CODING & PAYMENT GUIDE

For the Physical Therapist

An essential coding, billing and reimbursement resource for the physical therapist

Sample page

2020

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Getting Started with Coding and Payment Guide

The *Coding and Payment Guide for the Physical Therapist* is designed to be a guide to the specialty procedures classified in the CPT® books. It is structured to help coders understand procedures and translate provider narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

For ease of use, *Coding and Payment Guide for the Physical Therapist* lists the CPT and HCPCS Level II codes in ascending numeric order. Included in the code set are all surgery and medicine codes pertinent to the specialty. Each CPT code is followed by its official code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA has assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence. CPT codes within the Optum360 *Coding and Payment Guide* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the page following the sample.

Appendix Codes and Descriptions

Some procedure codes are presented in a less comprehensive format in the appendix. The CPT codes appropriate to the specialty are included in the appendix with the official code description and associated relative value units, with the exception of the Category II and III CPT Codes. Because no values have been established by CMS for the Category II and Category III codes no relative value unit and Medicare edits can be identified.

CCI Edit Updates

The *Coding and Payment Guide* series includes the a list of codes from the official Centers for Medicare and Medicaid Services' *National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 23.3, the most current version available at press time. The CCI edits are located in a section at the back of the book. Optum360 maintains a website to accompany the *Coding and Payment Guide* series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is https:// www.optum360coding.com/ProductUpdates/. The 2018 edition password is: **SPECIALTY18**. Please note that you should log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically.

For example:

Code 29540 Strapping; ankle and/or foot can be found in the index under the following main terms:

Ankle
  Strapping, 29540

Strapping
  Ankle, 29540

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group. Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Sample Page and Key

On the following pages are a sample page from the book displaying the format of *Coding and Payment Guide* with each element identified and explained on the opposite page.

Sample Page

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Procedure Codes

The Physicians' Current Procedural Terminology (CPT®) coding system was developed and is updated annually by the American Medical Association (AMA). The AMA owns and maintains the CPT coding system and publishes its updates annually under copyright. CPT codes predominantly describe medical services and procedures performed by physicians and nonphysician professionals. The codes are classified as Level I of the Healthcare Common Procedure Coding System (HCPCS).

Typically, physical therapists use CPT codes to describe their services. Government studies of patient care evaluate utilization of services by reviewing CPT codes. Because payers may question or deny payment for a CPT code, direct communication is often useful in educating payers about physical therapy services and practice standards. Accurate coding also can help an insurer determine coverage eligibility for services provided.

Appropriate Codes for Physical Therapists

The CPT book is divided into six major sections by type of service provided (evaluation and management, anesthesia, surgery, radiology, pathology and laboratory, and medicine). These sections are subdivided primarily by body system.

The physical therapist in general practice will find the most relevant codes in the physical medicine and rehabilitation (PM&R) subsection of the medicine section (codes in the 97000–97799 range). Other services physical therapists provide, particularly those in specialty areas, are described under their appropriate body system within the medicine or surgery section.

For example, the neurological procedures most often performed by physical therapists, including muscle and range of motion testing or electromyography (EMG), are located in the neurology subsection of the medicine section (95782–96020), while burn care codes (16000–16030) are located in the integumentary subsection of the surgery section. None of the codes for these procedures are listed in the PM&R subsection, although they accurately describe services provided by a physical therapist.

Although codes within the PM&R series (97000–97799) are most easily recognized by third-party payers as services provided by physical therapists they do not describe all physical therapy procedures. As noted above, some physical therapy services are described in other sections of the manual. Physical therapists may be able to obtain payment if they can provide a reasonable rationale directly to the payer for the service they are providing and support it with consistent, accurate documentation. However, payment policy may affect the payment of these codes when reported by a physical therapist.

CPT Symbols

There are several symbols used in the AMA's CPT book:

- A bullet (●) before the code means that the code is new to the CPT coding system in the current year.
- A triangle (▲) before the code means that the code narrative has been revised in the current year.
- The symbols ▶◀ enclose new or revised text other than that contained in the code descriptors.
- Codes with a plus (+) symbol are "add-on" codes. Procedures described by "add-on" codes are always performed in addition to the primary procedure and should never be reported alone. This concept is applicable only to procedures or services performed by the same provider to describe any additional intraservice work associated with the primary procedure such as additional digits or lesions.
- The symbol ⊘ designates a code that is exempt from the use of modifier 51 when multiple procedures are performed even though they have not been designated as add-on codes.
- The number (#) symbol indicates that a code is out of numeric order or "resequenced." The AMA employs a new numbering methodology of resequencing. According to the AMA there are instances where a new code is needed within an existing grouping of codes and an unused code number is not available. When the existing codes will not be changed or have minimal changes, the AMA will assign a code that is not in numeric sequence with the related codes. However, the code and description will appear in the CPT book with the other related codes.

  To facilitate the code sequence and maintain a sequential relationship according to the description of the codes, the CPT codes in this grouping will be resequenced. Resequencing is the practice of displaying the codes outside of numerical order according to the description relationship.

  For example, codes 97161–97172 evaluation and re-evaluation of a patient by a physical therapist, occupational therapist, and athletic trainer immediately follow code 96999 but are before 97010 out of numeric sequence.

