ACA CODING POLICY STATEMENTS

97010, HOT/COLD PACKS
It is the position of the ACA that the work of hot/cold packs as described by CPT code 97010 is not included in the CMT codes 98940-43 in instances when moist heat or cryotherapy is medically necessary in order to achieve a specific physiological effect that is thought to be beneficial to the patient.

ACA CLARIFICATION ON "CHIROVIEW PRESENTS" 97140 INFORMATION
The ACA has received a number of inquiries concerning information available on the Internet regarding correct CPT coding using CPT code 97140, Manual Therapy Techniques.

ACA STATEMENT ON CODING OF SURFACE ELECTROMYOGRAPHY
Surface electromyography (sEMG) is being marketed to doctors of chiropractic as a non-invasive procedure used to quantify the electrical activity of muscle tissue.

Electrodes are placed on the skin overlying the muscles of interest and the electrical activity of the muscles are transmitted to a receiver, which translates the data into graphic information. There are two types of sEMG-Static (muscles are at rest) and Dynamic (kinesiologic analysis – muscles are in movement).

ACA STATEMENT ON CODING X-RAYS AND OTHER IMAGING STUDIES
In the course of clinical practice, providers are faced with a variety of scenarios involving interpretation of x-rays or other imaging studies. Each of these services should be reported using the proper CPT code. Basically, reporting of imaging evaluation with report can be broken down into four categories. These include standard radiology services codes; professional component - 26 modifier; records review and consultation on x-rays made elsewhere.

ACA STATEMENT ON DOWNCODING AND BUNDLING
The ACA is the largest professional association representing doctors of chiropractic in the country. Through invitation of the American Medical Association (AMA), chiropractic is represented on both the CPT HCPAC and the RUC HCPAC. The individuals serving on these committees function in an advisory capacity with respect to both the CPT and RUC processes.

CMT/E&M REIMBURSEMENT SOLUTIONS
The ACA fields numerous inquiries regarding the use of Chiropractic Manipulative Treatment (CMT) codes with evaluation and management (E&M) services. The following statement reflects ACA's position on the use of CMT codes and evaluation and management (E/M) services.

CODING CLARIFICATION 97012, MECHANICAL TRACTION/SPINALATOR
The ACA receives numerous requests for clarification on describing the work associated with mechanical traction. According to CPT, mechanical traction is described as the force used to create a degree of tension of soft tissues and/or to allow for separation between joint surfaces. The degree of traction is controlled through the amount of force (pounds) allowed, duration (time), and angle of pull (degrees) using mechanical means. Terms often used in describing pelvic/cervical traction are intermittent or static (describing the length of time traction is applied), or autotraction (use of the body's own weight to create the force).

CODING CLARIFICATION 97112, NEUROMUSCULAR REEDUCATION
CPT Code 97112 Neuromuscular reeducation, does not describe chiropractic manipulative treatment and the services are not mutually exclusive. Chiropractic manipulation (CMT) is described by codes 98940, 98941, 98942, and 98943. From a CPT coding perspective, in certain circumstances it may be appropriate to report CMT procedures and CPT code 97112 on the same date of service. For example, if separate therapeutic procedures are being addressed by different techniques, then it is appropriate to report these services separately.

CODING CLARIFICATION: MANUAL MUSCLE TESTING (CPT # 95831-95834), RANGE OF MOTION MEASUREMENT (CPT # 95851-95852), AND PHYSICAL PERFORMANCE TESTING (CPT # 97750)

The purpose of this statement is to clarify appropriate billing for Manual Muscle Testing, Range of Motion (ROM) Measurement, and Physical Performance Testing in conjunction with Evaluation and Management (E/M) and/or Chiropractic Manipulative Treatment (CMT) services.

CODING CLARIFICATION: TENS UNIT PROFESSIONAL COMPONENT

The ACA fields numerous questions on properly describing the work inherent with fitting a patient with a tens unit and instructing them in its use. A doctor of chiropractic has the ability to use evaluation and management (E&M) services to describe their work. Certainly, one of the E&M services that describe the level of service rendered in an encounter with the patient when they receive their tens unit would be appropriate.

CODING CLARIFICATION: USE OF CMT WITH 97124

The ACA has fielded numerous calls concerning insurance company denials of CPT code 97124, Massage, when billed the same day as a Chiropractic Manipulative Treatment (CMT) code, 98940-98942. An example of the reason given for this denial is that massage is a part of CMT.

