Clinic Operation

For the readers of this manual who may lack experience in running a medical clinic, we can offer a few suggestions for implementing a MedX-based medical exercise and rehabilitation program. No claim is made herein that we're offering THE way or THE ONLY way; only some possibilities for getting started. For a brief period in the 1995 and 1996, a group of MedX practitioners formed a user's group to offer guidance in applying the technology in a clinical setting. While the steering committee is no longer in existence, much of the advice they provided is still relevant and is thus published in its entirety.

MedX Utilization Steering Committee: Consensus guidelines for the utilization of Medx medical testing and exercise machines in spinal rehabilitation programs.

Preamble: The following recommendations represent a consensus of the MedX Utilization Steering Committee. The Committee is composed of researchers and educators at the University of Florida, the University of California at San Diego, Syracuse University, and Indiana University, as well as numerous practicing clinicians throughout the country utilizing MedX equipment in their orthopaedic rehabilitation programs.
*The Committee seeks to clarify issues related to appropriate usage, CPT coding, and billing of rehabilitative services utilizing MedX equipment. These guidelines are expected to be a valuable resource for clinicians as well as third party payers who have questions about appropriate usage, charges, and expected outcomes of MedX-related rehabilitation programs. The Committee does not propose to **dictate** fees or protocols. However, guidelines are helpful to promote ethical practice and reasonable standardization of MedX equipment utilization based upon available scientific research. It is the Committee's position that practitioners who significantly deviate from these recommendations have the burden of proof to show that such actions are clinically valuable and cost-effective. While the Committee believes rehabilitation with MedX equipment is a significant advance in the treatment of spinal disease, it is the responsibility of all health care providers to deliver only care that is necessary and cost-effective.*
This document will be updated when necessary to reflect the latest research, changes in treatment protocols and billing procedures. Input from individuals outside the Committee is welcomed and encouraged.

SECTION 1. MEDICAL NECESSITY FOR RECONDITIONING THERAPY UTILIZING MEDX EQUIPMENT IN THE CHRONIC PAIN PATIENT POPULATION

Medical research has documented that individuals suffering from a variety of spinal disorders respond positively to a specific progressive resistance exercise rehabilitation program using MedX equipment.1-5 A typical outcome from this therapeutic approach includes improved muscular strength and endurance, increased joint mobility, enhanced physical functioning and a reduction in pain. Patients initially present with subnormal levels of muscular strength and endurance, and a limited range-of-motion (ROM). Functional restoration to normal levels is the ultimate treatment goal. Current epidemiological literature on the natural history of spinal soft tissue injuries indicates

that nearly 90% will resolve spontaneously within 90 days regardless of the type of intervention (including none).6 Therefore, standard rehabilitation protocols using MedX equipment are most appropriately administered when a patient:

I.) Has an appropriate ICD-9 diagnosis.

II.) Is beyond 45 days from initial injury.

III.) Has not shown a demonstrable and consistent trend towards improvement utilizing acute conservative care therapy. This does not mean that if a patient still has **any** symptoms at 45 days that MedX is indicated. For example, if a patient is 50% improved at 45 days and is functional enough to prevent significant deconditioning, it may be prudent to continue with the current care rather than beginning a course of treatment using MedX equipment. If the patient is showing **little or no** improvement after 45 days, MedX treatment may be appropriate.

IV.) Demonstrates at least two of the following four criteria for abnormal spinal function, as determined by isometric testing with MedX equipment:

1. Greater than a 10% deficit from normal ROM in the absence of extenuating clinical circumstances (i.e. fusion, old fracture, etc.) or in cases where distribution of body fat prevents full joint mobility.

2. In the fully extended position, greater than a 15% isometric strength deficit from average normative values for age matched norms.

3. In the fully flexed position, greater than a 15% isometric strength deficit from average normative values for age matched norms.

4. In any standardized midrange test position, greater than a 15% isometric strength deficit from average normative values for age matched norms.

Note: When comparing a patient's isometric strength to normal, relative torque (torque per unit of body weight) values should be used if such data are available.

