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Eli's Rehab Report

Know What to Expect From Medicare ESWT Policies

3 examples will save you a hassle in the long run

When you report ESWT for patients with epicondylitis and plantar fasciitis, you may find yourself scratching your head, because no national determination from CMS means that Medicare state policies outline varying guidelines.
Our three policy examples will help you know what to expect, so you can save yourself a hassle down the road.

Payer Policy #1: Follow Different Guidelines For High- and Low-Energy ESWT

Some carriers differentiate between high-energy and low-energy ESWT and detail separate guiding principles for each. For example, Montana's Medicare Part B LMRP gives time stipulations for each ESWT energy level.

High-energy ESWT: If the physician provides a single shock wave application (generally referred to as high-energy), you should note that Medicare will cover only one treatment per site for a six-month period (or two per calendar year).

Low-energy ESWT: Another patient has multiple applications of the shock wave modality (referred to as low-energy). Montana's Medicare will cover no more than three treatments during a six-month period (or six treatments per calendar year).
Montana's Medicare Part B LMRP lists the following as ICD-9 codes supporting ESWT (0020T, G0279, G0280) as a medical necessity:

1. **726.31** - Medial epicondylitis
2. 726.32 - Lateral epicondylitis
3. 728.71 - Plantar fascial fibromatosis.

Keep in mind: Your documentation must include more than just one of these diagnoses. It must also include documentation detailing failed previous treatment and the patient's response to this treatment that support the patient's need for the ESWT service.

You can strike 0019T (Extracorporeal shock wave therapy; involving musculoskeletal system) from your ESWT list because this is not a valid code for Medicare, according to Montana Medicare Part B.

Payer Policy #2: You Shouldn't Go Beyond Two ESWT Treatments

Although some payer policies may consider ESWT investigational for both plantar fasciitis and epicondylitis (such as BlueCross BlueShield of California), others may accept either plantar fasciitis or epicondylitis - not both.
For example, Wellmark, BlueCross BlueShield of Iowa and South Dakota will cover ESWT for plantar fasciitis (728.71) treatment only, as long as the patient's condition meets the following criteria:

4. The patient has symptoms for at least six months.
5. The last two months of conservative measures (rest, physical therapy, anti-inflammatory medications, corticosteroid

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injections, orthotics, or forearm sleeve) proves ineffective.

6. The physician considers the patient a candidate for surgical treatment.

Wellmark even allows a second treatment up to 16 weeks after the first ESWT, if the physician finds the results ineffective. However, you shouldn't go beyond that because Wellmark finds a third treatment to be not medically necessary.

Payer Policy #3: You Must Report More Than Just Payable ICD-9 Code

When payer policies accept ESWT for both plantar fasciitis and epicondylitis, you should make sure you note which ESWT codes (0019T, 0020T, G0279, G0280) they prefer.

For example, Empire Medicare of lower New York (including Queens) and New Jersey will reimburse ESWT but only when used to treat epicondylitis or plantar fasciitis. "You must link G0279-G0280 with either 726.32 or 728.71," says **Heather Corcoran**, coding manager at CGH Billing Services in Louisville, Ky.

Coders, beware: Empire's policy states, "Claims may be suspended for review of medical records documenting that simpler methods have been employed and failed." Therefore, you should be certain that you have all necessary supporting documentation.

For example, you should not link the ESWT procedure merely to the correct and payable ICD-9 code (726.32 or 728.71), because Empire will look for more information. You must show how prior, more conventional treatments failed. Otherwise, you may find yourself staring at a denial.

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