Optum

Coding &
Payment Guide

Physical Therapy/ Rehabilitation/ Physical Medicine

An essential coding, billing and reimbursement resource for physical, occupational and speech therapy, rehabilitation and physical medicine

2024

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Contents

Getting Started with Coding and Payment Guide

The *Coding and Payment Guide for Physical Therapy/Rehabilitation/Physical Medicine* 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, it is anticipated that 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 Physical Therapy/Rehabilitation/Physical Medicine* lists the CPT codes in ascending numeric order. Included in the code set are all 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 Optum Coding and Payment Guide series display in their resequenced order. **Resequenced codes are enclosed in brackets [ ] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for moreICD-10-CM coding information.

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.

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 Edits, RVUs, and Other Coding Updates

The *Optum Coding and Payment Guide* 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 version 28.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is https://www.optumcoding.com/ProductUpdates/. The 2024 password is: **XXXXXXXXXX**. Log in frequently to ensure you receive the most current updates.

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

or

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

The following pages provide a sample page from the book displaying the format of *Coding Guide* with each element identified and explained.

94660

94660 Continuous positive airway pressure ventilation (CPAP), initiation and management

Explanation

A mechanical ventilator is applied with a mask over the nose and mouth or through a tube placed into the trachea for patients requiring help breathing due to a lung disorder. Intermittent positive pressure breathing uses positive pressure during the inspiration phase of breathing. This code applies to initial evaluation or application of continuous positive airway pressure for ventilation assistance with positive pressure during inspiration and exhalation.

Coding Tips

Code 94660 is considered to be a part of critical care services, when provided, and is not reported separately when provided with these services.

Documentation Tips

When the documentation states that bilevel positive airway pressure (BiPAP) was performed, code 94660 is appropriate to report. BiPAP is noninvasive mechanical ventilation and includes continuous positive airway pressure (CPAP) and pressure support ventilation.

Reimbursement Tips

According to the medically unlikely edits, one unit of service is allowed for this procedure per date of service.

ICD-10-CM Diagnostic Codes

G47.33	Obstructive sleep apnea (adult) (pediatric)
J44.0	Chronic obstructive pulmonary disease with (acute) lower respiratory infection
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J44.9	Chronic obstructive pulmonary disease, unspecified
J80	Acute respiratory distress syndrome
J81.0	Acute pulmonary edema
J96.01	Acute respiratory failure with hypoxia
J96.02	Acute respiratory failure with hypercapnia
P22.0	Respiratory distress syndrome of newborn N
P22.1	Transient tachypnea of newborn N
P24.01	Meconium aspiration with respiratory symptoms N
P27.1	Bronchopulmonary dysplasia originating in the perinatal period
P28.3	Primary sleep apnea of newborn N
P28.4	Other apnea of newborn N
P28.5	Respiratory failure of newborn N
R06.03	Acute respiratory distress
R09.02	Hypoxemia

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.

Associated HCPCS Codes

A7030	Full face mask used with positive airway pressure device, each
A7031	Face mask interface, replacement for full face mask, each
A7032	Cushion for use on nasal mask interface, replacement only, each
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap
A7035	Headgear used with positive airway pressure device
A7036	Chinstrap used with positive airway pressure device
A7037	Tubing used with positive airway pressure device
A7038	Filter, disposable, used with positive airway pressure device
A7039	Filter, nondisposable, used with positive airway pressure device
A7044	Oral interface used with positive airway pressure device, each
E0601	Continuous positive airway pressure (CPAP) device

AMA: **94660** 2019,Mar,10; 2019,Aug,8; 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Oct,8; 2014,May,4; 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
94660	0.76	1.06	0.07	1.89
Facility RVU	**Work**	**PE**	**MP**	**Total**
94660	0.76	1.06	0.07	1.11

	FUD	Status	MUE	Modifiers				IOM Reference
94660	N/A	A	1(2)	N/A	N/A	N/A	80*	None

* with documentation

Terms To Know

critical care. Treatment of critically ill patients in a variety of medical emergencies that requires the constant attendance of the physician (e.g., cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, critically ill neonate).

empyema. Accumulation of pus within the respiratory or pleural cavity.

mediastinum. Collection of organs and tissues that separate the pleural sacs. Located between the sternum and spine above the diaphragm, it contains the heart and great vessels, trachea and bronchi, esophagus, thymus, lymph nodes, and nerves.

pleurisy. Inflammation of the serous membrane that lines the lungs and the thoracic cavity. Pleurisy may cause effusion within the cavity or have exudate in the pleural space or on the membrane surface.

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding and Payment Guide for the Physical Therapist* is updated with CPT codes for year 2023. The following icons are used in the *Coding and Payment Guide*:

- ● This CPT code is new for 2023.
- ▲ This CPT code description is revised for 2023.
- ✚ This CPT code is an add-on code.
- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services.
- [ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same provider on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice. The 97000 series contains the codes most often used by physical therapists and physical therapist assistants, many of which are timed codes (each 15 minutes) that do not include add-on codes. Physical therapists also use codes outside the 97000 series that do use add-on codes.

2. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, additional information might help coders in their determination of the proper code selection. In *Coding and Payment Guide for the Physical Therapist*, a step-by-step clinical description of the procedure is provided, in simple terms. Technical language that might be used by the physical therapist is included and defined. *Coding and Payment Guide for the Physical Therapist* describes the most common method of performing each procedure.

3. Coding Tips

Coding tips provide information on how the code should be used, related procedure codes, and help concerning common billing errors and modifier usage. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

4. Documentation Tips

Documentation tips provide code-specific tips to the coder regarding the information that should be noted in the documentation in order to support code assignment.

5. Reimbursement Tips

Reimbursement tips offer Medicare and other payer guidelines that could affect the reimbursement of this service or procedure.

6. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty.

Some ICD-10-CM codes are further identified with the following icons:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult:15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances, the ICD-10-CM codes for only one side may have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to a right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

7. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

8. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

9. Relative Value Units/Medicare Edits

The 2023 Medicare edits were not available at the time this book went to press. Updated 2023 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2023 edition password is **23SPECIALTY**.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Work component, reflecting the qualified provider's time and skill
- Practice expense (PE) component, reflecting the qualified provider's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) insurance component, reflecting the relative risk or liability associated with the service

There are two groups of RVUs listed for each CPT code. The first RVU group is for nonfacilities, which represents provider services performed in provider offices, patient's homes, or other nonhospital settings. The second RVU group is for facilities, which includes provider services performed in hospitals, ambulatory surgery centers, or skilled nursing facilities.

Medicare Follow-Up Days (FUD)

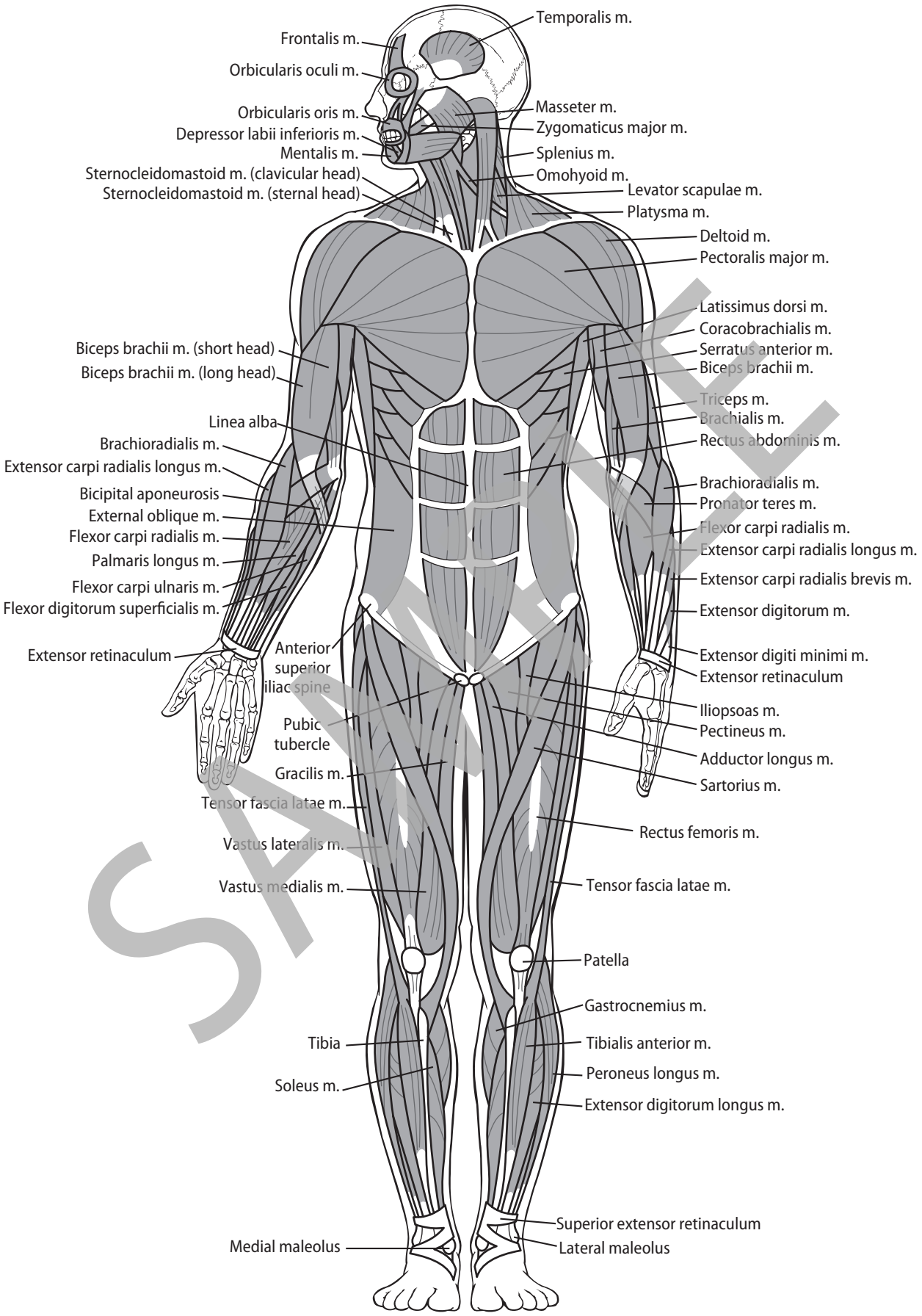
Information on the Medicare global period is provided here, even though it is not relevant to physical therapists' coding. These services, then, have a value of 0. The global period includes all the necessary services normally furnished before, during, and after a procedure. This includes preoperative visits after the decision is made to operate and follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery. These types of services cannot be separately reported.

