Dynamic Chiropractic

BILLING / FEES / INSURANCE

How Do You Code for Spinal Decompression?

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Q: I have a new spinal decompression unit and have been told I can bill for heat, therapeutic activities, electrical stimulation, joint mobilization and exercise when I use it.

That seems odd to me, since it is a traction device. Is there a code for using this machine?

A: Spinal decompression machines - vertebral axial decompression - have become quite popular and appear to be offering some positive responses to disc patients, at least empirically. But for insurance billing purposes, spinal decompression does not have a specific CPT code to describe the services of spinal decompression. In the HCPCS coding system, there is a code to describe "vertebral axial decompression," and that code is S9090. The code is noted as "per session" and indicates the amount of time or number of regions for which the unit is used, which is not relevant to its billing. In other words, it is billed once per treatment session.

Based on the code that best describes the service, S9090 certainly fits that category. I recently received information from several California providers that they were getting reimbursed $140 a session for S9090 from Blue Cross. I am concerned that these payments will later be reviewed and further payments for the code will not be made. The code S9090 has been around for a few years and, when initially introduced, was being paid by many Blue Cross and Blue Shield plans. However, payments did not persist and were eventually denied.

These denials were based on the Medicare (CMS) ruling that spinal decompression had insufficient data to support the benefits of its use. Manufacturers of the devices use as a sales tool the fact that spinal decompression units are FDA-approved, which they are. However, FDA approval does not necessarily equate to efficacy of use and the service may still be denied as not reasonable or necessary.

I have researched several insurance carriers and have found that AmeriHealth, Blue Cross and Blue Shield, CIGNA Health Care, UNICARE, United Healthcare, Regence and Humana all note the billing for a spinal decompression unit should be with S9090. Medicare requires the use of 97799; "unlisted physical medicine/rehabilitation service," with modifier GY and the explanation in block 19 of the 1500 form to state "VAV-D."

While the code S9090 is the one stated by most carriers to use, they also may have a policy that it is not to be reimbursed, noting the CMS stance on the service. This is quite the "catch-22" - you can use it, but we are not paying you for it. There is a policy from United Health and ACN Group that allows the provider to choose between S9090 and the code 97012. (97012 is the CPT code for mechanical traction.) While they will not pay for S9090, they will pay for 97012. The downside is the fee for 97012 is typically substantially less than what most providers bill for S9090. That ratio of billing for 97012 would be 15 percent to 25 percent of what is normally charged for S9090. One may choose to not use 97012 and use S9090, have the claim denied, and consequently bill the patient directly for spinal

decompression. This assumes that the provider is not a member of the plan, or is allowed to bill the insured (patient) for services not covered or denied under the plan benefit.

Spinal decompression appears to show great promise. I have some personal experience, with positive results. But while it is called "spinal decompression," it is, in my opinion, a form of mechanical traction. In that sense, it is still a "mouse trap," albeit a better one. Therefore, considering the lack of reimbursement for S9090, the future may hold more consistent reimbursement from 97012. The drawback is the high cost of the decompression devices and the ability of the provider to utilize them and generate enough reimbursement to justify cost.

As far as using codes for electrical stimulation, joint mobilization, therapeutic exercise or therapeutic activities, those codes would be inappropriate if used to code spinal decompression. Those services are individual modalities or procedures that are distinct services, which would require separate performance from the spinal decompression. Unless that is the case, do not bill for those services, as they are not included as part of spinal decompression and they do not describe spinal decompression.

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