AKTA
AMERICAN KINESIOTHERAPY ASSOCIATION

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GUIDELINES FOR DOCUMENTATION

UPDATED: November 2011
# GUIDELINES FOR KINESIOTHERAPY DOCUMENTATION

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**PURPOSE**
To establish national documentation standards in the field of Kinesiotherapy.

**OBJECTIVE**
To increase compliance with Federal health care program documentation requirements, Office of Inspector General compliance expectations and promote increased accuracy of medical records information for risk management purposes.

**UPDATED:** April 2011

**Preamble**
The American Kinesiotherapy Association (AKTA) is committed to upholding the highest standards of patient physical rehabilitation and compliance on the local, state and federal levels. To assist kinesiotherapists in maintaining these standards the AKTA has established these guidelines for effective documentation. These guidelines will address the essential elements to establish and validate medical necessity for patients under a Registered Kinesiotherapist’s (RKT) care. They will not cover every facet of possible care a RKT will be called upon to provide; but rather address general areas demanded by both clinicians and insurers. Individual practices should take elements of these guidelines relevant to their unique situation(s) and make them part of a Standard Operating Procedure (SOP). It is highly recommended that the guideline set be taught to every kinesiotherapist, whether a new hire or presently working. In this way medical reviewers will find consistency in documentation and likelihood of payment denials or charges of fraud or abuse will be minimized. These guidelines will apply to not only RKTs, but also all persons the RKT is allowed by policy or law to supervise.

Under the Administrative Simplification Act, nationally mandated guidelines for coding will be the Current Procedural Terminology (CPT) as written and interpreted by the American Medical Association (AMA). Where guidelines are unclear or non-existent, guidelines established by The Center for Medicare and Medicaid Services (CMS) will be considered equally enforceable. Guidelines for the proper use of ICD-9-CM codes are governed by the World Health Organization and the Cooperating Parties: American Hospital Association (AHA); National Center for Health Statistics (NCHS); American Health Information Management Association (AHIMA); and the Center for Medicare and Medicaid Services (CMS). These are nationally mandated guidelines and will not be changed under any circumstances.

It is understood there is a military subspecialty aspect to kinesiotherapists’ training. As such all guidelines and requirements set forth by the Veteran’s Administration will also apply. If there is any discrepancy between guidelines the stricter of them shall apply. If a guideline is unclear the appropriate governing body should be contacted for clarification.
DEFINITION OF TERMS

It is important to understand the abbreviations and acronyms used in this document to accurately interpret the information. Please reference the information below.

AMA: American Medical Association

CMS: Centers for Medicare & Medicaid Services.

CPT: All references made to procedures and services using the term “CPT” will mean the Current Procedural Terminology book written by the AMA.

HCPCS: Healthcare Common Procedural Coding System which has 2 levels: I – CPT written by AMA; II – written by CMS.

History of Present Illness Terms:

Location—where problem, pain, or symptom occurs (leg, chest, back, etc.).

Quality—description of problem, symptom or pain (dull, itching, constant, etc.).

Severity—description of severity of symptom or pain (1-10 rating, mild, moderate, etc.).

Duration—how long problem, symptom, or pain has persisted (one week, since last night, etc.).

Timing—when a problem symptom or pain occurs (morning, after eating, while lying down, etc.).
Context—instances that can be associated with the problem, symptom, or pain (while standing for long periods of time, when sitting, etc.).

Modifying factors—actions taken to make the problem, symptom, or pain better or worse (pain relievers help dull pain; nausea after eating etc.).

Associated signs and symptoms—other problems, symptoms, or facts that occur when primary problem, symptom or pain occurs (stress causes headache, burning during urination, etc.).

ICD-9:
All references to ICD-9 or ICD-9-CM will apply to the most current edition for diagnosis coding.

Kinesiotherapy:
Is the application of scientifically based exercise principles adapted to enhance the strength, endurance, and mobility of individuals with functional limitations or those requiring extended physical conditioning.

Kinesiotherapist (RKT or KT):
A health care professional competent in the administration of musculoskeletal, neurological, ergonomic, biomechanical, psychosocial, and task specific functional tests and measures. The RKT determines the appropriate evaluation tools and interventions necessary to establish, in collaboration with the client, a goal specific treatment plan. For purposes of these guidelines, the terms therapist, RKT, and kinesiotherapist are synonymous.

OIG:
Office of Inspector General, Department of Health and Human Services.

Scope of Practice:
Those standards and parameters as set forth by the Council on Professional Standards for Kinesiotherapy (COPS-KT). All documentation will be recorded to reflect these standards and clearly display that all treatment is conducted within them. No guideline shall be construed as allowing a RKT to function at a level higher than allowed by statute and COPS-KT.
What is Documentation, and Why is it Important?

For many years medical documentation was done only by physicians as a reference source for patient care. Up to somewhere around twenty years ago only the physicians and their staff saw these charts. Medicare, Worker’s Compensation and insurers did not request to see the charts and there was little possibility of a medical document becoming a legal document.

This changed dramatically in the 1970’s with the enormous increase in the amount of malpractice suits brought against providers. As many suits are brought years after the treatment, the providers do not remember many details. At this point the medical documentation becomes not only pivotal but critical. With the growth of federal programs and Medicare in particular cases against providers surged forward again. But now not only physicians were being put behind bars, all providers of medical services were being severely scrutinized, to include providers of physical medicine and rehabilitation. In 2003 alone the number of physical therapists prosecuted successfully by the Office of Inspector General (OIG) tripled and the OIG looks predominantly at federal health care cases.

ICD-9-CM codes set medical necessity for patient treatment, and CPT is the universally used procedure coding text. But especially for procedure coding, guidelines have either been abused or misunderstood for years by physical medicine practitioners and is costing them dearly in terms of fines and imprisonment. However, many guidelines are vague or unclear, even when CMS attempts to detail them, and the codes fail. A claim may be resubmitted in most cases, but often insurance companies still refuse to pay on the claim. At this point they demand to see therapists’ documentation. Auditors, or more commonly called medical reviewers, will look closely at therapy documentation to see if the therapist treated the patient by accepted standards of practice. If this cannot be proven, then at best the claim gets denied. At worst the therapist will be brought up on formal charges of fraud. Therefore attention to detail in therapist documentation is of the utmost importance. Cases can be much more readily won when the therapist’s clinical reasoning is clear.

Good, clear documentation is not only critical to patient care but also validates the choice of ICD-9-CM and CPT codes, as well as provides information to other health care professionals who may be treating the same patient, avoiding duplication of services. With cost containment being more restrictive than ever, proper documentation will aid in getting the best reimbursement possible in a timely fashion.

Although computerized documentation software and forms address issues of legibility, standardization of documentation within an agency, and efficiency, there can also be some shortcomings relating to narrative documentation that provides insight into the patient’s
limitations and impairments. Be sure to include appropriate comments about why the patient was unable to progress to more advanced activities, as well as when progress or response to interventions is appropriate for the patient’s diagnosis, co-morbidities, and other factors.

Some computerized documentation appears repetitious and may be interpreted as maintenance care or that which could be performed by the patient, family, or aides. For example, only indicating that 10 additional repetitions of an exercise were performed does not tell a reviewer why the skills of the kinesiotherapist were necessary for that service. Often times, the kinesiotherapy initial evaluation reflects a long term goal of stair climbing for the purposes of independence in entering/exiting the patient’s home. However, when the kinesiotherapist does not document a progression toward that advanced skill, it is difficult to justify several intervening visits that appear to be repetitious maintenance care prior to the final discharge visit in which the patient accomplishes this safely.

I. GENERAL GUIDELINES

1. All documentation will comply with applicable local, state and national requirements. Where a question may arise on which to follow, the most stringent requirement shall be considered as overriding all others.

2. All handwritten entries will be made in ink. Black or blue ink is acceptable.

3. Electronic signatures are acceptable. However, all such entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. Facilities should have policies and procedures (P&P) relating to electronic signatures. Only the Registered Kinesiotherapist is qualified to approve such entries: therefore the unique identifier will be the therapist’s.

4. Facsimile signatures are acceptable.

5. Errors in handwritten documentation shall be corrected by a single line strikethrough with the correcting party’s initials. Electronic errors shall be corrected in a manner consistent with the computerized documentation system, while insuring that all original electronic documentation was not altered or deleted.

6. All patients will have an appropriate referral, from an MD, DO or authorized Provider Extender. At the very least the referring provider will sign the Initial Evaluation and Plan of Care.

7. The Initial and Discharge note should address outcome measures recognized by the AKTA and COPS-KT. The outcome measures should be used for evaluating efficacy of all KT treatment programs.
II. INITIAL EVALUATION

General Guidelines

For certain groups of patients the information may vary slightly from what is described here. Specifically the medical records for infants, adolescents, children and pregnant women may need additional or modified information recorded in the history and examination area. Such information may include family history, details of status at birth, social history of family and family structure.

Documentation on the assessment (e.g., OASIS, MDS, or other) nursing notes, evaluations and progress notes, and other notations should reflect consistency in the patient’s level of function and medical history. However, there should be an increased specificity of functional deficits and objective measures in the kinesiotherapist’s documentation.

Phrases, such as, “see hospital records” or “tolerated well” do not provide adequate information on the therapist’s hands-on assessment of the patient’s abilities and show no quantifiable progress.

If a patient’s tolerance or capabilities do not allow for a full examination and evaluation, then document your intent and plan to assess at a later time, follow-up and document those items later in the episode of care.
Overview of General Guidelines

The following guidelines are set forth for each documentation category:

Medical History
Obtain only the medical history which is pertinent to, or influences the KT treatment rendered, including a brief description of the functional status of the patient prior to the onset of the condition requiring KT, and any pertinent prior KT treatment.

Date of Onset
The date of onset or exacerbation of the primary medical diagnosis for which KT services are being rendered by the billing provider.

Physician Referral & Date
Must be signed and dated

KT Initial Evaluation & Date
Documented on the date it is completed & signed by the KT.

Plan of Care & Date Established
Date must be same as Evaluation. If notes are dictated make certain dates are identical.

Date of Last Certification
Obtain the date on which the plan of treatment was last certified by the physician.

Progress Notes
Obtain updated patient status reports concerning the patient's current functional abilities/limitations.

Coding the Evaluation
Registered Kinesiotherapists at this time do not have specific evaluation codes assigned by the AMA in CPT. Therefore coding of the evaluation will be contingent upon the COPS-KT Directives and therapist’s treatment goals documentation. If insurers give written permission for RKT use of other Physical Medicine and Rehabilitation codes then they will be allowed. All AMA and payer guidelines shall apply. Evaluation and Management codes (E&M 99201-99499) are not authorized for use by therapists of any discipline.

