Eli's Rehab Report

5 Tips Guarantee Better Pay For Biofeedback Training

Use the right modifier for E/M visits and other services alongside 90911

If you think coding biofeedback training for urinary incontinence is easy because there's only one code to choose, think again. You need to know about documentation requirements and various modifiers to get biofeedback claims paid quickly and correctly.

What it is: The service represented by 90911 (Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry) is more involved than other conventional biofeedback methods (90901, Biofeedback training by any modality).

During anorectal/urethral biofeedback, the physiatrist places an anal probe into the anal canal to measure anal sphincter pressure or electrical activity. This procedure can use manometry (measuring pressure of gases or liquids by using a manometer) or EMG (electromyography--the recording of electrical activity initiated in the muscle tissue for testing purposes) to measure sphincter activity. This procedure is lengthy, taking at minimum 30 minutes, but typically lasting 45-60 minutes, according to the June 1999 CPT Assistant.

Next time you need to report **CPT 90911** for biofeedback, first see if you can check these five coding tips off your list:

1. Verify documentation of four-week PME. Having documentation of the patient's failed four-week period of pelvic muscle education (PME) is the number-one requirement before you can bill for biofeedback training, says **Cathy Yocum, PT**, with Women's Health and Rehab in Lafayette, Ind.

Depending on whether your carriers pay for biofeedback training as a primary treatment, you may also need documentation of failed conventional treatments for incontinence, such as medications or surgery, says **Michael A. Ferragamo, MD, FACS**, clinical assistant professor at State University of New York, Stony Brook.

2. Juggle different payer requirements. There is a National Coverage Determination (NCD) for biofeedback training, but you should still consult your local Medicare carrier/fiscal intermediary and private payers directly for any individual coding guidelines, Ferragamo says.

Note: You can access the NCD online at www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd.

For example, carriers have varying frequency limits for 90911. Biofeedback sessions are usually limited to six treatments over a four-week period, or variations of that. Carriers will deny claims that exceed the frequency limit unless you can prove the patient's specific condition requires additional services.

Acceptable diagnoses to justify medical necessity for 90911 may vary from carrier to carrier. Acceptable diagnosis codes may include:

- 625.6--Stress incontinence, female
- 728.2--Muscle wasting and disuse atrophy, not elsewhere classified
- 728.85--Spasm of muscle
- 788.30--Urinary incontinence, unspecified
- 788.31--Urge incontinence
- 788.32--Stress incontinence, male
- 788.33--Mixed incontinence (male) (female)

• 788.38--Overflow incontinence.

Important: Make sure that you code from your provider's documentation.

3. Remember to report the initial evaluation and 90911. You should be able to bill most payers for an initial evaluation with 97001 in addition to the first session of biofeedback training, Yocum says. Although current National Correct Coding Initiative (NCCI) edits do not bundle 90911 and 97001, you may need to append modifier 59 (Distinct procedural service) to 97001 to avoid a denial and receive payment. Keep in mind: Even if the initial evaluation takes place on the same day as the patient's first biofeedback training session, you should still be able to report these separately.

4. Look to modifier GP for physician office service. If your PTs or OTs work in a practice with physicians and bill for their services under physician ID numbers, you must remember to use modifier GP (Service delivered under an outpatient physical therapy plan of care) on Medicare claims to alert your carrier that a PT or OT performed the service. So if a PT or OT performs biofeedback training for a Medicare patient, you would list 90911-GP on the claim form.

Note: Biofeedback training requires direct supervision, according to CMS. Therefore the PT or OT must provide a continuous presence while a physician must be present and immediately available to furnish assistance and direction throughout the procedure, although not necessarily in the room, according to Northern California's National Heritage Local Coverage Determination (LCD).

5. Use modifier 25 for same-day E/Ms. In a physician office setting, if the PT or OT performs biofeedback training and the physician performs a completely separate and unrelated E/M service, you can--and should--bill for both services.

To recoup for the E/M service, you may need to add modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M code you report, Ferragamo says.

For instance, suppose an established patient comes in for biofeedback training but also has shoulder pain that he wants to see the physiatrist about. You would report 90911-GP for the therapist's biofeedback session and an established patient E/M code, such as 9921x (Office or other outpatient visit ...) with modifier 25 attached.

Caution: NCCI does not bundle the E/M codes with 90911 or vice versa. If you use modifier 25 routinely, you may encourage payer reviews.