V.) Has a chronic recurrence of acute symptoms. Some patients may present with acute symptoms, and upon taking a medical history it is discovered that such symptoms have recurred over an extended period of time. These individuals can be categorized as 'disguised chronic' patients, and are eligible for testing on MedX equipment to determine whether significant deconditioning has occurred. If so, active exercise reconditioning is justified. The significant history of a patient's recurrent acute symptoms should be well-documented. Significant history implies that the patient has been seen by a health care provider in the past.

SECTION 2. MEDX RECONDITIONING AND ACUTE CARE THERAPY PROTOCOLS

I.) Reconditioning therapy for chronic pain

1. Testing - An initial isometric test followed by testing every four weeks is recommended to document pre-treatment status, treatment efficacy, and to help determine whether the patient has reached normal musculoskeletal function. If the patient fails to demonstrate sufficient progress while adhering to the standard treatment protocol, a fatigue response test consisting of two isometric tests and one set of dynamic exercise may be administered in order to better individualize an exercise prescription. For most patients a fatigue response test will not be necessary. In summary, MedX treatment generally includes 2 to 6 isometric strength tests.

2. Frequency and length of treatment

a. After establishing baseline isometric strength and identifying functional deficits, patients are generally treated with progressive resistance exercises two times per week for the first four to six weeks. This regimen allows patients to adapt gradually to the specific exercise sessions, which usually induce some degree of delayed muscle soreness. Beyond four to six weeks, lumbar extension exercise may be reduced to one time per week. The reduction in exercise frequency generally corresponds to diminished muscle soreness, and an ability to exercise at intensity levels that elicit muscular fatigue.

b. Exercise sessions for the cervical region generally maintain a frequency of two times per week throughout the treatment protocol.

c. MedX protocols typically include 4-12 weeks of treatment. The length of treatment within this period is dictated by a variety of factors, including the amount of deconditioning a patient has sustained, and the rate/degree of treatment progress.

3. Treatment progression and program effectiveness

a. MedX rehabilitation programs are based upon principles of progressive resistance training, which are directed toward controlled, periodic and specific overload of isolated musculature. Exercise is performed to volitional fatigue within a prescribed repetition range. When the repetition range is exceeded, the resistance is increased by 5 to 10%. Progression of exercise intensity facilitates morphological adaptations of muscle, bone, and connective tissue, thereby improving the functional and structural integrity of the muscle/joint system.

b. Initial MedX exercise sessions generally consist of warm-up repetitions with a light weightload followed by 15 to 20 repetitions using a challenging weightload at approximately 7 seconds per repetition. When a patient is able to exercise to volitional fatigue (generally 4 to 6 weeks), exercise intensity is increased by reducing the repetition range to 10 to 15 and increasing the amount of resistance. Through this gradual adaptation to physiologic stress, research has shown that patients typically demonstrate increases in isometric and dynamic strength, improvements in ROM, a reduction in pain, and improvements in the performance of daily activities. Documented progress relative to these improvements determine the effectiveness of a MedX rehabilitation program.

c. MedX treatment should be terminated when objective measures fail to demonstrate continued improvement.

II.) Acute care protocols - The Committee has evidence that a number of facilities utilize MedX equipment for acute pain patients (< 45 days post-injury) with success, particularly in the Worker's Compensation population. Under these circumstances, MedX equipment is utilized for therapeutic, non-computerized ROM exercise, and therefore should be billed similar to traditional acute conservative care. Reasonable charges for MedX acute care protocols are discussed in Section 4, Number IV, 4c. It should be clear that treatment utilizing MedX equipment for acute pain patients is applied solely for pain relief, is not directed towards functional restoration through progressive resistance overload, and deviates from the primary goals and objectives of reconditioning therapy, as outlined above.

III.) Supplementary reconditioning - Since chronic pain patients generally present in poor physical condition, rehabilitation should emphasize a well-rounded conditioning program.7 The Committee recommends that specific low back and cervical rehabilitation utilizing MedX equipment be supplemented with supervised progressive strengthening exercises for the major muscle groups and low-impact cardiovascular conditioning. Within the context of these guidelines, supplementary reconditioning refers to the

application of specific, challenging and progressive exercise with meaningful equipment and qualified supervisory personnel. A program with a single exercise bike and/or a few free weights and/or no supervision and/or an untrained aide does not meet the Committee's criteria for adequate supplementary reconditioning exercise.