ICD-9 coding will be conducted in accordance with the Cooperating Parties’ guidelines. For outpatient kinesiotherapy the first listed diagnosis code will be from the V57.xx set.
Codes following the V57.xx will be determined in order by: primary condition to be treated; comorbidities also being treated, in decreasing order of severity/acuteness; and comorbidities that will affect treatment. These are clarified in Appendix C.

The therapist should assign all CPT and ICD-9 codes at the completion of the Initial Evaluation. Should codes be added, deleted or changed, documentation must reflect the reason(s) and if the physician was consulted.

**Documentation of Kinesiotherapy Evaluation**

Examples and elements of examination findings:

**Endurance and Aerobic Volume**

- Aerobic capacity during functional activities
- Aerobic capacity during standardized exercise testing
- Pulmonary signs and symptoms with exercise
- Cardiovascular signs and symptoms during exercise

**Morphogenetic Characteristics**

- General Appearance (deformity, development)
- Body dimensions
- Body composition
- Edemas

**Cognitive**

- Consciousness
- Attention
- Cognition
- Motivation
- Orientation
- Recall-memory
A safety problem exists when a patient, without skilled KT intervention, cannot handle him/herself in a manner that is physically and/or cognitively safe. This may extend to daily living or to acquired secondary complications which could potentially intensify medical sequelae such as fracture nonunion or skin breakdown.

Safety dependence may be demonstrated by high probability of falling, lack of environmental safety awareness, swallowing difficulties, abnormal aggressive/destructive behavior, severe pain, loss of skin sensation, progressive joint contracture, and joint protection/preservation requiring skilled KT intervention to protect the patient from further medical complication(s).

**Assistive Devices**

- Use of equipment during functional activities
- Devices alignment, fit and ability to assist
- Correction of limitations by use of assistive devices or equipment
- Safe use of assistive devices and equipment

**Barriers at Work, School and Home**

- Physical space and environment-limitations
- Current and potential barriers

**Body Mechanics**

- Dexterity and coordination
- Functional capacity
- Specific work environments
- Assistive devices or equipment for work or activities
- Self care
- Home care and leisure activities
Gait & Balance

- Misalignment and asymmetry
- Balance during activities with and without assistive devices or equipment
- Static balance with or without assistive devices and equipment
- Gait and motion during functional activities with or without assistive devices and equipment
- Safety during gait, balance and movement

Epidermis Integrity

- Activities or positioning that produces relief to the skin
- Assistive devices or equipment that provides relief to trauma of the skin
- Positioning or activities that aggravate the wound or scar
- Burn(s)
- Wound(s)
- Signs of Infection
- Scar tissue and wound characteristics

Joint Integrity

- Joint integrity and mobility
- Joint movements

Motor Function

- Dexterity, coordination and agility
- Hand function
- Control of movements

Muscle Performance

- Strength
- Power and endurance
- Muscle tension

Neuromotor Development

- Any atrophy noted
- Development and evolution of motor skills
- Oral and speech function
- Sensorimotor integration
Orthotic, Prosthetic Supportive and Protective Devices

- Alignment, fit and ability to serve
- Orthotic and protective devices and equipment during functional activities
- Functional corrections with use of assistive devices or equipment
- Safety during use of orthotic, supportive and protective devices

Pain

- Pain, soreness and aches
- Pain in specific body areas
- Nature of pain (radiating, burning, stabbing, etc.)
- Patterns, if any
- Sensory impairment
- Pain alone is not sufficient. More detail on the patient’s problem is required.

Posture

- Alignment and position during function
- Alignment and position while static
- Specific body parts

Range of Motion (ROM)

- ROM with notations of pain, crepitation or contracture
- Functional ROM
- Joint active and passive movement
- Muscle length and flexibility

Reflex

- Deep reflexes
- Postural reflexes and reactions including equilibrium

Respiration and Ventilation

- Signs of respiration and gas exchange
- Signs of ventilation functionality
- Pulmonary symptoms
- Pulmonary function during leisure work and home activities
To bill for skilled therapy services, the documentation should reflect the following:

- specific fall dates and/or hospitalization(s),
- most recent prior functional level,
- most recent level of assist for functional mobility and ADLs,
- patient’s cognitive status,
- prior therapy intervention,
- functional loss due to a recent change in medical condition,
- realistic goals and discharge plan,
- prior Tinetti score \[Note: If a Tinetti is used to document balance deficits, keep in mind the limitations of the Tinetti due to a patient’s comorbidity(ies)],
- functional maintenance program instruction and modification,
- caregiver training, and
- carry-over of therapy techniques to objective progress.
➢ Antalgic gait alone does not support the need for ongoing skilled gait training.

➢ If skilled gait training is rendered, therapists are expected to provide clear documentation of the patient’s gait deviations/deficits to support therapeutic intervention for gait training.

➢ The documentation must support the need for skilled gait training to restore functional abilities (or to design and establish a safe maintenance program) which can reasonably be expected to improve the patient's ability to walk or walk more safely.

➢ Documentation should describe the patient's gait deviations, current functional abilities and limitations, and/or safety dependence during gait.

➢ Documentation should identify the gait problem being treated (e.g., to correct a balance/incoordination and safety problem or a specific gait deviation, such as a Trendelenburg gait).

➢ Documentation must differentiate skilled gait training rendered from assistive walking, which is routine, repetitive ambulation to merely improve distance or endurance (assistive or non-assistive).
Assessment for non-specialized wheelchairs, cushions, lapboards, wheelchair trays, or lap buddies for a patient without a complicating condition does not require the unique skills of a therapist. A seating assessment is not reasonable and necessary for every patient.

The documentation for skilled seating evaluations should reflect the following:

- whether or not seating or positioning issues were assessed during a Part A SNF stay; what intervention was tried by nursing staff; functional deficits due to poor seating or positioning; most recent prior functional level; postural deficits that patient is unable to self-correct; what recent event prompted a seating evaluation;

- specific wheelchair, specialty items, dimensions and/or specific cushions evaluated or provided;

- clear explanation of how this seating device will make a significant improvement in functional abilities versus current wheelchair or seating device;

- transition to caregiver follow-up.

When wheelchair and seating assessments are reasonable, care should be turned over to supportive personnel or an appropriate caregiver when any necessary modifications are completed.

Ongoing visits for increasing sitting times are generally not reasonable and necessary when no patient problems are shown.

It is not reasonable to provide non-skilled services (routine ROM) while awaiting an ordered part or device to arrive. Care should be put on hold in this instance.
Note: It is expected that multiple deficits (related to wheelchair and seating assessments) discovered during the initial evaluation should be treated concurrently.

If not, documentation must indicate that a new problem/deficit just occurred or rationale why a problem being treated in the later stages of therapy was not addressed previously. Otherwise, medical reviewers will have difficulty determining if the services continue to be reasonable and necessary.)

**Improvements at each level must be documented** to compare the current cognitive and/or physical level achieved to that previously achieved. While cognitive assistance often is the more severe and persistent disability, physical assistance often is the major obstacle to successful outcomes and subsequent discharge. Therapists should interpret the levels as follows:

**Total Assistance**: Total assistance is the need for 100 percent assistance by one or more persons to perform all physical activities and/or cognitive assistance to elicit a functional response to an external stimulation.

An individual requires total assistance if the documentation indicates the patient is only able to initiate minimal voluntary motor actions and requires the skill of a kinesiotherapist to develop a therapeutic program or implement a maintenance program to prevent, or minimize, deterioration.

A cognitively impaired patient requires total assistance when documentation shows external stimuli are required to elicit automatic actions such as swallowing or responding to auditory stimuli. Skills of a kinesiotherapist are needed to identify and apply strategies for eliciting appropriate, consistent automatic responses to external stimuli.

**Maximum Assistance**: Maximum assistance is the need for 75 percent assistance by one person to physically perform any part of a functional activity and/or cognitive assistance to perform gross motor actions in response to direction. Patients require such assistance if maximum KT physical support and proprioceptive stimulation is needed for performance of each step of a functional activity, every time it is performed. A cognitively impaired patient, at this level, may need proprioceptive stimulation and/or one-to-one demonstration by the kinesiotherapist due to the patient's lack of cognitive awareness of other people or objects.
**Moderate Assistance:** Moderate assistance is the need for 50 percent assistance by one person to perform physical activities or constant cognitive assistance to sustain/complete simple, repetitive activities safely. A physically impaired patient requires moderate assistance if documentation indicates that moderate KT physical support and proprioceptive stimulation is needed each time to perform a functional activity.

The records submitted should state how a cognitively impaired patient requires intermittent one-to-one demonstration or intermittent cueing (physical or verbal) throughout the activity. Moderate assistance is needed when the kinesiotherapist/care-giver needs to be in the immediate environment to progress the patient through a sequence to complete an activity. This level of assistance is required to halt continued repetition of a task and to prevent unsafe, erratic or unpredictable actions that interfere with appropriate sequencing.

**Minimum Assistance:** Minimum assistance is the need for 25 percent assistance by one person for physical activities and/or periodic, cognitive assistance to perform functional activities safely. A physically impaired patient requires minimum assistance if documentation indicates that activities can only be performed after physical set-up by the kinesiotherapist or care-giver, and if physical help is needed to initiate, or sustain an activity.

A review of alternate procedures, sequences and methods may be required. A cognitively impaired patient requires minimal assistance if documentation indicates help is needed in performing known activities to correct repeated mistakes, to check for compliance with established safety procedures, or to solve problems posed by unexpected hazards.

**Standby Assistance:** Standby assistance is the need for supervision by one person for the patient to perform new procedures adapted by the therapist for safe and effective performance. A patient requires such assistance when errors are demonstrated or the need for safety precautions are not always anticipated by the patient.

**Independent Status:** Independent status means that no physical or cognitive assistance is required to perform functional activities. Patients at this level are able to implement the selected courses of action, demonstrate lack of errors and anticipate safety hazards in familiar and new situations. Significant improvement must be indicated by documenting a change in one or more of the following categories of patient responses:
The patient may respond by refusing to attempt an activity because of fear or pain. The documentation should indicate the activity refused, the reasons, and how the KT plan addresses them. These responses are often secondary to a change in medical status or medications. If the refusals continue over several days, the therapy program should be put on "hold" until the patient is willing to attempt functional activities.

