

WYOMING WORKERS' COMPENSATION DIVISION CHIROPRACTIC UTILIZATION GUIDELINES FOR THE CARE AND TREATMENT OF INJURED WORKERS IN CONSULTATION WITH THE CHIROPRACTIC ADVISORY PANEL DEPARTMENT OF WORKFORCE SERVICES

Chiropractic Introduction

Mission Statement

To ensure professionally appropriate chiropractic care within the scope of practice while adhering to the Wyoming Workers' Compensation statutes, rules and regulations. It is the intent of the Chiropractic Advisory Panel to ensure professional care management process that serves the injured worker, the Doctor of Chiropractic, and Employers in the State of Wyoming.

History

- A. The Chiropractic Advisory Panel was formed to assist the Workers' Compensation Division in meeting its statutory obligations. The formation of guidelines and protocols is intended to help clarify and govern the review and payment of Chiropractic claims.

- B. A Chiropractic Review panel consisting of three (3) members will be appointed by the Administrator after an interview process and recommendation by the Wyoming Chiropractic Association. Whenever it may become necessary to appoint a completely new review panel of three (3) members, the terms of those members will be on a staggered basis with one member serving a one (1) year term, one member serving a two (2) year term and one member serving a three (3) year term. After establishment of a new panel, any appointment or re-appointment of a panel member will be for a term of three (3) years. If a panel vacancy arises for an unexpired term, a new member will be re-appointed for the remainder of the unexpired term. No panel member may serve more than two (2) consecutive terms. Panel members must reside and practice chiropractic fulltime within the State of Wyoming. If applicable, panel members must be in good standing with the Wyoming Unemployment and Workers' Compensation Divisions. The Chiropractic Review Panel will provide guidance to the Wyoming Workers' Compensation Division on utilization matters and standard of care, and will function as peer review for the Division on chiropractic matters when requested. Panel members must accept Wyoming Workers' Compensation patients for treatment and Division fee schedules for payment of such treatment. Panel members must be cognizant of potential conflict of interest issues and recuse themselves from acting in any matter in which a conflict exists. Panel Members will be reimbursed for mileage and per diem according to the State of Wyoming established rates, for service performed on behalf of the Workers' Compensation Division. Panel members will be paid an hourly fee for their service on behalf of the Division as established by the Administrator. The Panel will meet when requested by the Division.

Authority

Doctors of Chiropractic may elect to provide care for injured Wyoming workers. Those providers who elect to serve patients within the Wyoming Workers' Compensation system must practice in a manner consistent with these guidelines. The authority for these guidelines is derived from the Wyoming Workers' Compensation Rules, Regulations and Fee Schedules, Chapter 8 Section 1, which states;... **The Division adopts...Chiropractic Utilization Guidelines for the Care and Treatment of Injured Workers, which will be used in its evaluation and payment of...chiropractic claims...**

Goal of Chiropractic Treatment

The goal of treating the injured worker is to return him/her to pre-injury function or M.M.I. As part of the assessment, the Doctor of Chiropractic's focus will be on identifying functional deficits that are causing impairment, recording them and documenting treatment and progress.

Fee Schedule

All bills and fees submitted for payment will be reviewed and audited for relatedness, appropriateness, and reasonableness in accordance with the adopted **Wyoming Workers' Compensation Rules and Regulations and Fee Schedules**.

Billing Guidelines

Chiropractic billing guidelines and fee schedule found at: <http://www.wyomingworkforce.org/service-providers/Pages/default.aspx>

For assistance with coding or billing issues you may also call 307-777-6982.

Medical Records

Health care is dependent on quality data. Good decisions are the result of accurate and complete facts being retrievable from a patient's record. **Incomplete, illegible, or ill prepared records will not be accepted**. Notes lacking patient specific information will not be accepted. Records must accurately reflect the current status of each patient, treatment goals and future treatment recommendations.