IV.) *Delivery of services* - MedX-related services should only be rendered by a clinician who has been certified in the use of MedX equipment at the either the University of Florida, Gainesville, or the University of California, San Diego.

Section 3. MedX Reconditioning Therapy Combined With Assorted Passive Modality Treatments

I.) *General statement* - In general, passive modalities and active reconditioning exercise represent separate phases of treatment for patients suffering from spinal disorders. Research has shown that some modality treatments are effective for symptom reduction during periods of acute pain. Current medical evidence does not support the continued use of modality treatment with chronic pain patients.8 Likewise, there is no scientific evidence to support the therapeutic benefit of passive modalities when rendered in conjunction with a MedX exercise reconditioning program. Passive modality treatment, which includes ultrasound, diathermy, electrical stimulation, massage, calisthenic exercises, traction, acupuncture, biofeedback, and enzyme injections, when combined with MedX rehabilitation, adds an additional layer of medical costs without any proven corresponding improvement in therapeutic outcome. Withstanding acute exacerbations (see Number II below), the Committee does not support the practice of combining (i.e. billing for) passive modality treatment in conjunction with the use of MedX equipment.

II.) *Acute exacerbations* - Occasionally (less than 10% of chronic patients) a patient will experience an acute exacerbation of symptomatology during a course of MedX spinal rehabilitation. In such cases, it is appropriate to utilize acute care therapy such as passive modalities and spinal manipulation to resolve the exacerbation and allow for the re-initiation of active reconditioning exercise. If a significant exacerbation occurs, it should be well documented and a **brief** plan of acute care management should be delineated which includes definite endpoints that correspond with a return to pre-exacerbation status. This clause should **not** be construed as a loophole to add any passive modality with all or most patients during a MedX rehabilitation program.

III.) *Chiropractic manipulation and MedX utilization* - The best spinal manipulation guidelines the Committee has found are the **"Guidelines for Chiropractic Quality Assurance and Practice Parameters"** from the Proceedings of the Mercy Center Consensus Conference published by Haldeman et al. in 1993.9 The Mercy Center guidelines state that most acute spine injuries resolve well within six weeks. This corresponds closely with the Committee's recommendation to delay standard MedX treatment protocols until 45 days post-injury. The Mercy Center guidelines suggest that chiropractic care may be necessary between 6 and 16 weeks after onset, and that patients may require an average of 4, but typically no more than 11 spinal manipulative sessions during this period. Beyond 16 weeks the guidelines recommend focusing upon active forms of treatment such as supervised rehabilitation to promote optimal health status and prevent physician dependency.

Considering the Mercy Center guidelines, the Committee, which includes chiropractic representation, recommends no concurrent use of spinal manipulation and MedX exercise reconditioning therapy beyond 16 weeks from onset in the absence of acute exacerbation. Between 6 and 16 weeks from

onset, MedX rehabilitation may be started for patients not showing significant improvement, and may be combined with limited spinal manipulation. However, it is anticipated that during the 6 to 16 week period the total number of spinal manipulation sessions would average 4, and would not exceed 11.

SECTION 4. TREATMENT CODING/BILLING PROCEDURES AND ASSOCIATED COSTS

I.) General statement - Current Procedural Terminology (CPT) coding for MedX rehabilitation programs can be confusing for several reasons. CPT codes frequently change. In January 1995, the Physical Medicine section of the CPT code book underwent a major revision which affected coding procedures for MedX rehabilitative services. Further changes are likely to occur in the future. Moreover, individual states and/or third party payers often have their own codes which contradict the national codes. Providers may not be paid unless they comply with local guidelines. For these reasons, the Committee has decided to issue general fee guidelines rather than specific codes and procedures that might not apply to all MedX practitioners. What is proper coding in Alabama may be unacceptable in Utah. Practitioners are encouraged to consult the CPT code book and local third party payers for specific CPT code recommendations related to MedX-based services. **Regardless of the codes providers choose to adopt, the Committee recommends certain maximum charges for MedX-related services**.