CODING MISUSE PROMPTS FRAUD INVESTIGATIONS

In an earlier Talking Point, we reported that the HHS Office of Inspector General (OIG) announced plans to increase anti-fraud staff and efforts. It only takes a quick glance at the media to see their efforts are exploding. Add to this, nearly all insurers employ in-house Special Investigation Units (SIU) that have now shifted their focus from the arsonist and car thief to the medical provider who commits fraud. Intentional misuse of CPT coding constitutes fraud in both the public and private sectors.

While a greater number of suspected fraud cases are being investigated in both the public and private sectors, you can take steps to avoid this potentially expensive and reputation damaging experience. Below are some risk areas to be aware of and to avoid.

Risk Areas

Most Practice Management seminars are helpful for many reasons and offer practical ideas to grow your business. Some Practice Management companies recommend reimbursement practices that can land you squarely in hot water. Here is a sampling of common practices being devised and promoted to gain reimbursement without regard to proper coding.

Billing an Evaluation and Management (E/M) Code on Every Visit with CMT: In general, it is inappropriate to bill an established office/outpatient E/M code (99211-99215) on the same visit as Chiropractic Manipulative Treatment (98940-98943) because CMT codes already include a brief pre-manipulation assessment. There are times when it would be appropriate, but it should not be routine. Examples of when it may be appropriate to bill an additional E/M service would be the evaluation of new patients, new injuries, exacerbations, or periodic re-evaluations. If you are being told that billing an E/M code on every visit is a proper form of billing, it is incorrect. Please refer to the American Chiropractic Association (ACA) website www.acatoday.com, Insurance and Reimbursement, for specific guidance on the proper use of E/M with a Chiropractic Manipulative Treatment Code (CMT).

Billing an Evaluation and Management Code in Place of CMT: In cases where a limited number of manipulations are allowed, DCs are being advised to use an E/M code instead of a CMT code to get around the limit on CMT. This is inappropriate. You are required to bill the code that best describes the service rendered. Pattern software used by many insurers will easily pick up the code deviation and refer that doctor's billings to the Special Investigations Unit (SIU) for fraud investigation. If a business pattern can be established that shows the doctor deliberately changed codes, a direct fraud prosecution can be initiated. This can apply to any code deviation and is not just limited to E/M codes billed with CMTs.

Inappropriately Billing 97140 in Place of CMT: Billing for multiple time-based codes such as several manual therapies (97140), when a CMT was the only service performed, is inappropriate. You cannot replace a CMT code with another code if the CMT was the actual service performed. Once again, you are required to use the code that best describes the service

rendered. In addition, each unit of 97140 describes 15 minutes of office time-it normally does not take 45 minutes to perform manipulative therapy and payers are fully aware of this.

Unbundling: Some providers are requiring a patient to return to the office on the next day to perform a service that would not otherwise be covered, or that may allow higher reimbursement if it is done as a "stand-alone" procedure on a separate day. Insurers respond to this form of coding manipulation by, at a minimum, combining services into bundled coding edits or, at worse, with limits or caps on services for the entire profession.

These are just a few examples of incorrect coding that have come to light recently. The American Chiropractic Association feels it is important to let you know that using these or other questionable practices puts both you and the entire chiropractic profession at risk. Make sure that you use proper coding procedures-intentional acts that misuse CPT codes hurt the entire chiropractic profession and thwart the profession in its ability to fully integrate into mainstream healthcare.

The American Chiropractic Association sponsors two doctors of chiropractic who sit on the AMA CPT and RUC coding committees and are intimately familiar with coding intent. ACA consistently publishes and keeps current on any new codes or changes to previous codes. If you have a coding question, please bring it to the attention of the ACA Professional Development and Research Department or the ACA Coding and Reimbursement Committee. In addition, you can purchase the ACA Coding Solutions Book for 2003 by contacting ACA Member Information Services at 703-276-8800.

CPT CODES FOR ACUPUNCTURE SERVICES

Beginning Jan. 1, 2005, a new reporting method for acupuncture services took effect. Effective on that date, CPT codes 97780 (acupuncture, one or more needles; without electrical stimulation) and 97781 (acupuncture, one or more needles; with electrical stimulation) were deleted.

Four new codes have been developed for reporting acupuncture services. Like the deleted codes of 97780 and 97781, the new codes are separated into acupuncture services with and without electrical stimulation. However, in addition to these distinctions, the reporting of acupuncture services will now be reflected in 15-minute intervals, as well as a separate reporting method for the initial versus additional 15 minutes of treatment.

The codes themselves are outlined as such:

97810: Acupuncture, one or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.

97811: Acupuncture, one or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with reinsertion of needle(s) (List separately in addition to code for primary procedure).

97813: Acupuncture, one or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.

97814: Acupuncture, one or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with reinsertion of needle(s) (list separately in addition to code for primary procedure).