1) Written Reports

To receive payment for chiropractic treatment of injured workers, Chapter 10, Section 20 of the Workers Compensation Rules and Regulations must be complied with and shall include:

a) For the first report use Health Care Providers Initial Medical Report MEDRPT revised 08/12 <http://www.wyomingworkforce.org/Documents/WSCD-CSS/hcp%20initial%20rpt.pdf> and the Exam/Re-exam form found at: <http://www.wyomingworkforce.org/Documents/WSCD-CSS/hcp%20initial%20rpt.pdf>

b) Daily Progress Notes: Soap Note Format (must be legible to anyone)

- i) Subjective complaints: The patient's complaints must be recorded at each visit (in the patient's own words when possible) indicating improvement, worsening or no change and a numerical pain scale 0-10.
- ii) Objective Findings: Clinical signs of a condition must be noted at each visit in the doctor's own words and supported by objective data.
- iii) Assessment or diagnosis: It is not necessary to update this category each visit.
- iv) Plan/Procedure: A plan of management must be made and maintained with the goal of returning the patient to work. Contemporaneous recording of procedures performed must include descriptions of manipulations performed, soft tissue techniques, modalities used with documentation to include area of treatment (body part), duration and who performed modality, exercises prescribed or prescribed diet and activity instructions and patient compliance or non-compliance.

c) **Re-exams at approximately every four (4) weeks of care**

- i) Use Division re-exam form found at: <http://www.wyomingworkforce.org/Documents/WSCD-CSS/hcp%20initial%20rpt.pdf>.
- ii) Re-examination notes are required for all treatments, including acupuncture.
- iii) Computerized office notes may be substituted if ALL the required information is included. Notes must be titled "Initial Exam" or "Re-exam Notes."

d) **Discharge**

- i) Injured workers who have undergone a course of care and are considered to be at either pre-injury status or MMI should be discharged from active care.
- ii) Non-compliance with and/or non-attendance of established treatment protocols and Doctor of Chiropractic recommendations must be documented and immediately reported to the Division.

Section 2

1) Treatment Parameters

- a) The Doctor of Chiropractic shall prepare a diagnosis based treatment plan, which includes specific treatment goals with an estimated time frame for completing, taking into consideration that the rate of healing varies from individual to individual and any complicating factors that could change the expectation of healing rate.
 - i) **Repair and Remodeling Phase** – Usage of more than one care session per day may constitute accepted clinical practice for selected conditions with supporting documentation. Treatment needs usually decrease with patient progress. Use of modalities or procedures in addition to manipulation with the initiation of rehabilitation may be used when beneficial to the patient. If therapy does not produce the desired effect within thirty(30) days, continued use would not be clinically indicated.
 - ii) **Rehabilitation/Stabilization** – Treatment needs usually continue to decrease with patient progress, therefore modality use decreases or is eliminated. Rehabilitative procedures are encouraged during this phase of care. The patient should reach pre-injury status during this phase of care and should be discharged from active chiropractic care. The Doctor of Chiropractic should provide a closing exam to determine the patient's level of recovery and determine if the patient has reached pre-injury status or MMI.
 - iii) **Exacerbation** – In the event of an exacerbation or re-injury, the attending Doctor of Chiropractic must document said incident according to date, etiology, updated subjective and objective findings, updated diagnosis, prognosis, and treatment plan.
 - iv) **Supportive Care** – The patient will be considered eligible for supportive care after the patient has reached MMI AND has received an impairment rating. Supportive care will consist of 1-2 visits per month but not to exceed 4 visits per month. The monthly Re-exam documentation is not required for approved supportive care. Documentation for continued supportive care may be requested and reviewed on a case by case basis.

Section 3

1) General Guidelines

- a) The Division will pay for an initial and discharge examination. It is expected that the Doctor of Chiropractic will perform periodic re-examinations (approximately 3-4 weeks) to show progressive benefit of care. A re-examination should be performed in the event of an exacerbation. These re-examinations will also be paid.
- b) Chart notes and supportive documentation must be attached to each billing. All ICD diagnosis codes and CPT treatment and procedural codes must be validated in the patient chart and coordinated as to the diagnosis and treatment code descriptors. All records must be legible and understandable. Uniform chiropractic language should be used for describing care and treatment. Non-standard abbreviations and indexes should be defined.
- c) Complete, appropriate, orderly and timely billing is required to receive a timely and correct payment.
- d) The nationally accepted CMS (formerly known as HCFA) billing 1500 form must be completed in detail. This means all required fields must be completed. Patient's name, social security number, address, date of birth, sex, county where injury occurred, case number, date of injury, employer's name, ICD code, itemized CPT codes, total charges, Doctor of Chiropractic's name, address, and date claim was filed. Completed claims are submitted to: Wyoming Workers' Compensation Division, PO Box 2661, Portland, Oregon 97208.

Section 4

Billing and Coding

Bills for services to Workers Compensation claimants must be submitted using the following codes:

Billing and Coding

1) E&M services.

