED KINESIOLOGY</p>	<p>TWO</p> <p>FOUR UNITS WILL BE ALLOWED FOR LYMPHATIC DRAINAGE</p>	<p><u>MDs, DOs, DCs do not use this code for your manipulations, they must be coded under 98925-98943</u></p> <p>DO NOT USE THIS CODE FOR MASSAGE THERAPY (97124)</p> <p>97140 WILL DENY CONTENT TO THE MANIPULATION</p> <p>This code includes:</p> <ul style="list-style-type: none"> a. Lymphatic drainage b. Manual traction c. MFR d. Soft tissue work e. Trigger point therapy f. Joint mobilization <p>If more than two units (23 through 37 minutes; note areas treated) of service attach medical records.</p> <p>May be medically justified with appropriate documentation.</p>

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., <i>activities of daily living</i> and use of adaptive equipment in the kitchen, bath and/or car). This service requires direct contact from 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. <u>MDs, DOs, DCs do not use this code unless you are truly performing the services listed.</u> This code includes: a. Shopping b. Transportation c. Money management d. A vocational activity or work environment/modification analysis e. Work task analysis If more than one unit (16+ minutes; note areas treated) of service attach medical records.
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 <i>Each additional hour</i> 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, (e.g., 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 (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (e.g., 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 <i>Per session</i> 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 ongoing 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 (e.g., 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 www.bcbsks.com/providers/medical-policies .
97606	NEGATIVE PRESSURE WOUND THERAPY (e.g., 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 www.bcbsks.com/providers/medical-policies .
97607	NEGATIVE PRESSURE WOUND THERAPY (e.g., 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 www.bcbsks.com/providers/medical-policies .

Code	Description	Units allowed per day	Special Instructions
97608	NEGATIVE PRESSURE WOUND THERAPY (e.g., 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 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.
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.
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.

Code	Description	Units allowed per day	Special Instructions
97813	ACUPUNCTURE <i>One or more needles; with electrical stimulation INITIAL 15 minutes of personal one-on-one contact with the patient</i> 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 <i>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)</i> 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.
98940	CHIROPRACTIC MANIPULATIVE TREATMENT, SPINAL <i>One to two regions</i>	1	
98941	CHIROPRACTIC MANIPULATIVE TREATMENT, SPINAL <i>Three to four regions</i>	1	
98942	CHIROPRACTIC MANIPULATIVE TREATMENT, SPINAL <i>Five regions</i>	1	
98943	CHIROPRACTIC MANIPULATIVE TREATMENT, EXTRASPINAL <i>One or more regions</i>	1	

Code	Description	Units allowed per day	Special Instructions
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.

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 – BCBSKS 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.

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?

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
01/01/2023	Page 6 – Updated Audit Red Flags section to reflect current practices
	Page 8 – Updated Evaluation and Management (E/M) codes section to reflect current and accurate information
	Page 9 – Updated Bi-directional to be “Static Progressive/Bi-directional” section, considered E&I, and included link to medical policy
	Page 10 – Added section XXII. HIVAMAT
	Page 34 – Removed code 97762
01/01/2024	Page 18 – Added medical policy information under Section XLVIII
	Page 38 – Under Bullet 10, added new bullet a
06/17/2024	Page 9 – Updated XVI, static Progressive/Bi-directional to reflect current practices
01/01/2025	Updated throughout manual to state FEP includes Federal Employee Health Benefit (FEHB) and new Postal Services Health Benefit (PSHB)
	Page 8 – Added Cupping Therapy Section and Epley Maneuver/Canolith Repositioning Procedures sections – thus updating section numbers throughout the rest of the manual
	Page 9 – Updated 6 th bullet under Static Progressive/Bi-directional header
	Page 15 – Renamed section XXXVII to Roller Bed Services
	Page 16 – Added Telehealth/Telemedicine bullet under section XLI: Physical Therapists
	Page 17 – Clarified verbiage under Section XLIV: Speech Therapy
	Page 18 – Clarified second bullet under section XLVII: Tiered Reimbursement
01/01/2026	Removed links throughout
	Page 9 – Clarified verbiage in Section XV: Dry Needling
	Page 13 – Clarified verbiage in Section XXX: Maintenance Care

	Page 15 – Clarified verbiage in Section XXXV: Multiple Units of Physical Medicine Modalities and Procedures on Same Date of Service
	Page 17 – Removed Section XXXVIII: Non-Contracting Providers for clarity.
	Page 17 – Combined Pathology (Labs) and Radiology into one section, XXXIX, to reduce redundancy.
	Page 18 – Updated XLI” Physical Therapist for clarity and to reduce redundancy.
	Page 19 – Reordered Roller Bed Services to XLIII for alphabetical purposes.
	Page 20 – Removed XLIX: Tiered Reimbursement for redundancy.
	Page 21 – Clarified verbiage in XLIX: Vertebral Axial Decompression Therapy
	Page 21 – Removed Section LIII: Wound Debridement Billed with Evaluation for clarity.
	Page 39 – Removed Documentation Guidelines – Chiropractic for redundancy.
	Page 46 – Removed Documentation Guidelines – Occupational and Physical Therapists for redundancy.
	Page 52 – Removed Limited Patient Waiver for redundancy.

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