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Eli's Rehab Report

NCCI 10.3 Update: Count Whirlpool and Hubbard as Component Codes

Watch for diskography, spinal stimulators, inpatient codes bundle

If you continue to report the Hubbard tank modality code separately from 97112, you'll experience denials very soon.

The National Correct Coding Initiative (NCCI) version 10.3 edits, which go into effect on Oct. 1, include four changes that may impact your PM&R practice.

Apply the Modality Edits of Aquatic Therapy

CPT 97112 (Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities) describes aquatic exercises, while 97113 (Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises) follows other land-based therapies but takes place in the water.

NCCI bundles both 97022 (Application of a modality to one or more areas; whirlpool) and 97036 (Application of a modality to one or more areas; Hubbard tank, each 15 minutes) into 97112 and 97113.

If a therapist provides a therapeutic procedure (e.g., therapeutic exercise, neuromuscular re-education) in a Hubbard tank or whirlpool tank, you should use 97113 to describe it, says **Andrea Salzman, MS, PT,** owner of the Aquatic Resources Network and Concepts of Physical Therapy in Amery, Wis. You should not code for both aquatic therapy and the Hubbard tank.

For example: "If you use a Hubbard or whirlpool tank to provide a modality such as wound care, you should never use the code 97113 to describe those services anyway," Salzman says.

The whirlpool (97022) and Hubbard tank (97036) codes are now components of both the neuromuscular re-education (97112) and aquatic therapy (97113) codes, according to NCCI 10.3.

Moral of the story: If you want to report these modalities separately, you can do so by appending modifier -59 (Distinct procedural service), but make sure you have documentation demonstrating how the whirlpool modality was distinctly separate from the aquatic therapy the therapist performed on the same date.

Diskography Includes Guidance

When your physiatrist performs a diskography, you won't be able to report ultrasound and fluoroscopic guidance for needle placement codes separately - as part of a huge number of bundling edits for those two codes.

When a patient presents with disk pain, the physiatrist may perform a diskography to assess the situation, but this pain management procedure is diagnostic and not therapeutic in nature. Depending on the level of injection, you should code either 62290 (Injection procedure for diskography, each level; lumbar) or 62291 (... cervical or thoracic).

These procedures now include the work of 76003 (Fluoroscopic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device]) and 76942 (Ultrasonic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device], imaging supervision and interpretation).

Note: You can override this edit with the appropriate modifiers, such as modifier -59.

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Have Spinal Stimulator Analysis Indication

If your physiatrist is among the small percentage of PM&R physicians who place stimulators, you should not report 95974 separately from 63688 or 63685.

NCCI 10.3 applies a bundling edit to spinal stimulator codes 63688 (Revision or removal of implanted spinal neurostimulator pulse generator or receiver) and 63685 (Incision and subcutaneous placement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling).

As of Oct. 1, these two spinal stimulator codes each include the work of 95974 (Electronic analysis of implanted neurostimulator pulse generator system [e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements]; complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour).

Keep in mind: If you do have the necessary supporting documentation for a modifier such as -59, you should append it to 95974.

"This edit makes sense because if the provider places or revises a generator, the RVU includes the analysis," says **Marvel Hammer, RN, CPC, CHCO,** owner of MJH Consulting in Denver. "Providers always perform the analysis when they first place or revise the generator so that he can evaluate the initial settings."

You would report the analysis portion only if it occurred at a different time and setting from the placement or revision, Hammer says.

Can't Override Inpatient Consult Bundle

NCCI bundled the initial and follow-up inpatient consultation codes (99251-99263) into the codes for same-day observation or hospital admission and discharge (99234-99236).

Translation: You can no longer bill for a consult if the physician also placed the patient under observation or admitted him as an inpatient and discharged him on the same day. You can't override these edits with a modifier.

"If one of our doctors was asked for an initial or follow-up consultation, then I would not expect him to report the observation or hospital admission/discharge because that should be billed by the attending doctor," says **Penny Schraufnagel,** office manager of OB-GYN Center PA in Boise, Idaho.

If the physician already codes for observation or hospital admission, he could not also code for an inpatient consultation on the same patient, Schraufnagel says, so the edit does not make much sense.

CMS has identified the reason for the edit as "a coding manual instruction/guideline." While CPT guidelines do indicate that the physician should report only the most extensive E/M service provided on a given date of service, these bundled codes would be almost impossible to report together under normal circumstances.

If the physician performed an inpatient consultation, he could not then admit the patient to observation or inpatient care on the same date unless she was discharged from the hospital after the consultation and readmitted by the physician who did the consultation later that day. And if the physician admitted the patient to observation or inpatient care first, he could not do the inpatient consultation.

For example: A primary provider asks a physiatrist for an inpatient consult regarding a patient's rehab needs. The patient is in an acute care inpatient setting, and the provider wants to transfer her to an inpatient rehab setting. The primary provider discharges the patient that day, and then the physiatrist admits her to an inpatient rehab hospital. Later that same day, the patient worsens or develops a new medical condition and needs to be transferred back to the

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acute care hospital setting.

"In this scenario, the physiatrist will not be able to report the inpatient consult services, even though it was performed at a separate setting and time," Hammer says.

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