ICD-9-CM categories 940–947 classify burns by degree and site. This category is to be used when the site of the burn is unspecified or when the site is specified. ICD-9-CM category 948 classifies burns according to the extent of body surface involved. In that situation, refer to category 948.

**Terms To Know**
- **debridement.** Removal of dead or contaminated tissue and foreign matter from a wound.
- **dressing.** Material applied to a wound or surgical site for protection, absorption, or drainage of the area.
- **Rule of Nines.** Rapid measurement system used to calculate the total body surface area (TBSA) involved in burns, based upon dividing the total area into segments as multiples of 9 percent. The plexiform or external genitals are 1 percent; each arm is 9 percent; the front and back of the trunk, and each leg separately counted as 18 percent; and the head is another 9 percent in adults. For infants and children, the head is 18 percent involvement and the legs are 14 percent each, due to the larger surface area of a child's head in proportion to the body.

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic codes here. Refer to your ICD-9-CM book.

**CCI Version 20.0**

Also not with 16020: 11719, 16000.
Also not with 16025: 16020.
Also not with 16030: 16020-16025.

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

<table>
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**ICD-9-CM Diagnostic Codes**

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<td>Medial epicondylitis of elbow</td>
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<tr>
<td>726.32</td>
<td>Lateral epicondylitis of elbow</td>
</tr>
<tr>
<td>727.05</td>
<td>Other tenosynovitis of hand and wrist</td>
</tr>
<tr>
<td>813.21</td>
<td>Closed fracture of shaft of radius (alone)</td>
</tr>
<tr>
<td>813.22</td>
<td>Closed fracture of shaft of ulna (alone)</td>
</tr>
<tr>
<td>813.23</td>
<td>Closed fracture of shaft of radius with ulna</td>
</tr>
</tbody>
</table>

**Coding Tips**

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. The code for the initial treatment of a fracture or dislocation includes the application, maintenance, and removal of the first cast or traction. See Application of Casts and Strapping in the CPT book in the Surgery Section, under the Musculoskeletal System. In general, casting supplies should be reported separately.

The musculoskeletal 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, 29505–29590), then arranged by general body region (e.g., upper body extremity, lower extremity).

ICD-9-CM coding guidelines require that the appropriate E code be used to describe the environmental event, circumstance, or other condition that caused the condition. Payer acceptance of E codes varies. Many payers will require an E code to determine if an injury is the result of an accident and, therefore, covered by another payer such as automobile insurance. Other payers will not process an E code. Check with payers for specific guidelines regarding the submission of E codes. An index for external causes of injury and poisoning can be found after the ICD-9-CM index.

**Terms To Know**

Splint. Brace or support. **Dynamic splint.** Brace that permits movement of an anatomical structure such as a hand, wrist, foot, or other part of the body after surgery or injury. **Static splint.** Brace that prevents movement and maintains support and position for an anatomical structure after surgery or injury.

**Application of long arm splint (shoulder to hand)**

**Explanation**

The physical therapist applies a splint from the shoulder to the hand. A long arm posterior splint is used to immobilize a number of injuries around the elbow and forearm. A cotton bandage is wrapped around the forearm from the midpalm region to midarm. Plaster strips or fiberglass splints are applied along the back of the arm and forearm to maintain the elbows and wrist in the desired position.

**Coding Tips**

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. The code for the initial treatment of a fracture or dislocation includes the application, maintenance, and removal of the first cast or traction. See Application of Casts and Strapping in the CPT book in the Surgery Section, under the Musculoskeletal System. In general, casting supplies should be reported separately.

