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Spinal Decompression Coding: Are Insurers Being Fair?

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As consultants for doctors who provide traction/decompression services and as postgraduate instructors on traction/decompression coding and marketing compliance, nothing happens in the spinal decompression arena without us (my wife and practice partner, Dr. Cynthia Vaughn, and I) hearing about it within hours.

A great deal has occurred since my first article on spinal decompression therapy, which appeared in the Feb. 12, 2007 issue of *Dynamic Chiropractic*. (See "Spinal Decompression 101": www.chiroweb.com/archives/25/04/03.html.) Perhaps the most important change is the ever-shifting position of insurance companies as they attempt to develop some kind of consistent policy regarding the appropriate coding of spinal decompression services.

While some carriers are all over the map on this issue, we remain convinced that the two appropriate codes for spinal decompression therapy are 97012 (traction), which will result in very limited reimbursement under insurance policies, and S9090 (Vertebral Axial Decompression), which usually will result in no reimbursement, but allow the doctor to collect from the patient. The validity of those codes is not just our opinion; it's the official position of the American Chiropractic Association. (To review the ACA's official coding policy on vertebral axial decompression, go to: www.marketdts.com/aca.doc.)

Most carriers are now echoing the advice we have been giving our clients. The position of Blue Cross Blue Shield of Louisiana reads as follows:

> "Spinal Decompression Therapy Devices: Services performed utilizing any type of spinal decompression therapy device must be billed with HCPCS code S9090. Blue Cross considers these services to be investigational. They are not payable and providers may bill the patient for these services. Blue Cross considers Vax-D, Triton DTS and 3-D Autotrack devices to be 'decompression therapy devices.' Audits conducted by Blue Cross that reveal the utilization and payment of particular machine charges may result in recoupments."

Blue Cross Blue Shield of Kansas City concurs. Below are the pertinent points from their May 18, 2007, communication to their contracted providers:

> "This is an important notice from Blue Cross and Blue Shield of Kansas City (BCBSKC) that vertebral axial decompression treatments are considered investigational and therefore not covered. The use of improper codes for these services could result in severe sanctions, including contract termination.
>
> "BCBSKC recently reviewed claims data related to vertebral axial decompression services. As a result of our review, we identified claims for vertebral axial

> decompression that were incorrectly coded as traction (CPT 97012). Vertebral axial decompression treatment sessions are accurately represented by HCPCS S9090, which clearly indicates 'vertebral axial decompression, per session."
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> "Again, BCBSKC does not provide coverage for vertebral axial decompression. Regardless of available coverage, all services reported on a claim must be accurately identified by appropriate CPT, HCPCS and/or ICD-9 codes and must be supported by the medical record documentation. BCBSKC relies on providers in the medical community to accurately code claims reflecting services provided so member benefits can be correctly applied. We expect vertebral axial decompression services to be billed appropriately as S9090."

But here's the "rub." While we agree with BCBSKC that S9090 is the most appropriate code, we strongly disagree with the following statement in their letter:

> "For vertebral axial decompression services, treatment sessions include all the therapeutic modalities performed in preparation for the service, as well as the actual decompression therapy and the post-decompression modalities performed to recover from the service."

That means any hot/cold packs (CPT 97010), infrared treatments (CPT 97026), therapeutic exercise procedures (97110), and/or therapeutic activities procedures (97530) would be denied if performed on the same date of service.

In truth, this assertion is a giant leap for them to attempt to make. Upon review of the *Current Procedural Terminology* codebook, nothing in the descriptors for any of these aforementioned procedures or services suggests that they are provided to "recover from" a decompression session. Rather, those treatments are quite clearly stand-alone procedures performed for an entire host of possible conditions and illnesses. A carrier might win this argument only if the provider indicated somewhere in documentation that the services were provided "to relieve soreness caused by application of the decompression service." Without question, most doctors provide these services to address the inflammation/symptoms associated with the patient's degeneration/herniation. Hopefully, BCBSKC will soon be challenged on their flawed policy and change it.

Now let's discuss the managed care entity with the most ridiculous policy regarding vertebral axial decompression. Without question, that distinction goes to the ACN/Great West/Golden Rule/United HealthCare multi-headed monster.

While the ACN is attempting to terminate our provider contracts on the basis that we offer decompression services, we have obtained a claim form that submitted "Vertebral Axial Decompression" (S9090) to Great West, along with Great West's EOB that reimbursed the provider for the service! Moreover, another client has informed us that Golden Rule/United Healthcare/ACN covers the S9090 service at the "negotiated rate" of zero. As a result, the provider is prohibited from collecting any payment from the patient! We find it disgustingly inconsistent to attempt to terminate the contracts of some providers while at the same time "covering" the service for other providers.

Should you have any questions regarding decompression coding/marketing compliance, please do not hesitate to contact me.