Modifiers

A system of two-digit modifiers has been developed to allow the provider to indicate that the service or procedure has been altered by certain circumstances or to provide additional information about a procedure that was performed, or a service or supply that was provided. Fee schedules have been developed based on these modifiers. Some third-party payers, such as Medicare, require physical therapists to use modifiers in some circumstances, and others do not recognize the use of modifiers by physical therapists for coding or billing. Communication with the payer group ensures accurate coding. Addition of the modifier does not alter the basic description for the service, it merely qualifies the circumstances under which the service was provided. Circumstances that modify a service include the following:

- Procedures that have both a technical and professional component were performed
- More than one provider or setting was involved in the service
- Only part of a service was performed
- Unusual events occurred

For example, modifier 59 Distinct procedural service, could be used when billing for both 97022 Whirlpool, and 97597–97606 Wound debridement, to indicate that the two services were distinct from one another, or performed on different areas of the body.

Note that the CPT book uses the term "physician" when describing how a modifier is to be used. This does not limit the use of the modifiers to physicians; any qualified healthcare professional, including the physical therapist, may use a modifier as long as the service or procedure to be modified can be performed within that practitioner's scope of work.

Sample Page

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97010

97010 Application of a modality to 1 or more areas; hot or cold packs

Explanation

The qualified health care provider applies heat (dry or moist) or cold to one or more body parts, with appropriate padding to prevent skin irritation and monitors patient's response. The patient is given necessary safety instructions. The treatment requires supervision only and typically only one unit is billed per visit. However, when multiple, separate treatment sessions are performed per day, it is appropriate to report one unit for each treatment session.

Coding Tips

Report code 97010 only once when both cold and hot packs are provided during a single session.

According to the American Medical Association, this code should be reported once for each distinct procedure performed. It is not necessary to append modifier 51.

This code requires supervision by the physical therapist but does not require direct patient contact (one-to-one).

Documentation Tips

When providing maintenance therapy services, develop and document maintenance goals as opposed to restorative goals. Also, indicate in the documentation that the skills of the physical therapist were necessary to maintain, prevent, or slow further deterioration of the patient's functional status, and that the services could not be conducted for or by the patient without the assistance of the physical therapist.

When modifier KX is reported with this or any code, the documentation may be additionally scrutinized for medical necessity.

This is a service-based code and is reported only once per date of service. If the service is performed more than once on any given day, the appropriate modifier should be reported and documentation should support its use.

Reimbursement Tips

Medicare bundles the payment of hot and cold packs into all other services, meaning there is no separate payment for hot and cold packs. Several private payers, citing the Medicare example, also will not cover this modality separately. Check with the specific payer to determine coverage.

This service is considered a "sometimes-therapy" service and is subject to the Medicare outpatient physical therapy cap when performed by the physical therapist. The following modifiers are used to identify therapy services, whether or not the financial limitations are in effect, although the common working file (CWF) does track the financial limitation using the therapy modifiers. The following three modifiers refer only to services provided under plans of care for physical therapy, occupational therapy, and speech-language pathology services, and should only be reported with codes on the list of applicable therapy codes:

GN Services delivered under an outpatient speech-language pathology plan of care

GO Services delivered under an outpatient occupational therapy plan of care

GP Services delivered under an outpatient physical therapy plan of care

There is a two-tiered exceptions process to the outpatient therapy caps: an automatic exceptions process and a medical review exceptions process. Under the automatic exceptions process, therapists must append reported codes with modifier KX when services will exceed the therapy cap. Services above the threshold initially are approved without medical review, but still are subject to review by the Medicare administrative contractor. Modifier KX is added to other required modifiers (GN for speech-language pathology services, GO for occupational therapy services, and GP for physical therapy services). The medical review exceptions process is required at the threshold amount. Under this process, CMS determine which therapy services to review by considering factors that include: (1) providers with patterns of aberrant billing practices compared with their peers; (2) providers with a high claims denial percentage or who are less compliant with applicable Medicare program requirements; and (3) newly enrolled providers.

According to the AMA (*CPT Assistant*, August, 2002), codes from range 97010–97028 (application of a modality to one or more areas) are intended to be reported only one time per modality, per treatment session. If two separate treatment sessions are provided on the same date of service (e.g., a.m. and p.m.), then both may be reported, but would require modifier 76 to indicate that the service-based code (not the time descriptors) is being reported for two separate sessions on the same date. Check with third-party payers as their guidelines may differ.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as modifier 51 exempt or as an add-on code in the CPT book.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: 97010 2017,Jan,8; 2016,Jun,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11; 2012,Jan,15-42; 2011,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
97010	0.06	0.11	0.01	0.18
Facility RVU	**Work**	**PE**	**MP**	**Total**
97010	0.06	0.11	0.01	0.18

	FUD	Status	MUE	Modifiers				IOM Reference
97010	N/A	B	0(3)	N/A	N/A	N/A	N/A	100-02,15,230; 100-02,15,230.1; 100-02,15,230.2; 100-02,15,230.4; 100-04,5,10

* with documentation

Terms To Know

modality (therapeutic). Broad group of agents or any physical agent applied to produce therapeutic/physiological changes to biologic tissue, including thermal, acoustic, radiant (light), mechanical, or electric energy.

Sample page