2024 Complete CPT and ICD10
For the Chiropractic Provider

Book 3

"it is critical to stay abreast of changes in CPT and ICD10 and payer billing guidelines related to coding...maintaining current knowledge is imperative for the long-term survival and safety of a practice."

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If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSIL may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSIL has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Chiropractic Care Services

Policy Number: CPCP016

Version 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: March 15, 2023

Plan Effective Date: March 15, 2023

Description

The practice of chiropractic care services focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. These services are provided on an inpatient or outpatient basis, within the scope of licensure and practice of a chiropractor, to the extent services would be covered if provided by a Medical Doctor or Chiropractor.

Definitions:

Chiropractic Manipulative Treatment (CMT) - CMT procedures use high-velocity, short-lever, low-amplitude

thrust by hand or instrument to remove structural dysfunction in joints and muscles that may be associated with neurologic or mechanical dysfunction of the spinal joints and surrounding tissue.

There are 2 types of CMT:

- **Spinal**: manipulative treatment of cervical, thoracic, lumbar, sacral, and pelvic regions
- **Extraspinal**: manipulative treatment of the appendicular skeleton

Chiropractic Maintenance Care - A maintenance program consists of activities that preserve the patient's present level of function and prevents regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur. Ongoing treatment after a condition has been stabilized or reached a clinical plateau (Maximum Therapeutic Benefit) does not qualify as medically necessary and is considered maintenance care. Supportive therapy also refers to therapy that is needed to maintain or sustain level of function. Maintenance Care and Supportive Care are not medically reasonable or necessary and are NOT payable.

Providers of Chiropractic Services – Qualified providers of chiropractic services act within the scope of their license that is regulated by the Federal and State governments. Only those healthcare practitioners who hold an active license, certification, or registration with the applicable state board or agency may provide services under the direction and supervision of a chiropractor. The scope and extent of such services, when provided as part of a chiropractic treatment plan and billed by the chiropractor, may be regulated by the applicable state board responsible for the licensure of the chiropractor. Nonqualified personnel that do not meet the definition of qualified healthcare professional (QHP) are limited to non-skilled services. They may not bill any direct treatments, modalities, or procedures.

Date of Injury (DOI) - The actual date of the current injury. This information is entered in Box 14 of the CMS-1500 claim form.

Durable Condition Specific Benefit- A measurable improvement in or restoration of a functional impairment that resulted from a specific disease, trauma, congenital anomaly, or therapeutic intervention; and able to be sustained long-term without significant deterioration.

Exacerbation - An increase in severity of the patient's condition or symptoms.

Qualified Healthcare Professional (QHP) - Is an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.

Initial Treatment Date (ITD) - The date of the initial treatment (visit). This information is entered in Box 15 (other date) of the CMS-1500 claim form.

Therapeutic Procedure - A manner of affecting change through the application of clinical skills and/or services that attempt to improve function.

Reimbursement Information:

Providers are to bill and document appropriately for all services submitted. The plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement. Claims may be reviewed on a case-by-case basis. If you have any questions, please contact your provider network representative.

Documentation Standards

Records must:

- Indicate the dates any professional service was provided.
- List the direct one-on-one contact time spent for each timed code per CPT nomenclature.
- Be **legible** in both readability and content. Documentation that is not legible cannot be used to support services rendered.
- Contain only those terms and abbreviations easily comprehended by peers of similar licensure. If a legend is needed to review your records, maintain it with your records. Include documentation showing the members need for chiropractic care and any changes since the last visit. Documentation must also include a clear description of the treatment provided and how the member tolerated the treatment.
- Contain clinically pertinent subjective information from the member. Include the chief complaint and any changes in the members condition, the members response to care since the previous visit, and the members subjective progress relative to the outcome measures documented in the treatment plan. **(Subjective information and history)**.
- Contain clinically pertinent objective data or examination findings from your exam of the member. This data provides a way to verify diagnosis codes, establishes changes in response to care and provides evidence for the necessity of the treatment that day. **(Objective data)**
- Indicate the initial diagnosis and the member's initial reason for seeking the provider's care. The diagnosis should be recorded in the record and reflected on the claim form. Each daily visit must also include an assessment of the member's condition. The assessment of the member's progression must be based upon the subjective and objective findings. Include the diagnosis being managed on the visit and the assessment of the overall progress. Provide rationale for continued care or changes in the therapeutic direction. Provide an evaluation of the treatment effectiveness and progress or lack thereof as it relates to the treatment goals and plan of care. **(Assessment)**
- Document the treatment details performed during the visit including the medical rationale. Include any member instructions. Documentation must support that each manipulation or treatment reported relates to a relevant symptomatic spinal and/or extraspinal region. Symptoms must bear a direct relationship to the level of subluxation cited. Documentation of "pain" is not sufficient; the location of pain or condition must be described. Also, include the member's immediate response to care and plans for future care. Indicate when the member is to return, visit number as it relates to the treatment plan with the anticipated date of next evaluation. Include any goals and outcome measures for a new problem or a problem re-assessment. **(Plan)**
- A written plan of treatment relating to the type, amount, frequency, and duration of care is required for all members. The plan of care must be updated as the member's condition changes. A treatment plan is not valid for longer than 90 calendar days from the first treatment day under the certified treatment plan. The goal of the treatment plan should be to achieve functional improvements in the member's condition. Specific treatment goals must be documented with anticipated time frames and objective measures to evaluate treatment effectiveness. Each complaint should be listed with selected treatment, duration, frequency, treatment goals, and objective measures to evaluate progress. The treatment plan

should include the rationale for all services provided. A plan of care should be individualized for each member. **(Plan of Care)**

- Signature requirements- Each medical record must be signed and dated by the clinician performing the service. A legible physical or electronic signature is required. The medical record should be signed at the time services are rendered. Providers should not add late signatures to the medical record beyond the short delay that occurs during the transcription process. Generally, 24-48 hours is the typical turnaround time for the provider transcription process.
- It is essential for the provider 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. (Subjective, Objective, Assessment, Plan) note format, which is considered a medical standard. Check marks, small entries and other commonly illegible notions seldom provide adequate documentation to support services billed. Please ensure that the medical records documentation is concise and complete.
- For additional information on Templated, Copy and Paste or Cloned Medical Records, please see CPCP029 Medical Record Documentation.

Coding Standards

- Proper coding is essential for correct reimbursement. Providers are encouraged to utilize current copies of ICD-10 -CM, CPT, and HCPCS books published by the American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS).
- Use the diagnosis and procedure codes effective for the date of service.

Diagnosis Codes

- New ICD10-CM diagnosis codes are updated annually in October.
- Some diagnosis codes require a 7th digit to code to the highest specificity.
- Update diagnosis and coding for every new episode, including a re-exam or an examination for a 'new' problem. Document any diagnosis coding change even if it is minor.
- Link the diagnosis to the service provided to support medical necessity and specificity. For example, when performing manual therapy with manipulation, the diagnosis pointer code(s) should point to the specific diagnosed condition that supports specific procedures billed. (Box 24E of the CMS-1500 claim form).

CPT Codes

Evaluation and Management (E/M) Services (CPT Codes: 99202-99205, 99211-99215)
To bill for an evaluation and management service, the complete CPT guidelines must be met for each service. The service must also be separately identifiable and distinct from any other service you perform on the member that day.

Chiropractic Manipulative Treatment (CPT codes 98940-98943)
Each CPT code reflects a specific number of regions, regardless of how many manipulations are performed in that region. For example, chiropractic manipulation applied to C3 and C5 during the same visit represent treatment to only one region (cervical) and should be reported with CPT code 98940.
All CPT codes for CMT must have a supporting ICD-10-CM diagnosis code to justify the level of care provided. For example, when billing CPT 98941, there must be ICD-10-CMcodes that incorporate at least three different

regions.

To bill these codes, the documentation must include:

- Location of pain/condition for which treatment is being sought.
- The specific spinal regions adjusted, and the technique used.
- The response to the treatment/adjustment, including whether or not the pain/condition being treated increased, reduced, or eliminated the problem.
- Each manipulation reported must be related to the patient's complaints and a relevant symptomatic spinal or extraspinal level.

For physical therapy services, providers should refer to CPCP040 Physical Medicine & Rehabilitation Services

CMT Components

Pre-Service	A brief evaluation of the member's medical record documentation and chart review, imaging review, test interpretation and care planning
Intra-Service	Treatment applied, Pre-manipulation (e.g., palpation, etc.), Manipulation, Post-manipulation (e.g., assessment, etc.)
Post-Service	Chart entry and documentation, including subjective, objective, assessment, plan consultation reporting

Evaluation and Management (E/M) Coding and CMT Codes

Billing an Evaluation and Management (E/M) Code **with a CMT code:**
In general, it is inappropriate to bill an established office/outpatient E/M CPT code (99211-99215) on the same visit as Chiropractic Manipulative Treatment (CPT code 98940-98943) because CMT codes already include a brief pre-manipulation assessment. There are times when it would be appropriate, but it should not be routine. Examples of when it may be appropriate to bill an additional E/M service would be the evaluation of new patients, new injuries, exacerbations, or periodic re-evaluations.

Billing an Evaluation and Management Code **in place of a CMT code:**
It is not appropriate to bill an E/M code instead of a CMT code to circumvent CMT limits. It is required to bill the code that best describes the service rendered.

Diagnostic Imaging Services

The purpose of diagnostic imaging is to gain diagnostic information regarding the member in terms of diagnosis, prognosis, and therapy planning. Required standards for each imaging study must meet the following four standards:

- The study must be obtained based on clinical need;
- The study must be of sufficient diagnostic quality;
- There must be documented interpretation of the study to reach a diagnostic conclusion; and
- The information from the study must be correlated with patient management.

The selection of patients for radiographic examination is based on the following criteria.

- The need for radiographic examination is based on history and physical examination findings.
- The potential diagnostic benefit of the radiographic examination is judged to outweigh the risks of ionizing radiation.
- Radiography is used to help the practitioner diagnosis pathology, identify contraindications to chiropractic care, identify bone and joint morphology, and acquire postural, kinematic, and biomechanical information.
- Routine radiography of patients as a screening procedure is not appropriate practice except under public health guidelines.

Components of a Written Radiology Report

As a written record of the interpretive findings, the radiology report serves as an important part of the member's medical record and must contain the following items:

- Patient identification
- Location where studies were performed
- Study dates
- Types of studies
- Radiographic findings
- Diagnostic impressions; and
- Signature with professional qualifications included

Radiology reports may also include recommendations for follow-up studies and comments for further patient evaluation.