II.) Categories of MedX-related rehabilitation program services:

1. Therapeutic exercise - Refers to supervised exercise involving computerized equipment, such as MedX medical testing and exercise machines. Specific to MedX equipment, therapeutic exercise refers to supervised progressive resistance dynamic exercise of an isolated muscle group (see Section 2, Number I, 3a,b,c).

2. Testing - Refers to an objective musculoskeletal evaluation on computerized equipment with printout. Specific to MedX medical machines, testing refers to a single multiple joint angle isometric test with computer printout. Testing is generally performed once every four weeks during a MedX rehabilitation protocol to document treatment efficacy. Fatigue response testing, a specialized testing protocol with MedX machines, involves an isometric test followed by a fatiguing set of dynamic exercise, immediately followed by second isometric test. This test protocol is recommended for patients who are exercising to fatigue but are not showing objective improvements by adhering to a standard treatment protocol. The Committee recommends that only one fatigue response test protocol per patient be performed, as the test results reflect genetic tendencies which are not likely to change. In addition, with cost-effectiveness in mind, it is the Committee's recommendation that all three portions of the fatigue response test should be billed as a single isometric test procedure.

III.) General billing guidelines - The Committee recommends the following general guidelines for reimbursement of MedX-related rehabilitative services:

1. One CPT code per each service provided - Each CPT code billed during a MedX rehabilitation program should represent a separate and distinct clinical procedure. A detailed description of each CPT code utilized and its associated rehabilitative procedure should be provided to the insurance carrier if requested. It is inappropriate to bill multiple CPT codes for a single clinical procedure.

2. Billing only for services provided - Each service provided during a MedX rehabilitation program should be clearly identified and documented.

3. Procedures included in a MedX rehabilitation session should not be billed separately - Procedures such as a brief cardiovascular warm up, warm up/cool down stretching exercises (on or off the MedX machine), and computer printouts are considered part of MedX testing and/or exercise therapy, and should not be billed separately. A program of supervised, progressive resistance and aerobic reconditioning exercises directed towards functional restoration represent additional services and should be billed separately using appropriate CPT coding.

4. Separate CPT codes should be used for MedX rehabilitation performed on different areas of the body - Each area of the body treated with MedX therapeutic exercises should carry a corresponding ICD-9 diagnostic code specific to the area being treated. Medical necessity for treating more than one area of the body concurrently with MedX equipment should be well-documented. For coding purposes however, it is irrelevant whether a patient spends time in 2, 3, or 4 different MedX machines on a given day. Total time spent remains the key factor when billing. Unless an individual state demands different coding, the use of multiple MedX medical machines during a single rehabilitative session should be billed in 15 minute increments.

5. Fees should remain within reasonable and customary guidelines - Fee structures for MedX exercise rehabilitation programs should fall within reasonable and customary guidelines established by the Committee (Section 4, Number IV). These guidelines are updated when necessary to reflect current industry and market standards.

IV.) Fee structures for MedX-related rehabilitation program services

1. General considerations - Fees related to MedX spine rehabilitation programs are time-based, and thus are relative to the number of machines utilized and the pathological region under treatment. A clinic will incorporate:

MedX extension equipment only, or;

MedX extension and rotation equipment.

For the treatment of:

a low back disorder, or;

a cervical disorder, or;

a lumbar and cervical disorder (approximately 12% of patients).

In general, the more services that are supplied, the greater the charge per session. Because MedX rehabilitation incorporates time-based services, a program offering MedX extension and rotation rehabilitation plus supplementary reconditioning is expected to cost more than a program providing only extension and rotation exercise therapy, which in turn would cost more than a program offering extension only exercise therapy. Programs providing supervised supplementary reconditioning can justify additional fees for these services. All services should be well-documented.

2. Fees for services - Given the range of clinical scenarios outlined above, in general, fees for MedX rehabilitative services should not exceed the following maximal limits for any one individual session:

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	Type of Patient					
	Low Back		Cervical		Lumbar + Cervical	
	8 weeks	12 weeks	8 weeks	12 weeks	8 weeks	12 weeks
extension only	$1,095 - $1,335	$1,460 - $1,940	$1,335	$1,940	$2,430 - $2,670	$3,400 - $3,880
extension + rotation	$2,190 - $2,670	$2,920 - $3,880	$2,670	$3,880	$2,750 (f)	$4,000 (f)

a. $60 for each MedX dynamic exercise training session;

b. $125 for each MedX isometric testing session;

c. $185 for each session which includes MedX isometric testing **and** MedX dynamic exercise training;

d. $125 for the total charge of any one visit that does not include isometric testing, regardless of the type and amount of services provided, including supplementary reconditioning (See Number 3 below);

e. $250 for the total charge of any one visit that includes isometric testing, regardless of the type and amount of services provided, including supplementary reconditioning.