Status

The Medicare status indicates if the service is separately payable by Medicare. The Medicare RBRVS includes:

A	Active code—separate payment may be made
B	Bundled code—payment is bundled into other service
C	Carrier priced—individual carrier will price the code
I	Not valid—Medicare uses another code for this service
N	Non-covered—service is not covered by Medicare
R	Restricted—special coverage instructions apply

Muscles



For example, modifier 59 Distinct procedural service, could be used when billing for both 97530 and 97750 to indicate the procedures were performed consecutively without any overlapping minutes. Some payers may require the use of modifier XE for greater specificity.

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.

The following is a list of CPT modifiers used most often by physical therapists:

26 Professional Component. Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When thephysician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

Coding Tip
Modifier 26 identifies that the professional component is being reported separately from the technical component for the diagnostic procedure performed. Payment is based solely on the professional component relative value of the procedure.

59 Distinct Procedural Service. Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Coding Tip
Append modifier 59 Distinct Procedural Service when two timed procedures are performed consecutively versus concurrently.

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional. It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service.

Coding Tip
Physical therapists in skilled nursing facilities might use modifier 76 for patients paid under Medicare Part B. These patients may receive services in both the morning and the afternoon of the same day, and modifier 76 would indicate that the services were not duplicative. (This applies only to untimed codes.)

96 Habilitative Services. When a service or procedure that may be either habilitative or rehabilitative in nature is provided for habilitative purposes, the physician or other qualified health care professional may add modifier 96 to the service or procedure code to indicate that the service or procedure provided was habilitative services. Habilitative services help an individual learn skills and functioning for daily living that the individual has not yet developed, and then keep and/or improve those learned skills. Habilitative services also help an individual keep, learn, or improve skills and functioning for daily living.

Note: Modifier 96 should be appended to the code for services or procedures that are considered habilitative. Habilitative services describe medically needed services and/or devices that help a patient partly or fully to learn, keep, and improve new skills or functioning required to perform daily living activities or manage a health condition. Habilitative services help patients acquire a skill for the first time. Some payers may require that HCPCS modifier SZ Habilitative services be reported. Additionally, HCPCS modifier SZ was deleted by CMS effective January 1, 2018. Please determine payer guidelines prior to using this invalid modifier.

97 Rehabilitative Services. When a service or procedure that may be either habilitative or rehabilitative in nature is provided for rehabilitative purposes, the physician or other qualified health care professional may add modifier 97 to the service or procedure code to indicate that the service or procedure provided was a rehabilitative service. Rehabilitative services help an individual keep, get back, or improve skills and functioning for daily living that may have been lost or impaired because the individual was sick, hurt, or disabled.

Note: Modifier 97 should be appended to services or procedures that are considered rehabilitative. Rehabilitative services describe a diverse range of services—from complete specialized medically based inpatient programs to outpatient therapy—provided in various settings such as nursing homes or ambulatory centers that encourage the best possible level of total well-being (physical, mental, emotional, psychological, social, and economic) of the patient to ensure he or she can function at the highest degree possible. Rehabilitative services are provided to help patients reacquire a skill that was lost or impaired due to an acquired condition.

Modifiers 96 and 97 are used to identify benefits and do not affect payment. The modifiers are used to identify coverage and limitation by the payer.

HCPCS Level II modifiers may also be appended to CPT codes for services. Refer to the HCPCS Level II Definitions and Guidelines for a listing of the HCPCS Level II modifiers.

CO Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

CQ Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant

Note: Services are reported using the de minimis standard of the PTA providing at least 10 percent of the service independent of the physical therapist. See section regarding Physical Therapy Assistants.

GO Services delivered under an outpatient occupational therapy plan of care

GP Services delivered under an outpatient physical therapy plan of care

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

▶The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service◀

Classification of Evaluation and Management (E/M) Services

▶The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.◀

New and Established Patients

▶Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

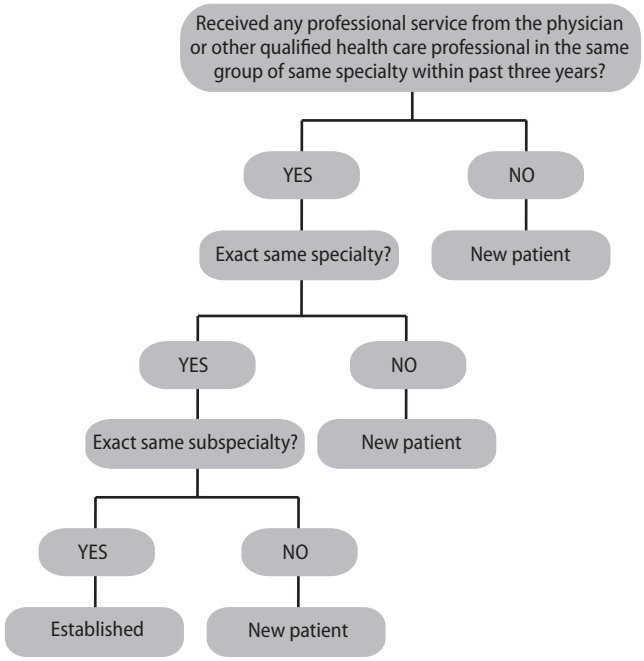
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.◀

