



Chiropractic Associates of Minnesota, LLC

Rehabilitation Documentation and Billing Guide

Purpose:

- 1) Develop a guide for doctors in Minnesota to follow when performing reviews on rehabilitation cases.
- 2) Provide doctors in Minnesota a reference guide to follow when performing and billing for rehabilitative services.

What is Rehabilitation?

Rehabilitation is a progressive program that takes a dysfunctional unit and attempts to make it function properly. It includes cardiovascular, flexibility, proprioception and strengthening. It involves one on one contact with a health care provider and the exercises performed are complex and require the supervision and assistance by a health care provider.

Many times patients are shown simple exercises in the office and are instructed to perform the exercises at home. It is appropriate for the provider to bill for the exercises. When the patient returns to the clinic the exercises are reviewed by the health care provider and once again bills for the service. Again this is appropriate. But if the patient continues to perform the simple exercises at home and when they come in the office there is no advancement of the exercises and they are just performing the exercises already performed then this is not appropriate to bill. Rehabilitation is a progressive process of exercises that need to be performed in the office, not exercises that the patient understands well and can easily perform at home. This is always difficult to determine but we need to determine if the patient requires continued in office rehabilitation or can they be sent home to perform the exercises.

Rehabilitation vs. Exercise:

- 1) Rehabilitation is taking an injured or weakened region of the body and returning it to a normal state.
- 2) Exercise is taking a normal person or body part and making it stronger.

Determining the Need for Rehabilitation:

- 1) Most if not all cases of musculoskeletal injuries require some form of rehabilitation.
- 2) The more complex the case the more complex the rehabilitation will be.
- 3) When the condition is chronic, severe, or recurrent these are typical scenarios that would require prolonged rehabilitation in the clinic.
- 4) When rehabilitation is being considered by a doctor the doctor will typically do some sort of evaluation to determine if the patient is a candidate for rehabilitation. This evaluation can include any of the following; functional evaluation, muscle testing, postural evaluation, one leg standing, cardiovascular testing (step test), flexibility testing, limits in activities of daily living or demands of employment, and also clinical knowledge of typical patterns of weakness and tightness for specific conditions.

Setting up a Rehabilitation Program and Billing for It:

- 1) If during the initial evaluation a deficit in cardiovascular fitness is discovered, the rehabilitation would include a cardiovascular component. If there is no cardiovascular fitness deficit, the initial portion of the rehabilitation program would consist of a short warm up. The time needed to perform the cardiovascular portion of the rehabilitation must be documented. The typical time needed for a warm up would be 5 to 10 minutes. The time for cardiovascular training for a deficit will vary depending on the goals of the rehabilitation. Commonly, a cool down using cardiovascular equipment will be performed following the rehabilitation session. The typical amount of time for this would be 5 to 10 minutes.

Effective July 1, 2005:

- * **Cardio Warm-up and Cool-down** – Do not require one-on-one supervision and are considered non-covered services
- * **Med-X Testing Typically Billed as Physical Performance Testing or Measurement (e.g., Musculoskeletal, functional capacity) with written report each 15 Minutes:**

The following rules will apply:

- 2 units of 97750 will be allowed if documentation supports 1 region of the body is being evaluated and the time needed to perform the service is 30 minutes.
- 3 units of 97750 will be allowed if documentation supports 2 regions of the body are being evaluated and the time needed to perform the service is 45 minutes.

(A written report must be included in the documentation and it must support the necessity of testing. Further rehab must be based on the patient's subjective complaints, effects on Activities of Daily Living (ADL's) and Demands of Employment (DE's), objective findings, the doctor's interpretation of findings, updated diagnosis and future treatment plan and goals.)

- 2) If deficits were found in flexibility then the muscles will be stretched. The time to perform a stretch on a specific muscle is typically one minute. The specific muscles stretched must be documented. It would be helpful to include the technique as well. Many times doctors document that stretches were performed to the lumbar spine. It would be helpful if they were more specific. However, if the time documented is for a short period of time (5 minutes), then it is often accepted. If a doctor performs prolonged stretching to a muscle, the documentation must include the duration and the reason(s) why it took that amount of time. It will be assumed by the reviewing doctor that each stretch takes one minute to perform. Each stretch performed must have a correlation to the patient's complaint. If the stretches take longer than this amount of time, the documentation must state why. Also, if muscles are stretched that do not correlate to the chief complaint, the documentation must explain why.
- 3) If muscles were found to be weak, strengthening or stabilization exercises would be prescribed. Specific exercises must be documented along with repetitions and sets of the exercise that were performed. It is always difficult to review cases that involve strengthening exercises when a great deal of time is documented to perform just a few exercises. It will be assumed that a set of 10 exercises including rest time will take the patient 2 minutes to perform. So each set of 10 exercises will be added up to determine if the time billed corresponds to the number of exercises performed. If a patient needs prolonged time it must be documented as to why it took so long. If strengthening exercises are performed that do not have a direct relationship to the chief complaint, the the documentation must state why it was performed.
- 4) If poor balance or proprioception is found on the evaluation, proprioceptive exercises will be performed. The time to perform the proprioceptive exercises must be documented along with a description of the exercise.

Billing:

When billing for rehabilitation the codes are all timed codes per 15 minutes. Time must be documented in the chart or on the flow chart. Each exercise must be documented and the time, as stated above, must correlate with the amount of exercises that are performed.

The codes used for the evaluation are also time based codes. The time must be documented and must correlate to the level of the evaluation that is performed.

Common codes used for rehabilitation are: 97110, 97530, and 97112.

The code for evaluation is: 97750.

When performing a time based service it is important to recognize that 15 minutes must be spent in performing the pre-, intra, and post-service work. If less than 15 minutes is spent performing the service, the modifier -52 should be appended to the code, and the fee must be reduced to the appropriate fee. For example; If the time needed to perform the service is 5 minutes, the amount billed should be 1/3 of the billing for a full unit.

Special Note: The 8 minute rule is a Medicare rule and does not apply to CASD policies.

If you have questions please contact the CAMN Utilization Review Department.