Additional Resources:

CPCP040 Physical Medicine & Rehabilitation Services

CPCP029 Medical Record Documentation Guidelines

References:

blue of california

Payment Policy

Chiropractic Care	
Original effect date:	Revision date:
04/08/2015	01/01/2023

IMPORTANT INFORMATION

Blue Shield of California payment policy may follow industry standard recommendations from various sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT) and/or other professional organizations and societies for individual provider scope of practice or other coding guidelines. The above referenced payment policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms or their electronic equivalent. This payment policy is intended to serve as a general overview and does not address every aspect of the claims reimbursement methodology. This information is intended to serve only as a general reference regarding Blue Shield's payment policy and is not intended to address every facet of a reimbursement situation. Blue Shield of California may use sound discretion in interpreting and applying this policy to health care services provided in a particular case. Furthermore, the policy does not address all payment attributes related to reimbursement for health care services provided to a member. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy such as coding methodology, industry-standard reimbursement logic, regulatory/legislative requirements, benefit design, medical and drug policies. Coverage is subject to the terms, conditions and limitation of an individual member's programs benefits.

Application

Blue Shield of California's Chiropractic Care Payment Policy will apply to professional services performed by a Chiropractor that are within her/his scope of license as defined by the State of California.

Policy

This payment policy shall apply to the following services, when allowable:

- Effective 12/01/2017, Blue Shield of California will pay the Evaluation and Management Services (99050-99499) that are within the scope of licensure, as per the updated Fee Schedule Rates.
- 100% of the Blue Shield of California published Physician Fee Schedule for radiology services within scope of licensure, except for radiology services that are subject to the Multiple Procedure Reduction for Radiology policy.

- 100% of the Blue Shield of California published Physician Fee Schedule for medical supplies within scope of licensure.
- 75% of the Blue Shield of California published Physician Fee Schedule for the initial service of: strapping[1,2], splinting, or other procedures, and 37.5% for the subsequent strapping, splinting and/or other procedures performed on a different body area on the same day within the scope of licensure.
- For Physical Therapy, Electrical Stimulation, and Chiropractic Manipulation, please refer to the Physical Medicine Payment Policy[3].

Note:

1. When the purpose of strapping or splinting is immobilization, then the strapping codes (29200, 29240, 29260, 29280, 29520, 29530, 29540, 29550, 29580, or 29799) may be appropriate; as those codes describe the use of a strap or other reinforced material applied post-fracture or other injury to immobilize the joint.
2. The strapping codes when used for Kinesiology Taping to increase mobility (for improving strength, range of motion, and coordination); are considered bundled, as they are inclusive to the therapy codes.
3. Physical Medicine Multiple Procedure Payment Reduction Payment Policy – Multiple Procedure Payment Reduction (MPPR) will apply as published for all physical therapy, electrical stimulation, and chiropractic manipulation services.

Procedure Unit	Percentage of Reimbursement
First unit with highest Relative Value Units (RVUs)	100% of allowed amount
Second unit with the next highest RVUs	85% of allowed amount
Third unit with the next highest RVUs	40% of allowed amount
Fourth unit with the next highest RVUs	40% of allowed amount
Fifth and subsequent procedure units	10% of allowed amount

Rationale

Blue Shield Multiple Procedure Payment Reduction policy applies to all the codes in the Physical Medicine section of the Current Procedural Terminology - AMA code book. Additionally, subsequent services do not require the same relative effort and are therefore paid as a percentage of the Blue Shield of California Physician Fee Schedule.

Reimbursement Guideline

Blue Shield of California will reference national or regional industry standards, such as Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and MUE (Medically Unlikely Edits) rules, and American Medical Association's (AMA) CPT guidelines, as coding standards and as guidance for payment policy. In

claims payment scenarios where CMS and/or CPT reference is lacking or insufficient, the Payment Policy Committee (PPC) may develop customized payment policies that are based on other accepted or analogous industry payment standards and or expert input.

Resources:
• **American Medical Association** https://www.ama-assn.org/ama • **Centers for Medicare & Medicaid Services** https://www.cms.gov/

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Payment Policy.

Effective Date	Action	Reason
04/08/2015	New Policy Adoption	Payment Policy Committee
01/01/2016	Maintenance	Payment Policy Committee
06/01/2016	Maintenance	Payment Policy Committee
06/15/2016	Maintenance	Payment Policy Committee
01/01/2017	Formatting Revision	Payment Policy Committee
07/08/2017	Formatting Revision	Payment Policy Committee
12/01/2017	Maintenance	Payment Policy Committee
08/03/2018	Maintenance	Payment Policy Committee
01/01/2023	Added strapping codes 29550, 29580	Payment Policy Maintenance

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under an enrollee's contract.

These Policies are subject to change as new information becomes available.

2024 CHIROPRACTIC MANIPULATION (98940-98943) PHYSICAL MEDICINE & REHABILITATION (97010 - 97799)

CHIROPRACTIC MANIPULATION

98940 Chiropractic manipulative treatment, spinal one or two regions
98941 Chiropractic manipulative treatment, spinal three or four regions
98942 Chiropractic manipulative treatment, spinal five regions
98943 Chiropractic manipulative treatment, extraspinal one or more regions

MODALITIES

Any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.

SUPERVISED

The application of a modality that *does not* require direct (one on one) patient contact by the provider.

Application of a modality to one or more areas;

97010 Hot or cold packs
97012 Traction, mechanical
97014 Electrical stimulation, (unattended)
G0283 Electrical stimulation, (unattended) **VA,MC, UHC**
97016 Vasopneumatic devices
97018 Paraffin bath
97022 Whirlpool
97024 Diathermy (Includes Microwave)
97026 Infrared
97028 Ultraviolet

CONSTANT ATTENDANCE

The application of a modality that requires direct (one on one) patient contact by the provider.

Application of a modality to one or more areas;

97032 Electrical Stimulation (manual), 15 min.
97033 Iontophoresis, each 15 minutes
97034 Contrast baths, each 15 minutes
97035 Ultrasound, each 15 minutes
97036 Hubbard tank, each 15 minutes
97039 Unlisted modality (specify type and time if constant attendance)
S8930 Electrical stimulation of auricular acupuncture points; each 15 minutes of personal one-on-one contact with the patient

LASER

S8948 Application of a modality with constant attendance to one or more areas; Low-level laser; each 15 minutes
0552T Low level laser therapy dynamic photonic and dynamic thermokinetic energies, provided by physician or other qualified health professional

THERAPEUTIC PROCEDURES

A manner of effecting change through the application of clinical skills and or services that attempt to improve function.

Physician or therapist required to have direct (one on one) patient contact.

Therapeutic procedure, one or more areas, 15 min;

97110 Therapeutic exercises to develop strength and endurance, range of motion and flexibility.
97112 Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception.
97113 Aquatic therapy with therapeutic exercises
97116 Gait training (includes stair climbing)
97124 Massage, including effleurage, petrissage, tapotement (stroking, compression, percussion)
97139 Unlisted therapeutic procedure (specify)
97140 Manual therapy techniques, one or more regions. (for example: mobilization/manipulation, manual traction, manual lymphatic drainage)

ADDITIONAL PROCEDURES

97150 Therapeutic procedure(s), group (2 or more)
97530 Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 min.
97535 Self care/home management training (eg. activities of daily living (ADL) and compensatory train ing, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes.
97537 Community/work reintegration training (eg. avocational activities and/or work environment/ modification analysis, work task analysis), direct one on one contact by provider, each 15 minutes.
97542 Wheelchair mgmt/propulsion trning, each 15 min.
97545 Work hardening/conditioning; initial 2 hrs.
97546 *each additional hour*
97799 Unlisted physical medicine/rehabilitation service.

ORTHOTIC FITTING AND TRAINING

97760 Orthotics management and training (including as sessment and fitting when not otherwise reported) upper and lower extremities or trunk each 15 min.
97763 Orthotic(s)/Prosthetic(s) management and or training upper and lower extremity(ties) and or trunk, subse quent encounter each 15 minutes

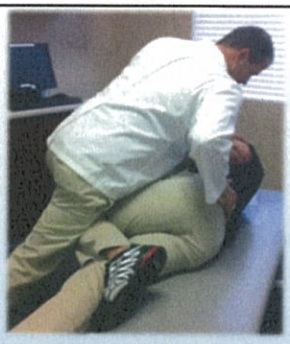
TESTS & MEASUREMENTS

97750 Physical performance test / measurement(eg, mus culoskeletal functional capacity) with written report, each 15 min.

MAINTENANCE CARE

S8990 Physical or manipulative therapy performed for maintenance rather than restoration

CMT



- 98940 1-2 regions
- 98941 3-4 regions
- 98942 5 regions
- 98943 Extraspinal regions (one or more)

- Code is determined by diagnosis and regions manipulated not the technique or style of manipulation alone
- Spinal regions not vertebra

- **98940** Chiropractic manipulative treatment (CMT); spinal, one to two regions. Documentation must include a validated diagnosis for one or two spinal regions and support that manipulative treatment occurred in one to two regions of the spine (region as defined by CPT).
- **98941** Chiropractic manipulative treatment (CMT); spinal, three to four regions. Documentation must support that manipulative treatment occurred in three to four regions of the spine (region as defined by CPT) and one of the following:

  1. validated diagnoses for three or four spinal regions
  2. validated diagnoses for two spinal regions, plus one or two adjacent spinal regions with documented soft tissue and segmental findings

- **98942** Chiropractic manipulative treatment (CMT); spinal, five regions. Documentation must support that manipulative treatment occurred in five regions of the spine (region as defined by CPT) and one of the following:

  1. validated diagnoses for five spinal regions
  2. validated diagnoses for three spinal regions, plus two adjacent spinal regions with documented soft tissue and segmental findings
  3. validated diagnoses for four spinal regions, plus one adjacent spinal region with documented soft tissue and segmental findings

- **98943** Chiropractic manipulative treatment (CMT); extraspinal, one to five regions. Documentation must support that manipulative treatment occurred in one or more extraspinal regions (as defined by CPT), and there is a validated diagnosis for one or more extraspinal regions for which manipulation has been shown to be both safe and efficacious
  - Optum Chiropractic Manipulative Treatment Reimbursement Policy

Counting Time as a Function of Work
Pre-service time includes assessment and management time - medical record review, physician contact while the patient is present, assessment of the patient's progress since the previous visit, and time required to establish a clinical judgment for the treatment session. Pre-service time is not the time required to get the patient ready to receive the treatment.
Intra-service time includes the hands-on treatment time.
Post-service time includes the assessment of treatment effectiveness, communication with the patient/caregiver to include education/instruction/counseling/advising, professional communications, clinical judgment required for treatment planning for the next treatment session, and documentation while the patient is present.

Counting Minutes for Timed Codes in 15 Minute Units
When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code on the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:
Units Number of Minutes
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
The pattern remains the same for treatment times in excess of 2 hours.

Only one time-based code may be performed at a time.
If more than one procedure code is billed for the same date of service, then in order to fully support all of the billed services the time must be separately documented for each specific procedure or time-based service. This will clearly document what portion of the total visit was spent performing each of the billed codes.

Methods and examples for time documentation:

Acceptable:
• Specific number of minutes. Example: "Manual therapy to lumbar spine x 15 minutes."
• Listing begin-time and end-time for service. Example: "E-stim to cervical neck, 09:30 – 09:45."