For the cognitively impaired patient, refusal to perform an activity can escalate into aggressive, destructive or verbally abusive behavior if the therapist or caregiver presses the patient to perform. In these cases, a reduction in these behaviors is considered significant progress, but must be documented, including the skilled KT provided to reduce the abnormal behavior.

This situation may apply to many patients who normally would not be considered “impaired”. For instance, if a patient has been in the military for 12 years and has never been injured, there may be pressure on this person to return to full duty quickly.

Family pressures, job competition and many other events may cause an otherwise normal patient to become destructive, inconsistent or noncompliant.

For the psychiatrically impaired patient, refusals to participate in an activity frequently are symptoms of the diagnosis. The patient should not be put on a "hold" status due to refusals. If the documentation indicates that the patient is receiving KT, is contacted regularly, and is actively encouraged to participate, intermediaries medically review the claim to determine if reasonable and necessary skilled care has been rendered.
Documentation of Inconsistency

The patient may respond by inconsistently performing functional tasks from day-to-day or within a treatment session. Intermediaries approve the claim when the documentation indicates a significant progression in consistency of performance of functional tasks within the same level of assistance.

Assignment of appropriate diagnosis code(s): This code or set of codes will be assigned upon completion of the initial evaluation and will show what problems, pathologies, signs and symptoms the therapist will be directly treating.

Documentation of prognosis (determination of the level of optimal improvement that might be attained through intervention and the amount of time required to reach that level. Documentation shall include anticipated goals, expected outcomes, and plan of care).

III. PLAN OF CARE/PLAN OF TREATMENT (POC/POT)

1. Patient/client (and family members and significant others, if appropriate) is/are involved in establishing anticipated goals and expected outcomes.
2. All anticipated goals and expected outcomes are stated in measurable terms.
3. Anticipated goals and expected outcomes are related to impairments, functional limitations, and disabilities and the changes in health, wellness and fitness needs identified in the examination.
4. The plan of care is based on the examination, evaluation, pathological findings, and prognosis: identifies anticipated goals and expected outcomes of all proposed interventions.
5. Describes the proposed interventions taking into consideration the expectations of the patient/client and others as appropriate.
6. Includes frequency and duration of all proposed interventions to achieve the anticipated goals and expected outcomes.
7. Involves appropriate coordination and communication of care with other professionals/services.
8. Includes plan for discharge.
9. The kinesiotherapist will consult with the patient, family, caregivers or legal guardians on the POC and Discharge criteria. Instructions and criteria are to be understood and documentation supporting this will be on record in the patient’s chart.

10. Therapeutic interventions will be documented to include: type of intervention, settings, anticipated frequency and duration and clinical rationale for use. Extension, discontinuation or changes will be documented along with clinical reason(s).

11. When a kinesiotherapist plans to use multiple interventions to treat a patient’s symptoms, the documentation must clearly support the use each intervention as safe and effective treatment for the condition. The patient’s response to each treatment intervention must also be clearly stated.

12. The POC/POT will corroborate the ICD-9-CM codes validating medical necessity. Documentation must be specific.

13. A physician may change her/his or the therapist’s POC at any time. A kinesiotherapist cannot change any portion of a POC written by the physician.

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<tr>
<th>Type of KT Procedures</th>
<th>Describes the specific nature of the therapy to be provided.</th>
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<tr>
<td>Frequency of Visits</td>
<td>An estimate of the frequency of treatment to be rendered (e.g., 3x week). The provider's medical documentation should justify the intensity of services rendered. This is crucial when they are given more frequently than 3 times a week.</td>
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<tr>
<td>Estimated Duration</td>
<td>Identifies the length of time over which the services are to be rendered in days, weeks, or months. Duration should be in the initial plan (i.e. x 4 wks) and also needs to be in the short and long term goals.</td>
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<tr>
<td>Diagnoses</td>
<td>Includes the KT diagnosis if different from the medical diagnosis. The KT diagnosis should be based on objective tests, whenever possible.</td>
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<td>Functional KT Goals (short or long-term)</td>
<td>Reflects the kinesiotherapist's and/or physician's description of what functional physical/cognitive abilities the patient is expected to achieve. Assume that factors may change or influence the level of achievement. If this occurs, the kinesiotherapist or physician explains the factors which led to the change in functional goal(s).</td>
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<tr>
<td>Rehabilitation Potential</td>
<td>The kinesiotherapist's and/or physician's expectation concerning the patient's ability to meet the established goals.</td>
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IV. REEVALUATIONS

Reevaluations will follow the same procedural guidelines as Initial Evaluations. Reevaluations will also contain the same information.

Many payors, especially CMS, consider reevaluations bundled into treatment as standard practice for physical medicine providers and will not reimburse separately for any reevaluation code.

Insurance should be consulted if possible before billing commences.

NOTE: Do not bill muscle testing or range of motion testing if billing for an evaluation or reevaluation. These services are included as part of an evaluation process.
V. PROGRESS NOTES

Subjective, Objective, Assessment & Plan (SOAP) format is acceptable.

Progress Notes (PN) will be written on an ongoing basis for each patient. Improvement, degradation, stalling/plateauing are all to be documented.

As the RKT is the only professional with the skills, qualifications and training to make a final decision on the effectiveness of care, the RKT will sign all PNs with full, original signature, title and date.

If the RKT uses any form of aide, technician or assistant the therapist will co-sign all notes. If the “Assessment” is unclear the RKT should make an addendum note and sign it as above. Weekly PNs are advised.
VI. FLOW SHEETS

- Flow Sheets will be filled in for every patient visit.
- Flow sheets will document time the patient is actually treated.
- Report writing and preparation time are not included in billable time.
- Flow sheets will only serve as evidence of attendance and treatment.
- They do not substitute for Progress Notes.
APPENDIX A:

PROCEDURE CODING

NOTE

CPT codes are used to capture KT services and productivity. The codes which most closely describes the service documented in the patient medical record should be selected.

Coding guidelines must be followed regarding time, use of modifiers, etc. Please reference the “Introduction” at the beginning of the CPT book to become familiar with how to use the book and assign codes. The codes most appropriate for KT use are found in the “Medicine” section of the book.

There may be codes which may be worded for nonphysician practitioner use. Be sure you are within your scope of practice, follow all CPT and insurance guidelines when assigning codes.

All documentation must match the procedure codes chosen. It is inappropriate to use CPT codes defining services greater or less than actually performed. As long as the procedures are within the Registered Kinesiotherapist’s scope of practice, most of the CPT book may be used when supporting documentation exists to validate the charge. Only the E&M section, as mentioned previously, is not allowed for KT use.

The evaluation codes accepted for kinesiotherapist use are listed on the next page. When warranted reevaluations will be conducted in accordance with applicable AMA, VA, individual payor and COPS-KT protocols, whichever is the strictest.
The focus of treatment should drive the code(s) the kinesiotherapist chooses. For example, the RKT documents “We will conduct functional advanced plyometric training to target this patient’s critical deficits in proprioception, kinesthetic sense and spatial awareness.” In this scenario the KT would probably choose neuromuscular reeducation code 97112, because the focus of treatment is geared toward elements most closely related to 97112.

All procedures in the **Physical Medicine and Rehabilitation** are one-on-one direct patient contact, except for the group therapy code 97150, which still requires constant attendance. One-on-one direct patient contact means the therapist is with one patient and one patient only. Constant attendance means there must be a qualified individual with the group for the group code to be billed. 97150 is also untimed, default value will always be 1 unit (See following Group Policy). All one-on-one codes are timed and are to be calculated using the 8 Minute Timetable (Appendix B).

### Coding Procedures for Kinesiotherapy

CPT codes are used for outpatient and facility reporting of therapy services. Individual insurances may have additional guidelines. The information below reports coding guidelines according to the Current Procedural Terminology (CPT) book written by the American Medical Association (AMA) and the authoritative guide to CPT, *The CPT Assistant*, also written by the AMA.

**Treatment: Therapeutic Procedures-Therapist Required to have 1-1 Direct Patient Contact.**

**Individual Assessment**

97750  Physical Performance Test or Measurement (e.g. Musculoskeletal, Functional Capacity), each 15 minutes.

*CPT® Assistant November 2001 Volume 11 Issue 11*

**Code 97750, Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes, identifies a number of multi-varied tests and measurements of physical performance of a select area or number of areas.**

*These tests include services such as extremity testing for strength, dexterity, or stamina, and muscle testing with torque curves during isometric and isokinetic exercise, whether by mechanized evaluation or computerized evaluation. They also include creation of a written report. Since this type of testing includes both manual and automated muscle testing, the manual muscle testing (95381-95834) and range of motion (95851-95852) codes, should not be separately reported with code 97750. In addition, the number of body areas treated does not determine the use of the code, as the code includes descriptor language that identifies use according to the total time necessary to provide the service, and not according to the number of body areas treated. If less than the 15
minute time increment identified in the code descriptor is provided, then modifier -52 should be appended to the code to identify the reduction of service.

The following vignette describes the physical performance testing service in a typical case.

**CPT Assistant Vignette for 97750**

Description: The physician refers the patient, a data entry person, for evaluation and treatment of suspected carpal tunnel syndrome. Nerve conduction studies are negative. However, the patient complains of numbness in the median nerve distribution and pain in the proximal palm while on the job and often at night.

Assessments are made of pinch grip strengths using computerized instruments that are calibrated before each evaluation. Sensibility tests of touch, pressure threshold, and vibration are also performed on the patient for their ability to detect early development of carpal tunnel syndrome. Computerized instruments are preferred over hand held instruments, as they are subject to unreliability. Test results are negative, and a work simulation is set-up (the patient performs keyboard entry for 30 minutes). Upon re-test, vibration detection and touch pressure threshold have decreased from normal to diminished light touch in the dominant hand. Pinch and grip strengths have also diminished because of the pain.

Conservative treatment is initiated which includes ergonomic changes in equipment and job pacing in conjunction with physician’s application of anti-inflammatory medication.

The pre-service work includes chart reviews for medical treatment, pre set-up of activities, equipment, and area to be used, and review of previous documentation as needed. Service also includes communicating with other health care professionals (e.g., social worker, nurse), discussions with family, and calls to the referring MD for additional information/clarification.

During the intra-service effort, a status check of patient’s level of pain, sensation, pinch and grip strength, and functional job abilities (i.e., which duties at work the patient is able to carry-out) is performed. The provider develops a program to address instruction/practice of accommodated work related activities. The provider also educates patient to safe job performance, job pacing, and self-management of program. Further intra-service work is detailed in the vignette.

