Eli's Rehab Report

New Trigger Point, Athletic Evaluation Codes Introduced for 2002

CPT 2002 includes several important changes for PM&R practices, including new codes for trigger point and carpal tunnel injections, motion analysis and athletic training evaluations. Because these procedures were previously billed using either inaccurate or unlisted codes, the new codes are being welcomed by physiatrists and their coders. The new modifications will take effect Jan.1, 2002, for Medicare, although it may take longer for some carriers to adopt them. Coders are advised to work closely with their carriers to determine when to begin implementing the new codes.

The following new and revised CPT Codes should help PM&R coders prepare for 2002.

20550: No Longer Universal Trigger Point Code<!--?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" /-->

Almost every PM&R practice can recite the existing trigger point code (20550) from memory. However, 2002 brings new, more accurate codes for billing for trigger point injections, and 20550 will no longer be accepted for these procedures. In fact, the words "trigger points" have been removed from 20550's descriptor. The revision to
20550 and the new codes are as follows:

20526 injection, therapeutic (e.g., local anesthetic, corticosteroid) carpal tunnel
20550 injection; tendon sheath, ligament, or ganglion cyst
20551 injection; tendon origin/insertion
20552 injection; single or multiple trigger point(s), one or two muscle group(s)
20553 injection; single or multiple trigger point(s), three or more muscle groups.

"The establishment of these new codes is intended to differentiate between injections for tendonitis, trigger point injections, and injections into the carpal tunnel or tarsal tunnel that don't qualify as true tendon injections," says **Gregory Mulford, MD, FAAPMR, FAAEM,** chairman of the department of rehabilitation medicine at Morristown Memorial Hospital in New Jersey, and former advisor to the AMA CPT Advisory Committee for the American Academy of Physical Medicine and Rehabilitation.

As most coders are aware, trigger point injections have always been coded according to the number of muscle groups injected and not the number of injections performed. For instance, if the physiatrist administers three injections into the trapezius muscle, only one unit of 20552 can be billed. This was not made clear according to the old code descriptor. However, CPT 2002 clarifies it by stating "single or multiple trigger points," and then listing the appropriate number of muscle groups allowable.

If, for example, the physiatrist performed three trigger point injections into the trapezius muscle, two injections into the supraspinal muscle and two injections into the paraspinal muscle, one unit of 20553 would be billed. In addition to more accurately representing the number of muscle groups treated, these new trigger point injection codes also eliminate the need for adding modifier -59 (distinct procedural service) to claims for more than one muscle group injected. Many carriers differed on whether modifier -59 or modifier -51 (multiple procedures) was appropriate, and practices often received denials by appending the incorrect modifier.

Motion Analysis Codes Added

As technology advances, more PM&R practices and therapists are performing computerized gait analyses to evaluate conditions such as gait abnormalities (781.2, abnormality of gait) or 781.3 (lack of coordination). In addition to watching how a patient walks, the practitioner may evaluate gait analysis with an electrodynogram (EDG), which is a computerized, diagnostic test that quantitatively measures the weight-bearing forces exerted on the feet and legs. Gait

analysis may also be evaluated by video tracking, pressure plate analysis or treadmill with or without video tracking. The physiatrist can recommend, based on the results of the test, therapy, surgery and/or orthotic management. These evaluations used to be coded as 99199 (unlisted special service, procedure or report), but additional documentation was usually required to more accurately report what type of service was provided.

Electrodynography was previously eligible for payment when patients had abnormal weight-bearing patterns in the foot, ulcers from diabetic feet, gait abnormalities, leg-length discrepancies, or neurological disorders related to gait. It is not yet known what reimbursement criteria will apply to the new codes, although carriers are expected to issue policies soon.

The new motion analysis codes are as follows:
96000 comprehensive computer-based motion analysis by video-taping and 3-D kinematics
96001 comprehensive computer-based motion analysis by video-taping and 3-D kinematics; with dynamic plantar pressure measurements during walking 96002 dynamic surface electromyography during walking or other functional activity, 1-12 muscles .
96003 dynamic fine wire electromyography, during walking or other functional activity, 1 muscle
96004 physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report.

Athletic Codes Introduced, Therapy Codes Revised
New athletic training evaluation and re-evaluation codes are among several code changes and additions in the PM&R section of CPT 2002. In the past, athletic trainers had to use the unlisted PM&R service code, 97799; now they can bill using the new codes 97005 (athletic training evaluation) or 97006 (athletic training re-evaluation).

"These new codes were developed and requested by the National Athletic Trainers' Association (NATA), and we intend for the codes to be used by certified athletic trainers who work in clinics and hospitals as part of a rehab team," says **Richard Rogers,** NATA's governmental relations manager. "Since athletic trainers do not yet have their own provider numbers for billing Medicare, the athletic training evaluation and re-evaluation codes should be billed as 'incident to' using the physician's provider number."