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

▶◀ = Contains new or revised text

99202-99205

★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For patients admitted and discharged from inpatient or observation care on the same date, see 99234-99236. For prolonged services with 99205, see 99417; for Medicare, see G2212. Medicare has identified these codes as telehealth/telemedicine services. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

Documentation Tips

Medicare allows only the medically necessary portion of the visit. Even if a complete note is generated, only the necessary services for the condition of the patient at the time of the visit can be considered in determining the level of an E/M code. Medical necessity must be clearly stated and support the level of service reported.

Reimbursement Tips

The place-of-service (POS) codes used for reporting these services are the same as those for a new patient: POS code 11 represents the clinician's office environment and POS code 22 represents the outpatient setting. When a separately identifiable E/M service is reported at the same time as another procedure or service, modifier 25 should be appended to the E/M service to indicate the service is distinct from the other service performed.

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: **99202** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99203** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99204** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99205** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan

29520-29550

29520 Strapping; hip
29530 knee
29540 ankle and/or foot
29550 toes

Explanation

The qualified health care provider uses tape to strap a lower extremity. Multiple strips are used to overlap and build support of the affected area. The strips are often placed from one area to another to construct temporary support to the tendons and muscles. Report 29520 if the site taped is the hip; 29530 for the knee; 29540 for the ankle and/or foot; and 29550 for the toes.

Coding Tips

Do not report 29540 in addition to 29580–29581 when performed on the same extremity.

Do not report 29540 in addition to application of multilayered compression system of the lower (29581) leg including ankle and foot.

According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure. In general, casting supplies should be reported separately.

The Musculoskeletal System subsection of the CPT book is generally arranged according to body region. Physical therapists most frequently use the strapping and splint application codes, which are grouped together (29105–29280, 29505–29584), then arranged by general body region (e.g., upper body extremity, lower extremity).

Documentation Tips

The anatomical location, as well as the condition necessitating the treatment, should be clearly identified in the medical record.

A dislocation is the traumatic displacement of the bones in any articulating joint severe enough to lose normal anatomic relationship. A dislocation (luxation) occurs when the bones completely lose contact with their articulating surfaces. A subluxation occurs when there is only a partial loss of contact. Closed dislocation is described by terms such as complete, NOS, partial, simple, and uncomplicated. Open dislocation is described by terms such as compound, infected, and with foreign body. Dislocations not specified as open or closed should be classified as closed.

A sprain is a complete or incomplete tear in any one or more of the ligaments that surround and support a joint. A strain is an ill-defined injury caused by overuse or overextension of the muscles or tendons of a joint.

Reimbursement Tips

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.

Under the RBRVS payment methodology, supplies that typically are used in the delivery of a service have been included in the calculation of the practice expense value for the code and should not be billed separately.

ICD-10-CM Diagnostic Codes

L03.031 Cellulitis of right toe ☑
M12.271 Villonodular synovitis (pigmented), right ankle and foot ☑
M20.11 Hallux valgus (acquired), right foot ☑
M20.21 Hallux rigidus, right foot ☑
M21.161 Varus deformity, not elsewhere classified, right knee ☑
M21.171 Varus deformity, not elsewhere classified, right ankle ☑
M21.251 Flexion deformity, right hip ☑
M21.261 Flexion deformity, right knee ☑
M21.271 Flexion deformity, right ankle and toes ☑
M21.371 Foot drop, right foot ☑
M21.531 Acquired clawfoot, right foot ☑
M21.541 Acquired clubfoot, right foot ☑
M21.611 Bunion of right foot ☑
M21.6X1 Other acquired deformities of right foot ☑
M22.01 Recurrent dislocation of patella, right knee ☑
M22.11 Recurrent subluxation of patella, right knee ☑
M22.41 Chondromalacia patellae, right knee ☑
M23.211 Derangement of anterior horn of medial meniscus due to old tear or injury, right knee ☑
M23.221 Derangement of posterior horn of medial meniscus due to old tear or injury, right knee ☑
M23.231 Derangement of other medial meniscus due to old tear or injury, right knee ☑
M23.241 Derangement of anterior horn of lateral meniscus due to old tear or injury, right knee ☑
M23.251 Derangement of posterior horn of lateral meniscus due to old tear or injury, right knee ☑
M23.261 Derangement of other lateral meniscus due to old tear or injury, right knee ☑
M24.371 Pathological dislocation of right ankle, not elsewhere classified ☑
M24.374 Pathological dislocation of right foot, not elsewhere classified ☑
M24.461 Recurrent dislocation, right knee ☑
M24.471 Recurrent dislocation, right ankle ☑
M24.474 Recurrent dislocation, right foot ☑
M66.251 Spontaneous rupture of extensor tendons, right thigh ☑
M66.261 Spontaneous rupture of extensor tendons, right lower leg ☑
M66.271 Spontaneous rupture of extensor tendons, right ankle and foot ☑
M66.351 Spontaneous rupture of flexor tendons, right thigh ☑
M66.361 Spontaneous rupture of flexor tendons, right lower leg ☑
M66.851 Spontaneous rupture of other tendons, right thigh ☑
M66.861 Spontaneous rupture of other tendons, right lower leg ☑

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.