Post-service effort includes writing-up of report/documentation of treatment, calls to the referring physician to report progress, and communication with other team members.
97110 Therapeutic Procedure(s) to one or more areas, 1-1, each 15 minute. (activities to improve strength, passive/active ROM, flexibility and endurance, tilt table, standing table, aerobic training; mat exercises; pulleys, ergometers; weights; and patient education in any of these areas). For computerized assistive devices see 97530.

97112 Neuromuscular reeducation to one or more areas, 1-1, each 15 minutes. (to improve motor control and motor learning, to improve balance, proprioception, kinesthetic and perceptual motor skills-utilizing recognized neuromuscular treatment techniques and patient education in any of these areas).

97113 Aquatic therapy with therapeutic exercise to one or more areas, 1-1, each 15 minutes.

97116 Gait Training, 1-1, each 15 minutes (to restore normal stance, balance, swing, speed of muscle contraction for walking, includes stair climbing).

97150 Therapeutic Procedures, group, 2 or more. (described 97110, 97112, 97113). No time increments. Whether you treat for 20 minutes or two hours you may only take credit for one (97150).

97530 Therapeutic (Kinetic) Activities, 1-1, each 15 minutes (to improve ability to perform- bed mobility, w/c mobility, lifting, basic blind mobility, floor recovery, use of adaptive devices, goal directed and task specific; use of computerized devices, use of dynamic activities to improve functional performance, i.e. isokinetic isodynamic; sensory integration activities, dexterity/coordination/ROM activities, and patient education in all these areas

97537 Community/Work Reintegration, 1-1, each 15 minutes *For use by KT's performing Drivers Training only.

97542 W/C Management/Propulsion Training, 1-1, each 15 minutes.
Biofeedback training by any modality

Code 90901

Biofeedback Services
Biofeedback identifies the use of training to help an individual gain some element of voluntary control over autonomic body functions. It is based on the learning principle that a desired response is learned when some type of information is received (such as a recorded increase in skin temperature [feedback]) that indicates a specific thought process or action has produced the desired physiological response (paraphrased from Stedman’s Medical Dictionary, 26th Edition). This is accomplished with various biofeedback monitoring equipment, which may vary from one session to another depending on the presenting symptomatology. This may include placement of temperature or EMG sensors to relevant musculature. Verbal and visual instruction may also be given to the patient to show how to interact with biofeedback information. The patient also receives directions for appropriately reducing tension in the targeted areas of treatment. Since various methods of biofeedback exist, the type of procedure employed is dependent on the needs of the patient.

The service components for biofeedback include reviewing the history/chart, preparing the equipment for use, placing electrodes, reading responses (including galvanic skin responses), and working with the patient to monitor and control/change muscle responses. It also includes disposal or cleaning of the electrodes, and documentation of the services and results. Code 90901 identifies use of biofeedback procedures without use of psycho physiological therapy.

Vignette: Code 90901

A 47-year-old man has a chronic history of muscle spasms in the neck and shoulders, and tension-type diagnosed headaches. He has not responded well to a prior history of treatment with antianxiety medication and physical therapy.
Patient is monitored with surface EMG electrodes placed bilaterally on the trapezius, frontalis, and sternocleidomastoid muscle areas, given specific instructions as to how to interact with biofeedback information (visual and/or auditory signals meaningfully related to amplitude of EMG) and provided with directions for appropriate reduction of tension in the targeted muscle group. Possible factors precipitating tension-type headaches are discussed and pain levels reviewed from charts supplied by patient. Session changes are reviewed with patient and recommendations are made for follow-up training during the week plus additional recommendations for monitoring. A 40 to 60 minute length session, with one-on-one interaction with treating therapist is then performed. A brief session could be 30 minutes. The sample note may be a computerized print out of changes in EMG values over time, plus comments of treating practitioner, patient’s responses, compendium of pain values, as well as recording of medication type and usage during the prior interval since last session.

The descriptor for code 90901 does not include a time element. Therefore, time is not considered a factor when using this code to identify the service performed. In addition, 90901 should be used once to identify all modalities of biofeedback training performed for that date of service, regardless of time increments and number of modalities performed. For example, if 1-1.5 hours of surface electromyography is spent for neuromuscular assessment and reeducation, code 90901 would be reported once. In addition, use of a modifier would not be necessary for the 90901 codes, since the intent of code 90901 is to denote the service itself, and not the time necessary to perform the service indicated.

97755 Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility) direct one-on-one contact by provider, with written report, each 15 minutes
Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes

97761 Prosthetic training, upper and/or lower extremity(s), each 15 minutes

97762 Checkout for orthotic/prosthetic use, established patient, each 15 minutes

More about Orthotics and Prosthetics

CPT Assistant February 2007, Volume 17, Issue 2

In 2006, the CPT code set introduced a new subsection to the Physical Medicine and Rehabilitation 97000 series of codes called Orthotic Management and Prosthetic Management. The three codes in the subsection are used for reporting orthotic and prosthetic management. Prior to 2006, codes related to orthotic and prosthetic management did not describe fully the services associated with these types of interventions. The previous 97504 code was revised and renumbered. Two other code narratives remained the same, however, the numbering changed.

Orthotic management includes assessing the patient; determining the most appropriate orthotic (e.g., static vs. dynamic, custom vs. prefabricated); designing, selecting, and possibly fabricating the orthotic; and training in the use of the orthotic including wear time, skin care, and safety precautions. The patient’s skin integrity, sensibility, and healing of tissues with or without surgical repair needs to be considered when determining the choice of materials, such as the type of thermoplastic or the use of pulleys and elastic tension.

The code also includes the time associated with providing the patient instructions in exercises that are to be performed while the orthotic is in place. A parenthetical note following code 97760 instructs users not to report code 97760 with 97116 for the same extremity.
The three codes in the subsection are:

97760  Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes

97761  Prosthetic training, upper and/or lower extremity(s), each 15 minutes

97762  Checkout for orthotic/prosthetic use, established patient, each 15 minutes

**Coding Tip**
The orthotic and prosthetic management codes are time based and intended to be reported once for each 15-minute increment. Materials and supplies may be reported separately with an appropriate supply or material code (e.g., CPT code 99070 or HCPCS Level II code). HCPCS L codes for orthotics include the evaluation and fitting component of the service. However, any training time associated with using the orthotic may be reported using 97760. The time reported must only be for time that the patient is present.

Code 97760 includes additional orthotic management and training during follow-up visits including exercises performed in the orthotic, instruction in skin care and orthotic wearing time, and time associated with modification of the orthotic due to healing of tissues, change in edema, or interruption in skin integrity.

**Clinical Example: 97760**
A 65-year-old woman lacerated the volar side of her left, middle finger at the level of the proximal interphalangeal (PIP) (flexor tendon zone II) while cutting a bagel. She sustained a full laceration of the flexor digitorum profundus and superficialis tendons and underwent surgical repair of both tendons. The patient was referred to therapy for postoperative rehabilitation that initially included protected passive range of motion within the surgical dressings.

**Description of Procedure: 97760**
The therapist removed the postoperative surgical dressing and fabricated a customized dorsal forearm-based wrist-hand low temperature thermoplastic orthotic. The orthotic’s purpose was to protect the tendon repair and permit limited but progressive active and passive range of motion as the tendon heals. Initially, the orthotic was positioned with the wrist in 60° of flexion, the metacarpophalangeal (MCP) in 90° of flexion, the PIP joint in 90° of flexion, and the distal interphalangeal (DIP) joint in 50° of flexion. The therapist had to assess the patient’s skin condition, degree of edema, and ability to follow directions.

A decision had to be made regarding the type of low-temperature thermoplastic material to use, and fabrication (including measuring, molding, padding, and applying the straps) had to be completed. The orthotic design included dynamic tension on the finger to protect the tendon repair and allow for limited exercise once enough healing occurs. The patient was trained in the wear and care of the orthotic. This education included safety information for preserving skin integrity as well as precautions to facilitate tendon healing.
and minimize the risk of rupture. At subsequent visits during a 6-week period, the orthotic was remolded to permit a greater degree of excursion of the flexor tendon by permitting greater extension of the wrist, MCP, and finger IP joints.

Prosthetic devices have become increasingly sophisticated over the years due to advances in medical technology. These devices have evolved from mechanically simple limb substitutes unable to truly mimic normal motion to highly engineered, lightweight computerized limb prosthetics.

Extensive training is necessary in order for the patient to learn how to use the prosthesis to replace the function of a limb or missing body part. This takes place over many visits and includes preparation of the stump, strengthening of the remaining musculature, modification of prosthetic fit using stump socks or socket liners, mobility training, use during functional activities as well as skin care and overall conditioning. Prosthetic training is reported with code 97761.

This code is intended to be reported for prosthetic training of upper and/or lower extremity(s). As stated previously, prosthetic training is a time-based code reported for each 15 minutes of time spent training. It should be noted that once a patient begins gait training with the prosthesis, it is appropriate to report such training with 97116.

Clinical Example: 97761
A 45-year-old male with a below elbow amputation required training in the use of a prosthesis including, but not limited to, stump preparation, donning and doffing the prosthetic, skin care, and use of the prosthesis during activities of daily living at home and in the community environment.

Code 97762 is intended for established patients who have already received the orthotic or prosthetic device (permanent or temporary). It is important for the health care practitioner to follow up with the patient after he or she has been provided with an orthotic or prosthetic device. The “checkout” visit would include assessment of the patient’s response to wearing the orthotic or prosthetic device (such as possible skin irritation or breakdown); of whether the patient is donning the orthotic or prosthetic device appropriately; of the patient’s need for padding, underwrap, or socks; and of the patient’s tolerance to any dynamic forces being applied. Code 97760 is appropriate to report if further training in the use of the orthotic or prosthetic device is required.

Coding Tip
Orthosis application differs from the purpose of an application of a cast or strapping device. Orthotics are used to support a weak or ineffective joint or muscle or they may be used to immobilize a part to facilitate a decrease in pain and inflammation. They may provide support while the patient transitions through treatment or they may be used permanently to facilitate movement or support a body part. Examples of orthotic devices include posterior leaf spring to facilitate ankle dorsiflexion after a cerebral vascular accident, shoe inserts for a patient with a pronated foot, or a static wrist orthotic for a patient with carpal tunnel syndrome.
It is important to note that casting and strapping codes (e.g. 29049) are not intended to report orthotics fitting and training. A parenthetical note appears at the end of the Application of Casts and Strapping subsection heading in the Musculoskeletal System series codes to refer the reader to codes 97760-97762 for orthotics management and training.