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ICD-9-CM Diagnostic Codes

359.6 Symptomatic inflammatory myopathy in diseases classified elsewhere — (Code first underlying disease: 135, 140.0-208.9, 277.30-277.39, 446.0, 710.0, 710.1, 710.2, 710.3, 714.0)

714.0 Rheumatoid arthritis — (Use additional code to identify manifestation: 357.1, 359.6)

715.14 Primary localized osteoarthrosis, hand

813.21 Closed fracture of shaft of radius (alone)

813.22 Closed fracture of shaft of ulna (alone)

813.23 Closed fracture of shaft of radius with ulna

813.41 Closed Colles' fracture

813.42 Other closed fractures of distal end of radius (alone)

813.43 Closed fracture of distal end of ulna (alone)

813.44 Closed fracture of lower end of radius with ulna

813.45 Torus fracture of radius (alone)

813.46 Closed fracture of navicular (scaphoid) bone of wrist

814.02 Closed fracture of lunate (semilunar) bone of wrist

814.03 Closed fracture of triquetral (cuneiform) bone of wrist

814.04 Closed fracture of pisiform bone of wrist

814.05 Closed fracture of trapezium bone (larger multangular) of wrist

814.06 Closed fracture of trapezoid bone (smaller multangular) of wrist

814.07 Closed fracture of capitate bone (os magnum) of wrist

814.08 Closed fracture of hamate (unciform) bone of wrist

815.01 Closed fracture of base of thumb (first) metacarpal bone(s)

815.02 Closed fracture of base of other metacarpal bone(s)

815.03 Closed fracture of shaft of metacarpal bone(s)

815.04 Closed fracture of neck of metacarpal bone(s)

815.09 Closed fracture of multiple sites of metacarpus

841.9 Sprain and strain of unspecified site of elbow and forearm

842.00 Sprain and strain of unspecified site of wrist

842.11 Sprain and strain of carpal metacarpal (joint) of hand

Please note that this list of associated ICD-9-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.

CCI Version 20.0


Also not with 29125: 12014-12047, 12052-12057, 29130, 29260, G0168

Also not with 29126: 12011-12057

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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<th>Code (Non-Fac)</th>
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<th>Work Value</th>
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</table>

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Application of finger splint; static
29130
dynamic
29131

Explanation
The physical therapist applies a finger splint. This type of splint is applied to immobilize the digits. A twin layer of cotton padding is applied by the physician to the digit, covering the last to joints of that digit. Plaster casting or fiberglass splint material is applied to the finger from just beyond the knuckle to the tip of the finger. Usually the finger is immobilized in a straight position. Report 29130 if the splint applied is static for full immobilization. Report 29131 if the splint applied is dynamic for some movement.

Coding Tips
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. The code for the initial treatment of a fracture or dislocation includes the application, maintenance, and removal of the first cast or traction. See Application of Casts and Strapping in the CPT book in the Surgery section, under the Musculoskeletal System. In general, casting supplies should be reported separately.

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Terms To Know
splint. Brace or support. Dynamic s. Brace that permits movement of an anatomical structure such as a hand, wrist, foot, or other part of the body after surgery or injury. Static s. Brace that prevents movement and maintains support and position for an anatomical structure after surgery or injury.

ICD-9-CM Diagnostic Codes
718.74 Developmental dislocation of joint, hand
727.03 Trigger finger (acquired)
727.05 Other tenosynovitis of hand and wrist
728.6 Contracture of palmar fascia
736.1 Mallet finger
736.20 Unspecified deformity of finger

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</table>

A strain is an ill defined injury caused by overuse or overextension of the muscles or tendons that surround and support a joint. 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. These categories also identify whether the ligament or tendon is upper with upper limb, and lower limb with upper with rib and sternum, are coded with category 819. Multiple fractures involving lower limbs, fractures involving both upper limbs or upper limb with ribs or sternum are coded in category 828.

A dislocation (luxation) occurs when the bones completely lose contact with their articulating surfaces. A subluxation occurs when there is only partial loss of contact. Closed dislocation is described by terms such as complete, NOS, partial, simple, uncomplicated. Open dislocation is more common and is classified as complete, NOS, partial, simple, uncomplicated. Open dislocation is more common and is classified as complete, NOS, partial, simple, uncomplicated.

ICD-9-CM coding guidelines require that the appropriate E code be used to describe the environmental event, circumstance, or other condition that caused the condition. Payer acceptance of E codes varies. Many payers will require an E code to determine if an injury is the result of an accident and, therefore, covered by another payer such as automobile insurance. Other payers will not process an E code. Check with payers for their specific guidelines regarding the submission of E codes.