Unacceptable:
• Documenting time in terms of "units". Examples: "One unit of pulsed ultrasound was administered." or "Ther Ex 1 unit."
• Documenting time using a range. Example: "Therapeutic activities x 6 – 12 minutes as appropriate per assessment and symptoms."
• Documenting a quantity but not specifying the measurement or increment used. Example: "97110 Exercises x 2"
• No time mentioned at all. Example: Checking or circling "NMR" or "TE" with no additional information documented.

- **Time-Based Codes**
  - For any time-based procedure codes, the duration of the service must clearly be documented in the medical record. If the duration of the time-based service is not clearly and properly documented in the medical record, then the service is not supported due to incomplete documentation; the procedure code will be denied as not documented.
  - If more than one procedure code is billed for the same date of service, in order to fully support all of the billed services, the time must be separately documented for each specific procedure or time-based service. This will clearly document what portion of the total visit was spent performing each of the billed codes.
    - Unacceptable documentation of time-based codes:
    - Documenting time in terms of "units"
    - Documenting time using a range
    - Documenting a quantity but not specifying the measurement or increment used
    - No time mentioned at all

UnitedHealthcare

Cigna

Physical therapy, occupational therapy, and chiropractic claims for greater than four units (60 minutes) of timed service

The portion of a physical therapy (PT), occupational therapy (OT), or chiropractic claim that is greater than four units (60 minutes) of timed, short-term rehabilitation services per patient, per day, per provider will be denied as being not medically necessary.

We will update the Omnibus Codes (0504) medical coverage policy to reflect this change. This update is effective for dates of service on or after October 15, 2022.

Use Modifier –GP on all physical medicine codes 97010-97799

- GP is appended on the following plans-
- United Health Care (including Optum Health)
- VA claims
- Anthem (BCBS)
- **Blue Cross of CA (not Blue Shield)**
- Medicare (Medicare does not pay but is necessary for a denial so a secondary may make payment
- Do not blanket for plans other than these as it may cause denial for plans that do not require

Extracorporeal shock wave therapy (ESWT)

- Non-invasive treatment that involves delivery of an acoustic shock wave to a specific area of the body. The objective of this treatment is to reduce pain and stimulate healing of the affected area. The acoustic waves travel through fluid and soft tissue, and their effects occur at sites where there is a change in impedance, such as the bone/soft-tissue interface.
- ESWT has become a proposed treatment option for specific musculoskeletal conditions. These conditions include, but are not limited to, calcific tendinopathy of the shoulder, elbow tendinopathy (lateral/medial epicondylitis), carpal tunnel syndrome (CTS), greater trochanteric pain syndrome (GTPS), fractures and delayed unions/nonunions, osteonecrosis of the femoral head (ONFH), and patellar tendinopathy (PT). (CMS LCD L38775)
- The FDA has approved the use of some ESWT machines for plantar fasciitis and lateral epicondylitis.

- **Premera BCBS** Extracorporeal shock wave treatment for plantar fasciitis may be performed by podiatrists, orthopedic surgeons, and primary care physicians.
- **Aetna** considers extracorporeal shock-wave therapy (ESWT) medically necessary for calcific tendinopathy of the shoulder of at least 6 months' duration with calcium deposit of 1 cm or greater, and who have failed to respond to appropriate conservative therapies (e.g., rest, ice application, and medications).
- **United Health Care** extracorporeal shock wave therapy (ESWT), whether low energy, high energy, or radial wave, is unproven and not medically necessary for any musculoskeletal or soft tissue indications due to insufficient evidence of efficacy.

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- **0101T** Extracorporeal shock wave involving musculoskeletal system, not otherwise specified
- **0102T** Extracorporeal shock wave performed by a physician, requiring anesthesia other than local, and involving the lateral humeral epicondyle
- **28890** Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia

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- **0864T** Low-intensity Extracorporeal shock wave involving corpus cavernosum, low energy

Vertebral Axial Decompression

- Vertebral axial decompression therapy is described as an alternative, noninvasive, nonsurgical procedure of applying axial (Y-axis) traction to the spine. Vertebral axial decompression is performed for symptomatic relief of pain associated with lumbar disk problems. The treatment combines pelvic and/or cervical traction connected to a special table that permits the traction application.
- **S9090** Vertebral axial decompression, per session
- **Aetna** Currently, there is no adequate scientific evidence that proves that vertebral axial decompression is an effective adjunct to conservative therapy for back pain. In addition, vertebral axial decompression devices have not been adequately studied as alternatives to back surgery.
- **Blue FEP** Benefit Application BlueCard/National Account Issues State or federal mandates (e.g., FEP) may dictate that all FDA-approved devices may not be considered investigational, and thus these devices may be assessed only on the basis of their medical necessity.

- **Summary of Evidence**
  For individuals with chronic lumbar pain who receive vertebral axial decompression, the evidence includes a systematic review and RCTs. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Evidence for the efficacy of vertebral axial decompression on health outcomes is limited. Because a placebo effect may be expected with any treatment that has pain relief as the principal outcome, RCTs with sham controls and validated outcome measures are required. The only sham-controlled randomized trial published to date did not show a benefit of vertebral axial decompression compared with the control group. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome Vertebral Axial Decompression - CAM 80309

Mechanical Traction 97012

- Current Procedural Terminology (CPT) code 97012 describes the "application of a modality to 1 or more areas; traction, mechanical".
- Third-party payer policies may differ regarding what constitutes mechanical traction, the CPT Assistant defines mechanical traction as follows: "The force used to create a degree of tension of soft tissues and/or to allow for separation between joint surfaces. The degree of traction is controlled through the amount of force (pounds) allowed, duration (time), and angle of pull (degrees) using mechanical means. Terms often used in describing pelvic/cervical traction are intermittent or static (describing the length of time traction is applied) or auto traction (use of the body's own weight to create the force)."
- The goals of mechanical traction typically include one or more of the following: re-establishing normal ranges of motion, reducing pain and/or muscle spasm, enhancing muscle relaxation, and improving blood flow to soft tissue.

Roller Tables IST

- The American Medical Association (AMA) currently has no specific CPT or HCPCS code that reflects the act of a patient lying recumbent on massage or roller tables.
- Roller tables do not meet the definition of auto-traction according to the AMA CPT Assistant. They do not create a sufficient force to allow for the separation of joint surfaces.
- The appropriate reportable code would be CPT code 97039 (unlisted modality; specify type and time if used under constant attendance).

acatoday.org

Coding Guidance

Flexion Distraction Technique

Introduction:

The American Chiropractic Association fields number requests from members asking for the proper coding of the technique known as "Flexion Distraction". The following information should clarify the proper coding for this technique.

Definition:

Flexion distraction is a Chiropractic Manipulative Technique. Per the preamble of the CMT code set (98940-98943) it is a procedure that is a form of manual treatment to influence joint and neurophysiological function.

Application:

The physician work included in the CMT codes was laid out in a work value survey of the chiropractic profession conducted in the spring of 1996 and included the work of flexion distraction. The procedure is taught in the curriculum in accredited chiropractic programs and institutions. Therefore, the appropriate coding for this technique is 98940, 98941, or 98942, depending on the number of body regions treated.[1]

Modalities

- Type and intensity if applicable
- Area(s) applied
- Time of application (timed services 8-minute rule)

Documentation-

97012 Cervical spine distraction with harness intermittent 30 pounds of force for 15 minutes. Supine with roll support.

97026 Infra-red heat lumbar spine 15 minutes

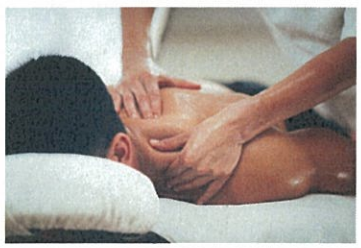
97014 E stim bilateral trapezius 4 pads to patient tolerance 50hz 15 minutes

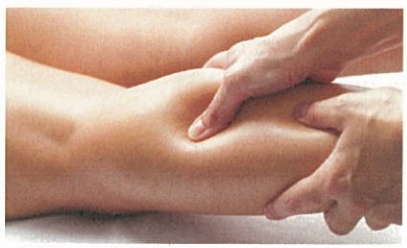
97035 Ultrasound left patellar tendon 8 minutes 0.5 intensity

- Provider groups have expressed confusion relative to coding of massage, manual therapy techniques, and chiropractic manipulative therapy (adjustment) when provided to the same patient on the same day.
- All three of these services have components that when incorporated in the definition or execution of the service may appear duplicative.

97124 Massage v 97140 Manual Therapy

- A massage is the use of rhythmically applied pressure to the skin and soft tissues of the body. Effleurage, petrissage, tapotement (stroking, compression, percussion).
- Some manual therapy techniques include soft tissue mobilization, myofascial release, strain-counter strain, muscle energy techniques, joint mobilizations and manipulations, and mobilization with movement.





97124 Massage

- Massage (CPT® code 97124), is a patterned and purposeful soft-tissue manipulation accomplished by use of digits, hands, forearms, elbows, knees and/or feet, with or without the use of emollients, liniments, heat and cold, hand-held tools or other external apparatus, for the intent of therapeutic change.

- Techniques may include and are not limited to:
- Compression
  - Friction
  - Gliding/Stroking (effleurage)
  - Holding
  - Kneading (petrissage)
  - Lifting
  - Movement and mobilization (stretching, traction, range of motion and gymnastics)
  - Percussion (tapotement)
  - Vibration

- Massage describes a service that is separate and distinct than those services described by Chiropractic Manipulative Treatment, Osteopathic Manipulative Treatment, and Manual Therapy Techniques and typically lacks a joint mobilization component.
- Massage is applied to a large area often crossing over several types and several areas of soft tissue, and is used primarily for its restorative effects. In some cases, massage may be used for stimulating soft tissue (tapotement).
- The expected outcomes of massage are also more general in nature and may, in fact, be what the patient can tolerate at the more acute stage of their treatment plans. This would include such goals as increasing circulation and decreasing muscle soreness and spasm.

- Manual Therapy Techniques, (CPT® code 97140) consist of, but are not limited to, connective tissue massage, joint mobilization and manipulation, manual traction, passive range of motion, soft tissue mobilization and manipulation, and therapeutic massage. As the code descriptor states, 'manual' providers use their hands to administer these techniques. Therefore, procedure code 97140 describes 'hands-on' therapy techniques.
- Typically, the goals of manual therapy are to modulate pain, increase joint range of motion, and reduce or eliminate soft tissue swelling, inflammation, or restriction. These techniques also induce relaxation and improve contractile and noncontractile tissue extensibility. Manual therapy techniques may be performed on individuals with symptoms that may include a limited range of motion, muscle spasm, pain, scar tissue or contracted tissue and/or soft tissue swelling, inflammation or restriction... and often involve joint function

APTA – Manual Therapy- 97140

- *Manual therapy techniques* are skilled hand movements and skilled passive movements of joints and soft tissue and are intended to improve tissue extensibility; increase range of motion; induce relaxation; mobilize or manipulate soft tissue and joints; modulate pain; and reduce soft tissue swelling, inflammation, or restriction. Techniques may include manual lymphatic drainage, manual traction, massage, mobilization/manipulation, and passive range of motion.
- 97124 relaxation versus 97140 muscle rehabilitation

CCI Edits

S. Chiropractic Manipulative Treatment

Medicare covers chiropractic manipulative treatment (CMT) of five spinal regions. Physical medicine and rehabilitation services described by CPT codes 97112, 97124, and 97140 are not separately reportable when performed in a spinal region undergoing CMT. If these physical medicine and rehabilitation services are performed in a different region than CMT and the provider is eligible to report physical medicine and rehabilitation codes under the Medicare program, the provider may report CMT and the above codes using modifier 59 or XS.

