Eli's Rehab Report

Rotator-Cuff Injuries: Learn Your ICD-10 and CPT® Coding Options for Sports Injuries' Rehab

Tip: You can't use the referring physician's diagnosis codes.

Summer means football, baseball games and swim meets resulting in rotator-cuff injuries. When a patient with this condition shows up at your rehab practice after surgery, you should know what to report and how to go about coding it.

Avoid Relying on Referring Provider's Code Selection

The first thing to remember when coding rotator-cuff injuries (also known as "swimmer's shoulder" or "pitcher's shoulder") is that you see patients for rotator-cuff therapy after the patients have undergone surgery for this condition. As a result, you probably won't be able to use the referring physician's diagnosis codes such as M66.211 Spontaneous rupture of extensor tendons, right shoulder; M66.212 Spontaneous rupture of extensor tendons, left shoulder; M66.811 Spontaneous rupture of other tendons, right shoulder; M66.812 Spontaneous rupture of other tendons, left shoulder; M75.101 Unspecified rotator cuff tear or rupture of right shoulder, not specified as traumatic; M75.102 Unspecified rotator cuff tear or rupture of left shoulder, not specified as traumatic; M75.51 Bursitis of right shoulder or M75.52 Bursitis of left shoulder. After surgery, these diagnoses no longer accurately represent the patients' current condition.

For diagnosis coding of these patients, you should focus on the problem(s) you are treating, such as scarring or adhesions, for example, M75.01 Adhesive capsulitis of right shoulder or M75.02, Adhesive capsulitis of left shoulder. For pain with joint movement your options are M25.511 Pain in right shoulder; M25.512 Pain in left shoulder.

For decreased range of motion your options are many: M25.60 Stiffness of unspecified joint, not elsewhere classified; M25.61 Stiffness of shoulder, not elsewhere classified; M25.611 Stiffness of right shoulder, not elsewhere classified; or M25.612 Stiffness of left shoulder, not elsewhere classified. These should serve as your primary diagnosis codes.

For a secondary diagnosis, you may try to use a Z code for status post-surgery such as Z98.89 Other specified post-procedural states. Two codes may be necessary to tell the insurer the complete story. You may also use a Y code to describe to the payer how the occurrence happened such as Y92.838 Other recreation area as the place of occurrence of the external cause.

Ask, What Is the Focus of the Treatment?

When the patient first presents to your office, you will evaluate him. For this service you should report either 97001 Physical therapy evaluation or 97003 Occupational therapy evaluation depending on the documentation. During this initial visit, you will focus on the mechanism of the injury, the history of the injury, the length of time the patient has played the sport, and how exactly the injury occurred such as, overuse, poor form, a one-time acute event. Then you will evaluate the surgery's effects and look for present pain, range of motion, scarring, as well as the extent/severity of the injury.

After an injury and again after surgery, the rotator cuff loses its ability to fire properly in the best neuromuscular sequence. Your work centers on helping your patient regain normal strength as well as stabilization, internal and external rotation.

After the evaluation (97001 or 97003), you will draw up a plan of care and sets goals. For the phases I-IV of rehabilitation (which may last up to six months), you may perform manual stretching, active-assisted exercises, and other specific exercises aimed at rotator-cuff sections independently. Because these exercises are essentially similar, you've got many related therapy code options to choose from.

Key: Ask, "What is the focus of the treatment accomplished by this exercise?" For example, if you perform dumbbell exercises to gain strength and help the muscles grow, you would report 97110 (Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility).

However, if you perform these same dumbbell exercises and document the rationale as proprioception and neuromuscular education, you would report 97112 (... neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities).

Other options: Your most likely choices will also include 97124 (... massage, including effleurage, petrissage and/or tapotement [stroking, compression, percussion]) for massage or 97140 (Manual therapy techniques [e.g., mobilization/manipulation, manual lymphatic drainage, manual traction], one or more regions, each 15 minutes) for manual mobilizations, if needed. When you perform a specific mechanical test, you'd report 97750 (Physical performance test or measurement [e.g., musculoskeletal, functional capacity], with written report, each 15 minutes).

"CPT® code 97750 is used for physical performance testing and is a 15-minute time based CPT® code," **Rick Gawenda, PT,** President of **Gawenda Seminars & Consulting** tells **Eli.** "Examples would be the Tinetti, Berg balance Test, Functional Capacity Evaluation, isokinetic/isometric strength testing, etc. The time that counts towards the 15 minutes is the time spent administering the test and analyzing the results with the patient present."

Each of these codes occurs in 15-minute increments. This means that you'll report units according to the 8-minute rule. For example, if your therapist documents performing 20 minutes of 97110, you should report only one unit. When you consult your 8-minute rule chart, you'll see that one unit equals 8 minutes to less than 23 minutes.

Heads up: You may also report 97530 (Therapeutic activities, direct [one-on-one] patient contact by the provider [use of dynamic activities to improve functional performance], each 15 minutes) for rotator-cuff repair rehab patients a more functional component code than 97110.

Another option could be 97150 (Therapeutic procedure[s], group [2 or more individuals]). Remember, Medicare expects no more than one group therapy code per day. More than that and you've got to provide supporting documentation. If you're a facility/institutional therapy setting, however, you can apply the group therapy more than once. To avoid confusion over reporting this group code alongside other one-on-one therapy codes, you may want to ask your payer for pre-approval.

Don't Discriminate Based on Age

Remember that when coding rehabilitation services, your coding stays the same regardless of the patient's age. Although you must constantly be aware of pediatric requirements and restrictions, the rotator-cuff tear is the same ICD-10 code for patients of any age. Your CPT® choices will also remain the same, but bear in mind that you may need to represent extra time you might need to spend with children.