Peripheral arterial disease (PAD) rehabilitation, per session

Code 93668

PAD physical exercise consists of a series of session, lasting 45-60 minutes per session, involving use of either a motorized treadmill or a track to permit each patient to achieve symptom-limited claudication.

Each session is supervised by an exercise physiologist or nurse. Specially trained Kinesiotherapists may be qualified to perform this service.

The supervising provider monitors the individual patient’s claudication threshold and other cardiovascular limitations for adjustment of workload. During this supervised rehabilitation program, the development of new arrhythmias, symptoms that might suggest angina or the continued inability of the patient to progress to an adequate level of exercise may require physician review and examination of the patient.
Pulmonary stress testing; simple (e.g. 6 minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)

Code 94620

94620 is a “global” service, including both the physician’s analysis of data and interpretation of the test (professional component) as well as the facility fee or technical component.

When a Kinesiotherapist is qualified through special training to perform this service, code 94620 should have modifier –TC appended to report the technical component only of this service. If this service is performed in a physician’s office by the Kinesiotherapist with the physician, 94620 may be reported without a modifier because the physician (professional component) and the technical components are both being performed at the expense of the physician.

CPT® Assistant June 2007 Volume 17, Issue 6

**Question:** We have had a number of questions regarding CPT 94620, Pulmonary stress testing; simple (e.g., 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry), being used for six-minutes of observed walking with no objective pulmonary assessment, with very short notes of simply stating the patient tolerated the six-minute walk test. Could you please review appropriate performance and reporting of the six-minute walk test that is reported with 94620?

**Answer:** The six-minute walk test is the most common test performed in pulmonary stress testing. Code 94620 was revised editorially in 2007 to include a six-minute walk test and oximetry in the example in the descriptor. The Question and Answer section of the July 2005 CPT Assistant clearly states that "spirometry is not required for the reporting of code 94620 with a six-minute walk test." A six-minute walk test with no objective ventilatory assessments should be reported with code 94761, Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (e.g., during exercise).

The appropriate code to report the six-minute walk test to evaluate distance, dyspnea, oxyhemoglobin desaturation, and heart rate is 94620, Pulmonary stress testing; simple (e.g., 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry). Most importantly heart rate, blood pressure, oxygen saturation, and liter flow of supplemental oxygen are to be reported at rest, during exercise, and during recovery.
Physician analysis of data and interpretation of the test are procedurally inclusive components of this code.

**Clinical Vignettes - 94620 Pulmonary stress testing; simple (e.g., prolonged exercise test for bronchospasm with pre- and post-spirometry)**

**Vignette #1:** A 65-year-old woman is seen because of dyspnea and cough after walking several city blocks. She has a normal physical examination and a spirogram is normal. A simple exercise test is performed with baseline spirogram. She walks on a treadmill until dyspnea occurs and a repeat spirogram is obtained to evaluate for exercise induced bronchospasm.

**Vignette #2:** A 65-year-old woman with documented COPD is evaluated for entrance into a pulmonary rehabilitation program. A six minute walk is performed to evaluate distance, dyspnea, oxyhemoglobin desaturation and heart rate. The test is usually repeated after a rest period to eliminate learning bias (but reported as one test).

Note: Exercise with pulse oximetry to document desaturation or to determine oxygen flow to prevent desaturation should be coded as 94761 (Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (e.g., during exercise). 94621 Pulmonary stress testing; complex (including measurements of CO₂ production, O₂ uptake, and electrocardiographic recordings)

**Vignette #3:** A 66-year-old male has unexplained dyspnea which interferes with his ability to work and exercise. A complex pulmonary stress test is ordered after other studies fail to identify the cause of the dyspnea. The complex stress test measures the integration of cardiac and pulmonary function and the status of the patient’s physical fitness. There is a measurement of CO₂ production, O₂ uptake, and electrocardiographic monitoring with recordings using a graded exercise protocol. Data are captured about peak cardiovascular and ventilatory responses. From this panel of complex metabolic tests, the physician, through his/her analysis and interpretation of the data, is able to calculate such items as a dyspnea index, an anaerobic threshold as a percentage of maximum O₂ uptake, and O₂ consumption as it relates to cardiac output. The **physician** prepares a written interpretation of the test results.
About Muscle and Range of Motion (ROM) Testing

Codes 95831 through 95852

Muscle and ROM are part of a therapy evaluation and/or re-evaluation. According to the CPT Assistant written by the AMA, there are instances where it is very appropriate to perform a thorough range of motion or manual muscle test during the course of treatment, separate from the typical evaluation and re-evaluation. Common examples include the treatment of patients diagnosed with multiple sclerosis, post-polio syndrome or Guillain-Barre. As always, the documentation should support the use of the CPT codes claimed.

CPT® Assistant November 2001 Volume 11 Issue 11

We present the following article as an update to physical medicine and rehabilitation coding. It addresses some of the more commonly asked questions regarding this section of the CPT coding manual, including information from other AMA publications regarding CPT physical medicine and rehabilitation coding. This article is not intended to be used as a complete review of physical medicine codes, but instead, serves as a supplement and update to other issues of the CPT Assistant that have discussed this topic.

Manual Muscle Testing/Range of Motion Testing:

Codes 95831-95834, 95851-95852 Codes 95831 through 95834 identify manual muscle testing procedures. Use of these codes specifies testing of muscle strength as graded by the examiner according to standardized grading scales, and includes manual testing based on numerical or verbal grading scales. The language included in each of the descriptors for use of these codes indicates 1) the body area(s) addressed by each code in the series (e.g., extremity or trunk, hand, with or without comparison to normal side); 2) the preparation of a formal, written report of the findings as a necessary component of the procedure; and 3) manual muscle testing. Automated muscle testing is included as part of physical performance testing/measurement (97750), and will be discussed later in this article.

Use of the manual muscle testing codes requires testing of muscle strength, the comparison of these values by the examiner to a standardized grading scale (whether verbal or numerical),
and the creation of a formal, written report of the findings. Muscle testing performed without recording the specific values for the muscles tested, or that does not include a separate report, should not be identified by codes 95831-95834.

Similar to the manual muscle testing procedures, range of motion procedures (ROM) codes 95851-95852:

1) include language that specifies the body areas that these codes are intended to identify; and
2) require the preparation of a formal, written report of the findings as a necessary component of the procedure.

ROM testing codes, however, may be used to identify manual or computerized ROM measurement. The ROM codes, designated as separate procedures, should not be reported with an evaluation and management services code when the range of motion measurements are performed as part of the physical examination, and only a statement about range of motion is made (e.g., range of motion painful at extreme). However, if each measurement is recorded and the physician prepares a separate, distinctly identifiable, signed, written report, then the ROM codes should be reported.

Neither manual muscle testing (95831-95834) nor range of motion (95851-95852) should be separately reported from physical performance testing/measurement (97750), as both services are included as part of physical performance testing procedures. To indicate this, “separate procedures” descriptor language is part of both the manual muscle testing and the ROM code descriptors to show that these services are integral components of a larger service.

About Health and Behavior Assessment/Intervention

Codes 96150 through 96155

Health and behavior assessment procedures are services provided to patients who present with established illness or symptoms. The difficulties associated with an acute or chronic illness can be devastating, and these patients may benefit from evaluations that focus on the biopsychosocial factors affecting physical health problems and treatments. Typically, the specific interventions may include discussion of health-promoting behaviors, symptom management and expression, and the provision of assistance with adherence to medical treatments.

Codes 96150-96155 were added to the CPT codebook in 2002 to provide a mechanism for reporting interventions used to modify the psychological, behavioral, emotional, cognitive, and social factors directly affecting the patient’s physical health and well-being. Prior to CPT 2002, no codes were available to describe these services. The central nervous system assessment/test codes (96100-96117) were not appropriate, as they are used to report the services provided during testing of the cognitive function of the central nervous system. The counseling and/or risk factor reduction intervention codes (99401-99429) were not appropriate because they are intended for patients without symptoms or established illness. The psychiatry codes were not appropriate because they refer to psychotherapy, psychological testing, and psychiatric evaluations and require a mental health diagnosis. In most cases, the difficulties associated with an acute or chronic illness, prevention of a physical illness or disability, and maintenance of health do not meet criteria for a psychiatric diagnosis.

Use of these codes eliminates the possibility of inappropriately labeling a patient as having a mental health disorder when in reality, the patient is experiencing a physical illness that may deeply affect the quality of his or her life.

Performance of a health and behavior assessment may include a health-focused clinical interview, behavioral observations, psycho physiological monitoring, use of health-oriented questionnaires, and assessment data interpretation. The elements of a health and behavior intervention are designed to improve the patient’s health, ameliorate specific disease related problems, and improve overall well-being.

**Clinical Example: Code 96150**

96150  Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psycho physiological monitoring, health oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment

A 5-year-old boy undergoing treatment for acute lymphoblastic leukemia is referred for assessment of pain, severe behavioral distress, and combative behavior associated with repeated lumbar punctures and intrathecal chemotherapy administration. Previously unsuccessful approaches have included pharmacologic treatment of anxiety (Ativan), conscious sedation using Versed, and, finally, chlorohydrate, which only exacerbated the child’s distress as a result of partial sedation. General anesthesia was ruled out because the child’s asthma increased anesthesia respiratory risk to unacceptable levels.

**Description of Procedure (96150)**

The patient was assessed using standardized questionnaires (e.g., the information seeking scale, pediatric pain questionnaire, coping strategies inventory), which, in view of the child’s age, were administered in a structured format. The medical staff and child’s parents were also interviewed. On the day of a scheduled medical procedure, the child completed a self-report distress questionnaire. Behavioral observations were also made during the procedure using the
CAMPIS-R, a structured observation scale that quantifies child, parent, and medical staff behavior. An assessment of the patient’s condition was thus performed through the administration of various health and behavior assessment instruments.

The health and behavior assessment or intervention codes may be reported by (but are not limited to) physicians, psychiatrists, psychologists, advanced practice nurses, clinical social workers, and other health care professionals within their scope of practice who have specialty or subspecialty training in health and behavior assessment or intervention procedures.

As noted in the code language, the health and behavior assessment or intervention codes (96150-96155) are reported according to the time spent providing these services. Therefore, documentation should also include the total amount of face-to-face time spent providing these types of services.

The psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems are an important component of treating a patient with an established physical illness. The health and behavior assessment or intervention codes are intended to be used to assess these biopsychosocial factors and provide evaluations that improve the patient’s health and well-being.

