

Advance (Range Of Motion)



Dynamic splinting is an adjunctive home based treatment for patients struggling to regain range of motion. This therapy may be used with either orthopedic or neurological conditions. These could include post-surgical immobilization, fracture, CVA, burns, cerebral palsy, and below knee amputation. Although most insurance plans do cover the Advance device it is recommended that the patient's medical record include documentation of the condition(s) that justifies medical necessity for an Advance 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: fracture, post operative contracture, etc.)
- Description of treatments that have been attempted and failed (i.e. joint mobilization, physical therapy, stretching etc.)
- Current range of motion limitation
- Follow-up office visit notes documenting the benefit the patient has received from the device (i.e. improved range of motion)

| Code | Description |
|-------|---|
| 97504 | Orthotics fitting and training, upper extremity, lower extremity and or trunk each 15 minutes |
| 97703 | Checkout of orthotic/prosthetic use, established patient, each 15 minutes |

CCI EDITS for ADVANCE

97504

- 97110 Therapeutic procedure one or more areas, each 15 minutes
- 97112 Neuromuscular reeducation of movement balance for sitting/standing activities
- 97116 Gait training
- 97001 PT evaluation
- 97002 PT reevaluation
- 97755 Assistive technology assessment
- 97703 Checkout for orthotic/prosthetic use, established patient each 15 minutes

The Correct Coding Initiative (CCI) was developed by the Centers for Medicare & Medicaid Services (CMS) to prevent payments from being made due to inappropriate HCPCS (Healthcare Common Procedure Coding System) code assignment.

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)]

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



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