

Eli's Rehab Report

Coding Case Study: Select Correct Therapy Codes To Avoid Scrutiny

If your PM&R practice undercodes its therapy services to avoid setting off red flags with insurers, you may as well hang a red banner over your practice's door. Assigning the correct therapy code not undercoding is the best way to avoid an audit.

If you perform services such as attended electrical stimulation (97032, Application of a modality to one or more areas; electrical stimulation [manual], each 15 minutes), but instead report unattended electrical stimulation (97014, Application of a modality to one or more areas; electrical stimulation [unattended]) because you don't want to attract the OIG's attention, your carrier may notice that you bill very differently than other PM&R practices, which could trigger an audit.

An audit is not a cause for concern if you code correctly, but you should worry if you're assigning the wrong codes.

Carriers Notice Unusual Billing Patterns

Consider the following message that an Atlanta subscriber submitted to Physical Medicine and Rehab Coding Alert:

"Medicare selected me for a prepayment review because I differed significantly from my peers in reporting the therapy codes 97014, 97032, 97110 and [CPT 97530](#). I am a physiatrist and I employ one physical therapist who treats my rehab patients. We report 97014 for most of our therapy visits, and 97530 (Therapeutic activities, direct [one-on-one] patient contact by the provider [use of dynamic activities to improve functional performance], each 15 minutes) for about 20 percent. I have never reported 97032, and I rarely report 97110 (Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility), so I can't imagine why they think I report these codes too often "

Several factors may have caused the audit, but we have listed the three most likely reasons below.

1. She Reports Mostly Modalities, Few Therapeutic Procedures. Our subscriber reports unattended electrical stimulation more frequently than she reports any other therapy code. Most payers, however, frown on therapy plans that include modalities only.

The PM&R local medical review policy (LMRP) for Arkansas Medicare, the Part B carrier for five states in the Southwest, says, "The use of modalities as stand-alone treatments are rarely therapeutic, and usually not required or indicated as a sole treatment approach to a patient's condition. Therefore, it is expected that treatment plans consist not solely of modalities, but include therapeutic procedures" as well.

"Therapists often use unattended electrical stimulation to relax a patient's muscles before starting exercises with them," says **Lynda Kuhne, PT**, director of AthletiCare in Exeter Hospital's outpatient rehabilitation department in Exeter, N.H. Medicare would most likely find this unattended electrical stimulation/therapeutic procedure combination more acceptable.

2. She Reports All Unattended Electrical Stimulation Codes, No Attended. Our subscriber tells us that she "never" reports 97032, which could be part of her problem. Although physiatrists and therapists report 97014 to Medicare significantly more often than they report 97032, most carriers probably expect you to report the attended code once in a while. (See article 5 "Compare Your Therapy Billing Pattern to CMS Averages" in article 5).

"If you are treating a stroke patient or a patient who suffered an accident, you might administer electrical stimulation at

such a high intensity that it generates a muscle contraction and then ask the patient to work with that contraction to perform range-of-motion exercises," Kuhne says. "This would qualify as attended electrical stimulation." In addition, Kuhne says, "Legally, you have the right to report the attended code if you're staying with the patient the whole time."

If you downgrade attended electrical stimulation codes to 97014, you are also missing out on reimbursement opportunities. Although 97014 carries an RVU of only 0.38, the attended code carries 0.44 RVUs, and you can report it once every 15 minutes.

3. Too Much "Activity," Not Enough "Exercise." Our subscriber rarely reports the therapeutic exercise code, but the Medicare data suggest that most physiatrists report this code seven times more often than they bill the therapeutic activities code.

In addition, 97530 reimburses slightly higher than 97110, so if you assign 97530 for all of your therapeutic exercise patients, you are actually "upcoding," a practice that could definitely attract the OIG's attention.

"We use the therapeutic activities code very sparingly," says **Ben Waide, PT, OCS, CHT**, director of physical therapy at Multicare Physical Therapy in Madisonville, Kent. "Unless you're using a dynamic activity to improve a patient's balance or functional movement, your insurer will probably deny 97530."

Healthnow's (upstate New York's Part B carrier) PM&R LMRP states that therapeutic activities "involve using functional activities (e.g., bending, lifting/carrying, reaching, catching, and overhead activities) to improve functional performance in a progressive manner."

For instance, Waide says, "If my patient is going to have a hip replacement and I see her preoperatively, I'll help her work on transfers so she'll be able to get out of bed or a car after surgery." Using functional activities to address the patient's specific functional need qualifies as therapeutic activities, and 97530 is therefore the correct code choice.

Healthnow's therapeutic exercise (97110) LMRP is slightly broader, suggesting that therapeutic exercise "may be reasonable and medically necessary for a loss or restriction of joint motion, strength, functional capacity or mobility which has resulted from a specific disease or injury."

Because the definition is so general, most therapeutic activities also qualify as therapeutic exercises, Waide says. For instance, if the hip replacement patient performs range-of-motion or arm exercises to improve her transfers, "you could probably argue that you performed therapeutic exercises and report that code instead," he says.

But it does not work the other way around. "An insurer would probably be concerned if you reported therapeutic activities all the time and you never reported therapeutic exercises," Waide says. "The therapeutic activities code reimburses higher than therapeutic exercises, but is less applicable in an average clinic setting."

Code Correctly No Matter What

If your practice legitimately performs unattended electrical stimulation and therapeutic activities, then by all means report 97014 and 97530. You should code for the services that you perform, not the codes that you think your carrier wants you to report. As long as you accurately report all of the services that your practice performs, you will have no reason for concern should an auditor ever visit your practice.