Pelvic Rehab Coding Pitfalls – Appropriate use of CPT Code 91122 – Anorectal manometry.

Multiple studies have demonstrated the benefits of pelvic rehabilitation for women with pelvic floor disorders. Many FPMRS clinics now include pelvic rehab programs operating in continuity with physician services. This article highlights a potential pitfall in coding for pelvic rehab therapeutic encounters, and alerts our membership to do a self-audit to assure your pelvic rehab coding is in compliance.

The CPT code 91122 is for the diagnostic test - anorectal manometry - which is used to diagnose defacatory disorders and must be linked to an appropriate ICD-9 code for defacatory dysfunction. Anorectal manometry is a diagnostic test that measures the anal sphincter pressures and provides an assessment of rectal sensation, rectoanal reflexes, and rectal compliance. The diagnostic test uses a multichannel catheter in the rectum, and continuous manometry readings during testing. The CPT code 91122 is not an appropriate code to use for serial encounters for pelvic rehab therapy, or to diagnose or treat urinary incontinence.

An anorectal manometry diagnostic test (CPT Code 91122) is clinically necessary when there is appropriate evaluation and justification prior to the test, and when the test is also likely to affect the course of therapy. Anorectal manometry is rarely performed a second or third time after the initial diagnostic test, and may be considered reasonable and necessary no more than once per year, in the cognitively intact patient when the results will assist in a treatment plan. Anorectal manometry is a diagnostic procedure and it not appropriate in a therapeutic encounter.

Documentation must support that a clinically appropriate evaluation of the patient (history and physical) was performed prior to anorectal manometry testing.

A test is considered reasonable and necessary when it is likely to be used to select or change the course of therapy for the disease. For most patients, these tests will usually lead the treating physician to recommend forms of treatment such as pelvic floor training, surgical intervention, pharmacologic intervention, biofeedback therapy, or other clinically accepted interventions.

Anorectal manometry testing must be performed personally by the physician or under the direct (available in the office) supervision of a physician experienced in the personal performance and interpretation of the test by an individual s/he has trained to perform the test.

Some Medicare Part B Contractors have issued Local Coverage Determinations regarding anorectal manometry. Below is a quote from an active LCD by First Coast Services Options, the Medicare Contractor for Florida, Puerto Rico, and the VI:

“ANORECTAL MANOMETRY (91122) is a diagnostic test that measures the anal sphincter pressures and provides and assessment of rectal sensation, rectoanal reflexes, and rectal compliance....Anorectal manometry will be considered medically reasonable and necessary when it is necessary to evaluate a diagnosis of fecal incontinence and dysfunctional anorectal elimination and the results are to be used in the management of the patient’s condition.
Limitations

A diagnostic test is medically necessary when there has been an appropriate evaluation and justification prior to the tests being performed and when the results of the diagnostic test is likely to affect the course of treatment.

There must be a complete history and physical exam documented before the decision to perform one of the diagnostic tests described above is made. See the documentation requirements section of this LCD for a complete description of the requirements. Potential treatable problems should be identified and treatment implemented if possible before ordering diagnostic tests (e.g., UTI should be treated, medication management for drugs that cause urinary retention or frequency).

Medicare would only expect to see 91122 or 51784/51785 billed during the initial diagnostic evaluation only when the cause of the fecal incontinence or urinary incontinence cannot be determined from the physician’s evaluation and that the physician has determined that diagnostic testing is needed to make a diagnosis. Medicare would not expect to see 91122 billed when the physician is trying to evaluate urinary incontinence. There may be rare occasions when the physician feels one of these diagnostic tests are needed after a course of treatment has been completed. In this instance, Medicare would expect the medical record to reflect that the results of the additional test are needed to determine additional therapy or treatment. The routine performance of 91122, 51784/51785 during the course of treatment or at the end of a course of treatment may prompt medical review of claims.”

Disclaimer:
The Coding Committee of the American Urogynecologic Society (AUGS) assists members with the application of governmental regulations and guidelines regarding terminology and CPT/ICD coding in urogynecologic practice. Such information is intended to assist with the coding process as required by governmental regulation and should not be construed as policy sanctioned by AUGS. The American Urogynecologic Society disclaims liability for actions or consequences related to any of the information provided. The AUGS does not endorse the diagnostic protocol or treatment plan designed by the provider.