Note: The Committee acknowledges that some providers may utilize several pieces of MedX equipment and incorporate supplementary reconditioning while treating more than one area of the body concurrently (i.e. combined lumbar and cervical pathology). Even in these situations, it is the Committee's recommendation to contain treatment costs relative to the fees outlined above.

The following table summarizes recommended maximum total fees for the various types of MedX-based rehabilitation programs:

3. Supplementary reconditioning - As described in Section 2, Number III, supplementary reconditioning exercises are often provided as part of a well-rounded rehabilitation protocol. Charges for these services should be kept separate and distinct from MedX fees. Services provided for supplementary reconditioning are generally time-based. **Regardless of the type and scope of supplementary supervised exercises/treatments provided, the daily total of all services should not exceed $125.**

4. Additional billing notations

a. All fees listed above are for chronic patients;

b. Note that just because the guidelines suggest a maximum fee does not mean practitioners must charge that amount. **The Committee recommends that clinicians establish their MedX-related rehabilitation program fees with cost-containment as a primary objective**;

c. Earlier (Section 2, Number II), conditions were discussed for the utilization of MedX equipment with acute patients. The Committee suggests a maximum program charge of $800 for acute patients with a per visit maximum of $60-$80, regardless of the type and scope of services provided;

d. All fee recommendations are exclusive of physician evaluations or imaging studies.

SECTION 5. INDISCRIMINATE OVERUTILIZATION OF MEDX EQUIPMENT

Only 10-15% of patients who sustain an acute spinal injury (for instance, a whiplash-associated disorder) should require a MedX reconditioning program. All other patients should follow the natural history of spinal injury (rapid, spontaneous and complete recovery) and do well with little treatment and expense invested.6, 8, 10 For example, a facility may treat both acute and chronic pain motor vehicle accident patients. However,

only 10-15% of the acute patients will likely become chronic and require a MedX reconditioning program. A facility that treats all or most of its acute patients with a MedX chronic patient reconditioning program is overutilizing MedX equipment, and is likely generating both unreasonable and unnecessary treatment costs.

REFERENCES

1. HIGHLAND T, DREISINGER T, VIE L, ET AL. Changes in isometric strength and range of motion of the isolated cervical spine after eight weeks of clinical rehabilitation. *Spine* 17(6S): S77-S82, 1992.

2. LEGGETT S, NELSON B, MOONEY V, ET AL. Successful management of chronic low back pain: A prospective multicenter study with one year follow-up. (in review)

3. NELSON B, O'REILLY E, MILLER M, ET AL. The clinical effects of intensive, specific exercise on chronic low-back pain: A controlled study of 895 consecutive patients with one year follow-up. *Orthopedics* 18(10): 971-981, 1995.

4. RISCH S, NORVELL N, POLLOCK M, ET AL. Lumbar strengthening in chronic low back pain patients: Psychological and physiological benefits. *Spine* 18(2): 232-238, 1993.

5. RUSSELL G, HIGHLAND T, DREISINGER T, ET AL. Changes in isometric strength and range of motion of the isolated lumbar spine following eight weeks of clinical rehabilitation. Presented at the Fifth Annual Meeting of the North American Spine Society, Monterey, CA, 1990.

6. SPITZER W, LEBLANC F, DUPUIS M, ET AL. Scientific approach to the assessment and management of activity-related spinal disorders: A monograph for clinicians. Report of the Quebec task force on spinal disorders. *Spine* 12(suppl 7): S1-S59, 1987.

7. FOSTER D, AND FULTON M. Back pain and the exercise prescription. *Clinics in Sports Medicine* 10(1): 197-209, 1991.

8. BIGOS S, BOWYER O, AND BRAEN G, ET AL. Acute low back problems in adults. Clinical Practice Guideline Number 14. AHCPR Pub. No 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December, 1994.

