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Eli's Rehab Report

Avoid Spasticity Claim Denials by Being Familiar With Specific Conditions

PM&R practices are often puzzled by denials for spasticity assessments after submitting claims with the codes for physical performance test (97750) or range-of-motion measurements testing (95851-95852). However, these assessments should be included in the E/M codes when performed by physiatrists, or with the therapy evaluation codes (97001-97004) when performed by a therapist.

Spasticity, the condition that is marked by stiff, rigid muscles and exaggerated deep-tendon reflexes, can severely interfere with muscular activity, gait, movement or speech for many patients seen in PM&R practices. Most commonly caused by conditions such as cerebral palsy (343.0-343.9), multiple sclerosis (340) and brain trauma or injury (854.0), spasticity is normally treated with drugs such as botulinum toxin (botox) and baclofen as well as physical and occupational therapy.

Because most insurers will not reimburse for baclofen and botox using merely the symptom codes, PM&R coders should know the specific conditions that will ensure payment for these procedures. In addition, the physiatrists' and therapists' evaluations of the patient's spasticity should be coded separately, and are not normally bundled into the spasticity treatment (such as the injection) as many coders believe. The following tips should help PM&R practices more accurately code for the most common spasticity treatments.

Start with Analyses

The first step that most physiatrists take when a patient with spasticity presents to the office is to perform a thorough assessment. This involves testing the patient's stretch reflexes, resistance and range of motion. Some coders bill for this assessment by using the specific testing codes:

1. **CPT 95851** range of motion measurements and report; each extremity [excluding hand] or trunk section [spine]
2. **CPT 95852** range of motion measurements and report; hand the muscle testing codes (95831-95834)
3. **CPT 97750** physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes.

Unfortunately, these are not appropriate for a full spasticity assessment because other aspects of an E/M will be included with the testing, and these testing codes are bundled into all of the E/M codes due to CCI edits.

"When the physiatrists personally perform the spasticity assessments, they should bill using the appropriate E/M codes," says **Susan Pannebaker,** billing manager for Rehab Medicine Associates in Mechanicsburg, Pa., a three-physician PM&R practice. In a rare situation when the muscle testing or range-of-motion tests are the only services performed that day, the coder would assign those codes to the claim; however, if an E/M were performed as well, the E/M code would take precedence and would be the only code assigned to the assessment.

If a physical or occupational therapist is performing the spasticity assessment to determine whether a patient is a candidate for therapy or to create a patient's plan of care, the therapist's own evaluation code would be used (97001 for physical therapist; 97003 for occupational therapist).

Treating Patients With Baclofen

In cases of severe, generalized spasticity, many physiatrists treat patients using baclofen, an antispasmodic drug that can be injected or delivered via a pain pump surgically implanted into the patient. Although a surgeon, not the physiatrist, normally implants the pump, the physiatrist often initially determines whether the patient will respond to the drug.

"We bill for a rehab facility where baclofen is being used. The policy here in New York [Empire Medicare] states that baclofen pump implantation will not be reimbursed unless a trial administration of the drug is attempted first to judge whether the patient's spasms will respond to it," says **Charles Siegel,** owner of RCS Reimbursement Management in Rye, N.Y., a medical consulting firm with two rehabilitation clients. "Any physician who implants the pump or who orders the implantation before performing such a trial is at risk of insurance denials."

After the assessment, the physiatrist injects the baclofen, and the patient is monitored for several hours to determine whether the spasticity has improved

The therapist or physician performing the pre- and postinjection assessments should maintain thorough notes to document any improvement following injection, including specific sites with decreased spasticity and percentage of spastic reduction. For instance, "Patient is now able to walk three feet in two minutes, whereas gait was hindered by 90 percent prior to injection. In addition, following injection, the patient's leg released from extension immediately on testing, whereas the leg froze in extension mode prior to injection."

Normally, the trial is performed in an outpatient facility and is attended by the physiatrist, therapist and often a nurse, who monitors for side effects of the drug. To bill for the baclofen trial, the physiatrist would use HCPCS code J0476 (injection, baclofen, 50 mcg for intrathecal trial) in addition to billing for any procedures and evaluations performed that day.

Baclofen is usually allowable for patients with multiple sclerosis, cerebral palsy and nerve root disorders (353.0-353.9), as well as many other brain and spinal trauma or pain diagnoses, but acceptable diagnoses vary widely among carriers. In light of the high cost of baclofen pump implantation, it is important to confirm your patient's condition with the insurer before beginning a baclofen trial.

Chemodenervation Via Botox

The standard treatment for more localized spasticity, such as that of the face or hand, is botox injections. These injections are coded using 64612 (chemodenervation of muscle[s]; muscle[s] innervated by facial nerve [e.g., for blepharospasm, hemifacial spasm]), 64613 (cervical spinal muscle[s] [e.g., for spasmodic torticollis]) and 64614 (... extremity[s] and/or trunk muscle[s] [e.g., for dystonia, cerebral palsy, multiple sclerosis]). The drug is billed with HCPCS code J0585.

Most insurers will not reimburse for generic diagnoses such as "muscle spasms" (728.85), so coders should be sure to list the actual cause of the patient's spasms, such as Bell's palsy (351.0) or torticollis (723.5). If the originating diagnosis is not listed on the chart, the coder should ask the physiatrist what caused the spasticity.

"It's important to note that you can only bill one unit per site. If you inject three times into the patient's left shoulder, it counts as one unit of the botox injection code," Pannebaker says. "And remember to watch your frequency when billing for botox, because using it too often will result in denials."

If the physiatrist injects into two sites, for example the face and spine, both 64612 and 64613 can be billed, and a modifier is not needed because each is specific to a different area of the body.

Pannebaker reports that, like many other PM&R practices, the physicians in her office often perform electromyographic (EMG) guidance to ensure the proper needle location within the treated muscles during the botox administration. Each Medicare carrier provides its own listing of allowable EMG codes for botox injections, but the most common are 95860-95861 and 95867-95869.

Therapy Is Administered Before Drugs

Most physiatrists try to treat patients with physical and occupational therapy (PT and OT) before administering baclofen or botox, and normally use therapy along with the drugs for patients who don't respond to PT and OT alone. Therapists use a wide range of procedures and modalities, including gait training (97116), therapeutic exercises (97110), aquatic therapy (97113) and activities-of-daily-living training (97535). Therapists often administer modalities such as hot packs (97010), ultrasound (97035), whirlpool (97022) or electrical stimulation (97032 for manual, 97014 for unattended) prior to exercises to allow the patient's muscles to relax long enough to perform the therapeutic procedures.

Include all components of a therapy plan in the plan of care that is signed by the treating physiatrist and updated and approved monthly to ensure appropriate documentation.