SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.8 CHIROPRACTIC AND PHYSICAL MEDICINE SERVICES

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

CHIROPRACTIC AND PHYSICAL MEDICINE SERVICES

Providers should adhere to the billing guidelines below for chiropractic and therapy services.

Date of Service

Services for a given date of service should be billed on **one claim form with each code listed one time per date of service** with the appropriate number of units. Date ranges or span dates should not be used on individual claim lines and could result in inaccurate payments.

Skilled, Reasonable and Necessary Care

Services should only be billed if they require direct or overall supervision of a therapist or provider licensed to perform skilled therapy services. Therapy services which require direct (one-on-one) patient contact (97032-97039, 97110-97150 and 97530-97546) may only be billed if provided by a physical or occupational therapist, a physical or occupational therapy assistant, or a provider licensed to perform skilled therapy services and operating within the scope of their license. For example, technicians, exercise physiologists, aides, chiropractic assistants, RNs, LPNs, etc. may assist but are not licensed to provide therapy services and therefore should not bill for those service which require direct (one-on-one) patient contact. Supervised modalities (97010-97028) do not require direct (one-on-one) patient contact and may be performed by unlicensed staff (i.e., technicians, CAs, LPNs, etc.) under the supervision of a provider licensed to perform the service.

If the service can be performed by the patient or an unskilled person without the supervision of a therapist or licensed provider, then it is not a skilled therapy service, and the service should not be billed. For example, after an exercise has been successfully taught to the patient, repeating the exercise and oversight of the completion of the exercise is not billable unless additional skilled care is provided.

Services should only be billed if they are reasonable and medically necessary. Any services rendered should be clinically appropriate for the patient's condition in regards to the type, frequency and duration of treatment. These services should fall within the generally accepted standards of care.

"Incident To" Billing of Therapy Services

Blue Cross does not follow CMS "incident-to" reimbursement rules for any provider who is eligible to contract with BCBSLA. Therefore:

- If the provider is eligible to contract with BCBSLA, then the provider is required to file claims under his/her own provider number for services rendered. This rule applies even while the provider is in the process of applying for his/her own provider number.
- "Incident-to" services are only eligible to be reimbursed under the supervising provider's number if the rendering provider is ineligible to contract with BCBSLA.

Services furnished by a physical therapist (PT) or physical therapy assistant (PTA) under the supervision of a PT, which were previously billed under the physician's or chiropractor's provider number, must be billed under the PT's provider number.

A PTA must practice under the direction and supervision of a licensed PT and not a physician or a chiropractor. Services performed by the PTA must be billed under the supervising PT's provider number.

Direct Patient Contact Required

CPT codes 97032-97039, 97110-97150 and 97530-97546 require direct patient contact. Time billed should be based on direct one-on-one constant contact by the provider with the patient. Only the actual time spent with the patient performing the service should be billed, and any time billed should be based on a clinical need for direct patient contact. Time that the patient spends resting or waiting for a piece of equipment should not be considered part of the treatment time. Supervising patients who are exercising independently is not a skilled service and is not billable.

Time Based Services

Blue Cross and Blue Shield of Louisiana follows the American Medical Association CPT guidelines for billing time-based codes. **Time is considered to be face-to-face contact with a patient delivering skilled services. A unit of time is attained when the mid-point is passed unless specific CPT guidelines state otherwise.** For example, 15 minutes is attained when eight minutes have elapsed. Incremental intervals of the same treatment at the same visit may be accumulated. If the mid-point of the unit of time is not attained, the code should not be billed. It is not appropriate to bill these services with the reduced services Modifier 52.

Modalities

Supervised modalities (97010-97028) should only be billed once per day regardless of the number of areas treated. Since supervised modalities do not require direct (one-on-one) patient contact, it would be acceptable for unlicensed staff (i.e., technicians, CAs, LPNs, etc.) to perform those services under the supervision of a provider licensed to perform the service.

Constant attendance modalities (97032-97036) are only reimbursable once per day. Since constant attendance modalities require direct (one-on-one) patient contact, there must be a clinical need to remain with the patient to deliver the service in order to bill these codes.

Multiple heating modalities should not be billed for the same area on the same day.

No Duplication of Treatment

If patients receive physical and occupational therapy, they must have separate goal and treatment plans. There should be no duplication of treatment.

Physical & Occupational Therapy Reevaluation

Reevaluation codes will bundle to therapy services, however, a reevaluation may be allowed upon appeal for certain circumstances. Once an initial therapy evaluation is completed, the patient is not eligible for a reevaluation until three months after the initial evaluation. If there is a significant change to the patient's diagnosis or a surgical procedure is performed, then a reevaluation is allowed sooner than the three-month waiting period. Providers should appeal with medical records for these situations.

