Codify
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Eli's Rehab Report

Myth Buster: Reporting an ROM Only Once Per Session? Read This First

Tip: Make sure your physiatrist states what he plans to do with the ROM results

If you think you can only report one range of motion (ROM) code when your physiatrist tests multiple extremities, then you could be missing out on the reimbursement you deserve. Learn these four ROM truths and find out why choosing the correct code doesn't have to be a stretch.

Myth #1: You should use only one diagnosis code for ROM loss.

Reality: Your diagnosis code depends on your patient's other systems because many conditions can cause range-of-motion loss. A patient with a back injury or broken leg may experience a decreased range of motion, so you should examine the physiatrist's documentation to determine what may have caused the range-of-motion loss.

For instance, a patient's chart states, "Range of motion in patient's left leg decreased 20 percent since last visit; osteoarthritis is suspected due to family history, ROM loss, stiff left knee joint, and pain on bending bilateral knees." In this case, you should report all of the confirmed symptoms: 719.56 (Stiffness of joint; lower leg), 719.46 (Pain in joint; lower leg), and **V17.7** (Family history of arthritis).

Myth #2: You should report 95851 only once per session.

Reality: You should report 95851 (Range of motion measurements and report [separate procedure]; each extremity [excluding hand] or each trunk section [spine]) **per limb** that the provider tests.

"The terminology states, 'each extremity ... or each trunk section,' so you can report this code more than once if applicable," says **Judy Thomas, MGA**, senior policy manager of the public affairs division of the American Occupational Therapy Association (AOTA).

Code 95851 describes manual testing of each arm or leg or sections of the spinal muscles in a separately reported procedure. To bill for each extremity, report 95851 on one line of the CMS-1500 or claim form, and you can use box 24G or its equivalent to indicate the number of limbs tested.

For example, if the physiatrist tests both arms, you should use 95851 x 2. If the physiatrist measures the cervical, thoracic and lumbar spine ROM, then you should report 95851 X 3, says **Carl Byron, ATC-L, EMT-I,** principal of Health Care Consulting Services Inc. in Hickory, N.C. The same goes for both arms and both legs -- if your physiatrist has documentation clearly showing medical necessity, you can report 95851 X 4.

Keep in mind: If you have different primary diagnoses for the different regions or extremities, you may need to separate the services onto individual line items on the claim form and link the corresponding primary diagnosis to each appropriate line. In the previous example, you will need to append modifier 59 (Distinct procedural service) to 95851 on the additional lines so that payers will not mistake these reported services as duplicate billings.

Heads up: To support the claim, the physician's documentation should include a report for each extremity or spinal section that the physician examines.

Also, "if you're billing this code, then [your physiatrist's] documentation should soundly substantiate its use -- as in, you probably won't use this code with general medical diagnoses but with more complex orthopedic and neurological conditions where [the physiatrist] anticipates significant improvement in more than a couple of movement patterns,"

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says **Pauline Franko, PT, MCSP**, president of Encompass Consulting and Education LLC in Tamarac, Fla.

Myth #3: Code 95851 is your only ROM choice.

Reality: CPT includes several testing codes other than 95851.

To document manual range-of-motion measurements for the hand, with or without comparison with normal side, use 95852 (Range of motion measurements and report [separate procedure]; hand, with or without comparison with normal side), Franko says.

To report manual muscle testing for the arm, leg or trunk, you should claim 95831 (Muscle testing, manual [separate procedure] with report; extremity [excluding hand] or trunk).

For manual muscle testing for the hand with or without comparison with normal side, report 95832 (Muscle testing, manual [separate procedure] with report; hand, with or without comparison with normal side).

For total muscle testing evaluation of the body, excluding hands, the correct code is 95833 (Muscle testing, manual [separate procedure] with report; total evaluation of body, excluding hands).

If your physiatrist's total evaluation of the patient includes hands, select 95834 (Muscle testing, manual [separate procedure] with report; total evaluation of body, including hands).

Important: "Most payers rank these codes as above and beyond what is inherent in evaluation and assessments -- therefore you must have clear clinical rationale for the ROM codes you report and a plan of action once the results are known," Byron emphasizes.

Note: CPT designates 95831-95834 as "separate procedures," which means you may code them separately only if your provider carries out the procedure independently or considers the procedure to be unrelated or distinct from other procedures/services provided at that time. What to do: You may report the separate procedure codes along with other services, but you'll usually need to append modifier 59 (Distinct procedural service) to the separate procedure code.

Myth #4: You can report ROM codes with an evaluation service.

Reality: You can expect denials for 95851-95852 and/or 95831-95834 when you bill them at the same time as an E/M visit. "Range of motion is inherent to the vast majority of evaluation codes and therefore is not separately reimbursable for the same visit," Byron says.

For example, the National Correct Coding Initiative (NCCI) version 12.0 highlights that you cannot report range of motion codes alongside the new nursing facility codes (99304-99306 for the initial assessment and 99307-99310 for the subsequent visits). These edits have a modifier indicator of "0," which means you cannot separate them by using a modifier.

Caution: If your physiatrist uses an occupational or physical therapist (OT/PT), then you should keep in mind that the National Correct Coding Initiative (NCCI) bundles range of motion testing with therapy evaluation and re-evaluation codes (97001-97004). You cannot use a modifier 59 to separate this edit, Franko states.

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