Modifiers

When these procedures are billed together, modifier -59 or the appropriate -X modifier, is required to be appended to CPT code 97140 to delineate that an independent procedure was performed. CMS has established a subset of modifiers and XS can be used in lieu of 59.

59 Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day.

XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure.

Current Procedural Terminology (CPT) instructions state that modifier 59 should not be used when a more descriptive modifier is available. Providers should utilize the more specific –X modifier when appropriate.

97124 & 97140: Massage or Manual therapy techniques (e.g. mobilization, manipulation, manual lymphatic drainage, manual traction) in one or more regions, each 15 minutes.

When reporting the CPT code 97124 or 97140 in conjunction with CMT codes, there are six criteria that must be documented to validate the service:

1. Manipulation was not performed on the same anatomic region
2. The clinical rationale for a separate and identifiable service must be documented e.g., contraindication to CMT is present
3. Description of the massage or manual therapy technique(s) e.g., manual traction, myofascial release, mobilization, etc.
4. Location e.g., spinal region(s), shoulder, thigh, etc.
5. Time i.e., the number of minutes spent in performing the services associated with this procedure meets the timed-therapy services requirement
6. CPT code 97124 & 97140 is appended with the modifier -59 or the appropriate -X modifier

Chiropractic Claim for CMT and 97124
Diagnosis pointers indicate separate regions

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [X] (Medicare#) / MEDICAID [ ] (Medicaid#) / TRICARE [ ] (ID#/DoD#) / CHAMPVA [ ] (Member ID#) / GROUP HEALTH PLAN [ ] (ID#) / FECA BLK LUNG [ ] (ID#) / OTHER [ ] (ID#)			1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123-456-789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Beasley, Joe	3. PATIENT'S BIRTH DATE MM DD YY: 10 15 1977 SEX M [X] F [ ]		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 1234 Maine	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]		7. INSURED'S ADDRESS (No., Street)
CITY: Any City / STATE	8. RESERVED FOR NUCC USE		CITY / STATE
ZIP CODE: 00000 / TELEPHONE (Include Area Code): (555) 555-1212			ZIP CODE / TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]		a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on file DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: Signature on file

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 06 2024 QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. M5412 B. M7912 C. M5450 D. M47894 E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 01 09 24	01 09 24	11		98940		AB	50 00	1		NPI	
2 01 09 24	01 09 24	11		97124	XS	CD	110 00	2		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 987654321 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 160 00	29. AMOUNT PAID $	30. Rsvd.for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION John Smith DC 54321 Spine Ave Any City a. NPI b.		33. BILLING PROVIDER INFO & PH # (555) 111-2222 John Smith DC 54321 Spine Ave Any City a. 111222333 b.		

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

Documentation must include

- The expected outcome and functional performance improvement should be discernable in the records.
- Area(s) being treated
- Objective clinical findings such as measurements of range of motion, description of muscle spasms and effect on function
- Subjective findings including pain ratings, pain location, effect on function
- the start and stop times of the treatment or at a minimum, the direct one-on-one contact time spent on each individual activity.

Are you stuck on the M's of care?

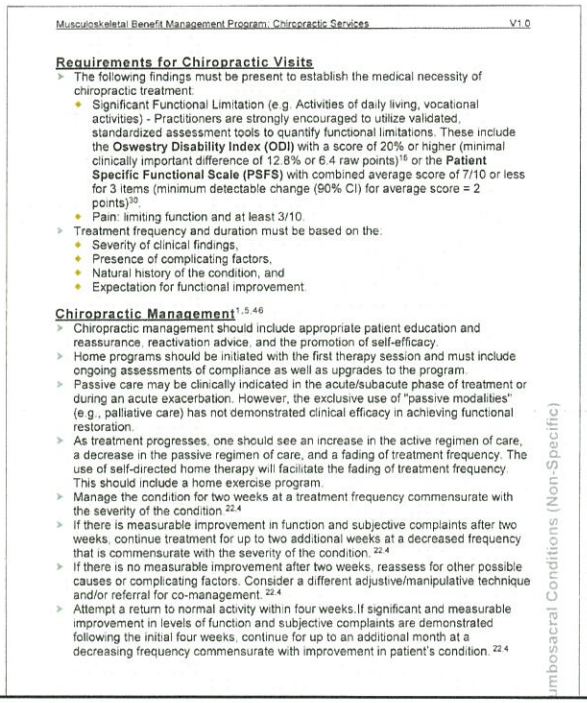
- Manipulation
- Mobilizations
- Muscle release
- Modalities.
- These interventions fall under the category of **passive care**. While these techniques can be useful in providing relief of symptoms, they don't often solve the problem.

The provider should attempt to integrate some form of active care as early as possible. Continued use of passive care modalities may lead to patient dependency and should be avoided.

The utilization of passive modalities is not considered medically necessary once the acute phase of care is over

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

CIGNA Policy CPG 278



Musculoskeletal Benefit Management Program: Chiropractic Services V1.0

Requirements for Chiropractic Visits

- The following findings must be present to establish the medical necessity of chiropractic treatment:
  - Significant Functional Limitation (e.g. Activities of daily living, vocational activities) - Practitioners are strongly encouraged to utilize validated, standardized assessment tools to quantify functional limitations. These include the **Oswestry Disability Index (ODI)** with a score of 20% or higher (minimal clinically important difference of 12.8% or 6.4 raw points)[16] or the **Patient Specific Functional Scale (PSFS)** with combined average score of 7/10 or less for 3 items (minimum detectable change (90% CI) for average score = 2 points)[30].
  - Pain: limiting function and at least 3/10.
- Treatment frequency and duration must be based on the:
  - Severity of clinical findings,
  - Presence of complicating factors,
  - Natural history of the condition, and
  - Expectation for functional improvement.

Chiropractic Management[1,5,46]

- Chiropractic management should include appropriate patient education and reassurance, reactivation advice, and the promotion of self-efficacy.
- Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program.
- Passive care may be clinically indicated in the acute/subacute phase of treatment or during an acute exacerbation. However, the exclusive use of "passive modalities" (e.g., palliative care) has not demonstrated clinical efficacy in achieving functional restoration.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency. The use of self-directed home therapy will facilitate the fading of treatment frequency. This should include a home exercise program.
- Manage the condition for two weeks at a treatment frequency commensurate with the severity of the condition.[22,4]
- If there is measurable improvement in function and subjective complaints after two weeks, continue treatment for up to two additional weeks at a decreased frequency that is commensurate with the severity of the condition.[22,4]
- If there is no measurable improvement after two weeks, reassess for other possible causes or complicating factors. Consider a different adjustive/manipulative technique and/or referral for co-management.[22,4]
- Attempt a return to normal activity within four weeks.If significant and measurable improvement in levels of function and subjective complaints are demonstrated following the initial four weeks, continue for up to an additional month at a decreasing frequency commensurate with improvement in patient's condition.[22,4]

Lumbosacral Conditions (Non-Specific)

ROM and muscle re-education exercise to restore appropriate muscle control and support to the cervical region in patients with WAD should be implemented immediately.

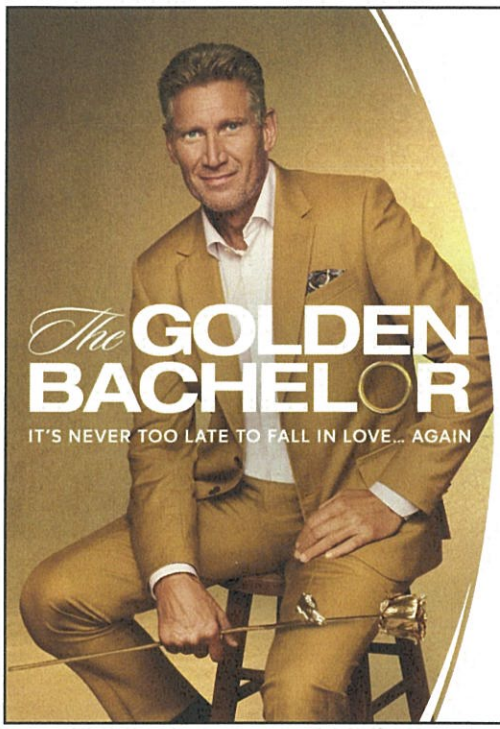
There are five new RCTs (level II) and six systematic reviews (level I) reporting an active physical regime including exercise results in enhanced pain reduction and shortening of post-injury disability. The primary RCTs utilized a range of exercise approaches including range of motion, cervical muscle endurance, stabilization, co-ordination, cervical muscle strengthening, McKenzie method and functional capacity exercises.

State Insurance Regulatory Authority: Guidelines for the management of acute whiplash-associated disorders – for health professionals. Sydney: third edition 2014.

Passive v Active Care

- It has been recommended that passive modalities not be employed except when necessary to facilitate participation in an active treatment program.
- A general conclusion about the treatment of chronic, noncancer pain is that the results from traditional, passive modalities are disheartening. Perhaps this may be due to the propensity of patients to seek out passive versus active treatments. In pain management, active treatments should be the primary focus, with passive interventions as an adjunct.

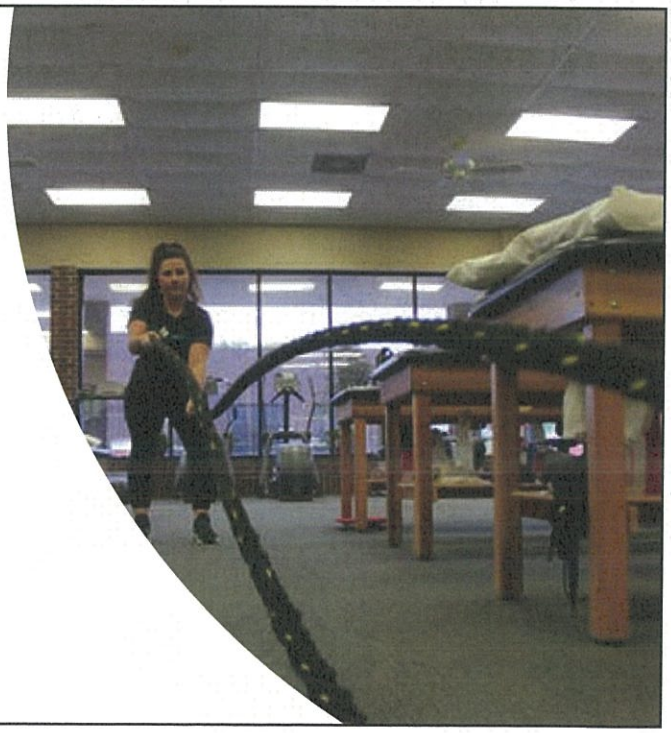
Role of Active Versus Passive Complementary and Integrative Health Approaches in Pain Management
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5896844/



The Bachelor reminds me of the CPT codes. He tends to be ambiguous, overlapping and not clear as to what his intent is

Therapeutic Procedures

- What is this service?
- TA, TE, or NMR?