Treatment Sessions and Documentation

Typical physical or occupational therapy treatment times per session are usually 45 to 60 minutes. Audits will be performed periodically to ensure claims are submitted appropriately. Proper coding and documentation will avoid inappropriate payments that may result in recoupment.

Documentation Elements

1. Initial Evaluation
   - Medical diagnosis
   - History
   - Exam
   - Assessment
   - Plan
2. Plan of Care
   - Medical diagnosis
   - Treatment details
   - Long-term functional goals
   - Type of services
   - Frequency of treatment
   - Duration of treatment
3. Flow sheets
   - Must be legible
   - Patient's name
   - Name of licensed performing provider rendering each service (i.e., if a PTA renders therapeutic exercise and the PT renders manual therapy on a patient, each provider should be documented in regards to the specific service they rendered)
   - Dates of service
   - CPT code and the activity performed
   - Start time and total time that supports the service rendered and clearly differentiates each service
   - Modalities to include specific locations treated

4. Daily Notes
    - Documentation in addition to and in support of the flow sheet is required for every treatment session
    - Patient feedback
    - Concrete measurements
    - Treatments performed, frequency, duration and equipment used
    - Assessment of patient's progression
    - Continued plan or discharge note
    - Licensed performing provider's signature

Multiple Procedure Reduction

Blue Cross and Blue Shield of Louisiana will apply multiple procedure reductions to codes 95851-95852, 97010-97150, 97169-97596, 97611-97799, 98940-98943 and G0283 when billed on the same day. If services are provided on the same day by providers in different specialties (i.e., physical therapy and occupational therapy), the multiple procedure reduction applies separately for each provider specialty. Multiple units will rank based on the highest per unit allowable charge across all codes eligible for a reduction.

Multiple units will be reimbursed based on the allowable charge at:

- 100% for the first unit
- 90% for the second, third and fourth unit
- 50% for the fifth unit
- 25% for the sixth unit
- 5% for seven or more units

Examples

Per Unit Allowable Charge*

97110 = $11
97140 = $10
97014 = $9
97012 = $7

**Not actual allowable charges. For illustration only.*

Code	Units	Fee
97110	2	$20.90
97140	1	$9.00
97014	1	$8.10

Code	Units	Fee
97140	2	$18.00
97110	2	$20.90

Code	Units	Fee
97140	1	$9.00
97014	1	$8.10
97012	1	$3.50
97110	2	$20.90

Please Note: Multiple procedure reductions may apply differently on coordination of benefits (COB).

Supplies are Not Billed Separately

Supplies (e.g., tape, gloves, electrical stimulation pads, hot and cold packs, needles, etc.) are included in the service. Supplies should not be billed separately or directly to members.

Hot and Cold Packs

Hot and cold packs will not be reimbursed separately. They are included in the therapy service.

Elastic Therapeutic Taping

Elastic therapeutic taping is not a separately billable. Elastic therapeutic tape is a supply, so its use is included in the reimbursement for the therapeutic procedure. Strapping codes (29000-29799) should not be used to bill for elastic therapeutic taping. Since strapping is intended to provide immobilization or restricted movement for acute injury treatment, it is not appropriate to bill elastic therapeutic taping with strapping codes.

Group Therapy

Group therapy code 97150 is not a time-based code so it is only billable once per session. Groups should contain no more than four individuals. Supervising patients who are exercising independently is not a skilled service and is not billable.

Therapeutic Activities and Neuromuscular Re-education

Codes 97530 (therapeutic activities) and 97112 (neuromuscular re-education) should not be used to describe massage therapy.

CPT code 97112 (neuromuscular reeducation) may be billed for impairments affecting the body's neuromuscular system that may result from disease or injury such as a stroke (CVA), severe trauma to the nervous system, and systemic neurological disease. Documentation for neuromuscular reeducation must show impairments which affect the neuromuscular system as described above.

Dry Needling (Intramuscular Manual Therapy)

Dry needling refers to a procedure whereby a fine needle is inserted through the skin and into a trigger point to induce a twitch response in order to relieve pain and increase range of motion. During dry needling, the needle can go deep inside muscle tissue that a provider is not able to directly manipulate. Dry needling is not acupuncture. For acupuncture billing guidelines, see subsection 5.2 of this manual.

Blue Cross does not recognize codes 20560 and 20561 for billing dry needling. CPT codes 20560 and 20561 are considered invalid for submission to Blue Cross and claims submitted with these codes will be denied. Blue Cross requires dry needling to be billed under manual therapy code 97140. In order to identify that dry needling was performed as part of manual therapy, Modifier CG should be appended to the manual therapy code.

If dry needling is performed on the same day as chiropractic manipulative treatment (CMT), Modifier 59 should be appended to 97140 so that it may be allowed for separate payment. Modifier 59 should only be appended if the midpoint of the unit of time billed for dry needling is reached. To clarify the billing of these services please review the examples in Manual and Massage Therapy Performed as Part of Chiropractic Care in this manual section.