- a) **CODE 99201** Office or other outpatient visits for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision-making. Counseling and / or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and / or family's needs. Usually, the presenting problems are self-limited or minor. Doctors of Chiropractic typically spend 10 minutes face-to-face with the patient and / or family.
- b) **CODE 99202** Office or other outpatient visits for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination, and straightforward medical decision-making. Counseling and / or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and / or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Doctors of Chiropractic typically spend 20 minutes face-to-face with the patient and / or family.

- c) **CODE99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate severity. Doctors of Chiropractic typically spend 30 minutes face-to-face with the patient and/or family.
- d) **CODE99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate to high severity. Doctors of Chiropractic typically spend 60 minutes face-to-face with the patient and/or family.
- e) **CODE 99211** Office or other outpatient visits for the evaluation and management of an established patient that may not require the presence of a Doctor of Chiropractic. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
- f) **CODE 99212** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components; a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and / or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and / or family's needs. Usually, the presenting problem(s) are self-limited or minor. Doctors of Chiropractic typically spend 10 minutes face-to-face with the patient and / or family.
- g) **CODE99213** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of low to moderate severity. Doctors of Chiropractic typically spend 15 minutes face-to-face with the patient and/or family.
- h) **CODE99214** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; a detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate to high severity. Doctors of Chiropractic typically spend 25 minutes face-to-face with the patient and/or family.
- i) **CODE 95851** Range of motion measurements and report, each extremity (excluding hand) or each trunk section (spine)
- j) **CODE 95852** Range of motion measurements and report for the hand, with or without comparison with the normal side.

- k) **CODE 95832** Muscle testing, manual (separate procedure) with report of the hand (grip strength), with or without comparison with the normal side.
- l) **CODE 95831** Muscle testing, manual (separate procedure) with report of the extremity (excluding hand), or trunk.

2) Diagnostic Radiology

- a) All injured areas are compensable.
- b) Codes include technical and professional component.
- c) **CODE 72020** Radiologic examination, spine, and single view, specify level. If billed 72020 and 72040 on the same date of service, the 72020 will be denied as it is usual and customary practice to include the AP open mouth within the 72040 x-ray code.
- d) **CODE 72040** Radiologic examination, spine, cervical; two or three views
- e) **CODE 72050** Radiologic examination spine, cervical; minimum of four views
- f) **CODE 72070** Radiologic examination, spine; thoracic, two views
- g) **CODE 72082** Radiologic examination, spine, entire, thoracic, lumbar, cervical, and sacral spine; two or three views
- h) **CODE 72100** Radiologic examination, spine; lumbosacral; two or three views If billed 72020 and 72100 only 72100 will be paid. St. Anthony's RVS states that this code reflects two or three views which would incorporate the L5-S1 spot, also known as "conedown".
- i) **CODE 72110** Radiologic examination, spine; lumbosacral; minimum of four views * IF BILLED 72040, 72070 AND 72100 THE CODES WILL BE COMBINED AND PAID AS CODE 72082.

3) CMT and Therapeutic modalities

- a) **CODE 2099** Dry Needling is a physical intervention to stimulate trigger points. It's used as a diagnostic tool and to treat neuromuscular pain and functional movement deficits. The approach is based on Western anatomical and neurophysiological principles. Dry needling is not the same as acupuncture, which is a Chinese medicine technique. Medical doctors, physiotherapists, chiropractors and acupuncturists are using dry needling in their practices for treatment of myofascial pain and dysfunction. Dry needling is considered to be within the scope of practice for chiropractors in the state of Wyoming, according to the Wyoming State Chiropractic Board. Chiropractors must show a minimum of 25 hours of face to face dry needling course study prior to using the dry needling technique. The billing code for dry needling per the Wyoming Division of Workers' Compensation is: 20999 – Trigger Point Dry Needling
Billable in 15 min. increments
- b) **CODE 98940** Chiropractic manipulative treatment (CMT); spinal, one to two regions