- **97110 Therapeutic Exercises are movements and physical activities designed to restore function and flexibility, improve strength and decrease pain**
- Includes instruction, feedback, and supervision of a person in an exercise program for their condition. The purpose is to increase/maintain flexibility and muscle strength. May be performed with a patient either actively, active-assisted, or passively. It is considered medically necessary for loss or restriction of joint motion, strength, functional capacity or mobility which has resulted from disease or injury.

- If an exercise is taught to a patient and performed for the purpose of restoring functional strength, range of motion, endurance training, and flexibility, CPT code (97110) is the appropriate code.
- For example, a gym ball exercise used for the purpose of increasing the patient's strength should be considered as therapeutic exercise when coding for billing. Also, the minutes spent taping, such as McConnell taping, to facilitate a strengthening intervention would be counted under 97110.
- Documentation should describe new exercises added, or changes made to the exercise program to help justify that the services are skilled.

97110 Therapeutic exercises

- One or more areas
- Strength
- Endurance
- ROM
  - Examples
    - Bike/Treadmill
    - Gym Equipment
    - Isotonic, Isokinetic, and Isometric Exercise
    - Stretching

EXERCISES TO STRENGTHEN YOUR NECK AND IMPROVE POSTURE

PATIENT NAME: ----------

DATE: ----------

1. BRÜGGER'S EXERCISE

Stand up straight with your hands at your sides. Begin by bending your elbows slightly as you rotate your arms outward. Slowly pull your shoulders back and down as you gently retract your head. Perform 2 sets of 10 repetitions.

2. HEAD RETRACTION

Begin by tucking your chin slightly then draw head upward toward the ceiling in a straight-line movement. Pause at end range for 4 seconds before returning to starting position. Perform 2 sets of 10 repetitions. This can also be performed in the seated position.

3. FLOOR ANGELS

Begin lying face up on floor with knees bent. Place arms with elbows bent comfortably on the floor with palms facing up. Slide arms upward above your head while maintaining forearm contact with floor. Do not let your back arch upward. Slowly return to start

4. CRANIO-CERVICAL FLEXION

Begin by lying face up with knees bent. Slowly lower chin down in a head-nodding motion as you simultaneously lift head approximating the chin towards chest. Pause and hold for 5-10 seconds before returning to the starting position. Perform 2 sets of 10 repetitions.

5. BLACKBURN T

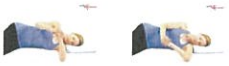
Begin lying face down. Arms should be extended shoulder level with thumbs pointing up. A pillow, or rolled towel, may be placed under forehead for comfort. Lift arms upward squeezing shoulder blades together. Neck muscles should remain relaxed. Hold for 5 seconds. Perform 2 sets of 10 repetitions.

6. BLACKBURN Y

Begin lying face down. Arms should be extended above shoulder level with thumbs pointing up. A pillow, or rolled towel, may be placed under forehead for comfort. Lift arms upward squeezing shoulder blades together. Neck muscles should remain relaxed.

GENERAL SHOULDER STRENGTHENING

PATIENT NAME: ..... DATE: .....



1. Sleeper Stretch at 90°

4. Rotator Cuff External Rotation

2. Cross Body Stretch

5. Rotator Cuff Internal Rotation

3. Scapular Protraction with Resistance Band

6. Seated High Rows

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POWERED BY webexercises

EXERCISES TO STRENGTHEN YOUR CORE AND LOW BACK

PATIENT NAME: .....

DATE: .....

1. CAT - CAMEL

Begin by rounding your back upward until you feel a gentle stretch in the mid and low back. Pause for 3-5 seconds then relax and let your stomach fall downward as you gently arch your back. Perform 2 sets of 10 repetitions to warm up prior to strengthening exercises.

2. BIRD DOG

Begin by gently tightening your stomach muscles to activate your core. Raise one arm to shoulder level as the opposite leg lifts simultaneously off the floor extending to hip level. Hold for 4 seconds and return to the start position and alternate sides. Perform 2 sets of 10 repetitions.

3. MCGILL CURL UP

Begin lying on your back with one knee bent and one leg straight- with both hands placed underneath low back. Lift yourshoulders off floor trying not to round your low back. Let your elbows assist you if needed. Hold for 2-4 seconds before slowly return to starting position. Perform 2 sets of 10 repetitions.

4. HIP BRIDGE

Begin lying down with both knees bent. Gently tighten your stomach muscles to activate your core. Squeeze your glutes and lift the hips off the floor to until knees, hips and shoulders are in alignment. Hold for 2-4 seconds before slowly returning to start position. Perform 2 sets of 10 repetitions.

5. PLANK

Begin lying face down with elbows under shoulders and legs extended. Gently tighten your stomach muscles to activate your core. Lift knees and hips off the floor so that forearms and toes are supporting your body weight. Hold for 20 – 30 sec. Repeat 2 times.

6. SIDE PLANK

Begin lying on your side with your elbow underneath your shoulder and knees bent. Gently tighten your stomach muscles to activate your core. Lift hips off the floor so thatknees and elbow are supporting your body weight. Hold for 20 – 30 sec. Repeat 2 times and repeat on opposite side.

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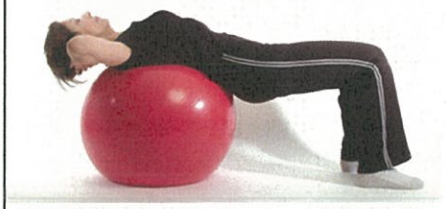
GENERAL HIP STRENGTHENING

97530 Therapeutic activities

- The CPT definition of 97530 is "Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes."

This procedure involves the use of functional activities (e.g., bending, lifting, carrying, reaching, catching and overhead activities) to improve functional performance in a progressive manner..

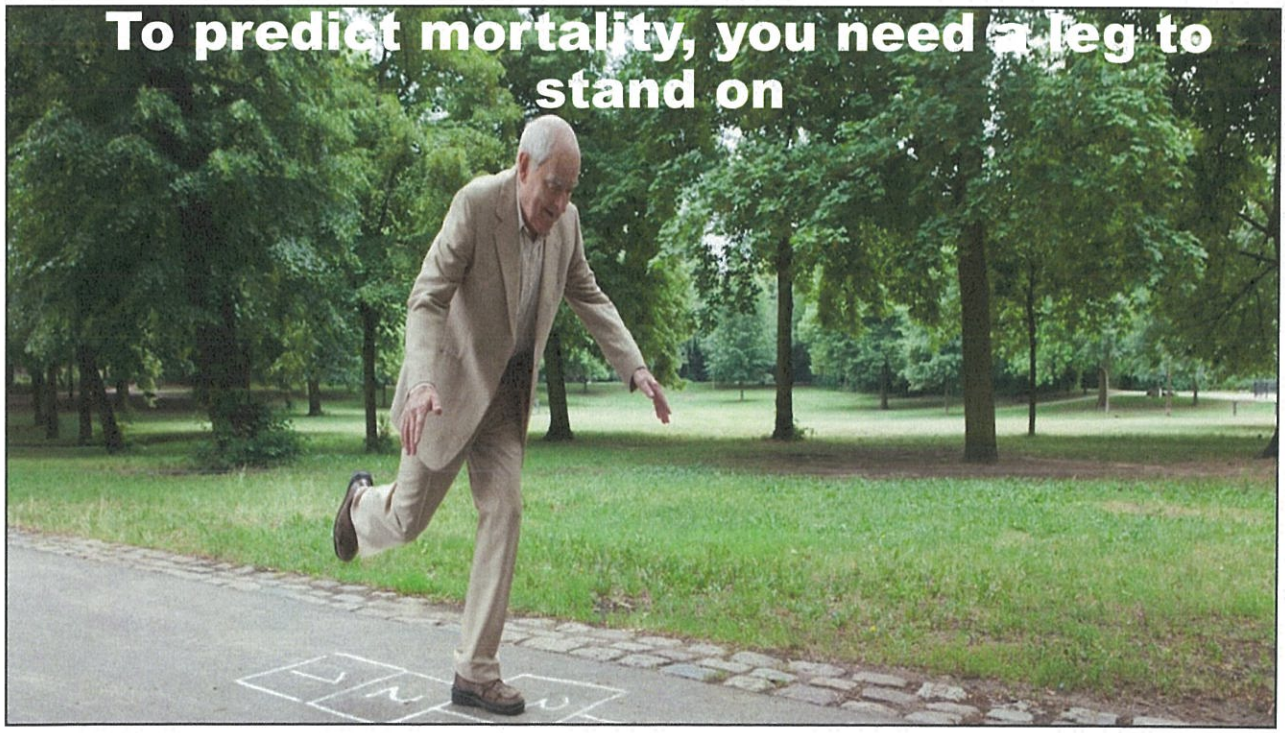
- **97530 Therapeutic Activities** This procedure involves using functional activities (e.g., bending, lifting, carrying, reaching, pushing, pulling, stooping, catching and overhead activities) to improve functional performance in a progressive manner. The activities are usually directed at a loss or restriction of mobility, strength, balance or coordination. They require the professional skills of a practitioner and are designed to address a specific functional need of the member. This intervention may be appropriate after a patient has completed exercises focused on strengthening and range of motion but need to be progressed to more function-based activities. These dynamic activities must be part of an active treatment plan and directed at a specific outcome.



- Choosing 97530 or 97110 depends on the intent of the task. For example, abdominal curls can be used for strengthening a weak abdominal muscles and billed as therapeutic exercise; however, if the patient is performing abdominal curls to improve and perform getting from a lying position it would be considered a therapeutic activity.
- Best practice is to determine what functional outcome is expected from the task. Is it simply a strength or flexibility outcome or one with a functional performance outcome?
- In differentiating between the two, it helps to think of therapeutic exercises as a path to therapeutic activities.

97112 Neuromuscular Reeducation

- Balance
- Proprioception
- Coordination
- Kinesthetic sense
- Activities that facilitate re-education of movement, balance, posture, coordination, and proprioception/kinesthetic sense.