Chiropractic Manipulative Treatment (CMT) and E&M Services

Any CMT service should be billed with the CPT code that best describes the services rendered. The codes that best describe CMT services are 98940-98943. Manual therapy (CPT 97140) and E&M codes should not be used to bill for CMT services.

Since CMT codes (98940-98943) include a pre-manipulation assessment, a separate E&M code should not be reported with a CMT service unless a significant, separately identifiable E&M service was performed. It may be appropriate to separately report an E&M service for the following situations if additional work is done above and beyond what is included in the CMT service:

- Initial evaluation of a new condition or injury.
- Significant change in the patient's condition (i.e., acute exacerbation of symptoms).

E&M codes may bundle to chiropractic or physical medicine services if they are considered an integral part of the primary procedure. Providers should appeal with medical records if there was a significant change to the patient's condition.

When billing E&M codes (i.e., 99202-99215), medical necessity of a service must be proven in addition to the required components of the code. It is not appropriate to bill a higher level E&M service when a lower level is warranted.

The correct code for an E&M visit should be chosen based on the complexity of the visit. This is determined by the complexity of medical decision making as documented in the record or the total time dedicated to the patient on the given date of service. The amount of documentation should not be the primary factor for what level of service is billed.

Either medical decision making or total time can be used to determine the correct code, but these two elements cannot be combined. Medical records may be required for reimbursement consideration for repeat E&M code submissions or for level 4 or 5 E&M codes.

For more information on E&M billing guidelines, refer to the Evaluation and Management Services section of this manual.

Manual and Massage Therapy Performed as Part of Chiropractic Care

Therapeutic procedures (i.e., 97124 and 97140) used to relax or prepare the patient for manipulation are considered fundamental to the manipulation and are included in the manipulation reimbursement when they are performed in the same area on the same day. Dry needling may be reimbursed separately even if performed in the same area on the same day and should be billed as code 97140 with Modifier 59 and Modifier CG.

When manual therapy (97140) or massage therapy (97124) is performed on an area of the body that is unrelated to the manipulation, services may be eligible for separate reimbursement. In order for separate reimbursement to be considered, the code must be filed with Modifier 59 and the following conditions must be met:

- Treatment must be skilled in nature and part of a specific, diagnosis-related goal. Devices such as hand-held vibrators are not considered skilled services and are not billable services.
- Manipulation should not have been performed on the same area of the body on the same day.
- The following must be documented:
    1. Specific description of the area treated and the utilized technique for treatment (i.e., manual traction, myofascial release, etc.).
    2. Time treatment began and ended along with the total number of minutes of treatment.
    3. Clinical rationale for the separate service. (i.e., contraindication to CMT).

Audits will be conducted on a periodic basis to ensure claims are submitted appropriately. Proper coding prevents inappropriate payments that eventually result in recoupment.

If a licensed massage therapist performs massage therapy incident to another provider, the service should be billed with Modifier HT.

Example 1:
Ten minutes of manual therapy (dry needling) and 10 minutes of manual therapy (not dry needling).

In this example with a total of 20 minutes of manual therapy, only one unit of manual therapy is billable. Since dry needling was performed for at least eight minutes, the midpoint of the 15 minute unit of time was reached and 97140 may be billed with Modifier 59.

Code	Modifier	Modifier	Units
97140	59	CG	1

Example 2:
Five minutes of manual therapy (dry needling) and 10 minutes of manual therapy (not dry needling) performed in the same area as CMT.

In this example with a total of 15 minutes of manual therapy, only one unit of manual therapy is billable. Since dry needling was performed for less than eight minutes, the midpoint of the 15 minute unit of time was not reached and 97140 should be billed without Modifier 59 since the remaining manual therapy was performed in the same area as CMT.

Code	Modifier	Modifier	Units
97140	CG		1

Example 3:
Ten minutes of manual therapy (dry needling) and 15 minutes of manual therapy (not dry needling) performed in different area than CMT.

In this example with a total of 25 minutes of manual therapy, two units of manual therapy are billable. Since dry needling was performed for 10 minutes, one unit of manual therapy may be billed with Modifier 59. The additional unit of manual therapy may also be billed with Modifier 59 since it was performed in a separate area from the CMT.

Code	Modifier	Modifier	Units
97140	59	CG	2

Example 4:
Ten minutes of manual therapy (dry needling) and 15 minutes of manual therapy (not dry needling) performed in the same area as CMT.

In this example with a total of 25 minutes of manual therapy, two units of manual therapy are billable. Since dry needling was performed for 10 minutes, one unit of manual therapy may be billed with Modifier 59. The additional unit of manual therapy should be billed without Modifier 59 since it was performed in the same area as CMT.

Code	Modifier	Modifier	Units
97140	59	CG	1
97140			1