- c) **CODE 98941** Chiropractic manipulative treatment; spinal, three to four regions
- d) **CODE 98942** Chiropractic manipulative treatment; spinal, five regions
- e) **CODE 98943** Chiropractic manipulative treatment; extra spinal, one or more regions. This code can be used by itself or in conjunction with a spinal CMT code. When used on the same day as another CMT code, the extra spinal code should have a “51” modifier and will be paid at 50% reduction.
- f) **CODE 97140** Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes. This code is a duplicate service when performed to the same compensable region as CMT (98940, 98941, 98942, 98943). The 97140 code encompasses a range of manual techniques, including, but not limited to, joint mobilization / manipulation, manual lymphatic drainage, manual traction, and manual soft tissue mobilization. If CMT and Manual Therapy (97140) are provided to separate compensable body regions, the codes will not be considered as a duplicate service. A “59” modifier should be added to the 97140 code to indicate a separate procedure. Since this code can include massage services, use of this code in the same compensable region as a massage code on the same encounter and will not be considered for reimbursement. If massage and manual therapy are provided to separate compensable body regions, the code will not be considered as a duplicate service. A “59” modifier should be added to the 97140 code to indicate separate procedure.
- g) **CODE 99050** Services requested after posted office hours in addition to basic service, and
- h) **CODE 99054** Services requested on Sundays and Holidays in addition to basic service Documentation must describe special circumstances under which extraordinarily unusual weekend or holiday appointments were medically necessary. These codes are intended to be reported for practices whose usual posted hours do not ordinarily included weekends or holidays.
- i) **CODE 97010** Application of a modality to one or more areas; hot or cold packs. If superficial heat is provided simultaneous through the predominant modality (i.e., traction tables, hydro tables, mechanical massage tables, whirlpool, etc.) no additional charge shall be made for hot packs (97010). The simultaneous application of superficial heat through a predominant modality, to the same region, during the same period of time, does not add value to the basic service performed.
- j) **CODE 97012** Application of a modality to one or more areas; traction, mechanical. Traction performed by use of mechanical means to effect elongation of soft tissue to increase joint mobility
 - i) Time to produce effect: 2 – 4 treatments.
 - ii) Frequency of treatment: 3 – 5 times per week.
 - iii) Documentation must state “mechanical” traction. Flexion/distraction, Intersegmental Distraction, Cox, Leander are considered techniques that would be inclusive in the manipulative codes (98940, 98941, 98942). In office mechanical traction will be considered a duplication of service and will not

be reimbursed when the patient is performing home traction to the same treatment area. Vertebral axial decompression will be paid as traction.

- k) CODE 97014** Application of a modality to one or more areas; electrical stimulation (unattended) the use of electrical current for peripheral nerve injuries or pain reduction which does not require constant attendance. Once applied this modality requires on-site supervision.
 - i)** Time to produce effect: 2 – 4 treatments.
 - ii)** Frequency of treatment: 2 – 5 times per week.
 - iii)** If electrical stimulation and ultrasound are provided through the same transducer, no additional charge shall be made for electrical stimulation. The simultaneous application of ultrasound and electrical stimulation through the same transducer, to the same region, during the same period of time, does not add value to the basic service performed.

- l) CODE 97018** Paraffin Bath: immersion or painting of specific body parts with molten paraffin
 - i)** Time to produce effect: 1 – 4 treatments.
 - ii)** Frequency of treatment: 1 – 3 times per week.

- m) CODE 97024** Application of diathermy to one or more areas; diathermy involves use of equipment which exposes soft tissue to magnetic or electrical field.
 - i)** Time to produce effect: 2 – 4 treatments.
 - ii)** Frequency of treatment: 2 – 3 times per week.
 - iii)** The use of diathermy and ultrasound on the same treatment area on the same visit will be considered a duplication of service as they both provide heat. Consideration will be given to one but not both therapies. Documentation must include the area of application.

- n) CODE 97026** Infrared Radiation: radiant form of heat application. Low level laser therapy will also be reimbursable through this code.
 - i)** Time to produce effect: 2 – 4 treatments.
 - ii)** Frequency of treatment: 3 – 5 times per week.

- o) CODE 97032** Application of electrical stimulation to one or more areas; electrical stimulation (manual), each 15 minutes. The use of electrical current for peripheral nerve injuries, muscle relaxation or pain reduction which requires continuous manual application and supervision or extensive teaching on the use of a device. Documentation must clearly state attendance at bedside for adjustments and safety.
 - i)** Time to produce effect: 12 – 15 treatments.

ii) Frequency of treatment: 3 – 5 times per week.

iii) If electrical stimulation and ultrasound are provided through the same transducer, no additional charge shall be made for electrical stimulation. The simultaneous application of ultrasound and electrical stimulation through the same transducer, to the same region, during the same period of time, does not add value to the basic service performed.

p) **CODE 97035** Ultrasound, each 15 minutes Ultrasound with or without Electrical Stimulation: using sonic generators to deliver acoustic energy for therapeutic thermal and/or non-thermal soft tissue treatment.