Associated HCPCS Codes

A4450 Tape, nonwaterproof, per 18 sq in
A4452 Tape, waterproof, per 18 sq in
A4649 Surgical supply; miscellaneous
L3260 Surgical boot/shoe, each

AMA: **29520** 2022,May; 2018,Jan **29530** 2022,May; 2018,Jan **29540** 2022,May; 2018,Jan; 2016,Aug **29550** 2022,May; 2018,Jan

94618, 94621

94618 Pulmonary stress testing (eg, 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed

94621 Cardiopulmonary exercise testing, including measurements of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings

Explanation

In 94618, a pulmonary exercise stress test is performed to determine how much air is moving in and out of the lungs during exercise and to establish where breathing problems are occurring since they may be in the lungs, heart, or circulation. An exercise stress test is done with the patient riding a stationary bike (ergometer) or walking on a treadmill. Heartrate, breathing, and blood pressure are monitored before beginning the exercise. Basic ventilation studies are performed with a spirometer and recording device as the patient breathes through a mouthpiece and connecting tube while a nose clip prevents nasal breathing. Measurement of the patient's oxygen level by pulse oximetry is included, as well as oxygen titration and heartrate, when performed. In 94621, cardiopulmonary exercise testing is performed. Electrodes are placed on the upper body to monitor the heart. Throughout the process, blood samples may be taken to measure oxygen uptake and carbon dioxide waste products in the blood, as well as other tests including minute ventilation and an electrocardiogram (ECG, EKG).

Coding Tips

Do not report pulse oximetry with these codes. Do not report 94621 in addition to ECG monitoring, cardiovascular stress testing, or oxygen uptake testing. Spirometry is included in this procedure and should not be billed separately. When a six-minute walk test is performed with no objective ventilatory assessments, report 97750.

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

Coverage may be limited to physical therapists specializing in the care of pulmonary patients in specific settings. 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 the complete procedure (i.e., both the professional and technical components), submit without a modifier.

ICD-10-CM Diagnostic Codes

B44.81 Allergic bronchopulmonary aspergillosis
E84.0 Cystic fibrosis with pulmonary manifestations
I50.21 Acute systolic (congestive) heart failure
I50.22 Chronic systolic (congestive) heart failure
I50.23 Acute on chronic systolic (congestive) heart failure
I50.31 Acute diastolic (congestive) heart failure
I50.32 Chronic diastolic (congestive) heart failure
I50.33 Acute on chronic diastolic (congestive) heart failure
I50.41 Acute combined systolic (congestive) and diastolic (congestive) heart failure
I50.42 Chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.43 Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
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
J45.51 Severe persistent asthma with (acute) exacerbation
J45.52 Severe persistent asthma with status asthmaticus
J82.81 Chronic eosinophilic pneumonia
J82.82 Acute eosinophilic pneumonia
J82.83 Eosinophilic asthma
J82.89 Other pulmonary eosinophilia, not elsewhere classified
J84.170 Interstitial lung disease with progressive fibrotic phenotype in diseases classified elsewhere
J84.178 Other interstitial pulmonary diseases with fibrosis in diseases classified elsewhere
M35.02 Sjögren syndrome with lung involvement

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: **94618** 2020,Dec; 2019,May; 2019,Mar; 2017,Oct **94621** 2020,Dec; 2019,May; 2019,Mar; 2017,Oct

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
94618	0.48	0.47	0.03	0.98
94621	1.42	3.03	0.13	4.58
Facility RVU	**Work**	**PE**	**MP**	**Total**
94618	0.48	0.47	0.03	0.98
94621	1.42	3.03	0.13	4.58

	FUD	Status	MUE	Modifiers				IOM Reference
94618	N/A	A	1(3)	N/A	N/A	N/A	80*	None
94621	N/A	A	1(3)	N/A	N/A	N/A	80*	

* with documentation

N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

[96125]

★**96125** Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

Explanation

The qualified health care provider administers standardized cognitive performance testing to evaluate such factors as the patient's immediate, recent, and remote memory; temporal and spatial orientation; general information recall; problem-solving and abstract reasoning abilities; organizational skills; and auditory processing and retention. This code includes face-to-face time administering tests to the patient, as well as interpretation and preparation of the report.

Coding Tips

This code is reported per hour of service. Information obtained through the assessment testing is interpreted and a written report is generated. This code includes the interpretation of the findings and preparation of the report.

To report neuropsychological testing evaluation with administration and scoring, see 96132–96146.

