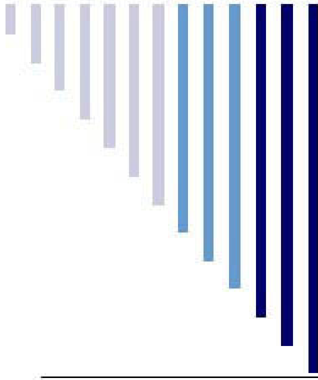
American Physical Therapy Association / Neurology Section



Vestibular Rehabilitation SIG

Spring 2006

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Future Directions

VR in view of the neurology section strategic plan 2006-2010

By Denise Gobert, PT, PhD
VR SIG Chair

The 2006 APTA CSM in San Diego was another hallmark event in view of future directions for Vestibular Rehabilitation in Physical Therapy practice.

Of note, let me draw your attention to two major activities that will affect our SIG.

First of all, please note that our Special Interest Group will return to a single focus area: Vestibular Rehabilitation (VR).

In response to the voices of concerned members, the Balance & Falls SIG was officially reestablished as a separate group during CSM 2006 to address the specialized needs of that practice area.

The Balance & Falls SIG was reestablished as a separate group during CSM 2006. Therefore, we reclaim our original name: Vestibular Rehabilitation SIG.

Therefore, we will reclaim our original name: Vestibular Rehabilitation SIG. In addition, all supporting communications and advocacy efforts will now reflect that single interest area.

The second important highlight of CSM includes the 5-year Neurology Section Strategic Plan 2006-2010.

This directive is best summarized with it's vision statement that aims to foster future neurologic physical therapy practice as a leading partner in the national and international rehabilitation communities by facilitating collaborative relationships, promoting knowledge translation, and influencing policy.

The action plan of this 5-year document includes six goals that codify specific efforts to advance neurologic physical therapy in clinical practice, academic training, translational research and innovative leadership.

What does this mean for the VR specialist? Now more than ever, it is time for all VR specialists to promote and advocate the physical therapist as the clinician of choice for proper care of patients with vestibular-related movement disorders.

Through innovative research and advancements in academic training, we have come a long way in demonstrating the efficacy of proper vestibular rehabilitation diagnosis and treatment.

However, more progress is still necessary.

As we step into the next five years, the VR SIG officers will continue to keep you aware of issues and concerns specific to VR practice.

We hope you enjoy this newsletter, which summarizes the CSM 2006 meeting and invites new volunteer leaders to help shape the future for Vestibular Rehab Physical Therapy!

Coding and Billing for Balance/Vestibular Rehabilitation

Introduction: The following is a summary of the information obtained through discussions at the Neurology Section Roundtables, Saturday February 4th 2006, APTA CSM, San Diego CA.

In attendance were Helene Fearon, PT our representative to the AMA, Teresa England, PT NCS, a Neurology Section member and facilitator, and about 18-20 clinicians who have balance programs in private practice and hospital based facilities.

The key to successful billing in balance & vestibular rehabilitation is to know your payers and their individual policies.

If you do not have a copy of your primarily payer's LCD/Local Coverage Determination for physical therapy, vestibular rehabilitation, vestibular function testing, etc, an important first step is to obtain them from the web. Specific to Medicare, to obtain your individual LCD, go to the Intermediary1/Carrier2 directory www.cms.hhs.gov/apps/contacts/incardir.asp and find your payer. Search "LCDs", draft and final, to list/view your payer's policies and obtain a working copy.

Your LCD will define any limitations or guidelines that your payer has placed upon the use of the coding strategies described herein.

Procedural Coding

The following table offers an appropriate coding strategy for the rehabilitation of the balance and vestibular patient.

Evaluation	Appropriate Coding	Time Requirements	National Avg
Intake Phase H & P/Synthesis -Musculoskeletal -Neurologic -Functional	97001	Variable Total: 15- 30 minutes	$64.43 (F,Facility) $75.80 (NF, Non-Facility)
-Diagnostic Support phase -Computerized Dynamic -Posturography -Dix Hallpike/CRM/ "Epley"/ Semont	92548-TC Computerized Dynamic Posturography (currently restricted) 97140	15 – 30 minutes 15 minutes	$80.34 $26.53
Balance Examination Phase -Computerized Balance and/or Gaze Stability Testing -Oculomotor Examination -Vestibular Autorotation -Functional Balance Test(s) -Gait Exam (*not* gait lab) -Balance/Dizziness -Disability Measure(s) -Aphysiologic Determination	97750 Balance Performance Testing	Individualized Total: 30 – 90 minutes	$29.94 each 15 minutes

These codes may be billed by a Physical Therapist and are within the scope of physical therapy practice. They may, however, be restricted for use by your payer's LCD/policy. For your convenience, the evaluation and treatment process has been broken into phases and includes categories of the tests and measures often utilized with balance/vestibular-impaired patients. The list provides and example and is not necessarily exhaustive. A more detailed listing of typical tests that may be considered within each category is available within the Appendix.