i) Time to produce effect: 6 – 9 treatments.

ii) Frequency of treatment: 3 – 5 times per week.

q) The use of ultrasound and diathermy on the same treatment area on the same visit will be considered a duplication of service as they both provide deep heat. Consideration will be given to one but not both therapies. If electrical stimulation and ultrasound are provided through the same transducer, no additional charge shall be paid for electrical stimulation. The simultaneous application of ultrasound and electrical stimulation through the same transducer, to the same region, during the same period of time, does not add value to the basic service performed.

r) **CODE 97124** Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and / or tapotement (stroking, compression, percussion). This is a soft tissue procedure performed on one-to-one direct patient contact. Only a Doctor of Chiropractic, or massage therapist under the Doctor of Chiropractic's supervision and in conjunction with an active chiropractic treatment program, can be compensated for this. Documentation must note the person providing this service or the bill will be returned to the vendor for clarification. Massage, including effleurage, petrissage, and / or tapotement (stroking, compression, percussion) will be considered for reimbursement when performed to the same region as CMT with appropriate documentation (i.e. myofascial release, trigger point therapy, myelotherapy, soft tissue mobilization, massage). The documentation must be co-signed by the supervising Doctor of Chiropractic. Reimbursement for massage will only be made for massage applied to the area(s) of the original compensable injury.

s) **CODE 97139** Unlisted procedure, modality or supply code (i.e. 97139, 97039, 99070) If no specific procedure code is available fitting the description of the procedure performed and an unlisted procedure code must be used, include the narrative description on item 19 of the HCFA 1500 form, if a coherent description can be provided within the confines of that box. If not, an attachment must be submitted with the claim. The unlisted procedure must be supported by documentation in the patient's record.

4) Rehabilitation

a) **Supervised Reconditioning / Exercise Code Cap.** The Division may pay up to four units (1 unit = 15 minutes) per day of any (one code or combination) of supervised exercise code as listed.

- i) 97110 Therapeutic exercise
 - ii) 97112 Neuromuscular re-education
 - iii) 97116 Gait training
 - iv) 97530 Therapeutic activity
 - v) The application of these codes requires supervision by the Doctors of Chiropractic.
- b) Coding / Billing Procedures** Each CPT code billed should represent a separate and distinct clinical procedure. Each CPT code utilized and its associated rehabilitative procedure should be clearly identified and well documented. Procedures such as brief cardiovascular warm up / cool down stretching exercising, etc. are considered components of other predominant procedures and should not be billed separately. CPT codes should be viewed as descriptors of service only, not billable items in their own right. Generally, CPT codes related to supervised reconditioning / therapeutic exercise are time based, billed in 15 minute increments. Total time must be documented in the chart notes.
- c) CODE 97110** Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility The instruction of a patient in a supervised exercise program which may include: strengthening, stability, flexibility, ROM, and/or cardiovascular conditioning. The intent of the program should be to improve the level of function progressing to an independent exercise program. The progress toward goals can be objectively measured.
- i) Time to produce effect: 9 treatments.
 - ii) Frequency of treatment: 2 – 5 times per week.
- d) CODE 97112** Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception Neuromuscular Reeducation: movement, balance, coordination, kinesthetic sense, posture and proprioception techniques to normalize muscle tone, patterns of specific movement, automatic neuromuscular response and motor control. These techniques require constant assessment and reassessment during treatment period.
- i) Time to produce effect: 9 treatments.
 - ii) Frequency of treatment: 2 – 5 times per week.
- e) CODE 97116** Gait training: skilled training of a patient with significant gait abnormalities and/or complex adaptation of equipment to normalize weight-bearing and movement patterns.
- i) Time to produce effect: 2 – 4 treatments

