Clinical Practice Guideline: Manual Muscle Testing and Range of Motion Testing

Date of Implementation: April 19, 2012

Product: Specialty

POLICY

Manual Muscle Testing and Range of Motion Testing used pertinent to the treatment plan and diagnosis are clinically effective, are professionally recognized and have a favorable benefit:risk profile when further testing or evaluation beyond service included in the Evaluation and Management (E&M) service is required, or for practitioners not performing E&M services, beyond the evaluation/reevaluation service.

PROCESS AND DEFINITIONS

When developing, reviewing, and approving clinical policy, American Specialty Health – Specialty (ASH) peer-review committees consider whether the technique/procedure:

- Is established as clinically effective by:
  - Scientific information published in an acceptable peer-reviewed clinical science resource, and
  - The consensus opinion of the Evidence Evaluation Committee (EEC) when available;
- Is professionally recognized by:
  - Inclusion in the educational standards accepted by the majority of the professions' educational institutions,
  - Wide acceptance and use of the practice, and
  - Recommendations for use made by healthcare practitioners practicing in the relevant clinical area
- Poses a health and safety risk; and
- Is plausible or implausible
  - A belief, theory, or mechanism of health and disease that can be explained within the existing framework of scientific methods, reasoning, and available knowledge is considered plausible.
  - A treatment intervention or diagnostic procedure that requires the existence of forces, mechanisms, or biological processes that are not known to exist within the current framework of scientific methods, reasoning, and available knowledge is considered implausible.

Substitution harm (indirect harm): Compromised clinical outcomes caused by:

- Utilizing a specific diagnostic or therapeutic procedure when the safety, clinical effectiveness, or diagnostic utility is either unknown or is known to be unsafe, ineffective, or of no diagnostic utility, *instead of* a diagnostic or therapeutic

procedure known to be safe, be clinically effective, or to have diagnostic utility; or

- The utilization of a diagnostic or therapeutic procedure that is substantially less effective or safe than another procedure with established safety, and clinical effectiveness or utility.

Labeling effects (non-specific harm): The harm that results from identifying in a patient a condition or a finding that is not clinically valid.

Safe: The terms "safe" and "safety," are used only with specific reference to the absence of direct harm. Direct harm would include any injury to a patient caused by the mechanical, thermal, biological, chemical, pharmacological, electrical, electromagnetic, or psycho-dynamic properties of a diagnostic or therapeutic procedure, and as such, the procedure would be considered unsafe.

Direct harm: Any injury to a patient caused by the mechanical, thermal, biological, chemical, pharmacological, electrical, electromagnetic, or psycho-dynamic properties of a diagnostic or therapeutic procedure.

Benefit versus risk profile: The relative effectiveness or utility of a therapeutic intervention or diagnostic procedure versus its potential for direct harm.

- Positive (benefits outweigh risks),
- Negative (risks outweigh benefits), or
- Equivocal (available information is inconclusive).

Introduction

CPT Codes: 95851 – 95852 (ROM testing) as well as 95831 through 95834 (manual muscle strength testing) are designated as separate procedures and require the practitioner's interpretation of the results along with a separate, distinct, dated and signed written report. The rationale for the necessity of a separate assessment service(s) is also required. Appropriate ROM and/or muscle strength testing are included within E&M or Evaluation/Reevaluation codes and treatment codes for many practitioners (e.g., chiropractic manipulative treatment); as such these are considered mutually exclusive with E&M, Evaluation/Reevaluation, or treatment codes. Further, billing for these services on different dates than the E&M, Evaluation/Reevaluation, or treatment service does not justify their medical necessity as separate and distinct services.

On rare occasion, a patient with a complicated condition may warrant specialized tests and measures with standardized reports. For example, a patient with an incomplete C5 quadriplegia at six (6) months following their injury may need specialized testing for ROM or strength measurements to address specific deficits and goals.

CPT Code and Documentation Requirements to Substantiate Medical Necessity

"Medically necessary" or "medical necessity" shall mean health care services that a Healthcare Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and considered effective for the patient's illness, injury, or disease; and (c) not primarily for the convenience of the patient or healthcare provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

Testing must be pertinent to the plan of care and the diagnosis. All muscles or muscle groups or all joints in the affected extremity or trunk section, as described in the code descriptor, must be tested when coding these procedures. For example: Code 95831 is "Muscle testing, manual with report: extremity (excluding hand) or trunk". To use this code for extremity manual muscle testing, all muscles or muscle groups of at least one extremity would need to be tested, with documentation of why such a thorough assessment was warranted. It would not be appropriate to bill code 95831 if only hip strength needed to be tested.

CPT Code	Manual Muscle and ROM Testing Description
95851	Range Of Motion Test with Report; Each Extremity Or Trunk
	Testing determines active and passive range of motion for extremities and joints. This code applies to manually testing each arm or leg or sections of the spine in a separately reported procedure
95852	Range Of Motion Measurements with Report; Hand
	Testing determines active and passive range of motion for joints of the hand. This code applies to manually testing the hands.
95831	Muscle Testing, Manual with Report; Extremity Or Trunk
	Muscles or muscle groups are tested for strength. This code applies to manually testing the arm, leg, or trunk.

95832	Muscle Testing, Manual with Report; Hand
	Muscles or muscle groups are tested for strength. This code applies to manually testing the hands.
95833	Muscle Test, Manual with Report, Total Body Evaluation Excluding Hands
	Muscles or muscle groups are tested for strength. This code applies to manually testing the body exclusive of the hands.
95834	Muscle Test, Manual with Report, Total Body Evaluation Including Hands
	Muscles or muscle groups are tested for strength. This code applies to manually testing the body inclusive of the hands.

Code 95851 is "Range of motion measurements and report; each extremity (excluding hand) or trunk section (spine)." To use this code for an upper extremity, both passive and active ROM for all motions of the extremity (e.g., shoulder, scapula, elbow, and wrist) would need to be tested, with documentation of why such a thorough assessment was warranted. If only the shoulder ROM needed to be tested, use of this code would not be substantiated.

These codes are typically consultative. It is expected that the administration of these tests will generate material that will be formulated into a report. That report should clearly indicate the purpose and rationale for the test, the test performed with results and how the information affects the treatment plan. It is not reasonable or necessary for these codes to be performed on a routine basis or to be routinely used for all patients (e.g., monthly or in the place of a reevaluation).

Practitioner Scope and Training

Practitioners should practice only in the areas in which they are competent based on their education training and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

It is best practice for the practitioner to appropriately render services to a patient only if they are trained to competency, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and training, it would be best practice to refer the patient to the more expert practitioner.

Depending on the practitioner's scope of practice, training, and experience, a patient's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is essential for the practitioner to refer the patient for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate.

References

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