9. HALDEMAN S, CHAPMAN-SMITH D, AND PETERSEN D (EDS). Guidelines for chiropractic quality assurance and practice parameters: Proceedings of the Mercy Center consensus conference. Gaithesrsburg, MD, Aspen Publishers, 1993.

10. SPITZER W, SKOVRON M, SALMI L, ET AL. Scientific monograph of the Quebec task force on whiplash-associated disorders: Redefining "whiplash" and its management. *Spine* 20(suppl 8S): 1S-73S, 1995.

This document was prepared by a MUSC subcommittee task force from April to August, 1995. The guidelines were circulated to all MUSC members, voted upon, and approved for adoption in September, 1995. This document was mailed to all MedX practitioners in January of 1996.

Recommended Reading

Carpenter, D., Pollock, M., Graves, J., Leggett, S., and Foster, D. Effect of 12 and 20 weeks of resistance training on lumbar extension strength. *Physical Therapy* 71(8): 580-588,1991.

Graves, J., Pollock, M., Carpenter, D., Leggett, S., Jones, A., MacMillan, M., and Fulton, M. Quantitative assessment of full range of motion isometric lumbar extension strength. *Spine* 15(4): 289-294, 1990.

Graves, J., Pollock, M., Foster, D., Leggett, S., Carpenter, D., Vuoso, R., and Jones, A. Effect of training frequency and specificity on isometric lumbar extension strength. *Spine* 15(6): 504-509, 1990.

Highland, T., Driesinger, T., Vie, L., and Russell, G. Changes in isometric range of motion of the isolated cervical spine after eight weeks of clinical rehabilitation. *Spine* 17:6S: S77-S82, 1992

Leggett, S., Pollock, M., Shank, M., Carpenter, D., Holmes, B., and Fulton, M. Quantitative assessment and training of isometric cervical extension strength. *American Journal of Sports Medicine* 19(6): 653-659, 1991.

Mooney, V., Kron, M., Rummerfield, P., and Holmes, B. The effect of workplace based strengthening on low back injury rates: A case study in the strip mining industry. *Journal of Occupational Rehabilitation* 5(3): 157-167, 1995.

Mayhew, T., Rothstein, J. Measurements of muscle performance with instruments. In Rothstein, J. (Ed.) Measurement in Physical Therapy. New York: Churchhill Livingstone, 1985.

Nelson, B., O'Reilly, E. Miller, M., Hogan, M., Wegner, J., and Kelly, C. The clinical effects of intensive, specific exercise on chronic low back pain: A controlled study of 895 consecutive patients with a 1-year follow up. *Orthopedics* 18(10): 971-981, 1995.

Nelson, BW, DM Carpenter, TE Dreisinger, M Mitchell, CE KElly, JA Wegner. Can spinal surgery be prevented by aggressive strengthening exercises? A prospective study of cervical and lumbar patients. *Archives of Physical Medicine and Rehabilitation* 80(1):20-25 .

Pollock, M., Leggett, S., Graves, J., Jones, A., Fulton, M., and Cirulli, J. Effect of resistance training on lumbar extension strength. *American Journal of Sports Medicine* 17(5): 624-629, 1989.

Tucci, J., Carpenter, D., Pollock, M., Graves, J., and Leggett, S. Effect of reduced training frequency on lumbar extension strength. *Spine* 17(12): 1497-1501, 1992.

Office Procedures Recommendations

Third-party reimbursement is a key issue facing MedX clinicians. It take years to fully understand because of all the unknown rules that are constantly changing from insurance companies and state and federal agencies. Therefore, the basic approach must be one of common sense.

DevelopService and Fees

We recommend that if you're new to MedX-based therapy and medical exercise that you follow closely the standard treatment protocols outlined in this manual. The efficacy of these protocols has been well established. However, clinics may be set up differently and should therefore arrange the protocols accordingly.

Staffing

We recommend that you dedicate a full time equivalent (FTE) to pre-authorization/ verification and initial handling of all patient details/referrals (fee coordinator). This person will have the initial contact with the patients and should also have strong PR skills. In the competitive market of rehab it is not uncommon for patients to shop for health care.