- ii) Frequency of treatment: 2 – 3 times per week.
- f) **CODE 97504** Orthotics fitting and training, upper and / or lower extremities, each 15 min Orthotics will be considered on an individual case basis.
- g) **CODE 97530** Therapeutic activities, supervised patient contact (use of dynamic activities to improve functional performance), each 15 minutes Functional Activities: instructing, monitoring, and progressing a patient in adaptations of functional activities that result in the patient's ability to perform the activity independently and safely with or without adaptive devices. Functional activities could range from getting out of bed and self-care to positioning themselves at a machine and driving heavy equipment
 - i) Time to produce effect: 2 – 4 treatments.
 - ii) Frequency of treatment: 2 – 3 times per week.
- h) **CODE 97535** Self-care / home management training, each 15 minutes. Activities of daily living: performance of physical and psychological self-care skills and/or daily life management skills to a level of independence.
 - i) Time to produce effect: 2 – 4 treatments.
 - ii) Frequency of treatment: 2 – 3 times per week. Patient Education: imparting information and developing skills to promote independence after discharge. Teaching patient and/or their care givers in the programs (e.g. exercises, TENS instruction) to meet long term goals.
 - iii) Time to produce effect: 1 – 3 sessions.
 - iv) Frequency of treatment: Total 1 – 3 sessions.
 - v) The Division will pay up to four teaching/monitoring sessions for up to two units per session maximum per case. The documentation must demonstrate medical necessity and goals.
- i) **CODES 29200, 29240, 29260, 29280, 29530, 29540** Body and Extremity strapping, any age (Kinesio Tape)
- j) **CODE 97750** Physical performance test or measurement (e.g., musculoskeletal, functional; capacity), with written report, each 15 minutes.
- k) **CODE 97810** Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient. **Provider must provide documentation of advanced training for acupuncture.**

1) **CODE 97811** Acupuncture without electrical stimulation, each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s). (List separately in addition to code for primary procedure.)

2) **D.M.E.**

a) **CODE 99070** Supplies and material (except spectacles), provided by the Doctor of Chiropractic over and above those usually included with the office visit or other services rendered (list braces, supplies, nutritionals, or materials provided). Supplies will be paid per Workers' Compensation Division guidelines and may require itemization. Nutritionals will only be approved for impairments or disabilities requiring the use of a wheelchair, (Statute 27-14-102, Definitions.(a)(xii) Medical and Hospital Care)

b) **CODE 99071** Educational supplies, such as books, tapes, and pamphlets, provided by the Doctor of Chiropractic for the patient's education at cost to Doctor of Chiropractic. An invoice and supportive documentation must be supplied with the billing.

1. References

- a. Wyoming Laws – Wyoming Chiropractic Examiners Licensing Act
- b. ICA Best Practices and Practice Guidelines, International Chiropractic Association, 2008, Donald 3.Harrison, PhD, DC, MSE, Leonard Siskin, BS, DC
- c. Relative Values for Doctors of Chiropractic, St. Anthony's Publishing, Inc. (current edition)
- d. ACA's Official Chiropractic Coding Solutions (current edition), American Chiropractic Association, (current edition)
- e. Rehabilitation of the Spine, Williams and Wilkins, 1996, Craig Leibsen, D.C.
- f. The Chiropractic Profession NCMIC Group Inc., (current edition)
- g. ACA Clinical Documentation Manual, (current edition)
- h. Chirocode Deskbook 2012, (current edition)
- i. Council on Chiropractic Guidelines and Practice Parameters, subject specific, (current edition)
- j. Practicing Chiropractor's Committee on Radiology Protocols (PCCRP)
- k. Quantitative Functional Capacity Evaluation by Steven G. Yeomans, DC, FACO
- l. Exercise Manual for (QFCE deficits) Steven G. Yeomans, DC, FACO
- m. The Clinical Application of Outcome Assessments by Steven G. Yeomans, DC, FACO

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WYOMING WORKERS' COMPENSATION DIVISION
Chiropractic Patient Exam/Re-exam Form (Use if patient is under active care)

Return to: Workers' Compensation Division
 1510 East Pershing Boulevard, South Wing
 Cheyenne, Wyoming 82002
<http://www.wyomingworkforce.org>

Patient _____ Claim # _____ Date: _____

Has patient been discharged from care? Yes ____ If yes, please list date of discharge, sign and return form via fax to 307-777-6552
 No ____ If no, please complete the form in its entirety ____ Number of prior treatments

1) Current Subjective Complaints:

2) Activities of Daily Living Limitations or Duties Under Duress:

3) Exacerbations Since Last Exam:

4) Current Orthopedic / Neurologic Evaluation:

5) Measured Range of Motion: Cervical, Thoracic, Lumbar , Other _____ (circle)

| | Normal | Current | Pain | Notes |
|----------------|--------|---------|------|-------|
| Flexion | | | | |
| Extension | | | | |
| Right Lat Flex | | | | |
| Left Lat Flex | | | | |
| Right Rotation | | | | |
| Left Rotation | | | | |

6) Muscle Strength Test:

7) P.D.Q. Scores:

8) Assessment :

9) Plan :

10) Additional Info. / Complicating Factors:

Doctor of Chiropractic Name: _____ Signature: _____

