Kinetisense Coding Guide for Chiropractors & Physical Therapists

Functional Capacity and Assessment Codes

- **97750: Physical Performance Test/Measurement (FCE)**
  - Definition: Assesses musculoskeletal and functional capacity, using standardized tests and activities of daily living with a written report (each 15 minutes).
  - Appropriate for: Workers' comp, disability assessments, rehab progress, pre-employment screenings.
  - Documentation: Requires a detailed written report of tests performed, equipment used (e.g., dynamometers, motion tracking, AI tools), and patient outcomes.
  - Billing: Timed code (15-minute increments). May be billed up to 2 hours/session, but verify payer guidelines.
  - Notes: Do **not** bill 95851 (ROM) with 97750; ROM is included in 97750. Modifier 59 may be used for distinct, independent procedures on the same day. GP modifier for services under a physical therapy plan. Modifier 25 if performed with an EM service.
- **95851: Range of Motion Measurement**
  - Measures/document ROM of spine or extremity (excluding hand).
  - Not timed; bill one unit per tested area.
  - Only bill if documentation supports distinct, reportable measurement separate from standard evaluation.
  - Do **not** bill with 97750 on the same day.
  - Use Modifier 59, GP, or 25 as needed.

Therapeutic Procedures

CPT Code	Description	Billing Details	Notes
97530	Therapeutic Activities	Direct, one-on-one activities to improve functional performance (15 min increment)	Choose code based on activity; supports medical necessity from initial tests
97112	Neuromuscular Reeducation	Therapeutic procedure, 1+ areas, 15 min, for movement, balance, posture, coordination, proprioception	Document clinical skills and expected improvement; must relate to justified test results

97110	Therapeutic Exercise	Designed exercise programs for mobility, strength, fitness, or disability recovery (15 min increment)	Customize protocol for rehab, post-op, osteoporosis, pregnancy, etc.
97116	Gait Training	Direct intervention for improving walking, balance, functional mobility	Used in rehab/therapy for ambulation improvement
97535	Self-Care/Home Management Training	Instruction for recovery, daily living activities	Use for billing training of patients in ADLs, self-care tasks

All above "97xxx" codes:

- Are timed (8-min rule applies, billed in 15-min increments).
- Use Modifier 59 (distinct procedure), GP (PT plan), and 25 (reduced time, 8-15 min).
- Frequency based on EM findings, treatment plan, and medical necessity.[2]

Advanced Motion/Gait Analysis

CPT Code	Description	Documentation	Notes
96000	Comprehensive Computer-Based Motion Analysis	Includes video/3D kinematics recording	High-tech analysis of abnormal gait, functional movement
96004	Review & Interpretation of Motion Studies	By physician/qualified provider	For integrated review of computer-based analysis, EMG, dynamic pressure, etc.
97542	Wheelchair Evaluation/Training	Patient need, skills for mobility aids	Covers evaluation of wheelchair necessity and training

Telehealth and Remote Monitoring

CPT Code	Description	Billing Details	Notes
99421–99423	Online Digital EM Services	Established patient, up to 7 days (5–10 min, 11–20 min, 21+ min)	Cumulative time over 7 days; use for telehealth check-ins
99453	Remote Patient Monitoring Setup	One-time app/device setup and education	Eligible healthcare providers; billed once per episode
99454	Remote Patient Monitoring Device Supply	Monthly device provision and data transmission (min. 16 days/month)	Can bill with 99453 in same month, not same day
99457, 99458	Remote Monitoring by Clinical Staff	First 20 min, each add'l 20 min/month	Track and manage patient's progress via phone/video/email[in-app] messages
97161	PT Evaluation (Telehealth)	Video PT eval and plan of care	One-time cost per episode
97110	PT Telehealth Visits	Weekly video exercise review/adjustment	Per session billing

Fall Risk Analysis & Reporting

- **CPT II Codes:** Used for documentation, not direct reimbursement (Medicare quality measures).
    - 3288F: Fall risk assessment performed and documented.
    - 1100F: Screened for falls risk (multiple falls/any fall with injury in past year).
    - 1101F: No falls in past year/only one fall without injury.
    - HCPCS M1069/M1070: Medicare fall risk assessment reporting as needed.[3]
- Documentation must match assessments performed.

Billing and Documentation Principles

- Documentation: Always provide written reports for tests, measurements, progress, and treatment justification.

- Modifiers: Commonly used are 59 (distinct procedure), GP (PT plan), 25 (if paired with EM service).
- Frequencies: Initial evaluation, scheduled re-evaluations (e.g., every 30 days), and on condition changes.
- Check payer and Medicare guidelines for code combinations and required documentation.
- Do not routinely bill codes for services considered part of standard evaluations; only bill separately when medical necessity is supported by documentation.