You might also want to dedicate an FTE to abstracting. This person would be responsible for checking all abstracts as they are completed by the physician or therapists and post the bills to the computer.

Dedicate another FTE to billing and follow-up on collections with the insurance companies.

In smaller clinics the functions of the abstractor, biller and office manager could be combined or interchanged. For example, the abstractor could function as the office manager. We recommend to cross training each of these positions to assist each other. Another alternative would be to contract with an outside vendor for these services.

Recommended Procedures

1. Contact the patient upon receipt of referral to obtain insurance information (fee coordinator).

2. Pre-authorize or verify all insurance companies prior to treatrnent. Pre-authorize all work-comp cases. (fee coordinator)

3. After insurance has been authorized or verified, notify the patient by phone or mail as to their financial responsibility for each session, including an estimated cost for entire program and the initial appointment date. By advising the patient in advance, you will avoid any frustrations that may occur due to the patient being unhappy with the charges.

4. Develop a daily or weekly report on receivables. Determine which insurance companies pay promptly and those that do not, and how much money is written off in contractuals.

5. Invite the insurance company representatives to your facility for a presentation/ demonstra tion of your program. Insurance company education is vital in gaining reimbursement.

6. Make sure your program is fundamentally sound and fees are structured appropriately to limit difficulty collecting fees. However, if a particular insurance company won't authorize treatment then treat the patient on a cash basis, if the patient will agree. Enlist the help of the patient in lobbying his or her insurer.

7. Send written S.O.A.P. notes with rehab billings and written test reports and graphs with test billings.

Red Flags

1. Do not bill the same code excessively for the same session, particularly using different descriptors.

2. To keep total cost down, consider cost reduction for multi-services performed the same day.

3. Always justify patients that are beyond normal protocols for excessive lengths of time.

4. Do not use a generic diagnostic code with each treatment. There are many conditions treatable with MedX and therefore the proper diagnosis should be used.

5. Assure that all diagnoses match with the service rendered.

6. The MedX tool is a physical medicine/therapy modality and should be authorized as such under the provision of a physician, physical therapist, or chiropractor.

7. Avoid tacking on charges for cryotherapy etc.

Offer this as a free service when rendered with MedX or possibly a one-time charge for an ice pack that the patient can take home with them.

Other Recommendations

1. Front office personal should be well versed with the product or service that you are offering. Staff must appear to be knowledgeable about the program whether they are in contact with patients, insurance or physicians.

2. Promote your program. Make advertising an integral part of the budget, and track results so that you can improve.

3. Offer seminars, luncheons, open houses or even isolated meetings with the insurance claims adjuster.

4. Develop materials that can be mailed to insurance carriers to clearly identify your program goals and objectives and fee structure.

5. Collect all co-pays upon rendering each service.

CPT Codes

The following information is not meant to be conclusive, but merely a starting point in your own investigation to ascertain third-party reimbursement for services involving MedX treatment protocols and equipment. Insurance billing depends on a host of variable factors such as diagnosis, treatment plan, credentials, geographic location, etc. This is why precise billing information remains your responsibility and is independent of your purchase of MedX equipment.

With this in mind, feedback from our customers indicates commonly used basic coding:

CPT CODE:

97001 - Physical therapy evaluation

97110 - Therapeutic Procedures/Exercises to develop strength and endurance - @ $_____/unit

97750 - Physical performance testing or measurement w/written report, usual IM - @ $_____/unit

95851 - Range of Motion measurements, and report (separate procedure); each trunk section (spine), $_____/unit

97530 - Therapeutic activities, direct (1 on 1) Patient contact. Dynamic activities to improve functional performance ...can be used 2X/6 mo; alternate code for IM testing or other testing - @$35-45/unit

97535 - Self care/home management training - @ $_____/unit

The Procedure codes listed above may be utilized in timed units. Typically, time units are a minimum of 8 minutes, up to 15 minutes. Most coverages limit number of useable units per visit, or per week, or per whatever time interval. We encourage you to check with your billing specialist to make sure your CPT Codes are current.

Again, please remember this information is intended to expedite your own investigation and evelopment of a workable plan for your practice. Applicability of billing codes will vary according to your diagnosis and treatment protocol.