PHYSICAL MEDICINE GUIDELINES

The general guidelines and modifiers found in the 2009 CPT®-4 were adopted by reference by the Industrial Commission and are applicable when utilizing Arizona's Physicians' Fee Schedule. The following Commission guidelines are in addition to the CPT® guidelines and represent additional guidance from the Commission relative to the use of certain procedures and their unit value for these services. To the extent that a conflict may exist between the adopted portions of the CPT®-4 and a code or guideline unique to Arizona, the Arizona code or guideline shall control.

Items used by all physicians in reporting their services are presented in the INTRODUCTION. In addition to the definitions and commonalities preceding the coded medical procedures, several other items unique to this section on PHYSICAL MEDICINE are defined or identified here:

1. During the course of physical medicine treatments, only one evaluation and management billing will be allowed per week, except that the following evaluations are allowed once every two calendar weeks; 97002, 97004 and 99213 Additional billing for evaluation and management procedures may be allowed when specific additional services are warranted. Approval of the insurance carrier or self-insured employer 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.

2. 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 the appropriate percent of its listed value as shown below:

   100% - Full value for the first modality
   50% - For the second modality
   25% - For the third modality
   10% - For the fourth modality
   5% - For the fifth modality

   Any additional modalities or therapeutic procedures must have prior approval of insurance carrier or self insured employer.

   Example: During a visit a patient receives the following care; therapeutic exercise (97110) for 45 minutes, mechanical traction (97012), and moist heat (97010). Under the multiple procedure rule, you would bill 100% of the total value for (97110) therapeutic exercise ($31.78 x 3), 100% of the total value for (97012) mechanical traction ($16.40 x 1) and 50% of the total value for (97010) hot pack ($12.00 x .50%), for a total billing of $117.74.

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3. Codes 97110 - 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, a maximum of 60 minutes is allowed each day. Approval must be obtained by the insurance carrier or self-insured employer prior to performing therapeutic procedures in excess of 60 minutes.

4. 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).

5. Work hardening program is limited to 6 1/2 hours per day, not to exceed a 6 week period of time.

6. The insurance carrier/self-insured employer has the right to require documentation to establish that a modality or therapeutic procedure was performed. Inasmuch as the 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 insurance carrier or self-insured employer 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 re-evaluation visit, the medical provider should be providing documentation regarding changes in strength, stamina, and flexibility.

7. In the text of the Fee Schedule, we utilize * and ** to denote "add-on" codes and those codes that are exempt from the multiple procedure rule.

   a. * Denotes Add-On Codes

   (List separately in addition to code for primary procedure)

   Note: This code is an add-on procedure and as such is valued appropriately. Multiple procedure guidelines for reduction of value are not applicable.

   b. ** Denotes Codes Exempt from Modifier "-51"

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Note: Multiple procedure guidelines for reduction of value are not applicable for this code.

The Industrial Commission of Arizona has retained unique codes that deal with the Arizona workers' compensation program. These services involve administrative and billing procedures and are identified by a "Δ". Code 97799, while not unique to Arizona, has unique Arizona language not in CPT.

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