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Billing and Coding for Moxibustion

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Q: I am trying to locate a code for cupping and moxibustion, and have had various fellow acupuncturists indicate that they bill using the existing codes for heat, 97010 hot packs or 97026 infra-red for moxa and 97016 vasopneumatic device for cupping. Would these be appropriate and correct?

A: This is a common question in the acupuncture profession and one I receive mulitple times at every seminar. There is not, as you note, any specific codes for cupping or moxibustion among the Current Procedural Terminology (CPT) code set. Therefore many will simply seek a code that they interpret or feel approximates the service with an existing CPT code. However, per the CPT instructions, "select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided."

This means 97010 is for hot or cold packs and 97026 is for infra-red heat and while moxa certainly does generate heat, it would not be considered a hot pack nor infra-red device. Also, 97016 is for a vasopneumatic device which may be considered reasonable and necessary for the application of pressure to an extremity for the purpose of reducing edema. Specific indications for the use of vasopneumatic devices include: reduction of edema after acute injury; lymphedema of an extremity; and/or education on the use of a lymphedema pump for home use. Think of a large blood pressure cuff style device placed over an extremity and that is essentially what a vasopneumatic device is. While cupping does create suction and pressure to tissue, it would not fit the definition for use of CPT code 97016. Therefore, choosing the codes you were told would not be appropriate.

In cases where no specific code exists for a service, CPT has provided codes defined as "unlisted procedure or service codes" and these codes are intended and used for services where no current code exists. When unlisted codes are reported, the claim must include an explanation of the specific service.

The physical medicine and rehabilitation section of the CPT code set provides an unlisted code that may be used to report moxibustion and/or cupping. This code is 97039 and is defined as an unlisted modality. A modality is any physical agent applied to produce therapeutic changes to biologic tissue and includes but is not limited to thermal, acoustic, light, mechanical or electrical energy. Further, these services may or may not require direct one-on-one contact. This means that the patient may be unattended by the provider during the course of the therapy but the service may also require direct one-on-one contact as well.

In either case, this is why the service must be described so not only the specific therapy is elucidated, but also whether it required direct contact or only supervision. Note for constant attendance, the service may be billed for more than one unit assuming that the time to perform the service matches the units billed. In this case, the eight minute rule for timed services applies, meaning one unit is 8 to 22 minutes, 23 to 37 minutes is 2 units, 38 to 52 minutes and so on. The explanation for this code need not require any additional forms or attachments as it can be done in block 24 of the 1500 form, in the pink shaded region above the line where the code is reported and may simply indicate cupping or moxibustion.

But the $64,000 question is will the payer make payment for the service. The good news is there has been a recent trend for carriers to reimburse for moxibustion however, generally not so for cupping. If the service is considered non-payable by the insurance plan, the patient is simply liable for it. But it is worthwhile to give the opportunity for the patient to receive their proper and maximum benefits and that will never be known if it is never billed. The worst case scenario would

be non-payment by the insurance with patient responsibility. My rule is always provide an opportunity for the insurance to reimburse for the patients allowed benefits. Further a trend where these services are commonly billed and used, would lend to a carrier identifying common services and possibly adding it to the covered benefits.

If you bill and use a code such as 97026 and 97016, it may indeed be reimbursed, but the carrier is making the assumption the services were infra-red heat and a vasopneumatic device. If the claim were reviewed and the services were not those but moxa and cupping, a demand and request for reimbursement would occur. Do not code a service based on an approximate coding where no available code accurately describes it, use the unlisted modality code 97039.

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