Medicare has provisionally identified this code as telehealth/telemedicine services. Current Medicare coverage guidelines, including place of service, should be reviewed. Commercial payers should be contacted regarding their coverage guidelines.

Documentation Tips

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

Reimbursement Tips

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.

Claims for services above the $2,230 threshold require the use of modifier KX. When appending modifier KX, the physical therapist indicates that the service thresholds are reasonable and medically necessary, and that there is documentation of medical necessity for the services in the patient's medical record. Services exceeding modifier KX thresholds for outpatient therapy and do not have modifier KX appended are denied by Medicare contractors.

Services provided over the $3,000 annual threshold are subject to a targeted review process, which focuses on providers who have had a high percentage of claims denials, providers with a pattern of billing that is aberrant compared with peers or suggests questionable billing practices, and providers newly enrolled in Medicare.

According to the Physical Therapy Disposition List, this service is bundled under the Medicare physician fee schedule with any therapy codes. Regardless of whether it is reported alone or with another therapy code, this service will be denied.

ICD-10-CM Diagnostic Codes

F84.0	Autistic disorder
F84.3	Other childhood disintegrative disorder P
F84.5	Asperger's syndrome
F84.8	Other pervasive developmental disorders
F88	Other disorders of psychological development
F90.0	Attention-deficit hyperactivity disorder, predominantly inattentive type
F90.1	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F90.2	Attention-deficit hyperactivity disorder, combined type
F90.8	Attention-deficit hyperactivity disorder, other type
F91.1	Conduct disorder, childhood-onset type
F91.2	Conduct disorder, adolescent-onset type
F91.3	Oppositional defiant disorder
F93.0	Separation anxiety disorder of childhood P
F94.0	Selective mutism
F94.1	Reactive attachment disorder of childhood P
F94.2	Disinhibited attachment disorder of childhood P
F95.1	Chronic motor or vocal tic disorder
F98.4	Stereotyped movement disorders
F98.5	Adult onset fluency disorder
I69.020	Aphasia following nontraumatic subarachnoid hemorrhage
I69.120	Aphasia following nontraumatic intracerebral hemorrhage
I69.220	Aphasia following other nontraumatic intracranial hemorrhage
I69.320	Aphasia following cerebral infarction
I69.820	Aphasia following other cerebrovascular disease

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: **96125** 2018,Nov; 2018,Oct

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
96125	1.7	1.27	0.09	3.06
Facility RVU	**Work**	**PE**	**MP**	**Total**
96125	1.7	1.27	0.09	3.06

	FUD	Status	MUE	Modifiers				IOM Reference
96125	N/A	A	2(3)	N/A	N/A	N/A	80*	100-02,15,160; 100-02,15,230.4

* with documentation

97032

97032 Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes

Explanation

The qualified health care provider applies electrical stimulation to one or more areas to promote muscle function, wound healing, and/or pain control using a handheld probe or other manual mechanism. This treatment requires direct contact by the provider and is billed in multiple 15-minute units.

Coding Tips

This modality requires direct (one-to-one) patient contact by the physical therapist and includes a time component. According to CMS guidelines, at least eight minutes of direct contact with the patient must be provided for a single unit of service to be appropriately billed in all instances and included in the total time of direct contact services provided to the patient.

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.

Medical record documentation should indicate the total amount of time for the direct one-to-one patient contact provided by the physical therapist, as well as total treatment time (as defined by all timed and untimed codes). AMA guidelines state that incremental intervals of treatment performed on the same session may be added together when determining total time. Check with other third-party payers for their guidelines.

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

Reimbursement Tips

Under the RBRVS payment methodology, supplies that typically are used in the delivery of a service (such as electrodes) have been included in the calculation of the practice expense value for the code and should not be billed separately.

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.

This service is considered an "always-therapy" service. 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

Claims for services above the $2,230 threshold require the use of modifier KX. When appending modifier KX, the physical therapist indicates that the service thresholds are reasonable and medically necessary, and that there is documentation of medical necessity for the services in the patient's medical record. Services exceeding modifier KX thresholds for outpatient therapy and do not have modifier KX appended are denied by Medicare contractors.

Services provided over the $3,000 annual threshold are subject to a targeted review process, which focuses on providers who have had a high percentage of claims denials, providers with a pattern of billing that is aberrant compared with peers or suggests questionable billing practices, and providers newly enrolled in Medicare.

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.

Associated HCPCS Codes

A4595 Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)

E0720 Transcutaneous electrical nerve stimulation (TENS) device, two-lead, localized stimulation

E0730 Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation

AMA: 97032 2019,Jul; 2018,Oct; 2018,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
97032	0.25	0.17	0.01	0.43
Facility RVU	**Work**	**PE**	**MP**	**Total**
97032	0.25	0.17	0.01	0.43

	FUD	Status	MUE	Modifiers				IOM Reference
97032	N/A	A	4(3)	N/A	N/A	N/A	80*	100-02,15,230; 100-02,15,230.1; 100-02,15,230.4; 100-03,10.3; 100-03,10.4; 100-03,160.12; 100-03,160.15; 100-03,160.17; 100-04,5,10; 100-04,5,20.2

* with documentation

Terms To Know

electrical stimulation. Electrical impulses are used to promote healing by way of electrodes placed externally on the skin surface or internally into muscle or bone.

