Eli's Rehab Report

CPT Code 97014 Vs 97032 : Make Sure You Know How to Code Electrical Stimulation and Avoid Triggering an Audit

Tip: Report G0281-G0283 to Medicare for unattended stimulation

If your physiatrist performs attended electrical stimulation (97032) but you're reporting unattended electrical stimulation (97014) because you don't want to attract the OIG's attention your carrier may notice you bill differently than other PM&R practices which could trigger an audit anyway.

Know When to Report Electrical Stimulation

Although this treatment is neuromuscular electrical stimulation you should not report it using 64565 (Percutaneous implantation of neurostimulator electrodes; neuromuscular).

Electrical stimulation uses an electrical current to cause a single muscle or a group of muscles to contract. By placing electrodes on the skin in various locations the provider can recruit the appropriate muscle fibers to contract and strengthen the affected muscle. The current setting can be changed to allow for a forceful or gentle muscle contraction. Along with increasing muscle strength the contraction of the muscle also promotes blood supply to the area that assists in healing says **Marvel Hammer RN CPC CHCO** president of MJH Consulting in Denver.

You should report 97032 (Application of a modality to one or more areas; electrical stimulation [manual] each 15 minutes) for electrical treatments that require "constant attendance" and therefore direct patient-to-provider contact according to **CPT**. 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.

Note: For Medicare you cannot >bill 97014 in any case. You've got to use G0281 (Electrical stimulation [unattended] to one or more areas for chronic stage III and stage IV pressure ulcers arterial ulcers diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care) for wound care and G0282 (Electrical stimulation [unattended] to one or more areas for wound care other than described in G0281) and G0283 (Electrical stimulation [unattended] to one or more areas for indication[s] other than wound care as part of a therapy plan of care) for all other unattended stimulation says **Paula Franko PT MCSP** owner of Encompass Consulting & Education LLC in Tamarac Fla.

Differentiate 97014 and 97032

Key idea: The biggest difference between 97032 and 97014 is that the therapist or physician must stay with the patient during the treatment to report the attended >**code (97032)**. When you're reporting 97032 you're saying that your provider promoted muscle function wound stimulation etc. and was directly involved one-on-one throughout the entire treatment. When you report 97014 the provider sets up the electrodes and then can go and treat someone else Franko says.

Another big difference is that 97014 is not a time-based code so you should only bill it once per session. Example: 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.

Note: Each 15 minutes as referenced in the supervised modality code descriptors (such as 97032) describe the total time i.e. preservice intraservice and postservice time spent in performing the modality according to the December 1998 **CPT Assistant** . Therefore if the physiatrist examines a patient before performing the electrical stimulation to determine

whether his condition changed since his last visit that time should be counted as preservice minutes would be included in the documented total time spent with the patient and billed toward 97032 Franko says.

Although these codes are different the amount of caution you should feel reporting them is the same. The reason is that the use of one more than the other--or one not at all--could set you up for an audit.

Audit Trigger 1: Mostly Modalities Few Therapies

Payers consider 97032 a modality not a therapeutic procedure. This means that if you're reporting more modalities than therapy codes you need to re-examine your coding practice. Use of modalities should be a minimal part of the treatment Franko says. Billing of only modalities as well as prolonged use of modalities is a big red flag.

For example the PM&R local medical review policy for Wisconsin Physician Service says The use of modalities as stand-alone treatments are rarely therapeutic and usually not required or indicated as a sole treatment approach to a patient's condition. Therefore it is expected that treatment plans consist not solely of modalities but include therapeutic procedures as well.

Reporting modalities on a prolonged basis may also be an audit flag. A way to check: Generally almost any modality that exceeds four weeks of application would be questionable Franko says.

Audit Trigger 2: No Attended Electrical Stimulation

Although physiatrists and therapists report 97014 to Medicare significantly more often than they report 97032 most carriers probably expect you to report the attended code once in a while.

Example: Your provider treats a stroke patient or a patient who had an accident. Your provider administers electrical stimulation at such intensity that it generates a muscle contraction. Then the provider asks the patient to work with that contraction to perform range-of-motion exercises. In this situation you're probably going to report 97032. Make sure your documentation supports that your provider stayed with the patient the whole time.

If you downgrade attended electrical stimulation codes to 97014 you are also missing out on reimbursement opportunities. Although 97014 has 0.38 relative value units the attended code carries 0.42 RVUs and you can report it for every 15 minutes of therapy.