**Self-care/home management training (e.g. activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistance technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes**

**Code 97535**

Code 97535, Self-care/home management training, should be reported for the therapist devoting a separate and distinct procedural service to the patient for the purpose of instruction in managing his or her injury at home and preventing secondary injury.
If the intervention focused on skills that would be incorporated into the work environment (e.g., proper body positioning at a computer or analysis of activities that could be of potential risk for secondary injury), then the proper code would be community/work reintegration training (97537).

**Work hardening/conditioning; initial 2 hours / Code 97545**

**Work hardening/conditioning; each additional hour (list separately in addition to code 97545) / Code 97546**

**Codes 97545 and 97546**

*CPT Assistant, July 2003, Volume 13, Issue 7, pages 15-16*

Question: Is code 97530, Therapeutic activities, direct (one-on-one) patient contact by the provider, considered a component of code 97545, Work hardening/conditioning; initial 2 hours?

AMA Comment: Code 97545, Work hardening/conditioning; initial 2 hours, is a work related, intensive, goal-oriented treatment program specifically designed to restore an individual’s systemic, neuromusculoskeletal and cardiopulmonary functions. The objective of the work conditioning program is to restore the client’s physical capacity and function so the client can return to work. Code 97530 is not considered a component of code 97545 and therefore could be separately reported.
Back to Basics: ⚫ Add-on Codes - Most of the procedures listed in CPT can be reported using “stand-alone” codes that describe the total procedure or service performed. In fact, under certain circumstances it may be necessary to report two or more stand-alone codes to completely describe the procedure performed.

“Add-on” codes describe procedures/services that are always performed in addition to the primary procedure/service. They describe additional intra-service work associated with the primary procedure/service. Such services would never be reported using stand-alone codes.

These additional or supplemental procedures are designated as “add-on” codes and identified in CPT with a ⚫ symbol (listed in Appendix E of CPT). Add-on codes can also be identified by specific language in the code descriptor, such as “each additional” or “(List separately in addition to primary procedure).”

Only codes with the add-on code designation (i.e., proceeded by a + symbol, include descriptive language in the code descriptor, or are included in Appendix E) are considered add-on codes. Codes that precede or follow a designated add-on code are not automatically considered add-on codes. Add-on codes are exempt from the multiple procedure concept, and therefore, modifier ‘-51’ cannot be appended to these codes.

Defining Add-on Codes [Recognized by a plus sign “⚫” in front of the CPT code]

The following criteria are used to identify add-on codes in CPT:

a. The service/procedure can never serve as a stand-alone code and must be reported in conjunction with another primary service/procedure.

b. The service/procedure is commonly carried out in addition to the primary service/procedure performed. If not commonly performed in addition to the primary service/procedure, it is then defined as a stand-alone code; and when performed in addition to another procedure, the modifier -51 should be appended.

c. The service/procedure must be performed by the same physician/provider.

d. The add-on code describes a special circumstance under which a specific service/procedure is performed in conjunction with the primary procedure.

e. The add-on code describes an additional segment of time in a time-based code (e.g., each additional 30 minutes).
Education and training for patient self-management by a qualified, *nonphysician* health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; *individual patient*

- **98961** 2-4 patients
- **98962** 5-8 patients
Two (2) New 2008 Codes Allowing Non-Physician Providers to Code Medical Team Conferences!

► Medical Team Conference, *Direct (Face-to-Face) Contact* with Patient and/or Family

● 99366 Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional

► Medical Team Conference, *Without Direct (Face-to-Face) Contact* with Patient and/or Family

● 99368 Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional

**Guidelines When Coding Team Conference Services**

- Requires a minimum of 3 qualified health care professionals from different specialties or disciplines.
- Each of these professionals should be currently providing health care services to the patient.
- The provider reporting these codes must have performed a face-to-face evaluation or treatment of that patient with the previous 60 days.

**Documentation Requirements:**

- Participation in the team conference
- Contributed information & subsequent treatment recommendations
Supplies Code 99070 Versus HCPCS Level II codes

CPT Code 99070 is provided by the AMA to bill for supplies and materials used or dispensed to the patient during an encounter. It is “generic” code and does not specify the supply. It is necessary to provide a description of the supply on the claim form on the electronic claim along with the price of the item. CMS provides HCPCS (Healthcare Common Procedural Coding System) level II codes to report supplies, services and drugs. These codes are very specific and can be billed to insurances other than Medicare. HCPCS level II codes are updated each January and throughout the year. To obtain a current listing of HCPCS level II codes, follow these instructions:


2. Scroll down the page until you see “Coding”, not too far from the top on the left.

3. Click on “HCPCS Release & Code Sets”

4. Select the downloads you want/need!
Educational Supplies, CPT Code 99071

The AMA provides code 99071 as a “generic” method of reporting educational supplies used during an encounter. Please specify price and type of supply on the claim form.

HCPCS LEVEL II PROCEDURE CODES

HCPCS Level II has a section named “ Temporary National Codes (Non-Medicare)”. Within this section are several codes which could be used by Kinesiotherapists. The list below is not an all-inclusive list.

S9445  Patient Education, Not Otherwise Classified, Non-Physician Provider, Individual, Per Session

S9446  Patient Education, Not Otherwise Classified, Non-Physician Provider, Group, Per Session

S9452  Nutrition Classes, Non-Physician Provider, Per Session

S9472  Cardiac Rehabilitation Program, Non-Physician Provider, Per Diem

S9473  Pulmonary Rehabilitation Program, Non-Physician Provider, Per Diem

S9476  Vestibular Rehabilitation Program, Non-Physician Provider, Per Diem
APPENDIX B

GROUP THERAPY AND 1:1 (one-on-one)

TREATMENT POLICY

Individual (One-On-One) versus Group Therapy Guidelines

Policy
The American Kinesiotherapy Association strives to be compliant with Managed Care and Federal health care programs regarding coding, billing and documentation in the area of skilled therapy utilizing direct one-on-one patient criteria.

Objective
To ensure compliance in coding and billing direct one-on-one versus group therapy against providing actual group therapy treatment services. To abide by the American Medical Association’s definitions in CPT regarding the need for direct one-on-one between patient and physician/therapist for individual therapy.

Specifics

1. Documentation must consistently show skilled therapy being performed, one-on-one and with a group. If patients are working on their own with minimal assistance from the therapist, those patients’ training cannot be billed.

2. When any assistant under the therapist’s supervision performs any of the CPT Physical Medicine timed procedures with two or more individuals it is considered a group and CPT code 97150 is reported. 97150 is not a timed code; therefore only one unit should be billed for a calendar day for a patient.

3. If a therapist or assistant treats two or more patients during the same time period treatment must be reported using 97150.

4. Appropriate patients for group therapy will have the cognition and motivation to understand instructions, carry them out in a group setting, learn from the clinician leading the group, work for periods independently while the clinician attends to other participants and be able to work toward short and long term goals. There must be documented benefit from the therapy provided in the group setting.

5. If a patient has met all goals, plateaued, is completely independent in all exercises, or the patient or responsible authority (e.g. family, physician) orders discharge, then discharge criteria from group therapy have been met.
6. Only the therapist, qualified assistant, or individual authorized by statute may treat or bill for treatment of Medicare patients. Technicians, aides, students, exercise physiologists and life skills trainers do not meet the definition of authorized by statute. If an unlicensed person assists the licensed therapist, it is billable to Medicare only if the therapist is in attendance the entire treatment time.

7. The plan of treatment may prescribe, for example therapeutic exercise. On Monday, the patient receives 30 minutes of direct one-on-one skilled therapy from the KT and 97110 is billed for 2 units. On Wednesday, however, due to scheduling conflicts, the therapist is cueing and directing the patients’ therapy while providing gait training to another patient. Wednesday’s therapy is then billed 97150.

8. When individual therapy is provided (direct one-on-one) and the services is a Constant Attendance Modality or a Therapeutic Exercise billed in 15 minute increments, then the 8 minute rule is used for rounding units as follows:

   CMS-Counting Minutes for Timed Codes in 15 Minute Units
   (1-1 therapy procedures)

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers 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.

- If a service represented by a 15 minute timed code is performed in a single day for at least 15 minutes; that service shall be billed for at least one unit.

- If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc. It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes.
When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service (as noted on the chart above) determines the number of units billed.

If any 15 minute timed service that is performed for 7 minutes or less than 7 minutes on the same day as another 15 minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater than 8 minutes, then bill one unit for the service performed for the most minutes. This is correct because the total time is greater than the minimum time for one unit. The same logic is applied when three or more different services are provided for 7 minutes or less than 7 minutes.

The expectation (based on the work values for these codes) is that a provider’s direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

If more than one 15 minute timed CPT code is billed during a single calendar day, then the total number of timed units that can be billed is constrained by the total treatment minutes for that day.

Pub. 100-02, chapter 15, section 230.3B Treatment Notes indicates that the amount of time for each specific intervention/modality provided to the patient is not required to be documented in the Treatment Note. However, the total number of timed minutes must be documented. These examples indicate how to count the appropriate number of units for the total therapy minutes provided.

Example 1 –

24 minutes of neuromuscular reeducation, code 97112,
23 minutes of therapeutic exercise, code 97110,
47 minutes total timed code treatment time

See the chart above. The 47 minutes falls within the range for 3 units = 38 to 52 minutes. Appropriate billing for 47 minutes is only 3 timed units. Each of the codes is performed for more than 15 minutes, so each shall be billed for at least 1 unit. The correct coding is 2 units of code 97112 and one unit of code 97110, assigning more timed units to the service that took the most time.
Example 2 –

20 minutes of neuromuscular reeducation (97112)
20 minutes therapeutic exercise (97110),
40 minutes total time

Appropriate billing for 40 minutes is 3 units. Each service was done at least 15 minutes and should be billed for at least one unit, but the total allows 3 units. Since the time for each service is the same, choose either code for 2 units and bill the other for 1 unit. Do not bill 3 units for either one of the codes.

Example 3 –

33 minutes of therapeutic exercise (97110),
7 minutes of manual therapy (97140),
40 minutes total time

Appropriate billing for 40 minutes is for 3 units. Bill 2 units of 97110 and 1 unit of 97140. Count the first 30 minutes of 97110 as two full units. Compare the remaining time for 97110 (33-30 = 3 minutes) to the time spent on 97140 (7 minutes) and bill the larger, which is 97140.

