

Iontophoresis



Iontophoresis is a method of active transdermal drug delivery and is defined as the introduction of a chosen ion into the tissues by means of an electrical current. It is either administered in clinic with DUPEL B.L.U.E., or using Action Patch. Insurance coverage and reimbursement for iontophoresis varies by state. Clinicians can increase the likelihood of reimbursement by ensuring the patient’s medical record includes specific items. Among these items is a description of the condition(s) that justify medical necessity for iontophoresis.

The following documentation is recommended:

- Diagnosis that describes the patients condition(s)
- Documentation of how treatment is benefiting patient (improved outcomes, functional gains, reduced medication)
- Other treatments that have been tried and failed
- A prescription specifying iontophoresis and compound written by the treating physician

Code	Description
*97033	Application of modality one or more areas; Iontophoresis each 15 minutes

*Note: It is recommended to verify patient’s policy guidelines to insurance coverage for this procedure. Some states will allow for 99070 (miscellaneous code for supplies) – Check policy in your state

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)]