Reimbursement Strategies with MR System

Testing

97750 Physical Performance Test or Measurement (eg Musculoskeletal, Functional Capacity) with written report, each 15 minutes

Billing guidelines recommend using this code no more than 1x / mo, though some plans may approve every 2 weeks. For shorter rehab stints, it is acceptable to use this code 3x during the course of treatment: at the beginning of the treatment to establish baseline levels of function, at the middle of treatment to evaluate progress, and at discharge to determine post treatment status.

Successful use for this code requires a post-test report along with discussion of how the results of the testing will impact the treatment plan.

There are only 482 ICD-9 diagnosis codes which can serve as medical necessity for the 97750 code use, ie you must link a valid ICD-9 code to 97750 on the HCFA-1500 form (box 24). **Note:** Valid ICD-9 codes only include 711.xx – 729.xx, which do not include sprains/strains, ligament or meniscus tears, or fractures. Therefore, in order to expect reimbursement for this code, you must include a ICD-9 from the above range to justify the use of 97750. **If you do not, the computer reviewing your claim may automatically reject it!** In addition to the primary diagnosis, 719.4x (joint pain) and/or 719.5x (joint stiffness) may be viable options to justify the use of 97750.

Typical reimbursement for this code varies based on geography but 95% in Midwest is \$100, and in the Northeast \$120. Consult www.medicode.com for reimbursement for your specific zip code.

Rehab

97530 Therapeutic Activities, direct patient contact by the provider (use of dynamic functional activities to improve functional performance), each 15 minutes

97110 Therapeutic procedure, one or more areas, each 15 minutes: therapeutic exercises to develop strength and endurance, range of motion and flexibility

97112 Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception

All three codes are suitable for billing rehab performed on the MR system. Each code is mutually exclusive of the other in a given rehab session, ie all 3 can be used, but each must have its own 15 min interval; in other words you cannot use 2 or all 3 of these codes to describe the same 15 min of time spent in the clinic.

Most all ICD-9 codes for musculoskeletal pathologies can be linked to these CPT codes without creating a red flag.

Any if these CPT codes may also be used on the same visit as the 97750 code, assuming a separate 15 minute rehab session has been performed above and beyond the testing.

Hypothetical example (for illustrative purposes only) - 12 visits approved

Visit 1 - 97750 2 units (<u>23 minutes minimum</u>) - \$200 (if testing >38 mins, 3 units can be billed) 97530 1 unit - \$50

Visit 2 - 5 97112 1 unit (F5 functional activities in software) - \$50 97110 1 unit (F6 rehab in software) - \$50

Visit 6 - 97750 2 units (23 minutes minimum) - \$200 97530 1 unit - \$50

Visit 7-11 97112 1 unit (F5 functional activities in software) - \$50 97110 1 unit (F6 rehab in software) - \$50

Visit 12 97750 2 units (23 minutes minimum) - \$200 97530 1 unit - \$50

Total Return - \$1650

Sample HCFA-1500 Form Documentation (linking of CPT & ICD-9 in Box 24)

4. A DATE(S) OF SERVICE To						B Place	C	D PROCEDURES, SERVICES, OR SUPPLIES		E
ММ	From	YY			YY	of	of	(Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE
6	22	04						97530		1,2,3
6	22	04	-				Ц	97750		2,3
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It is imperative to ensure that in box 24E, the proper link is established between the diagnosis and the clinical procedure that is being rendered, using ICD-9 codes suitable for the CPT code.

References

Code Correct Medical Billing Software - www.codecorrect.com

Medicode Fee Guidelines – www.medicode.com

AMA CPT Guidebook