ICD-9-CM Diagnostic Codes

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<td>807.02</td>
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<td>Closed fracture of three ribs</td>
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<td>807.07</td>
<td>Closed fracture of seven ribs</td>
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<td>807.08</td>
<td>Closed fracture of eight or more ribs</td>
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<td>807.09</td>
<td>Closed fracture of multiple ribs, unspecified</td>
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<td>807.2</td>
<td>Closed fracture of sternum</td>
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<td>839.21</td>
<td>Closed dislocation, thoracic vertebra</td>
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<tr>
<td>839.69</td>
<td>Closed dislocation, other location</td>
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<tr>
<td>848.8</td>
<td>Other specified sites of sprains and strains</td>
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<tr>
<td>V54.17</td>
<td>Aftercare for healing traumatic fracture of vertebrae</td>
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<tr>
<td>V54.19</td>
<td>Aftercare for healing traumatic fracture of other bone</td>
</tr>
<tr>
<td>V54.27</td>
<td>Aftercare for healing pathologic fracture of vertebrae</td>
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<tr>
<td>V54.29</td>
<td>Aftercare for healing pathologic fracture of other bone</td>
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</tbody>
</table>

Please note that this list of associated ICD-9-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.

CCI Version 20.0

<table>
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<th>Condition</th>
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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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<td>1.42</td>
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</table>

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**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**CCI Version 20.0**


Also not with 29505: 29515, 29540, 64425-64450

Also not with 29515: 11055-11056, 29540-29582, 64445-64449

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

**Terms To Know**

**strapping.** Application of overlapping strips of tape or bandaging to put pressure on the affected area.
of an accident and, therefore, covered by another payer such as automobile insurance. Other payers will not process an E code. Check with payers for specific guidelines regarding the submission of E codes. An index for external causes of injury and poisoning can be found after the ICD-9-CM index.

**Terms To Know**

- **Strapping**: Application of overlapping strips of tape or bandaging to put pressure on the affected area.

**ICD-9-CM Diagnostic Codes**

- 718.75  Developmental dislocation of joint, pelvic region and thigh
- 835.00  Closed dislocation of hip, unspecified site
- 835.01  Closed posterior dislocation of hip
- 835.02  Closed obturator dislocation of hip
- 835.03  Other closed anterior dislocation of hip
- 843.0  Illofemoral (ligament) strain and sprain
- 843.1  Ischiocapsular (ligament) strain and sprain
- 843.8  Sprain and strain of other specified sites of hip and thigh
- 843.9  Sprain and strain of unspecified site of hip and thigh
- V54.89  Other orthopedic aftercare

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**CCI Version 20.0**

- Also not with 29520: 29445, 64445-64449
- Also not with 29530: 29445, 64445-64450
- Also not with 29540: 11900, 29445
- Also not with 29550: 42120, 29550, 64445-64449
- Also not with 29550: 11719, 11900, 64445-64450, G0127

*Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.*

**Coding Tips**

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.

Do not report 29540 in conjunction with application of multilayered compression system of the upper (29520) or lower (29520) leg and ankle and foot.

The musculoskeletal 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 (29105–29180, 29150–29190, 29205–29250), then arranged by general body region (e.g., upper body extremity, lower extremity).

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. A ‘charleyhorse’ is an idiom for a strain of a muscle, usually one of the major muscles such as the quadriceps femoris or gastrocnemius. These categories also include muscle, tendon, ligament, or joint capsule ruptures. Strains and sprains are classified according to site (e.g., wrist, foot, knee, leg, etc.) at the category level. Subcategory and subclassification further specify site or structure (e.g., joint or ligament).