All balance tests & measures that meet the following criterion can be considered as performance tests and be billed under 97750 Physical Performance Test.

- The test has a specialized protocol & procedures
- The patient receives specialized instruction before, during, and after the testing procedures
- Data is gathered and analyzed
- The findings from analysis impact and direct the Plan of Care

CPT 97750 is a timed code that includes all elements listed above and may be billed in multiples based upon the amount of time spent from patient contact through completion of the test and analysis. Documentation must reflect the elements as listed above.

For Medicare Beneficiaries, 97750 may not be billed on the same day as the evaluation (97001 OR 97002) by CCI/Correct Coding Initiative edit. Submitting documents in support of 97750 is not required but may be requested. Documentation is required to be in chart and available since 97750 is a "by report code".

Specific to the assessment/treatment of BPPV, manual therapy 97140 is the advised procedural code to use at this time. For Medicare Beneficiaries, 97140 may not be billed in conjunction with 97750 by CCI edit.

Specific to CDP/Computerized Dynamic Posturography 92548, this is a general supervision (Level 5) procedure3 at the current time, requiring the physician's presence within the building in addition to a specific referral for the testing procedure. Physical Therapists may bill the technical component, which will require a -TC modifier. The presence and type of restrictions for the use of this code should be confirmed.

Note: This table provides an example of an appropriate billing strategy in this population. The reimbursement amounts presented are based upon the national average values within the Medicare Fee Schedule for 2005. Fee schedules vary from payer to payer and it may be considered reasonable to take an average among your payers, Medicare and private, when estimating your own reimbursement values and setting your billing strategy/plan.

Treatment Phase			
-Balance Retraining	97112, 97110	Variable	$28.04, $29.56 Each 15 min
-Gait Training	97116		$24.63/ea 15
-ADL Training	97535		$29.56/ea 15
-Visual Biofeedback	90901		21.60 (F), $40.93 (NF)
-CRM/Epley/Semont	As above, 97140		

Treatment coding is perhaps less of a mystery to most therapists in balance -code and document what you do. Certainly 97112 is often thought of as a good option for training the balance component. However, the diagnostic codes submitted may limit the treatment codes available for use. Your payer LCDs can provide you with this information.

Specific to 90901 Biofeedback, this may be an appropriate procedural code to consider for those interventions that utilize visual biofeedback for the enhancement of the neuromuscular control of balance. The presence and type of restrictions for the use of this code should be confirmed.

Note: Again, it cannot be stressed enough that there is tremendous inconsistency between payers and their policies relative to the use of these codes. Check your payer LCD/Local Coverage Determinations and/or work with your billing office to determine if you are restricted from billing in the manner described. There are practice statements, policies, and precedent supporting the use of this strategy as recommended.

If you identify codes/services that are within the Physical Therapist's scope of practice, but you are restricted (unable to receive reimbursement; limited) by local policies, contact your Neurology Section Reimbursement Liaison to the APTA.

Diagnostic Coding

As of June 6th, 2005, Physical Therapists must list a physical therapy diagnosis as the primary diagnosis. From the Medicare Intermediary Review Guidelines for Documentation (CMS Transmittal R36BP).

Diagnosis - List, by ICD-9-CM code, the primary diagnosis for which OPT services were first furnished. Follow with other Dx(s) (diagnoses), applicable to the patient or that influence care.