Example 4 –

18 minutes of therapeutic exercise (97110),
13 minutes of manual therapy (97140),
10 minutes of gait training (97116),
8 minutes of ultrasound (97035),
49 minutes total time

Appropriate billing is for 3 units. Bill the procedures you spent the most time providing. Bill 1 unit each of 97110, 97116, and 97140. You are unable to bill for the ultrasound because the total time of timed units that can be billed is constrained by the total timed code treatment minutes (i.e., you may not bill 4 units for less than 53 minutes regardless of how many services were performed). You would still document the ultrasound in the treatment notes.
Example 5 –
7 minutes of neuromuscular reeducation (97112)
7 minutes therapeutic exercise (97110)
7 minutes manual therapy (97140)
21 Total timed minutes

Appropriate billing is for one unit. The qualified professional (See definition in Pub 100-02/15, sec. 220) shall select one appropriate CPT code (97112, 97110, 97140) to bill since each unit was performed for the same amount of time and only one unit is allowed.

NOTE

The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the eighth should be excluded from the total count.

The total minutes of active treatment counted for all 15 minute timed codes includes all direct treatment time for the timed codes. Total treatment minutes— including minutes spent providing services represented by untimed codes— are also documented.

For documentation in the medical record of the services provided see Pub. 100-02, chapter 15, section 230.3: Documentation, Treatment Notes.
APPENDIX C

ICD-9-CM CODING

It is strongly recommended all health care professionals/providers, review and ICD-9-CM Official Guidelines. The national Center for Health Statistics, branch of the CDC (Center for Disease Control) published current ICD-9-CM Updates and Official Guidelines.

The web site link is: http://www.cdc.gov/nchs/icd9.htm

When you click on this link – look for the “What’s New” section of the web page under Classifications of Diseases and Functioning & Disability. “ICD-9-CM Addenda and Updated Guidelines”, shown with an arrow below, is where you need to click. It takes you to the web page where you can obtain the guidelines and current tabular and index addenda!

What’s New

- ICD-9-CM Advice for Healthcare Encounters in Hurricane Aftermath (9/15/2005) (3 pages) PDF
- Classification of Death and Injury Resulting from Terrorism
- ICD-10-CM
- ICD-9-CM Addenda and Updated Guidelines
- International ICD-10 Training Materials Products and Capacity

The information below has been extracted from the official guidelines to provide guidance related specifically to therapy encounters.
Under Administrative Simplification, every provider and insurer will be held to the guidelines set forth by the Cooperating Parties. Remember, one of the Cooperating Parties is CMS. These guidelines were made with very specific ends in mind.

The beginning of each ICD-9-CM book contains the entire Coding Guidelines. However there are several codes kinesiotherapists need to be very aware of:

1. The primary reason for the visit should be sequenced first. For outpatient rehabilitation (which is actually an exception to the overall rule), the reason for the visit will be a V57.x(x) code, to exactly describe exactly the encounter reason. These codes set medical necessity: therefore it is imperative to follow the rules correctly. The possible codes for kinesiotherapist use are:

   V57.0   Breathing Exercises
   V57.1   Other Physical Therapy (therapeutic and remedial exercises, except breathing)
   V57.2  5th   Occupational therapy and vocational rehabilitation
           V57.21 Encounter for occupational therapy
           V57.22 Encounter for vocational therapy
   V57.3   Speech therapy
   V57.4   Orthoptic training
   V57.8  5th   Other specified rehabilitation procedure
           V57.81 Orthotic training (gait training in the use of artificial limbs)
           V57.89 Other (multiple training or therapy)
   V57.9   Unspecified rehabilitation procedure

V57.1 is accepted for use for kinesiotherapy services, and V57.9 is recognized as the reason for the encounter for kinesiotherapists providing cardiac rehabilitation services.

There are many other V codes which may apply to a therapist’s situation. However, V codes outside of the V57.x(x) range are clarification or status codes, to help further define a patient’s status in rehab. These codes will not go on the first or second diagnosis line on the bill, but may go on the third or fourth. Some possible V codes are V43.61 through V43.67 for joint replacements; V45.4 for status post surgical arthrodesis and V45.89 for status post surgical; V49.1 through V49.5 for problems with limbs, and V49.61 through V49.77 for limb amputations.

There are many other V codes applicable to therapy & rehab. Review this section of ICD9 and make a list applicable to your facility.
2. The therapist is expected to draw her or his own conclusions from the Initial Evaluation. In most cases the diagnosis code must be different than the referring physician’s. This is the case with:

a) Status post surgery patients. The referring physician’s working or operative diagnosis cannot be used by therapists because that diagnosis no longer applies to the patient. The problem is presumed cured by the surgery. The therapist will be working with a Late Effect.

b) Status post stroke patients. Except for Home Health Agencies under CMS and the Observation and Assessment Information Set (OASIS), therapists are never to use ICD-9-CM 436, acute stroke, for any patient. Again the therapist is working with a Late Effect (of CVA). These codes can be found from 438.0, Cognitive deficits, to 438.89 (Other late effects of CVA).

c) AMI, or Heart Attack. AMI is coded somewhat differently: up to the eighth week the AMI is considered acute. At the eighth week the condition becomes chronic and needs to be re-coded appropriately.

3. Manifestation coding. Manifestation coding can be very complex. The most common patients therapists will encounter requiring manifestation coding will be diabetic patients. For one diabetic ulcer there may be numerous codes assigned. When a diagnosis code is chosen, if there is another diagnosis code in indented brackets below the primary code, both must appear on the claim, in the order you find them. The order may never be reversed. The bracketed code is the manifestation (code) of the primary diagnosis code chosen.

4. E Codes. E codes are reserved for injuries due to accidents or violence, and will not go on the first or second diagnosis code line on the claim. As with most of the V codes the E series further details a patient’s condition. E codes kinesiotherapists may well encounter and use are in series E990-E999, INJURY RESULTING FROM OPERATIONS OF WAR. Learn the E codes to find applicable codes. In certain instances, insurers such as Worker’s Compensation want the therapist to sequence two E codes; one for what happened, and one for where the accident happened. This way insurers can coordinate who will be primary and secondary payor.

5. Coding comorbidities. It is contravening coding guidelines to co-code for conditions which are inherent in the overall disease process. In therapy this often happens with the coding of pain. For example spinal stenosis, herniated nucleus pulposus, sciatica and cervicalgia. If the therapist chose these conditions to treat, then it would be inappropriate to also code for pain, no matter how severe or limiting it was. Pain is part of the overall condition. However, if a patient had spinal stenosis, for example, but had surgical laminectomy to cure it, then pain may be used to treat this patient. But remember that now, spinal stenosis cannot! It is presumed cured by the surgery.
6. Difficulty walking (719.7) and abnormality of gait (781.2). These two codes have very different meanings and cannot be interchanged. Difficulty walking is joint/mechanically based; abnormality of gait is inherently more complex and neurologically based.

7. As with procedure coding, evaluative findings and the therapist’s focus of treatment will drive the choice of code(s). For example if the RKT is going to be treating a soldier to return to combat, which is considered to be that soldier’s “vocation” then the reason for the visit code could be V57.22. It is not necessary to fill in every diagnosis line but if the pathology requires all be filled in then do not hesitate to do so.

Coding “PAIN”

#1. Location of the pain:
   - Joint?
   - Back?
   - Muscle?
   - Bone?
   - Due to a device?

#2. Identify the type of pain:
   - Post-operative?
   - Acute?
   - Chronic?
   - Associated with trauma?
Location of Pain

Referencing “Pain” in the alphabetical index, verifying the code in the tabular, we find the following results:

Joint Pain

Joint pain is coded as 719.4X with the 5th digit assigned to represent location. Joint pain always requires a 5th digit!

Joint stiffness is coded as 719.5X (different 4th digit), again, choosing the correct 5th digit contingent upon location. Code both joint pain and stiffness if both conditions exist and are clearly documented in the initial evaluation.

Back Pain

Back pain codes in category 724 exclude conditions related to: collapsed vertebra due to osteoporosis, etc., intervertebral disc disorders and spondylosis.

General low back pain, low back syndrome and lumbalgia conditions all fall under code 724.2.

Muscle Pain

Documentation of “muscle pain” leads us to code 729.1 for myalgia, myositis, unspecified and fibromyositis. Again, this is an unspecified code which may affect reimbursement.

Bone Pain

Code 733.90 for disorder of bone and cartilage, unspecified is referenced when “bone pain” is documented (again, an unspecified code which may affect reimbursement).

Due to a Device

Referencing the word “Pain” in the alphabetical index, then “due to” lead us to reference the word “complication” instead and code 996.7! The rule for coding pain as a complication from a device is to code 996.70. For instance, code 996.78 is the correct code to assign when pain is due to an internal orthopaedic device, implant or graft.

Pain associated with devices, implants or grafts left in a surgical site (for example painful hip prosthesis), use additional code(s) from category 338 to identify acute or chronic pain due to presence of the device, implant of graft (338.18-338.19 or 338.289-338.29).
**Type of Pain**

Referencing “Pain” in the alphabetical index, verifying the code in the tabular, we find the following results:

**Postoperative Pain**

ICD9 coding rules indicate that pain is normal postoperative. Postoperative pain may be reported as a secondary diagnosis code when a patient develops an unusual or inordinate amount of postoperative pain, code 338.18.

**Acute Pain**

338.19 is appropriate for acute pain (other than postoperative and neoplasm related).

**Chronic Pain**

Document as much as possible about the chronic pain to provide coding options. Examples of how to code various chronic pain conditions:

- Lower limb 355.71
- Upper limb 354.4
- Chronic Pain Syndrome 338.4
- Myofascial Pain Syndrome 729.1
- Neoplasm Related Chronic Pain 338.3
- Reflex Sympathetic Dystrophy upper limb 337.21
- Reflex Sympathetic Dystrophy lower limb 337.22
- Reflex Sympathetic Dystrophy other specified site 337.29

**Associated with trauma**

- Acute pain due to trauma is coded 338.11
- Chronic pain due to trauma is coded 338.21
Appendix D

CMS Eleven (11) Billing Scenarios for Therapy

CMS has gone to great lengths to detail requirements for therapy and rehabilitation. Since the AMA does not address much of the Physical Medicine aspects of CPT, CMS has done so. In most cases CMS is the only regulating authority to put these guidelines in writing. Therefore, particularly under Administrative Simplification, where there are only CMS guidelines we must use them as standard for every insurer. Many insurers, for example Worker’s Compensation in many states, already follow these guidelines and refer therapists to them when questions arise.

The following billing scenarios formerly appeared on the Frequently Asked Questions (FAQ) website and on the Therapy Medlearn website as "11 FAQs" - posted 9/13/02 Open Door on Group Therapy.