ICD-9-CM coding guidelines require that the appropriate E code be used to describe the environmental event, circumstance, or other condition that caused the condition. Payer acceptance of E codes varies. Many payers will require an E code to determine if an injury is the result of an accident and, therefore, covered by another payer such as

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Coding and Payment Guide for the Physical Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>29520-29550</td>
<td>Strapping: hip</td>
</tr>
<tr>
<td>29520</td>
<td>Strapping: hip</td>
</tr>
<tr>
<td>29530</td>
<td>Strapping: knee</td>
</tr>
<tr>
<td>29540</td>
<td>Strapping: ankle and/or foot</td>
</tr>
<tr>
<td>29550</td>
<td>Strapping: toes</td>
</tr>
</tbody>
</table>

**Explanation**

The physical therapist uses tape to strap a lower extremity. Taping of the hip for immobilization is rarely used because of the hip muscles' superior strength to that of the tape. A hip spica taping procedure may be used to hold analgesic packs in place and to offer mild support to injured hip adductors or flexors. The patient stands with all weight on the unaffected leg. Six inch Ace wrap is usually used. The end of the wrap begins at the upper part of the thigh and immediately encircles the upper thigh and groin, crossing the starting point. When the starting end is reached the roll is taken completely around the waist and fixed firmly above the iliac crest. The wrap is carried around the thigh at groin level and up again around the waist. The end is secured with tape. Report 29520 if the site taped is the hip. Report 29530 if the site taped is the knee. Code 29540 is reported when the site taped is the ankle or foot, and code 29550 if the site is the toes.

**Coding Tips**

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.

Do not report 29540 in conjunction with application of multilayered compression system of the upper (29520) or lower (29520) leg and ankle and foot.

The musculoskeletal 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 (29105–29180, 29150–29190, 29205–29250), then arranged by general body region (e.g., upper body extremity, lower extremity).

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. A “charleyhorse” is an idiom for a strain of a muscle, usually one of the major muscles such as the quadriceps femoris or gastrocnemius. These categories also include muscle, tendon, ligament, or joint capsule ruptures. Strains and sprains are classified according to site (e.g., wrist, foot, knee, leg, etc.) at the category level. Subcategory and subclassification further specify site or structure (e.g., joint or ligament).

ICD-9-CM coding guidelines require that the appropriate E code be used to describe the environmental event, circumstance, or other condition that caused the condition. Payer acceptance of E codes varies. Many payers will require an E code to determine if an injury is the result of an accident and, therefore, covered by another payer such as
ICD-9-CM Diagnostic Codes

249.71 Secondary diabetes mellitus with peripheral circulatory disorders, uncontrolled — (Use additional code to identify manifestation: 443.81, 785.4) (Use additional code to identify any associated insulin use: V58.67)

249.80 Secondary diabetes mellitus with other specified manifestations, not stated as uncontrolled, or unspecified — (Use additional code to identify manifestation: 707.10-707.19, 707.8, 707.9, 731.8) (Use additional code to identify any associated insulin use: V58.67)

249.81 Secondary diabetes mellitus with other specified manifestations, uncontrolled — (Use additional code to identify manifestation: 707.10-707.19, 707.8, 707.9, 731.8) (Use additional code to identify any associated insulin use: V58.67)

250.70 Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled — (Use additional code to identify manifestation: 443.81, 785.4)

250.71 Diabetes with peripheral circulatory disorders, type I [juvenile type], not stated as uncontrolled — (Use additional code to identify manifestation: 443.81, 785.4)

250.72 Diabetes with peripheral circulatory disorders, type II or unspecified type, uncontrolled — (Use additional code to identify manifestation: 443.81, 785.4)

250.73 Diabetes with peripheral circulatory disorders, type I [juvenile type], uncontrolled — (Use additional code to identify manifestation: 443.81, 785.4)

454.0 Varicose veins of lower extremities with ulcer

454.1 Varicose veins of lower extremities with inflammation

454.2 Varicose veins of lower extremities with ulcer and inflammation

454.8 Varicose veins of the lower extremities with other complications

459.10 Postphlebitic syndrome without complications

459.11 Postphlebitic syndrome with ulcer

459.12 Postphlebitic syndrome with inflammation

459.13 Postphlebitic syndrome with ulcer and inflammation

459.31 Chronic venous hypertension with ulcer

459.32 Chronic venous hypertension with inflammation

459.33 Chronic venous hypertension with ulcer and inflammation

682.7 Cellulitis and abscess of foot, except toes — (Use additional code to identify organism, such as 041.1, etc.)

707.13 Ulcer of ankle — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)

707.14 Ulcer of heel and midfoot — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)

707.15 Ulcer of other part of foot — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)

Note: Please note that this list of associated ICD-9-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.