- 10-second test
- Stork position with foot placed on the weight-bearing leg
- Lower risk of death in the next 7 years
- Middle age (51) or older who could not perform a 10 second one leg stand were 84% greater to die of causes such as heart attacks, strokes, and cancer
- British Journal of Sports Medicine
- June 21, 2022

- Optimal control of balance in an upright stance is an essential requirement for sport, daily activities, and prevention of injury. For example, impaired postural control is associated with an increased risk of ankle sprain.
- Because of this strong association, balance and coordination training are common components of prophylactic and therapeutic intervention programs used to treat patients with a variety of musculoskeletal conditions. Moreover, mounting evidence demonstrates that various balance-training programs improve postural control and reduce the recurrence of musculoskeletal. Injuries.

recovery or require prolonged treatment beyond the natural history of recovery. The natural history of recovery is the anticipated recovery either with conservative treatment/care or without conservative treatment/care. The lack of continued functional improvement with continued treatment and complicating factors indicates a stable condition. Although the patient's condition may continue to change over time, the continuation of treatment is no longer necessary in order to affect those further changes. Furthermore, according to the evidence-based literature, the continuation of treatment after a patient has stabilized promotes patient/treatment dependence and feelings of unresolvable disability and may delay a return to normal function. The scientific literature supports a therapeutic withdrawal after the patient has stabilized which focuses more on home-based stretches and exercises and promotes a more active role of the patient.

CPT code 97112 is intended to identify therapeutic exercise that is used for the treatment of upper motor neuron lesions (i.e. stroke, paralysis). Neuromuscular re-education may also be considered medically necessary if at least one of the following conditions is present and documented: the patient has the loss of deep tendon reflexes and vibration sense accompanied by paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers; the patient has nerve palsy, such as peroneal nerve injury causing foot drop; or the patient has muscular weakness or flaccidity as a result of a cerebral dysfunction, a nerve injury or disease, or has had a spinal cord disease or trauma. According the records provided for review, the patient did not exhibit any of the necessary signs or symptoms needed in order to initiate this type of therapy. Therefore, the dates of service in question are not medically necessary in relation to the motor vehicle accident.

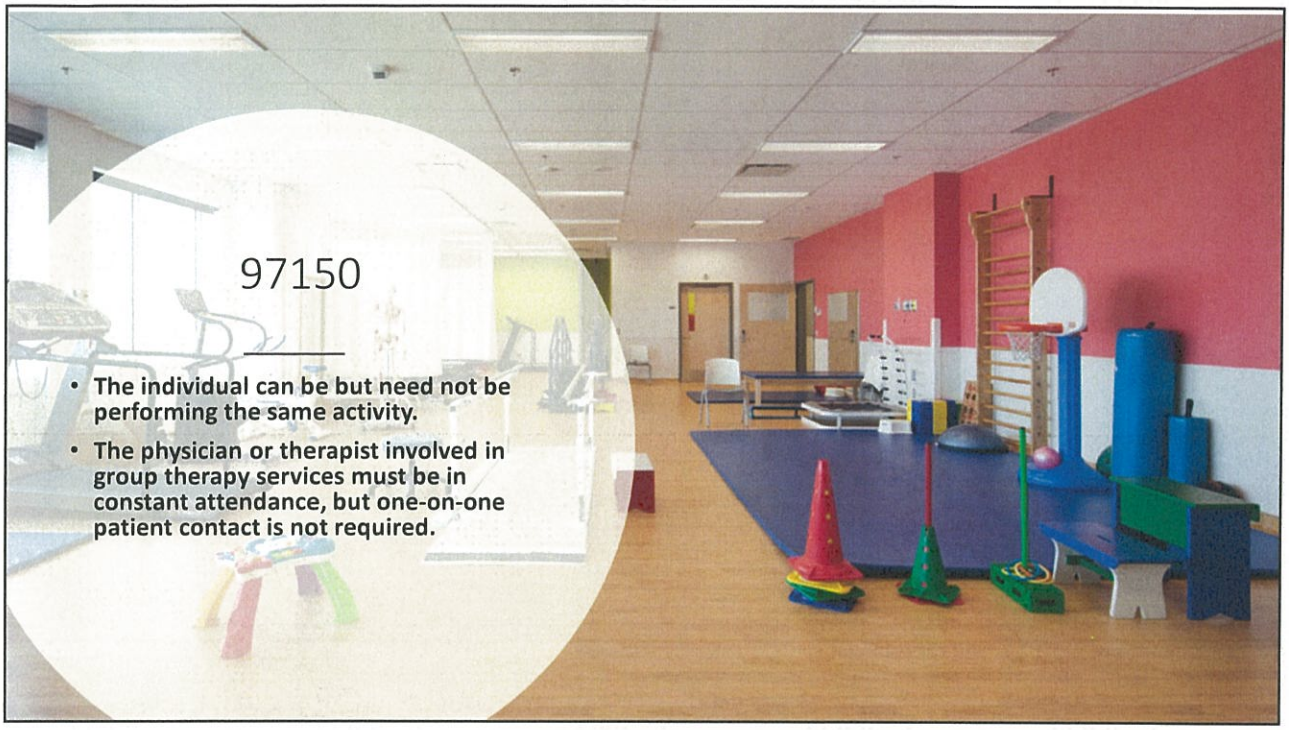
In conclusion, I do not recommend reimbursement for treatment rendered on 02/14/19, 03/05/19 or 04/01/19

- **97112 Neuromuscular Reeducation** This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, and proprioception to a person who has reduced balance, strength, functional capacity or mobility which has resulted from disease, injury, or surgery. The goal is to develop conscious control of individual muscles and awareness of position of extremities.
- The procedure may be considered medically necessary for impairments which affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination) that may result from musculoskeletal or neuromuscular disease or injury such as severe trauma to nervous system, post orthopedic surgery, cerebral vascular accident and systemic neurological disease.

- It is critical that the notes paint a picture of why the patient needs NMR if the patient does not have a true neuro diagnosis. Also, the flow sheet should support what activities are included in NMR vs Therapeutic Exercise to support the billing.

97150 Group Therapeutic Exercise

- Report 97150 for each member of the group.
- *Group therapy consists of therapy treatment provided simultaneously to two or more patients who may or may not be doing the same activities. If the therapist is dividing attention among the patients, providing only brief, intermittent personal contact, or giving the same instructions to two or more patients at the same time*, one unit of CPT code 97150 is appropriate per patient.



- Report 97150 for each member of the group.
- *Group therapy consists of therapy treatment provided simultaneously to two or more patients who may or may not be doing the same activities. If the therapist is dividing attention among the patients, providing only brief, intermittent personal contact, or giving the same instructions to two or more patients at the same time*, one unit of CPT code 97150 is appropriate per patient.

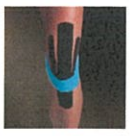
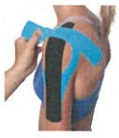
- Supervision of a previously taught exercise program or supervising patients who are exercising independently is not a skilled service and is not covered as group therapy or as any other therapeutic procedure. Supervision of patients exercising on machines or exercise equipment, in the absence of the delivery of skilled care, is not a skilled service and is not covered as group therapy or as any other therapeutic procedure.

- Strapping - the application of overlapping strips of adhesive tape to an extremity or body area to exert pressure and hold a structure in place, performed in the treatment of strains, sprains, dislocations, and certain fractures.
- Taping – the process of using an elastic cotton strip with an acrylic adhesive with the intent of treating pain and disability from athletic injuries and a variety of other physical disorders.
- Kinesio-Taping does not fit these definitions
-

- **29200** Thorax
- **29799** Unlisted procedure of casting or strapping and to be used for low back strapping
- **29240** Shoulder (eg, Valpeu)
- **29260** Elbow or wrist
- **29280** Hand or finger
- **29520** Hip
- **29530** Knee
- **29540** Ankle and/or foot
- **29550** Toes
- **29580** Unna Boot

Kinesiotaping = 97110 / 97112 if active therapy done in conjunction

- CPT® Assistant, March 2012, states that "Kinesio taping is a supply and therefore is included in the time spent in direct contact with the patient to provide either re-education of a muscle and movement or to stabilize one body area to enable improved strength or range of motion. This includes the application of Kinesio tape or McConnell taping techniques.

	X-Ray Common Codes for Chiropractic
CPT Code	Description
	Head and Neck Soft Tissue
70140	Facial bones, less than 3 views
70160	Nasal bones, min 3 views
70328	Temporomandibular joint, unilateral
70330	Temporomandibular joint, bilateral
70360	Neck, soft tissue
	Chest
71045	Chest, single view
71046	Chest, 2 views
71047	Chest, 3 views
71048	Chest, 4 or more views
71100	Ribs, unilateral, 2 views
71110	Ribs, bilateral, 3 views
	Spine
72020	Spine, single view, specify level. Use 72081 if view includes entire thoracic spine.
72040	Cervical spine, 2 or 3 views
72050	Cervical spine, minimum 4 or 5 views
72052	Cervical spine, 6 or more views
72070	Thoracic spine, 2 views
72072	Thoracic spine 3 views
72074	Thoracic spine, 4 views
72080	Thoracolumbar, 2 views
72081	Spine entire thoracic and lumbar including skull 1 view
72082	Spine entire thoracic and lumbar including skull 2-3 views
72083	Spine entire thoracic and lumbar including skull 4-5 views
72084	Spine entire thoracic and lumbar including skull 6 views
72100	Lumbosacral spine, 2 or 3 views
72110	Lumbosacral spine, minimum 4 views
72114	Lumbosacral spine, minimum 6 views
72120	Lumbosacral spine, bending only 2 or 3 views
	Pelvis
72170	Pelvis, 1 or 2 views
72190	Pelvis complete, minimum 3 views
72200	Sacroiliac joints, less than 3 views
72202	Sacroiliac joints, 3 or more views
72220	Sacrum and coccyx, minimum 2 views
	Upper Extremities
73000	Clavicle, Complete
73010	Scapula, Complete
73020	Shoulder, 1 view
73030	Shoulder, complete, minimum 2 views
73050	Acromioclavicular joints bilateral with or without weighted distraction
73060	Humerus, minimum 2 views
73070	Elbow, 2 views
73080	Elbow, complete, minimum 3 views

73090	Forearm, 2 views
73092	Upper extremities, infant, minimum 2 views
73100	Wrist, 2 views
73110	Wrist, complete, minimum 3 views
73120	Hand, 2 views
73130	Hand, minimum 3 views
73140	Fingers, minimum 2 views
	Lower Extremities
73501	Radiologic exam hip, unilateral with pelvis when performed 1 view
73502	Radiologic exam hip, unilateral with pelvis when performed 2-3 views
73503	Radiologic exam hip, unilateral with pelvis when performed 4 views
73521	Radiologic exam, hips bilateral with pelvis when performed 2 views
73522	Radiologic exam, hips bilateral with pelvis when performed 3-4 views
73523	Radiologic exam, hips bilateral with pelvis when performed minimum 5 views
73525	Radiologic examination, hip, arthography, supervision and interpretation
73551	Radiologic examination, femur, 1 view
73552	Radiologic examination, femur, 2 views
73560	Knee, 1 or 2 views
73562	Knee, 3 views
73564	Knee, complete 4 or more views
73565	Knees, both standing anteroposterior
73590	Tibia and Fibula, 2 views
73600	Ankle, 2 views
73610	Ankle, complete, minimum 3 views
73620	Foot, 2 views
73630	Foot, complete, minimum 3 views
73650	Calcaneus, minimum 2 views
73660	Toes, minimum 2 views
	Consultation & other
76140	Consultation on x-ray made elsewhere, 2nd opinion and report
76499	Unlisted radiogrpahic procedure