97750

★**97750** Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes

Explanation

The qualified health care provider performs a test or measure of physical performance and/or function of one or more body areas. This code is also used to describe a complete functional capacity evaluation, which comprises an organized set of functional tests/measures for the purpose of making recommendations regarding the return to specific or general work activities or activities related to ADLs.

Coding Tips

This code is time specific and is billed in 15-minute increments. This includes the preparation of a separate report. According to CMS guidelines, at least eight minutes of direct contact with the patient must be provided for a single unit of service to be appropriately billed. AMA guidelines state that incremental intervals of treatment performed on the same session may be added together when determining total time. Check with other third-party payers for their guidelines.

Included in this service is manual muscle testing and range of motion measurements; therefore, these services should not be reported separately. For testing joint range of motion, see 95851–95852; electromyography, see 95860–95872, 95885–95887; nerve velocity determination, see 95905–95913.

Medicare has provisionally identified this code as telehealth/telemedicine services. Current Medicare coverage guidelines, including place of service, should be reviewed. Commercial payers should be contacted regarding their coverage guidelines.

Documentation Tips

Medical record documentation should indicate the total amount of time for the direct one-to-one patient contact provided by the physical therapist, as well as total treatment time (as defined by all timed and untimed codes). Documentation should include description of the test or measure performed, data collected, and how the outcome impacts the patient, such as progressing the plan of care or referring to another provider.

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

Reimbursement Tips

This code requires direct one-on-one patient contact, as well as a separate written report. Third-party payers may limit reporting this code on the same day as a physical therapy evaluation or re-evaluation. When these procedures are performed following an individual's work injury, they primarily are performed to determine the ability to return to work or to clarify the individual's disability status. Payment for these services depends on the worker's compensation or disability payment policies in effect for the provider.

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.

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.

This service is considered an "always-therapy" service. 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

Claims for services above the $2,230 threshold require the use of modifier KX. When appending modifier KX, the physical therapist indicates that the service thresholds are reasonable and medically necessary, and that there is documentation of medical necessity for the services in the patient's medical record. Services exceeding modifier KX thresholds for outpatient therapy and do not have modifier KX appended are denied by Medicare contractors.

Services provided over the $3,000 annual threshold are subject to a targeted review process, which focuses on providers who have had a high percentage of claims denials, providers with a pattern of billing that is aberrant compared with peers or suggests questionable billing practices, and providers newly enrolled in Medicare.

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: 97750 2018,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
97750	0.45	0.52	0.02	0.99
Facility RVU	**Work**	**PE**	**MP**	**Total**
97750	0.45	0.52	0.02	0.99

	FUD	Status	MUE	Modifiers				IOM Reference
97750	N/A	A	8(3)	N/A	N/A	N/A	80*	100-02,15,230.4; 100-03,10.4; 100-04,5,10

* with documentation

Terms To Know

functional assessment. Measurement or quantification of those activities identified by an individual as essential to support physical, social, and psychological well-being and to create a personal sense of meaningful living.

N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

HCPCS Level II Definitions and Guidelines

Introduction

One of the keys to gaining accurate reimbursement lies in understanding the multiple coding systems that are used to identify services and supplies. To be well versed in reimbursement practices, coders should be familiar not only with the American Medical Association's (AMA) Physicians' Current Procedural Terminology (CPT®) coding system (HCPCS Level I) but also with HCPCS Level II codes, which are becoming increasingly important to reimbursement as they are extended to a wider array of medical services.

HCPCS Level II—National Codes

HCPCS Level II codes commonly are referred to as national codes or by the acronym HCPCS (pronounced "hik-piks"), which stands for the Healthcare Common Procedure Coding System. HCPCS codes are used for billing Medicare and Medicaid patients and have been adopted by some third-party payers.

These codes, updated and published annually by the Centers for Medicare and Medicaid Services (CMS), are intended to supplement the CPT coding system by including codes for nonphysician services, administration of injectable drugs, durable medical equipment (DME), and office supplies.

When using HCPCS Level II codes, keep the following in mind:

- CMS does not use consistent terminology for unlisted services or procedures. The code descriptions may include any one of the following terms: unlisted, not otherwise classified (NOC), unspecified, unclassified, other, and miscellaneous.
- If billing for specific supplies and materials, avoid CPT code 99070 Supplies and materials, and be as specific as possible unless the Medicare administrative contractor or local payer directs otherwise.
- Coding and billing should be based on the service provided. Documentation should describe the patient's problems and the service provided to enable the payer to determine reasonableness and necessity of care.
- Refer to the Online CMS Manual System (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html or third-party payment policy to determine whether the care provided is a covered service.
- When both a CPT and HCPCS Level II code share nearly identical narratives, apply the CPT code. If the narratives are not identical, select the code with the narrative that better describes the service. Generally, for Medicare claims, the HCPCS Level II code is more specific and takes precedence over the CPT code.

