Codify
BY AAPC

Eli's Rehab Report

6 Easy Coding Tips for Amputation Rehabilitation

From wound care to aquatic therapy, keep amputee's rehab codes straight

Do you know which amputation rehab procedures your insurer bundles into your E/M codes and which you can bill separately? If not, you may be coding your rehab care incorrectly.

About 133,000 patients undergo amputations each year, and rehab physicians often see these patients following surgery. Coding the complications that result from a loss of limb can present coders with unique challenges. Follow our example of an amputee patient's path to recovery, and you can submit your claims accurately every time.

1. Include Wound Care in E/M

Suppose a surgeon amputates the left lower leg (below the knee) of a 62-year-old female patient with diabetes mellitus (DM). The patient begins her rehabilitation after surgery during the acute treatment phase.

If the same surgeon who performed the amputation performs stump wound care, then insurers would bundle that service into the surgery. And, if your rehab physician performs wound care during his E/M visit, you should not report wound care separately. "Any wound care that a rehab physician performs would be included in the E/M visit unless he performed a debridement (11040-11044)," says **Heather Corcoran,** manager at CGH Billing Services in Louisville, Ky.

But if a therapist or nurse administers the wound care, he should bill 97601 (Removal of devitalized tissue from wound[s]; selective debridement, without anesthesia [e.g., high-pressure waterjet, sharp selective debridement with scissors, scalpel or tweezers], including topical application[s], wound assessment, and instruction[s] for ongoing care, per session) or 97602 (Removal of devitalized tissue from wound[s]; non-selective debridement, without anesthesia [e.g., wet-to-moist dressings, enzymatic, abrasion], including topical application[s], wound assessment, and instruction[s] for ongoing care, per session), depending on your carrier's individual guidelines.

Problem: Suppose the patient's stump becomes infected. The physiatrist performs an incision as well as a purulent drainage service and debridement of the necrotic tissue. He leaves the wound open to pack and drain.

Solution: For this situation, you should use 27301 (Incision and drainage, deep abscess, bursa, or hematoma, thigh or knee region). You should not bill a debridement code, because insurers consider the debridement incidental to the opening of the wound.

2. Report Evaluation as **CPT 99201** Series, Not as Consult

Suppose the patient goes home to recuperate until her surgeon determines that the wound and bone are healing well, and then refers her to the physiatrist for a full rehabilitation course. "Because the physiatrist knows the patient's condition and what she requires, this would not qualify as a consult (99241-99245)," Corcoran warns. Instead, you should report the appropriate E/M code (99201-99215), depending on whether you have treated the patient before.

The physiatrist examines the patient's residual limb again and determines that she is well enough to begin physical therapy, and brings in a physical therapist to help evaluate her condition. The PT performs an evaluation and, along with the physician, writes a plan of care for the therapy services. The patient has already been fitted for a prosthetic lower leg, so they ask her to return at the end of the week to receive the prosthesis.

This practice should bill the appropriate E/M code for the patient's visit. Although the surgeon still sees the patient regularly as part of the global surgical care to ensure that the wound and bone heal properly, the physiatrist can still bill

separately for the rehabilitation care, assuming the insurer allows it.

For the PT's evaluation, you should use 97001 (Physical therapy evaluation). This code includes writing the patient's plan of care.

3. Prosthetic Training? Count 15-Minute Increments

Prosthetic training is often the first step in amputation rehabilitation. Eventually, prosthetic training will move into weight-bearing exercise, knee extensions and therapeutic exercise and, from there, to gait training. Therapists do not normally perform these training sessions on the same day. Often the dysvascular amputee patients endure a slow progression of prosthetic training.

For the prosthetic training, you should use 97520 (Prosthetic training, upper and/or lower extremities, each 15 minutes). During prosthetic limb training, the physician or therapist must have constant, direct, one-on-one patient contact, which you should report in 15-minute increments, regardless of the number of body areas that the therapist actually treats.

Most insurers require additional documentation for prosthetic training that the therapist performs for more than three months, because the majority of patients are comfortable using their prosthesis by that point.

If the therapist also begins weight-bearing exercises, you should also report either 97110 (Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility) or 97112 (... neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing ...), depending on which service most accurately reflects the types of exercises your practitioner performed.

4. Insurer May Allow Gait Training 3-7 Times/Week

After your patient is comfortable putting weight on the prosthesis, the therapist normally teaches the patient how to walk, climb stairs, sit and stand with the new leg. You should code walking and stair climbing with 97116 (... gait training). Most insurers will reimburse gait training from three to seven times per week for amputees.

Heads Up: Without proof that the physiatrist performed gait training and either orthotics training (97504, Orthotic[s] fitting and training, upper extremity[ies], lower extremity[ies], and/or trunk, each 15 minutes) or prosthetic training (97520, Prosthetic training, upper and/or lower extremities, each 15 minutes) during separate sessions, you cannot report them together, Corcoran says. "Not all amputation patients receive prosthetics or orthotics, but just in case, you should report only one code per session." You should ask your local carrier for its specific requirements.

5. Aquatic Therapy Is Not a Modality

Your therapist may also use aquatic therapy (97113, Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises) for your amputation patient.

Important: Although therapists use various kinds of aquatic environments to perform these specific techniques, aquatic therapy, unlike whirlpool for wound care (97022, Application of a modality to one or more areas; whirlpool), is not considered a modality. Instead, CPT considers aquatic therapy a therapeutic procedure, says **Andrea Salzman, MS, PT,** owner of the Aquatic Resources Network and Concepts of Physical Therapy in Amery, Wis.

Aquatic therapists require specific skills and training in order to implement the techniques correctly. Therefore, relative value units for therapeutic procedures rank higher than monitored modalities, which means Medicare and others who follow the Medicare model will deliver increased reimbursement.

Most insurers reimburse for this one-on-one service that therapists administer in the water. Often, in a pool, a physical therapist performs this service in a group format. In this situation, you should report 97150 (Therapeutic procedure[s], group [2 or more individuals]) for each member in the group instead of reporting 97113.

Remember, you can use 97150 only once per session, regardless of the length of treatment. National Correct Coding

Initiative (NCCI) edits may apply to Medicare patients and some private-payer policies. You can use modifier -59 (Distinct procedural service) if you perform both aquatic therapy (97113) and group therapy (97150) on the same date, as long as your documentation supports this claim. "This should be the exception, not the rule," Salzman says.

6. Goals Determine Occupational Therapy Codes

The patient in the example also sees an occupational therapist. The OT performs 15 minutes of therapeutic exercise (for instance, prosthesis training) and spends another 30 minutes teaching her how to climb in and out of the bathtub using the prosthetic limb.

Depending on the goals of the session, you should use either 97110 (Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility) and 97535 (Self-care/home management training [e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment] direct one-on-one contact by provider, each 15 minutes) or 97520 (Prosthetic training, upper and/or lower extremities, each 15 minutes) if the visit's emphasis focused on the use of the prosthesis.

Best bet: Split the time: "If the OT focused on the use of the prosthetic, the OT would document most of the time spent in the session as 97520," says **Judy Thomas, MGA,** director of reimbursement and regulatory policy for the American Occupational Therapy Association. "However, if part of the session addressed a specific patient need (for example, the ability to climb into and out of the bathtub), then you would code the OT's time teaching compensatory techniques as 97535."