Data Driven Care

- Tracking changes in restrictions of activities of daily living
- Quality based care model

CHIRO-2.1: Recommended Standardized Assessments

Standardized assessment tools are used to assess and track changes in restrictions in Activities of Daily Living. Recommended standardized assessment tools are listed below:

Measure of Function	Reference
Disabilities of Arm, Shoulder, Hand (DASH and QuickDASH)	Franchignoni 2014; Angst 2011; Rysstad 2020
Hip Disability and Osteoarthritis Outcome Score (HOOS)	Ornetti 2009
Knee Injury and Osteoarthritis Outcome Score (KOOS)	Roos 2003; Ornetti 2009
Lower Extremity Functional Scale (LEFS)	Williams 2012; Binkley 1999
Neck Disability Index (NDI)	Young 2019; MacDermid 2009
Oswestry Disability Index (ODI)	Davidson 2002; Maughan 2010; Clohesy 2018
Patient Specific Functional Scale (PSFS)	Horn 2012; Helford 2012; Maughan 2010; Rysstad 2020
Roland Morris Disability Questionnaire (RMDQ)	Stratford 1996; Ostelo 2004; Clohesy 2018; Maughan 2010
Short Form-12 of the Short Form-36 Health Survey (SF-12)	Diaz-Arribas 2017; Cheak-Zamora 2009; McHorney 1994; Davidson 2002
Shoulder Pain and Disability Index (SPADI)	Schmidt 2014; Angst 2011

CHIRO-2.2: Mental Health Considerations

Referral to a qualified mental health professional is required when there are signs of an unmanaged behavioral health disorder. Immediate referral to a counselor or helpline is required if there are ANY indications of thoughts or plans for self-harm. The National Suicide Prevention Lifeline is available 24 hours every day at 1-800-273-8255.

PROMIS
Patient Reported Outcome Measurement Instruments

- General Pain Index
- Patient Specific Functional Scale
- PROMIS Short Form – Pain Interference
- Pain and Functional Rating Scale (VA & DOD)
- Oswestry (LBP index)
- Neck Disability Index

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

PATIENT NAME _____ DATE _____

SCORE _____ [60] BENCHMARK = 5 _____

Pain Interference – Short Form 6a

Please respond to each question or statement by marking one box per row.

In the past 7 days…

		Not at all	A little bit	Somewhat	Quite a bit	Very much
1	How much did pain interfere with your day to day activities?	☐	☐	☐	☐	☐
2	How much did pain interfere with work around the home?.....	☐	☐	☐	☐	☐
3	How much did pain interfere with your ability to participate in social activities?	☐	☐	☐	☐	☐
4	How much did pain interfere with your household chores?.....	☐	☐	☐	☐	☐
5	How much did pain interfere with the things you usually do for fun?	☐	☐	☐	☐	☐
6	How much did pain interfere with your enjoyment of social activities?.....	☐	☐	☐	☐	☐

Pain Interference – Short Form 6b

Please respond to each item by marking one box per row.

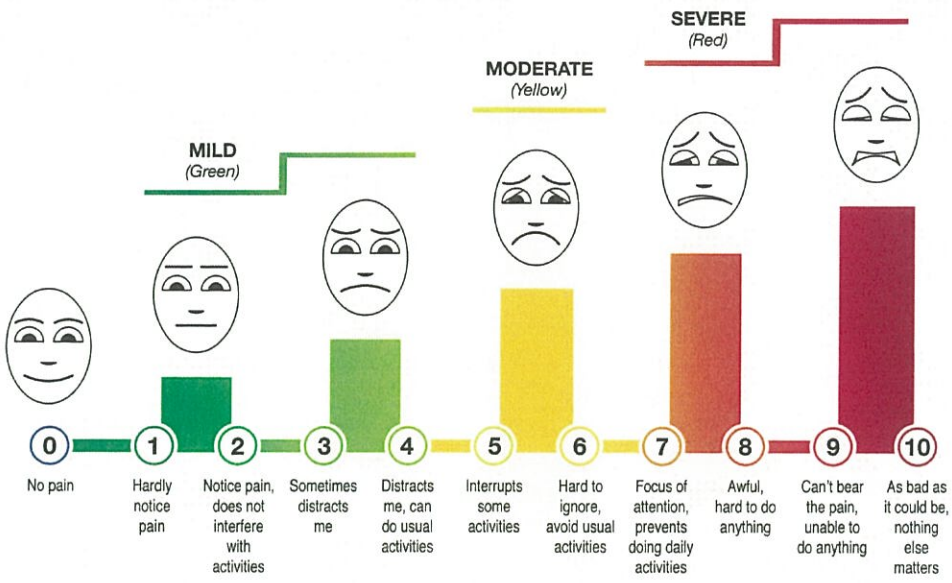
In the past 7 days…

		Not at all	A little bit	Somewhat	Quite a bit	Very much
PAININ3	How much did pain interfere with your enjoyment of life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ8	How much did pain interfere with your ability to concentrate?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ9	How much did pain interfere with your day to day activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ10	How much did pain interfere with your enjoyment of recreational activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ14	How much did pain interfere with doing your tasks away from home (e.g., getting groceries, running errands)?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

In the past 7 days…

		Never	Rarely	Sometimes	Often	Always
PAININ26	How often did pain keep you from socializing with others?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Defense and Veterans Pain Rating Scale



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DoD/VA Pain Supplemental Questions

For clinicians to evaluate the biopsychosocial impact of pain

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual ACTIVITY:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere — Completely interferes

2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your SLEEP:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere — Completely interferes

3. Circle the one number that describes how, during the past 24 hours, pain has affected your MOOD:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not affect — Completely affects

4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your STRESS:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not contribute — Contributes a great deal

*Reference for pain interference: Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. Ann Acad Med Singapore 23(2): 129-138, 1994.

v 2.0

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Modifier	Definition
22	Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding the modifier '-22' to the usual procedure number or by use of the separate five-digit modifier code 09922. A report may also be appropriate.
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure or Other Service: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative or postoperative care associated with the procedure that was performed. This circumstance may be reported ay adding the modifier '-25' to the appropriate level of E/M service, or the separate five digit modifier 09925 may be used. Use this modifier on the E&M code when it is performed in the same visit at chiropractic manipulation.
26	Professional Component: Certain procedures combine a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '-26' to the usual procedure number, or the service may be reported by use of the separate five-digit modifier code 09926.
32	Mandated Services: Service related to mandated consultation and/or related services (e.g. PRO, 3rd party payer) may be identified by adding the modifier '-32' to the basic procedure or the service may be reported by use of the five-digit modifier 09932.
50	Bilateral Procedure: is used to report bilateral procedures that are performed during the same operative session by the same physician in either separate operative areas (e.g. hands, feet, legs, arms, ears), or one (same) operative area (e.g. nose, eyes, breasts).
51	Multiple Procedures: When multiple procedures, other than Evaluation and Management Services, are performed on the same day or at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier '-51' to the additional procedure or service code(s) or by the use of the separate five-digit modifier 09951. This modifier should not be appended to designated "add-on" codes

52	Reduced Services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier '-52,' signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Modifier code 09952 may be an alternative to modifier '-52.' This modifier is also not be used for timed services done 7 minutes or less when a timed service is done 7 minutes or less it is not billable. United Health Care will reduce the payment by 50% when this modifier is used. It is also not appropriate to use this modifier with evaluation and management codes.
59	Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier "-59" is used to identify procedures/services that are not normally reported together but are appropriate under the circumstances. Modifier code 09959 may be an alternative to modifier "-59". Use this modifier on 97112, 97124, & 97140 when done in the same visit as Chiropractic Manipulative Therapy, to a separate region from the spine regions of CMT. However, it would be more accurate to use the XS modifier to demonstrate a separate region.
XE	Separate Encounter: A service that is distinct because it occurred during a separate encounter
XS	Separate Structure: A service that is distinct because it was performed on a separate organ/structure. This modifier would be used for services such as 97112, 97124 and 97140 when provided in the same visit as spinal CMT to demonstrate a separate region from CMT.
XP	Separate Practitioner: A service that is distinct because it was performed by a different practitioner
XU	Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap the usual components of the main service.
76	Repeat Procedure by Same Physician: The physician may need to indicate that a procedure or service was repeated after the original service. This circumstance may be reported by adding the modifier '-76' to the repeated service or the separate five-digit modifier code 09976 may be used
90	Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician by adding the modifier '-90' to the usual procedure number.

95	Synchronous telemedicine service is rendered via a real-time interactive audio and video telecommunications system. Append this modifier to an appropriate CPT code for real-time interaction between a physician or other qualified healthcare professional and a patient who is located at a distant site from the reporting provider. Some payers may request modifiers GT or GQ. Note that with the use of this modifier, it must also be indicated place of service 02.
GT	Telemedicine via interactive audio and video telecommunication systems. Use only when directed by your payer instead of modifier 95.
GQ	Telemedicine via an asynchronous telecommunications system applies only when reporting telehealth services.
GP	Services delivered under an outpatient physical therapy plan of care are also referred to as the "always therapy" modifier. This modifier is required on all physical medicine services on claims to the VA, United Health Care, and Medicare claims performed by Doctor of Chiropractic.
97	When a service or procedure that may be either habilitative or rehabilitative is provided for rehabilitative purposes, the physician or other qualified healthcare professional may add modifier 97- to the service or procedure code to indicate that the service or procedure provided was rehabilitative. Humana requires this modifier for chiropractic claims on CMT and physical medicine services.
GA	The GA modifier is used when you report a mandatory advance beneficiary notice of noncoverage (ABN) for an item or service. This means the patient knows the item or service doesn't meet the definition of any Medicare or Medicaid policies and will therefore not be covered. Waiver of Liability Statement Issued, as Required by Payer Policy. This is used for chiropractic claims where spinal CMT is considered maintenance, and the patient has signed an ABN
GY	Item or service statutorily excluded does not meet the definition of any Medicare benefit. For chiropractic claims, this would be appended to all services that are not spinal manipulation
AT	Acute treatment (chiropractic claims) - This modifier should be used when reporting CPT codes 98940, 98941, and 98942 for chiropractic Medicare claims
GX	The GX modifier is used to report that a voluntary Advance Beneficiary Notice of Noncoverage (ABN) has been issued to the beneficiary before/upon receipt of their Part B procedure/service because it is statutorily noncovered or does not meet the definition of a Medicare benefit. This modifier is not typically used but could be used for an excluded service to indicate a waiver of liability was signed and would be included with a GY. A waiver of excluded services is not required to be signed and therefore is not required or often used.

