

Traction



Traction is used to treat a variety of musculoskeletal disorders of the neck and back, including muscle spasm, radiculopathy, discogenic pain and degenerative changes. Although most insurance plans do cover traction (Saunders cervical is a Medicare covered benefit), clinicians can increase the likelihood of reimbursement by ensuring that the patient's medical record contain items such as a description of the condition(s) that justify medical necessity for a traction device. Many payors request that a Letter of Medical Necessity be completed by the treating physician. An Empi Representative will contact you directly if documentation for claim submission is required.

The following documentation is recommended:

- Diagnosis that describes the patient's condition(s) (examples include: radiculopathy, neck/back pain, muscle spasm)
- Evidence of treatments that have been attempted and failed (i.e. medications, physical therapy)
- Evidence that treatment with supine traction of at least 20# has been beneficial
- Description of an underlying TMJ condition which may be aggravated by halter type (over the door) traction.
- Follow-up visit notes documenting patient benefit from the device (i.e. improved range of motion, decreased pain, decreased medication or improved sleeping/ working patterns)

Code

Description

97012

Application of modality to one or more areas traction mechanical

CCI EDITS for TRACTION

97012

97002 PT reevaluation

GUIDELINES TO CPT® CODES FOR EMPI PRODUCTS

EMPI has compiled this coding information for your convenience. Every reasonable effort has been made to provide all commonly billed codes that may be applicable to procedures involving the cleared uses of Empi's products. It is ultimately the provider's responsibility to determine coverage, and submit appropriate codes, modifiers and charges for the services rendered. The clinician must use independent clinical judgment in choosing codes that most accurately describe the products and/or services provided. Empi makes no representation, guarantee or warranty, expressed or implied, that this compilation is error-free or that the use of this information will prevent differences of opinion or disputes with Medicare or other third-party payers, and will bear no responsibility or liability for the results or consequences of its use.

The clinician should also be aware that codes can change over time and/or interpretations of whether a code is properly used in a particular situation is often subject to medical policy interpretation and judgment. There is no guarantee that a local carrier/payer will cover the codes or pay the reimbursement amounts stated in this document. Local carriers/payers frequently change their reimbursement policies and interpretations. Providers should contact the local carriers/payers for their current interpretation of coverage and coding policies. The key in all coding and billing to the federal government is to be truthful and not misleading and make full disclosures to the government in all attempts to seek reimbursement for a product and/or service.

Documentation recommendations are only guidelines to help our customers to properly document for coverage of medically necessary treatments when using our products. The clinician must use their own judgment when documenting treatment plans assessments.

Empi's customer service department will handle all insurance verification for you, and our reimbursement department can answer any questions that may arise regarding coverage and coding. Empi works with almost all insurance companies, covering approximately 110 million lives.

We hope the following information will assist you in getting the best outcomes and reimbursement when using the Empi product line.

Empi

Your Partner In Rehabilitation and Pain Management



1 Current Procedural Terminology© 2005 American Medical Association. All Rights Reserved.

2 Ingenix (2004), HCPCS Level II, 2005 Expert. Salt Lake City, St. Anthony Publishing/Medicode.

3 The National Medicare allowable is determined by multiplying the physician fee schedule conversion factor [for year 2005, \$37.89750 by the total non-facility RVU. 69 Fed Reg (November 15, 2004)]