Acupuncture is reported based on 15-minute increments of personal (face-to-face) contact with the patient, not the duration of acupuncture needle(s) placement.

If no electrical stimulation is used during a 15-minute increment, use 97810, 97811. If electrical stimulation of any needle is used during a 15-minute increment, use 97813, 97814

Evaluation and management services may be reported separately, using modifier 25, if the patient's condition requires a significantly separately identifiable E/M service, above and beyond the usual pre-service and post-service work associated with acupuncture services. The time of the E/M service is not included in the time of the acupuncture service.

CPT POSITIONS ON THE PROPER USE OF 97140
The CPT position on the use of code #97140 for manual therapy techniques states the following: "Manual therapy techniques consist of, but are not limited to, connective tissue massage, joint mobilization and manipulation, manual traction, passive range of motion, soft tissue mobilization and manipulation, and therapeutic massage. As the code descriptor states, 'manual' providers use their hands to administer these techniques. Therefore, code 97140 describes 'hands-on' therapy techniques.

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

HYDROBED MODALITY
The ACA receives numerous requests for information concerning the modality known as a "hydrobed." ACA's coding experts have been advised that 97039, unlisted modality, would best describe the procedure. This code describes services for which there is no specific AMA CPT code assigned. Documentation should be provided to describe the work involved.

ICD-9-CM NEW & REVISED CODES (Effective Oct. 1, 2005)
The 2006 ICD-9-CM code changes have been released, with an implementation deadline of October 1, 2005. Please note that CMS no longer allows a 90-day grace period for using discontinued codes. It is time to review and update your billing systems.

NEW HCPCS INFORMATION FOR 2004: CERVICAL PILLOW
In 2004, the routinely billed code for a cervical pillow-E0943- was deleted. In its place, the Centers for Medicare and Medicaid Services, who develop the HCPCS codes, has suggested that providers bill the code, E0190-positioning cushion/pillow/wedge, any shape or size for cervical pillows.

SPINAL DECOMPRESSION TREATMENT
Vertebral axial decompression therapy is described as an alternative, noninvasive, nonsurgical procedure of applying axial (Y-axis) traction to the spine. It can be used in the treatment of several conditions, including low back pain associated with lumbar disc herniation, degenerative disc disease, posterior facet syndrome, and radiculopathy. The clinical objectives of this therapy include relief of disabling low back pain and return to normal function. Length of the episode of care is partially dependent on the patient’s response to treatment.

TIMED CODES: CONSTANT ATTENDANCE MODALITIES & THERAPEUTIC PROCEDURES
The American Chiropractic Association frequently receives calls concerning timed CPT codes (e.g. What does Constant Attendance mean? How do you determine the time to be billed?) It is our hope the following information will help clarify some of these issues.

UNITED HEALTHCARE (UHC) AUDITS ON CHIROPRACTIC MANIPULATIVE TREATMENT (CMT) CPT CODE # 98943
Revised Date: November 4, 2004
American Chiropractic Association is aware that UHC has recently:

1. Reduced reimbursement by 50% for CPT Code # 98943, when reported with another CMT code (# 98940 - 98942), and is also
2. Requested a refund from DCs previously reimbursed for CPT Code # 98943 and CPT code(s) # 98940 - 98942 on the same date of service.

UHC includes in its Explanation of Benefits (EOBs), and in refund request letters, a statement indicating the reduction/request for a refund is per ACA policy. You should note that UHC's reference to ACA policy is under review.

ACA is aware of the time constraint surrounding the situation and is working diligently in the investigation of this situation. Updates will be provided daily. Any formal statement will be posted on ACA's List Serve and website at: www.acatoday.com or you may call ACA's Insurance Relations Department at 703-276-8800, for that update.

What You Can Do

If you have received an EOB noting CPT # 98943 reduction by 50%, or a letter requesting a refund for that code, please forward the following:

1. Copy of the UHC EOB (or refund request letter) and
2. Your submitted claim form

Please fax these to ACA's Department of Professional Development and Research at: 703/243-2593. **Please remove all patient identifying information (e.g., name, Social Security number)**.

USE OF PHYSICAL MEDICINE MODALITIES BY DOCTORS OF CHIROPRACTIC

Doctors of chiropractic are authorized to utilize physical medicine modalities and procedures, and perform this work in compliance with statutory and regulatory authority according to the state in which the doctor practices. CPT codes, 97001-97799, specifically indicate modalities that are supervised or constant attendance and the CPT 2000 version specifically notes, "contact by the provider." There is absolutely no reference that the codes must be performed by a, "licensed therapist."