For the Physical Therapist

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

2021

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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® book. 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.

CPT/HCPCS Codes
For ease of use, Coding and Payment Guide for the Physical Therapist lists the CPT 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 2. 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 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 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 2021 edition password is: XXXXXXXXXX. 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

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.
Musculoskeletal System

Anatomical Illustrations

Bones and Joints

1. Frontal bone
2. Orbit
3. Nasal bone
4. Ethmoid bone
5. Lacrimal bone
6. Zygomatic bone
7. Temporal bone
8. Mandible
9. Maxilla
10. Palatine bone
11. Ethmoid bone
12. Lacrimal bone
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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 predominately describe medical services and procedures performed by physicians and nonphysician professionals. The codes are classified at 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 range of motion testing (95851-95852) or electromyography (EMG) (95860-95887), are located in the neurology subsection of the medicine section, 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 some 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 ▶ and ▼ 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 Ø 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 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

• Two timed procedures were performed consecutively (versus concurrently)

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 or other qualified health care professional” when describing how a modifier is to be used. This does not limit the use of the modifiers to physicians; any qualified health care 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.
Explaination
Pulmonary function testing is performed in a pulmonary lab using helium, nitrogen open circuit or another method to check lung functions to include residual capacity or residual volume, the volume of air remaining into the lung after a patient exhales. The qualified health care provider interprets the results. The code applies to measuring the respirator flow volume loop. This code includes laboratory procedures and interpretation of test results.

Coding Tips
If a separate identifiable evaluation or re-evaluation is performed (97161–97164), report additionally.
Do not report 94150 in addition to spirometry (94010) or airway resistance by impulse oscillometry (94728).

Documentation Tips
Documentation may include terms such as pink puffer (a descriptor for a patient with COPD and severe emphysema, who has a pink complexion and dyspnea) or blue bloater (a descriptor to indicate the appearance of a patient with COPD who has symptoms of chronic bronchitis). Verify the condition before assigning a code for emphysema.

Reimbursement Tips
Procedure 94375 has both a technical and professional component. To report only the professional component, append modifier 26. To report only the technical component, append modifier TC. To report the complete procedure (i.e., both the professional and technical components), submit without a modifier.

ICD-10-CM Diagnostic Codes
A15.0 Tuberculosis of lung
A15.7 Primary respiratory tuberculosis
B44.81 Allergic bronchopulmonary aspergillosis
B95.3 Streptococcus pneumoniae as the cause of diseases classified elsewhere
C34.01 Malignant neoplasm of right main bronchus 
C34.11 Malignant neoplasm of upper lobe, right bronchus or lung 
C34.2 Malignant neoplasm of middle lobe, bronchus or lung 
C34.31 Malignant neoplasm of lower lobe, right bronchus or lung 
C34.81 Malignant neoplasm of overlapping sites of right bronchus and lung 
E84.0 Cystic fibrosis with pulmonary manifestations
J43.0 Unilateral pulmonary emphysema [MacLeod’s syndrome]
J43.1 Panlobular emphysema
J43.2 Centrilobular emphysema
J43.8 Other emphysema
J44.0 Chronic obstructive pulmonary disease with (acute) lower respiratory infection
J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation
J45.40 Moderate persistent asthma, uncomplicated
J45.41 Moderate persistent asthma with (acute) exacerbation
J45.42 Moderate persistent asthma with status asthmaticus
J45.50 Severe persistent asthma, uncomplicated

Relative Value Units/Medicare Edits

Terms To Know
acute. Sudden, severe.
aspiration. Drawing fluid out by suction.
chronic. Persistent, continuing, or recurring.
COPD. Chronic obstructive pulmonary disease.
foreign body. Any object or substance found in an organ and tissue that does not belong under normal circumstances.
Explanation
Needle electromyography (EMG) records the electrical properties of muscle using an oscilloscope. Recordings, which may be amplified and heard through a loudspeaker, are made during needle insertion with muscle at rest and during contraction. Internal smooth muscle tissue in the larynx (95865) and hemidiaphragm (95866) are measured by needle placement in muscular organ tissue.

Coding Tips
Single-fiber EMG testing is the innervation of one or more nerve cells and some of the muscles stimulated. Code 95872 describes testing of each muscle studied. Normally, 20 pairs of nerves must be studied to significantly study each muscle. Each muscle is coded only once. However, if another muscle is studied, then the code is reported again. This code may be used in addition to the standard evaluation. This code does not include nerve conduction studies. When needle electromyography with nerve conduction, amplitude and latency/velocity is performed, see code 95587.

Documentation Tips
Documentation should clearly identify the number of extremities and, if appropriate, the paraspinal areas tested. Documentation should clearly indicate needle placement, which is particularly important when the code is billed bilaterally. The absence of documentation to support repeated testing on the same patient or testing every patient referred for pain may lead to claim denial.

Reimbursement Tips
Physical therapists in private practice may bill for the technical and professional component of certain diagnostic tests in the 95860–95937 code range, such as electromyograms and nerve conduction studies. These codes have both a technical and professional component. To report only the professional component, append modifier 26. To report only the technical component, append modifier TC. To report only the technical component, submit without a modifier.

The professional component is covered by Medicare as outpatient physical therapy when performed by a physical therapist who meets the following criteria:

- The physical therapist is certified by the American Board of Physical Therapy Specialties (ABPTS) as a clinical electrophysiologic-certified specialist and is permitted to provide the service under state law.
- The physical therapist is personally supervised by an ABPTS-certified physical therapist; only the certified physical therapist may bill for the service.

Medicare will permit a physical therapist without ABPTS certification to provide certain electromyography services if that physical therapist was not ABPTS-certified as of July 1, 2001, and had been furnishing such diagnostic tests prior to May 1, 2001. The requirements vary depending on the CPT code billed.

Some third-party payers, such as Medicare, reimburse only for the technical portion of many procedures whose codes are in this subsection of the CPT book. It is important for each therapist to determine how insurers require physical therapists to bill services. Therapists should keep track of experiences with each insurance company and policy, providing data for future claims.

The multiple procedure payment reduction (MPPR) policy applies to this service. Under MPPR, when multiple “always therapy” procedures are rendered to the same patient on the same date of service (even in separate sessions), the procedure with the highest practice expense value that day is paid at 100 percent, and the practice expense component of the second and subsequent therapy services is paid at 50 percent. The work and malpractice components of the therapy service payment are not reduced. For payers other than Medicare, the amount of the reduction may vary by payer and by insurance plan.

ICD-10-CM Diagnostic Codes

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<td>J98.8</td>
<td>Other specified respiratory disorders</td>
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<td>R05</td>
<td>Cough</td>
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<tr>
<td>R06.6</td>
<td>Hiccough</td>
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<tr>
<td>R07.1</td>
<td>Chest pain on breathing</td>
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<tr>
<td>R07.81</td>
<td>Pleurodynia</td>
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</table>

Please note that this list of associated ICD-10-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

AMA: 95866 2018, Jan, 16; 2017, Jan, 18; 2016, Jan, 13; 2015, Mar 6; 2015, Jan, 16; 2014, Jan, 11; 2013, May, 8-10

Relative Value Units/Medicare Edits

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Terms To Know

atrophy. Reduction in size or activity in an anatomic structure, due to wasting away from disease or other factors.

electromyography. Examining and recording the electrical activity of a muscle.

innervation. Nerve distribution to a body part.

neuropathy. Abnormality, disease, or malfunction of the nerves.

technical component. Portion of a health care service that identifies the provision of the equipment, supplies, technical personnel, and costs attendant to the performance of the procedure other than the professional services.
CPT Index

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