

PHYSICAL MEDICINE GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2019 Edition of the American Medical Association's *Physicians' Current Procedural Terminology*, Fourth Edition (CPT®-4), including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule CPT® codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT®-4 are preceded by an AZ identifier and numbered in the following format: AZ0xx-xxx. Additional information regarding publications adopted by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to the CPT® guidelines and represent additional guidance from the Commission relative to unit values for these services. To the extent that a conflict may exist between an adopted portion of the CPT®-4 and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

General requirements in reporting services are found in the Introduction of the Fee Schedule. In addition to the definitions and commonalities preceding the coded medical procedures, several other requirements unique to this Section on PHYSICAL MEDICINE are defined or identified as follows:

- A. During the course of physical medicine treatments, only one evaluation and management billing is allowed per week, except that the following evaluations are allowed once every two calendar weeks: 97164, 97168, and 97172. Additional billing for evaluation and management procedures may be allowed when specific additional services are warranted. Approval of the payer must be obtained prior to performing additional services.

IT IS IMPORTANT TO NOTE THAT THESE LIMITATIONS DO *NOT* APPLY TO REFERRING PHYSICIANS OR TO PHYSICIANS WHO TREAT PATIENTS ONCE PER MONTH.

- B. When multiple modalities (97010* through 97039) are performed, the first modality is reported as listed. The second modality is identified by adding modifier “-51” to the code number. The second and each subsequent modality should be valued at 50% of its listed value.

100% - Full value for the first modality

50% - For the second and additional modalities

*97010 is always bundled in the payment for another Physical Therapy Service.

Any more than 5 additional modalities or therapeutic procedures must have prior approval of the payer.

Example: During a visit a patient receives the following care; therapeutic exercise (97110) for 45 minutes, mechanical traction (97012), electrical stimulation (97014) and moist heat (97010). Under the multiple procedure rule, you would bill 100% of the total value for (97110) therapeutic exercise (\$56.23 x 3), 100% of the total value for (97012) mechanical traction (\$27.15 x 1) and 50% of the total value for (97014) electrical stimulation (\$27.15 x 50%) and 0% (zero percent) for moist heat (97010), for a total billing of \$209.42.

- C. Codes 97110 – 97150 and 97530 -97546 are not subject to the multiple procedure rule and shall be paid at 100% of their listed value. When performing therapeutic procedure(s), excluding work hardening (97545/97546) and Functional Capacity Evaluation (FCE)(97750), a maximum of 60 minutes is allowed each day. Approval must be obtained by the payer prior to performing therapeutic procedures in excess of 60 minutes.
- D. The values for codes in this section apply to provider's time, expertise and use of equipment. Medications and disposable electrodes used in these procedures should be considered supplies, code 99070, (see item 1, Guidelines for Medicine Section regarding billing for supplies).
- E. A work hardening program is limited to 6 1/2 hours per day, not to exceed a 6 week period of time.
- F. The payer has the right to require documentation to establish that a modality or therapeutic procedure was performed. Inasmuch as these Guidelines allow for re-evaluations to be performed every two weeks, it is at that time the medical provider should be required to address the success of the treatment protocol, i.e. improvements or lack of improvements regarding stamina, flexibility and strength.

It is not appropriate for the payer on a per billing basis to require a medical provider to provide unnecessary detailed documentation to justify payment. A medical provider is required to comply with A.R.S. § 23-1062.01 when submitting a bill. For example, the purpose of modalities like hot and cold packs, paraffin baths, and whirlpools are straightforward. Modalities are utilized as a sub-element of the over-all treatment protocol to prepare the injured worker for therapy or to minimize the impact of the therapy on the injured worker. Other than a statement that certain modalities were performed, any additional documentation such as the purpose of the application of modalities, resulting flexibility or comfort is unnecessary. Additionally, listing the amount of weight an individual is lifting, repetitions, and sets is, again, unnecessary. During a re-evaluation visit, the medical provider should provide documentation regarding changes in strength, stamina, and flexibility.