CCI Version 20.0


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
ICD-9-CM Diagnostic Codes

- 29581-29584
  - 29581 Application of multi-layer compression system; leg (below knee), including ankle and foot
  - 29582 thigh and leg, including ankle and foot, when performed
  - 29583 upper arm and forearm
  - 29584 upper arm, forearm, hand, and fingers

Explanation

The physical therapist applies a multilayer compression device. Compression therapy is often used in the treatment of extensive venous ulcers. The device may consist of a multilayer bandaging system composed only of elastic bandages, or may be paired with a knitted, tubular compression garment. In one method, after wound debridement and dressing, cotton gauze and cotton crepe bandages are applied. Next, a positioner is placed over the bandages and adjusted to the desired position. The compression device is slipped over the positioner, adjusted to ensure appropriate placement, and the positioner is removed. Report 29581 for application of the system below the knee (including ankle and foot). Report 29582 for an application that includes the thigh, lower leg, ankle, and foot, when applicable. Report 29583 when the compression system is applied to the upper arm and forearm. Report 29584 when it is applied to the upper arm, forearm, hand, and fingers.

Coding Tips

Codes 29581 and 29582 should not be reported with strapping of ankle and/or foot (29540), Unna boot (29580), or endovenous ablation (36475-36479). Also, do not report 29581 or 29582 with each other. Likewise, code 29582 should not be reported together with 29580 or 29581.

Depending on payer guidelines for the separate payment of supplies used when providing this procedure, it may be appropriate to separately report the supplies using one or more of the following HCPCS Level II codes that describe the supply: A6530–A6535, A6545, and A6549. Check with the specific payer to determine coverage.

The musculoskeletal 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, 29505–29590) and then arranged by general body region. Physical therapists most frequently use the strapping and splint application codes, which are grouped together (29105–29280, 29505–29590) and then arranged by general body region and dressing, cotton gauze and cotton crepe bandages are applied.

Terms To Know

Compression sleeve. Fitted wrap that accelerates recovery in patients with vein disease, lymphedema, or diabetes. Compression sleeves increase circulation and decrease swelling and fluid buildup following surgery.

ICD-9-CM Diagnostic Codes

- 440.23 Atherosclerosis of native arteries of the extremities with ulceration — (Use additional code for any associated ulceration: 707.10-707.19, 707.8, 707.9)
- 454.0 Varicose veins of lower extremities with ulcer

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Procedure Codes

- 454.2 Varicose veins of lower extremities with ulcer and inflammation
- 459.11 Postphlebitic syndrome with ulcer
- 459.13 Postphlebitic syndrome with ulcer and inflammation
- 459.31 Chronic venous hypertension with ulcer
- 459.33 Chronic venous hypertension with ulcer and inflammation

- 707.10 Ulcer of lower limb, unspecified — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)
- 707.12 Ulcer of calf — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)
- 707.13 Ulcer of ankle — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)
- 707.14 Ulcer of heel and midfoot — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)
- 707.15 Ulcer of other part of foot — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)
- 707.19 Ulcer of other part of lower limb — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)

Please note that this list of associated ICD-9-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.

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Also not with 29581: 15852, 29540-29580, 29700, 87070, 87076-87077

Also not with 29582: 15852, 29540-29550, 29581

Also not with 29583: 29075-29085, 29105-29126, 29705, 76000-76001, 77001-77002

Also not with 29584: 28190-28193, 29075-29085, 29125-29131, 29260, 29583, 29700-29705, 76000-76001, 77001-77002, G0168

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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64550

Application of surface (transcutaneous) neurostimulator

Explanation

A transcutaneous neurostimulator is applied to the patient. The physical therapist places electrode pads over the area to be stimulated and connects a transmitter box to the electrodes (e.g., TENS unit). Current is transmitted through the skin to sensory fibers which helps decrease the pain sensation along the nerve distribution.