Rogers says that since CMS has not yet released a reimbursement policy on the new athletic training codes, it is unclear how often the re-evaluation code will be reimbursed. But he expects that the policy will be similar to the re-evaluation rules for therapists (most carriers pay for therapy evaluations/reevaluations no more than once per 30-day period).

The PM&R section of CPT also has three therapy procedure codes that have been revised to describe more accurately the types of services performed. According to **Judy Thomas, MGA,** director of reimbursement and regulatory policy at the American Occupational Therapy Association (AOTA) in Bethesda, Md., the AOTA requested the changes "not to try and change the meaning of the codes, but to clarify, update and broaden the language." The details about the three revised codes are as follows:

The descriptor for 97112 now reads, "therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities."

The previous descriptor for 97112 led payers to believe that the code was intended for mobile patients, and many insurers denied claims for this code when it was used for patients who had mobility deficits. The AOTA requested the addition of the words "sitting and or standing activities" to demonstrate that patients with limited mobility should be included in the code descriptor. For example, if a patient recovering from a stroke (436) uses a wheelchair, but has trouble eating due to problems with balance and muscle control, therapists may work on balance and proprioception with the patient to regain coordination.

The descriptor for 97504 now reads, "orthotic(s) fitting and training, upper extremity(ies), lower extremity(ies), and/or

trunk, each 15 minutes."

The AMA added the term "trunk" to the descriptor because orthotics such as lumbar and trunk pad supports are often used in skilled nursing facility settings, and the AOTA wanted to ensure that therapists were reimbursed appropriately for fitting and training patients on how to use these devices. The previous descriptor implied that only upper and lower extremity orthotics required training.

The new descriptor for 97535 reads, "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."

The addition of the term "assistive technology devices" recognizes that ADL training is often utilized when training patients on how to adapt to devices such as speech generating mechanisms and voice prostheses. Often used by patients who have lost speaking ability due to stroke, ALS (335.20), or other conditions, products such as speech synthesizers can help patients communicate. HCFA allows regional Medicare carriers to decide whether to cover the actual augmentative and alternative communication devices on an individual-carrier basis.

Changes in Care Plan Oversight, Nerve Conduction

The descriptors for care plan oversight services (99374, 99377, 99379) have been changed to specify who constitutes a "nonphysician professional" involved in a patient's care. The new descriptor for 99374 is as follows:
99374 physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (e.g., Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), and surrogate decision-maker(s), e.g., legal guardian and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes.

The codes for hospice patients (99377) and nursing facility patients (99379) have also been changed to denote the appropriate caregivers.

Care plan oversight services can only be billed by one physician per patient each month, and the physician who bills the services must personally perform the services, and must be the same person who originally signed the home health or hospice plan of care.

In addition, the descriptor for nerve conduction study (NCS) code 95904 has been changed to read, "nerve conduction, amplitude and latency/velocity study, each nerve; sensory." The word "mixed" is no longer part of the code descriptor. That one word, although it seems minor, has caused a dramatic number of denials because many carriers aren't aware of what constitutes a mixed nerve conduction study and assume that 95904 can be used to bundle motor and sensory studies. However, 95904 was never meant to serve as a code for motor and sensory studies performed together. The code was intended to be used when the NCS is performed on a section of the nerve that contains both motor and sensory fibers a "mixed" nerve. This change in the descriptor should dramatically decrease the number of denials that physiatrists face for coding 95904.

Modifier -60 Deleted

PM&R coders may recall that earlier this year CMS' Program Memorandum B-00-75 advised physicians that it would no longer accept claims using modifier -60 (altered surgical field). The reason is verification of the status of an altered surgical field would be difficult for its contractors, requiring manual review on almost all claims submitted. The AMA has taken the next step, deleting modifier -60 from CPT 2002 altogether. Physical medicine and rehabilitation practices are asked to use modifier -22 (unusual procedural services) for any procedures that are complicated due to an altered surgical field.

For instance, a patient had a hip replacement (27130) five years ago and is now in a rehab facility for a stroke (436). The attending rehab physician attempts a simple removal of a foreign body in a muscle (20520), but the patient's prior hip replacement caused excessive scarring, which complicates the foreign body removal. This claim would now be coded using 20520 with modifier -22 appended.

It's also important to note that the descriptor for modifier -22 has been changed in CPT 2002 to remove the text following the word "Note," which had advised coders to use modifier -60 instead of modifier -22 for procedures complicated by altered surgical fields. The modifier's descriptor now simply reads, "Unusual procedural services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier -22 to the usual procedure number or by use of the separate five digit modifier code 09922. A report may also be appropriate."

Home Health Codes Added
Physiatrists who often refer for home healthcare may be interested in several new codes introduced in this area. These codes do not yet have policies or reimbursement guidelines. The following codes are intended for use by skilled home health nursing professionals:

99506 home visit for intramuscular injections
99509 home visit for assistance with activities of daily living and personal care
99539 unlisted home visit service or procedure
99551 home infusion for pain management (intravenous or subcutaneous), per diem
99552 home infusion for pain management (epidural or intrathecal), per diem.