Part B Insider (Multispecialty) Coding Alert

Yes, You CAN Report Electrical Stimulation

Report Using 97032, Not 64565

If your physician performs neuromuscular electrical stimulation for patients with spinal cord injuries, you can finally bill Medicare for this tricky procedure.

On July 22, the **Centers for Medicare & Medicaid Services** announced that it would expand coverage of neuromuscular electrical stimulation (NMES) "to assist people with spinal cord injuries in walking" - but only if you report the appropriate code and provide the necessary documentation.

Although electrical spinal cord treatment is "neuromuscular electrical stimulation," you should not report it using **CPT 64565** (Percutaneous implantation of neurostimulator electrodes; neuromuscular).

Rather, the neurologist must provide - and you must report - an attended electrical stimulation application. You should report 97032 (Application of a modality to one or more areas; electrical stimulation [manual], each 15 minutes) for electrical spinal cord treatments.

You should not report an electrical stimulation code such as 97014 (... electrical stimulation [unattended]) because it refers to a therapy modality that does not require the presence of a clinician, says **John Whitemore, PT**, a physical therapist in Duluth, Ga.

"The biggest difference between 97032 and 97014 is that the therapist or physician must stay with the patient during the attended code [97032]," Whitemore says. "Another big difference is that 97014 is not a time-based code, so you should only bill it once per session. Even if the patient receives unattended electrical stimulation for 45 minutes, you would bill only one unit of 97014, whereas 45 minutes of 97032 would be billed as three units."

Not all spinal-cord-injured patients can use NMES devices for walking. Therefore, CMS has declared that it will only cover NMES for patients with:

1. intact lower motor units (L1 and below)
2. at least six-month postrecovery spinal cord injury and restorative surgery
3. no hip and knee degenerative disease
4. no history of long bone fracture secondary to osteoporosis.

And, patients must demonstrate a "willingness to use device long-term," must have completed regular sessions of physical therapy with the device over a period of three months, and must "demonstrate brisk muscle contraction in response to NMES and have sensory perception of electrical stimulation sufficient for muscle contraction," according to CMS.

The physician must include evidence in the medical record that the patient meets these qualifications.

Note: For complete information on CMS' coverage decision regarding NMES, go to http://www.cms.hhs.gov/coverage/8b3-mm.asp.