For the balance/vestibular impaired patient, the following ICD-9 codes5 can be appropriate (list including, but not limited to the following as examples) based upon the medical diagnosis and presentation:

- 719.7 [Other and unspecified disorders of joint] Difficulty in walking
- 781.2 Abnormality of gait Ataxic, paralytic, spastic, staggering DEF: Abnormal, asymmetric gait
- 781.3 Lack of Coordination Ataxia NOS (non-specific), muscular incoordination
- 780.4 Dizziness/Giddiness Lightheadedness, Vertigo NOS (non-specific)

Additional functional codes may be added, reflecting elements additional affecting balance control. As examples:

- 781.0 Abnormal involuntary movements Tremor NOS, Spasms NOS, Fasciculation, Abnormal head movements
- 728.2 Muscle wasting and disuse atrophy, not elsewhere classified
- 438.2 [Late effects of cerebrovascular disease] Hemiplegia/hemiparesis
- 438.6 [Late effects of cerebrovascular disease] Alterations in sensation
- 438.8 [Late effects of cerebrovascular disease] Other late effects of cerebrovascular disease Ataxia, Vertigo, Other

It is important that the v- code, V 15.88 History of Fall/Risk to Fall (effective October 2005) be listed if there is a fall risk present or a history of falling. This should not be listed as the primary diagnosis.

Carrier and intermediary claim submission forms allow for the listing of one primary diagnosis and multiple secondary diagnostic codes.

Diagnostic coding should occur after the Physical Therapy Evaluation process has been completed.

Many hospital PTs feel 'disconnected' from their billing office and procedures. A strong recommendation was made to 'get connected' - identify one billing officer to represent your program/department and their balance services to the payers.

Many Physical Therapists do not appeal payer denials (if they are made aware of them) for their services. Given the high rate of denial reversal upon appeal, a strong recommendation was made to be certain to use your APTA resources wisely and appeal denials for payment when appropriate.

Other News & Updates

In 2007, CMS will begin the process of moving to Regional Medicare Administrative Contractors. Under each regional contractor will be one intermediary and one carrier. This should improve processes and communication, and should also decrease the amount of inconsistencies we face today when billing for rehabilitation of patients with balance and vestibular disorders.

Many thanks to Helene Fearon and Teresa England for the facilitation of this valuable roundtable discussion and for their assistance in generating an action and advocacy plan for the future. We are hopeful that Helene will be able to join us in the Neurology Section Roundtables yearly to discuss issues related to the billing strategies and issues in the care of patients with neurologic disease.

Balance Examination Specifics

The following are a brief (partial) listing of examples of typical tests and measures of balance that are protocol

driven and in which the data is analyzed to impact the treatment plan.

- Visual/VOR Tests
  - Oculomotor Exam (visualized, recorded)
  - Computerized gaze stability testing (DVA/Dynamic Visual Acuity Test, DVAT, GST/Gaze Stabilization Test)
  - Vestibular autorotation testing (VAT, Vorteq)
- Clinical Balance Tests
  - CTSIB
  - BESS/Balance Evaluation Scoring System
- Computerized Balance Testing
  - Forceplate sway measures
  - Balance system impairment tests (SOT, MCT, LOS, mCTSIB, etc)
- Functional Balance Tests
  - BESTest, TUG/Timed Up n Go, DGI/Dynamic Gait Index, FGA/Functional Gait Assessment, Tinetti POMA, BBS/Berg Balance Scale, etc.
- Gait Examination (protocol based; not gait analysis)
- Participation ("Disability") & Life Impact Measures
  - DHI/Dizziness Handicap Inventory, ABC/Falls Efficacy, VADL, etc
- Aphysiologic Determination

References:

American Medical Association (c) 2006, Physician ICD-9-CM, International Classification of Diseases, 9th Revision.

American Medical Association (c) 2006, CPT 2006, Current Procedural Terminology, Professional Edition.

RBRVS EZ Fees(r) 2005 Standard Edition, Version 1.0.0 Copyright (c) 2005, Registered to Marcia Thompson, PT DPT.

Centers for Medicare and Medicaid Services, www.cms.hhs.gov

American Physical Therapy Association, www.apta.org

Noridian Medicare Services, Inc, www.noridianmedicare.com

It cannot be stressed enough that there is tremendous inconsistency between payers and their policies relative to the use of these codes.

Check your payer Local Coverage Determinations and work with your billing office to determine if you are restricted from billing in the manner described.

Combined Sections Meeting 2006 San Diego, Calif.

Verti-Go-Go Dinner, Feb. 4, 2006

Navy Cmdr. Michael E. Hoffer, Army Col. Kim R. Gottshall, Angela Drake, PhD and Christine Parrish, MA, CCC-SLP, presented *Vestibular Disorders After Head Trauma: Cutting Edge Diagnosis and Management. The Team Approach.*