CMS Assumptions

1. Billing - CPT Codes: Not Permitted

In the same 15-minute (or other) time period, a therapist cannot bill any of the following pairs of CPT codes for outpatient therapy services provided to the same, or to different patients. Examples include:

a. Any two CPT codes for "therapeutic procedures" requiring direct one-on-one patient contact (CPT codes 97110-97542);

b. Any two CPT codes for modalities requiring "constant attendance" and direct one-on-one patient contact (CPT codes 97032 - 97039);
c. **Any two CPT codes requiring either constant attendance or direct one-on-one patient contact - as described in (a) and (b) above -- (CPT codes 97032-97542).** For example: any CPT code for a therapeutic procedure (e.g., 97116-gait training) with any attended modality CPT code (e.g., 97035-ultrasound);

d. **Any CPT code for therapeutic procedures requiring direct one-on-one patient contact (CPT codes 97110 - 97542) with the group therapy CPT code (97150) requiring constant attendance.** For example: group therapy (97150) with neuromuscular reeducation (97112);

e. **Any CPT code for modalities requiring constant attendance (CPT codes 97032 - 97039) with the group therapy CPT code (97150).** For example: group therapy (97150) with ultrasound (97035);

f. **Any untimed evaluation or reevaluation code (CPT codes 97001-97004) with any other timed or untimed CPT codes, including constant attendance modalities (CPT codes 97032 - 97039), therapeutic procedures (CPT codes 97110-97542) and group therapy (CPT code 97150)**

See reference numbers 4. and 5. above.

### 2. Billing - CPT Codes: Permitted

In the same 15-minute time period, one therapist may bill for more than one therapy service occurring in the same 15-minute time period where "supervised modalities" are defined by CPT as untimed and unattended -- not requiring the presence of the therapist (CPT codes 97010 - 97028). One or more supervised modalities may be billed in the same 15-minute time period with any other CPT code, timed or untimed, requiring constant attendance or direct one-on-one patient contact. However, any actual time the therapist uses to attend one-on-one to a patient receiving a supervised modality cannot be counted for any other service provided by the therapist.

See reference numbers 4. and 5. above.

### 3. Group Therapy-vs - Individual Therapy:

The following is provided to assist you in determining whether to bill for group therapy (97150) or individual therapy (defined by the timed CPT codes for therapeutic procedures requiring direct one-on-one patient contact), when treating two patients during the same time period.

When direct one-on-one patient contact is provided, the therapist bills for individual therapy, and counts the total minutes of service to each patient in order to determine how many units of service to bill each patient for the timed codes. These direct one-on-one minutes may occur continuously (15 minutes straight), or in notable episodes (for example, 10 minutes now, 5 minutes later). Each direct one-on-one episode, however, should be of a sufficient length of time to provide the appropriate skilled treatment in accordance with each patient's plan of care. Also, the manner of practice should clearly distinguish it from care provided simultaneously to two or more patients.
Group therapy consists of simultaneous treatment 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, it is appropriate to bill each patient one unit of group therapy, 97150 (untimed).

a. **One-on-One Example:** In a 45-minute period, a therapist works with 3 patients - A, B, and C - providing therapeutic exercises to each patient with direct one-on-one contact in the following sequence: Patient A receives 8 minutes, patient B receives 8 minutes and patient C receives 8 minutes. After this initial 24-minute period, the therapist returns to work with patient A for 10 more minutes (18 minutes total), then patient B for 5 more minutes (13 minutes total), and finally patient C for 6 additional minutes (14 minutes total). During the times the patients are not receiving direct one-on-one contact with the therapist, they are each exercising independently. The therapist appropriately bills each patient one 15 minute unit of therapeutic exercise (97110) corresponding to the time of the skilled intervention with each patient.

b. **Group Example:** In a 25-minute period, a therapist works with two patients, A and B, and divides his/her time between two patients. The therapist moves back and forth between the two patients, spending a minute or two at a time, and provides occasional assistance and modifications to patient A’s exercise program and offers verbal cues for patient B’s gait training and balance activities in the parallel bars. The therapist does not track continuous or notable, identifiable episodes of direct one-on-one contact with either patient and would bill each patient one unit of group therapy (97150) corresponding to the time of the skilled intervention with each patient.

See reference numbers 4. and 5. above.

4. **Team Therapy:**

Therapists, or therapy assistants, working together as a "team" to treat one or more patients cannot each bill separately for the same or different service provided at the same time to the same patient.

CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same patient(s). Where a physical and occupational therapist both provide services to one patient at the same time, only one therapist can bill for the entire service or the PT and OT can divide the service units. For example, a PT and an OT work together for 30 minutes with one patient on transfer activities. The PT and OT could each bill one unit of 97530. Alternatively, the 2 units of 97530 could be billed by either the PT or the OT, but
not both. Similarly, if two therapy assistants provide services to the same patient at the same time, only the service of one therapy assistant can be billed by the supervising therapist or the service units can be split between the two therapy assistants and billed by the supervising therapist(s).

See reference numbers 4. and 5. above.

5. Counting Minutes of Service Units

Billing of six units over a 60-minute period by providing direct one-on-one treatments to six patients for 10 minutes each:

If more than one timed CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time. Medicare's expectation (based on the work values for these CPT codes) is that a therapist's direct one-on-one patient contact time will average 15 minutes in length, for each unit. Therapy sessions of should not be structured to consistently provide less than an average of 15 minutes treatment for each timed unit. Routine billing of the above-described practice (10-minute treatment sessions) results in an average workload that exceeds the expected time frames and would likely cause the contractor to question whether the services were reasonable and necessary.

In the case of group therapy, an untimed code, Medicare expects that skilled, medically necessary services will be provided as appropriate to each patient's plan of care. Therefore, group therapy sessions should be of sufficient length to address the needs of each of the patients in the group.

See reference number 5. above.

6. Group and Individual CPT Codes Billed on Same Day:

Billing for both individual (one-on-one) and group services provided to the same patient in the same day:

This is allowed, provided the CPT and CMS rules for one-on-one and group therapy are both met. However, the group therapy session must be clearly distinct or independent from other services and billed using a -59 modifier.

The group therapy CPT code (97150) and the direct one-on-one 15-minute CPT Codes for therapeutic procedures (97110 - 97542) are subject to Medicare’s Correct Coding Initiative (CCI). The CCI edits require the group therapy and the one-on-one therapy to occur in different sessions, timeframes, or separate encounters that are distinct or independent from each other when billed on the same day. The therapist would use the -59 modifier to bill for both group therapy and individual therapy CPT codes to distinguish that the two coded services represent different sessions or separate encounters on the same day. Without the -59 modifier, payment would be made for the lower-priced
group therapy CPT Code, in accordance with CPT/CCI rules. The CCI edits are based upon interpretation of coding rules.

The National Correct Coding Initiative website contains a section titled "How To Obtain Assistance With Questions Related to CCI Edits" that may be helpful. In addition to the group therapy edits, CCI edits are applied to certain other pairs of CPT codes used by physical and occupational therapists. The CCI website contains a link to the National Technical Information Service (NTIS) website for information on obtaining the CCI Edits Manual and now lists current CCI edits.

See reference number 7. above.

7. **Supervision:**

The services of a therapist or therapy assistant **cannot** be billed for supervising a patient who is independently performing a therapeutic exercise program.

Medicare pays only for skilled, medically necessary services delivered by qualified individuals, including therapists or appropriately supervised therapy assistants. Supervising patients who are exercising independently is not a skilled service.

See reference numbers 1. and 3. above.

8. **Qualified Personnel:**

You **cannot** bill Medicare for the services of an aide that is supervised by the therapist or therapy assistant.

Medicare Part B does not pay for the services provided by aides regardless of the level of supervision. Medicare pays only for skilled, medically necessary services delivered by qualified individuals, including therapists and appropriately supervised therapy assistants.

See reference numbers 1. and 3. above.

9. **Group Frequency:**

In private practice settings for physical and occupational therapists and in physician offices where therapy services are provided incident to the physician, Medicare expects the group therapy code (97150) to be billed only once each day per patient. In the facility/institutional therapy settings, the group therapy code could be applied more than once. However, the occasional situation where group therapy is billed more than once each day would require sufficient documentation to support its medical necessity and clinical appropriateness of providing more than one separate session of group therapy.

See reference number 4. above.
10. Documentation:

Records need to be maintained in order to demonstrate that billing for individual therapy or group therapy was proper:

CMS provides guidance on the reporting of service units that includes documentation instructions. A therapist or therapy assistant should record the total treatment time (or the actual beginning and ending time of treatment) for services described by timed codes, untimed codes and unattended (billed and unbilled) activities. **The total number of timed 15-minute units that can be billed by the therapist (whether performed by the therapist or therapy assistant) for each patient is constrained by the total time of the skilled therapeutic one-on-one intervention by the therapist or therapy assistant.** For the untimed codes, including "supervised" modalities, group therapy, and the evaluation codes, documenting the session time can help to justify the appropriateness of the services provided.

Alternatively, in cases where recording the total treatment time may not be sufficient to describe the extent of the therapeutic procedures or where certain practice policies require it, the time spent delivering each service described by either a timed or untimed CPT code could be recorded. In these cases, the therapist could document (a) the total time or the beginning and ending time for each session defined by a timed code and/or (b) the total time (or segments of time) in which the patient is involved in services defined by untimed codes and unattended codes.

See reference number 5. above.

11. SNF Part B Billing:

In a SNF, when a therapist is working simultaneously with two or more residents - at least one each from Part A and Part B - providing the same or different activities, the regulations for each payer source must be followed. Examples of possible billing scenarios follow:

- A therapist treats one Part A resident and one Part B resident during the same 30-minute session, providing different activities to each, and does not track identifiable one-on-one episodes of direct care with either patient. The therapist would bill one unit of 97150 (group) for the Part B resident, and code the total time, 30 minutes, toward the MDS as individual treatment time for the Part A resident.
- A therapist treats one Part A resident and one Part B resident during the same 30-minute session, providing the same or similar activities to each, and not tracking identifiable one-on-one episodes of care with either patient. The therapist would bill one unit of 97150 (group) for the Part B resident and code the total time, 30 minutes, toward the MDS as group treatment time for the Part A resident.

Note: Part A therapy is different from Part B:
• In order to be considered group therapy under Part A, the SNF residents perform similar activities whereas, under Part B, the therapeutic interventions can be similar or different; and,
• SNF therapy services are paid as part of the bundled PPS rate and not reimbursed under the physician fee schedule as they are under Part B.

See reference numbers 6. and 8. above.

This Concludes the AKTA Documentation Guidelines