Structure and Use of HCPCS Level II Codes

The main terms are in boldface type in the index. Main term entries include tests, services, supplies, orthotics, prostheses, medical equipment, drugs, therapies, and some medical and surgical procedures. Where possible, entries are listed under a common main term. In some instances, the common term is a noun; in others, the main term is a descriptor.

HCPCS Level II Codes: Sections A–V

Level II codes consist of one alphabetic character (letters A through V) and four numbers. Similar to CPT codes, they also can have modifiers, which can be alphanumeric or two letters. National modifiers can be used with all levels of HCPCS codes.

The HCPCS coding system is arranged in 16 sections:

A codes	A0021–A9999	Transportation Services Including Ambulance, Medical/Surgical Supplies, and Administrative, Miscellaneous, and Investigational
B codes	B4034–B9999	Enteral and Parenteral Therapy
C codes	C1052–C9899	Outpatient PSS
E codes	E0100–E8002	Durable Medical Equipment
G codes	G0008–G9999	Procedures/Professional Services (Temporary Codes)
H codes	H0001–H2037	Alcohol and Drug Abuse Treatment Services
J codes	J0120–J9999	Drugs Not Self-administered, Chemotherapy Drugs, Oral Immunosuppressive Drugs, Inhalation Solutions
K codes	K0001–K1027	Durable Medical Equipment for Medicare Administrative Contractors (DME MACs) (Temporary Codes)
L codes	L0112–L9900	Orthotic and Prosthetic Procedures, Devices
M codes	M0001–M1210	Medical Services, QPP Quality Measures
P codes	P2028–P9615	Pathology and Laboratory Services
Q codes	Q0035–Q9992	Miscellaneous Services (Temporary Codes)
R codes	R0070–R0076	Radiology Services
S codes	S0012–S9999	Commercial Payers (Temporary Codes)
T codes	T1000–T5999	Medicaid Services
U codes	U0001–U0005	COVID-19 Related Services
V codes	V2020–V5364	Vision, Hearing and Speech-Language Pathology Services

Section Guidelines

Examine the instructions found at the beginning of each of the 16 sections. Instructions include the guidelines, notes, unlisted procedures, special reports, and the modifiers that pertain to each section.

Use the alphabetic index to initially locate a code by looking for the type of service or procedure performed. The same rule applies: never code directly from the index. Always check the specific code in the appropriate section.

L3915 Wrist hand orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L3916 Wrist hand orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, off-the-shelf

L3917 Hand orthosis, metacarpal fracture orthosis, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L3918 Hand orthosis, metacarpal fracture orthosis, prefabricated, off-the-shelf

L3923 Hand finger orthosis, without joints, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L3924 Hand finger orthosis, without joints, may include soft interface, straps, prefabricated, off-the-shelf

L3925 Finger orthosis, proximal interphalangeal (PIP)/distal interphalangeal (DIP), non torsion joint/spring, extension/flexion, may include soft interface material, prefabricated, off-the-shelf

L3929 Hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L3930 Hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, off-the-shelf

L3931 Wrist hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment

L3956 Addition of joint to upper extremity orthosis, any material; per joint

L3960 Shoulder elbow wrist hand finger orthosis, abduction positioning, airplane design, prefabricated, includes fitting and adjustment

L3962 Shoulder elbow wrist hand finger orthosis, abduction positioning, Erb's palsy design, prefabricated, includes fitting and adjustment

L3980 Upper extremity fracture orthosis, humeral, prefabricated, includes fitting and adjustment

L3981 Upper extremity fracture orthosis, humeral, prefabricated, includes shoulder cap design, with or without joints, forearm section, may include soft interface, straps, includes fitting and adjustments

L3982 Upper extremity fracture orthosis, radius/ulnar, prefabricated, includes fitting and adjustment

L3984 Upper extremity fracture orthosis, wrist, prefabricated, includes fitting and adjustment

Orthotic Supplies, Miscellaneous

L4000 Replace girdle for spinal orthosis (CTLSO or SO)

L4002 Replacement strap, any orthosis, includes all components, any length, any type

L4350 Ankle control orthosis, stirrup style, rigid, includes any type interface (e.g., pneumatic, gel), prefabricated, off-the-shelf

L4360 Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L4361 Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, off-the-shelf

L4370 Pneumatic full leg splint, prefabricated, off-the-shelf

L4386 Walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L4392 Replacement soft interface material, static AFO

L4394 Replace soft interface material, foot drop splint

L4396 Static or dynamic ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L4398 Foot drop splint, recumbent positioning device, prefabricated, off-the-shelf

Q Codes: Temporary Q4049–Q4051

CMS assigns Q codes to procedures, services, and supplies on a temporary basis. When a permanent code is assigned, the Q code is deleted and cross-referenced.

This section contains national codes assigned by CMS on a temporary basis. This list contains current codes.

Q codes fall under the jurisdiction of the local contractor unless they represent an incidental service or are otherwise specified.

Q4049 Finger splint, static

Q4051 Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and other supplies)

Coding Tips

Since Q codes are under the jurisdiction of local Medicare contractors, coverage and coding guidelines may vary.

Check specific Medicare contractors' coding guidelines and coverage issues before reporting services using these codes.