GZ	The provider expects a medical necessity denial, however, did not provide an Advance Beneficiary Notice of Noncoverage (ABN) to the patient. The line item containing the GZ modifier is denied the provider liable. This would be used when an ABN should have been issued but did not and to inform Medicare it is maintenance. This is used to meet the mandatory submission of a spinal CMT and will automatically be denied with provider liability and no collection from the patient for the covered service.
GW	The GW modifier is used when a physician is providing a service that **is not** related to the diagnosis for which a patient has been enrolled in hospice. This physician is not associated with the hospice and is providing services as the attending physician.
Q6	Service furnished by a locum tenens physician
QU	Physician service in an urban HPSA.
KR	Rental item, durable medical equipment billing for a partial month
RR	Rental (use the RR modifier when DME is a rental)
NU	New equipment (DME)
LT	Left Side - Used to identify procedures performed on the left side of the body.
RT	Right Side - Used to identify procedures performed on the right side of the body.

HCPCS Codes

HCPCS (often referred to as *"hick-picks"*) is a uniform coding system designed for health care providers to report supplies and other professional services. Many health insurance companies are now requiring the use of these codes to identify supports and or other supplies. The following list is a compilation of commonly used supplies in chiropractic offices.

97760, Orthotic management and training including assessments and fitting (when not otherwise reported), for the upper extremity, lower extremity, and/or trunk; each 15 minutes. Assessment includes but is not limited to, determining the patient's need for an orthotic, determining the type of orthotic required, assessing the ROM, strength testing, sensation testing, and designing and fabricating the orthotic.

97763 Orthotic and prosthetic management and/or training for the upper and lower extremities and/or trunk for each 15 minutes on subsequent encounter
Status check for fit of orthotic-skin integrity, sensation and observation are performed. Using one on one contact. Necessary modifications to the orthotic are completed. Patient is trained on proper use, wearing schedule , care and precautions

Use of an L code includes the following items.

- Assessment of the patient regarding the orthotic
- Measurement and/or fitting
- Supplies to fabricate or modify the orthotic
- Time associated with making the orthotic

CPT 97760 should be used for orthotic "training" completed by qualified professionals/auxiliary personnel. CPT 97760 may be used in conjunction with the L code only for the time spent training the patient in the use of the orthotic. Orthotic training may include teaching the patient regarding a wearing schedule, placing and removing the orthosis, skin care and performing tasks while wearing the device. To avoid duplicate billing, the time spent assessing, measuring and/or fitting, fabricating or modifying, or making the orthotic may not be included in calculating the number of units to bill for CPT 97760 when also billing the appropriate L code

Modifiers for Durable Medical Equipment

Rental Modifiers The following modifiers indicate that an item has been rented:

- RR Rental
- KH Initial Claim, purchase or first month rental
- KI Second or third monthly rental
- KJ Capped rental months four to fifteen
- KR Partial month

Purchase Modifiers The following modifiers indicate that an item has been purchased:

- NU New Equipment (use the NR modifier when DME which was new at the time of rental is subsequently purchased)

- UE Used Equipment
- NR New when rented
- KM Replacement of facial prosthesis including new impression/moulage
- KN Replacement of facial prosthesis using previous master model

➢ LT = Left RT = Right

Cervical

L0120	Cervical Collar *(foam),* flexible, non-adjustable. Prefabricated, off-the -shelf
L0130	Cervical Collar flexible, thermoplastic collar molded to patient
L0140	Cervical Collar semirigid *(plastic) adjustable*
L0150	Cervical Collar semirigid, adjustable molded chin cup (plastic collar with mandibular/occipital piece)

Pillow or Wedge

E0190	Positioning Cushion/Pillow/ Wedge any shape or size includes all components and accessories or (neck, low back, leg spacer etc.)

Thoracic

L0220	Thoracic, rib belt, custom fabricated
L0450	TLSO, flexible provides trunk support, upper thoracic region, produces intracavity pressure to reduce load on IVD with rigid stays or panel(s) includes shoulder straps and closures, prefabricated, off-the – shelf
L0452	TLSO, flexible provides trunk support, upper thoracic region, produces intracavity pressure to reduce load on IVD with rigid stays or panel(s) includes shoulder straps and closures, prefabricated, custom fabricated
L0454	TLSO flexible, provides trunk support, extends from sacrococcygeal junction to above t-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L0455	TLSO flexible, provides trunk support, extends from sacrococcygeal junction to above t-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, off-the-shelf

Sacroiliac

L0621	Sacroiliac orthosis flexile, provides pelvic sacral support, reduces motion about the SI joint includes straps, closures and may include pendulous abdomen design, prefabricated off-the-shelf
L0622	Sacroiliac orthosis flexile, provides pelvic sacral support, reduces motion about the SI joint includes straps, closures and may include pendulous abdomen design, custom fabricated
L0623	Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, off-the-shelf
L0624	Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated

Lumbar

L0625	Lumbar orthosis, flexible, provides lumbar support, posterior extends from l-1 to below l-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated off-the-shelf
L0626	Lumbar orthosis, sagittal control with rigid posterior panel(s) posterior extends from l-1 to below l-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise.
L0627	Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from l-1 to below l-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise.

Lumbosacral

L0628	Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, prefabricated off-the-shelf
L0629	Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated
L0630	Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, that has been trimmed, bent molded, assembled or otherwise customized to fit a specific patient by and individual with expertise.
L0631	Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, that has been trimmed, bent molded, assembled or otherwise
L0632	Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated.
L0633	Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, that has been trimmed, bent molded, assembled or otherwise customized to fit a specific patient by and individual with expertise.

Shoulder

L3650	Clavicle/Shoulder Brace figure 8 design, prefabricated
A4565	Slings
A4566	Shoulder sling or vest design abduction restrainer
A4570	Splint

Elbow, Wrist & Hand

L3908	Wrist hand orthoses, wrist extension control cock up, prefabricated *(includes fitting and adjustment)*
L3710	Elbow orthoses elastic with metal joints, prefabricated *(includes fitting and adjustment)*
L3999	Upper limb orthoses not otherwise specified
A4466	Garment, belt, sleeve or other covering elastic or similar stretchable material any type, each. (tennis elbow, forearm etc neoprene sleeve)

Knee

L1812	Knee orthosis, elastic with joints prefabricated , *off the shelf*
L1820	Knee Support elastic with condylar pad and joints with or without patellar control prefabricated *(includes fitting and adjustment)*
A4466	Garment, belt, sleeve or other covering elastic or similar stretchable material any type, each. (thigh, knee etc. neoprene sleeve)

Ankle

L1902	Ankle Gauntlet prefabricated *(includes fitting and adjustment)*
L2999	Lower extremity orthoses not otherwise specified
A4466	Garment, belt, sleeve or other covering elastic or similar stretchable material any type, each. (calf neoprene sleeve)

Compression Stocking

A6530	Gradient compression stocking below knee 18-30mmHg, each
A6531	Gradient compression stocking below knee 30-40mm Hg, each
A6532	Gradient compression stocking below knee 40-50mm Hg, each
A6533	Gradient compression stocking thigh length 18-30mmHg, each
A6534	Gradient compression stocking thigh length 30-40mm Hg, each
A6535	Gradient compression stocking thigh length 40-50mm Hg, each

Cane, Crutches, Walker

E0100	Cane, includes canes of all materials, adjustable or fixed with tip
E0105	Cane, quad or three prong includes canes of all materials, adjustable or fixed with tip
E0112	Crutches, underarm, wood, adjustable or fixed, pair with pads, tips and handgrips
E0113	Crutch, underarm, other than wood, adjustable or fixed, pair with pads, tips and handgrips
E0114	Crutches, underarm, other than wood, adjustable or fixed, pair with pads, tips and handgrips
E0116	Crutch, underarm, other than wood, adjustable or fixed, pair with pads, tips and handgrips
E0130	Walker rigid (pick up) adjustable or fixed height
E0135	Walker folding (pick up) adjustable or fixed height
E0141	Walker rigid, wheeled adjustable or fixed height

Foot Orthoses

L3010	Foot insert, molded to patient model longitudinal arch support
L3020	Foot insert, molded to patient model longitudinal/metatarsal support
L3030	Foot insert, removable, formed to patient foot
L3040	Full Foot, arch support removable premolded, each foot
L3060	Foot arch support, removable, premolded
S0395	Impression casting of a foot performed by a practitioner other than the manufacturer of the orthotic

A4580 Cast supplies (e.g plaster)
CPT 29799-RT and CPT 29799-LT when casting for custom orthotics.

L3480	Heel, pad and depression for spur
L3485	Heel, pad, removable for spur
L3300	Lift tapered to metatarsals
L3310	Lift, elevation, heel, and sole, Neoprene, per inch
L3320	Lift, elevation, heel, and sole, cork, per inch
L3334	Lift, elevation, heel, per inch

Tape/Ace Bandages

A4450	Tape non waterproof per 18 square inches
A4452	Tape waterproof per 18 square inches
A6445	Ace Wrap / Elastic Tape cotton/latex

Miscellaneous

99070	Supplies and materials (except spectacles), provided by the physician over and above those usually included in the office visit (list or describe specific item)

Traction (cervical)

E0849	Traction equipment, cervical, free standing stand/frame, pneumatic applying traction force other than the mandible
E0850	Traction stand, free standing, cervical traction
E0855	Cervical traction equipment not requiring an additional stand or frame
E0856	Cervical traction device, cervical collar with inflatable bladder(s)
E0860	Traction equipment, overdoor, cervical
E0942	Cervical head harness/halter
E0941	Gravity assisted traction device, any type
A9285	Inversion eversion corrective device

TENS, Electrical Stimulation and Supplies

E0720	TENS Unit *(two lead)*
E0730	TENS Unit *(four lead)*
E0731	Form-fitting conductive garment for delivery of TENS or NMES with conductive fibers separated from the patient's skin by layers of fabric
E0745	Neuromuscular stimulator, electronic shock unit

E0744	Neuromuscular stimulator for scoliosis
A4595	Electrical stimulator supplies, 2 lead, per month (e.g, TENS, NMES)
A4558	Conductive paste or gel Tens, NMES device
A4559	Conductive paste or gel Ultrasound device
A4630	Replacement batteries

Exercise Equipment

A9300	Exercise equipment (any type)

Heat and Cryotherapy

E0210	Electric Moist Heat Pad
E1399	Unlisted DME. May be used for hot or cold packs but must be sent with explanation
A9273	Hot water bottle, Ice cap or collar, heat and or cold wrap, any type

Vitamins, Supplements, Non-Rx and Food

A9150	Nonprescription drug or similar substance
A9152	Single vitamin/mineral/trace element, per dose
A9153	Multiple vitamins, w or w/ minerals, per dose
S9433	Medical food nutritionally complete, administered orally, providing 100% of nutritional intake