Coding Tips

Application of surface neurostimulator includes instructing the patient on the purpose and operation of the unit, placement of the electrodes, and setting the parameters of the TENS unit. If using the TENS as a treatment modality, see 97014 (unattended) or 97032 (attended). Documentation must support the procedure identified on the claim. Some third-party payers provide specific guidelines for the coverage and reporting of this service. Contact specific payers to determine their policies.

Acute pain is defined as a sensation generated in the nervous system that may be an alert to possible injury, as a response to trauma, or as a postoperative sequela. Chronic pain may also be due to ongoing causes, such as arthritis, cancer, or current infections. Some patients suffer chronic pain in the absence of past injury or signs of body damage.

A fifth digit is required when reporting spinal stenosis of the lumbar region. The fifth-digit subclassification indicates if neurogenic claudication is present.

Terms to Know

cauda equina. Spinal roots occupying the lower end of the vertebral canal and descending from the distal end of the spinal cord, named for their appearance resembling that of the tail of a horse. c.e. syndrome. Compression of the spinal nerve roots presenting with pain and tingling radiating down the buttocks, back of the thigh, calf, and into the foot in a sciatic manner with aching in the bladder, perineum, and sacrum. Loss of bowel and bladder control may also occur. This syndrome is reported with a code from ICD-9-CM subcategory 344.6.

lumbago. Low back pain.

sciatica. Low back, buttoc, and hip pain that radiates down the leg, sometimes accompanied by paresthesia and weakness, usually caused by a herniated disk in the lumbar spine or neuropathy affecting the sciatic nerve.

TENS. Transcutaneous electrical nerve stimulator. TENS is applied by placing electrode pads over the area to be stimulated and connecting the electrodes to a transmitter box, which sends a current through the skin to sensory nerve fibers to help decrease pain in that nerve distribution.

ICD-9-CM Diagnostic Codes

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<td>Acute pain due to trauma — (Use additional code to identify pain associated with psychological factors: 307.89)</td>
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<td>338.19</td>
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<td>Chronic pain due to trauma — (Use additional code to identify pain associated with psychological factors: 307.89)</td>
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<td>Other chronic postoperative pain — (Use additional code to identify pain associated with psychological factors: 307.89)</td>
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<td>338.29</td>
<td>Other chronic pain — (Use additional code to identify pain associated with psychological factors: 307.89)</td>
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<tr>
<td>344.60</td>
<td>Cauda equina syndrome without mention of neurogenic bladder</td>
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<td>354.4</td>
<td>Causalgia of upper limb</td>
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<tr>
<td>719.46</td>
<td>Pain in joint, lower leg</td>
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<td>722.11</td>
<td>Displacement of thoracic intervertebral disc without myelopathy</td>
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<td>723.1</td>
<td>Cervicalgia</td>
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<td>723.4</td>
<td>Brachial neuritis or radiculitis NOS</td>
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<td>724.02</td>
<td>Spinal stenosis of lumbar region, without neurogenic claudication</td>
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<td>724.03</td>
<td>Spinal stenosis of lumbar region, with neurogenic claudication</td>
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<tr>
<td>724.2</td>
<td>Lumbago</td>
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<tr>
<td>724.3</td>
<td>Sciatica</td>
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<td>729.1</td>
<td>Unspecified myalgia and myositis</td>
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<td>729.2</td>
<td>Unspecified neuralgia, neuritis, and radiculitis</td>
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<tr>
<td>846.0</td>
<td>Sprain and strain of lumbosacral (joint) (ligament)</td>
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</table>

Please note that this list of associated ICD-9-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.

IOM References

100-3,10.2; 100-4,5,10.2

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<table>
<thead>
<tr>
<th>Code</th>
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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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ICD-9-CM Diagnostic Codes

**90901-90911**

90901  Biofeedback training by any modality
90911  Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry

**Explanation**

Biofeedback trains patients to control their autonomic or involuntary nervous system responses to regulate vital signs such as heart rate, blood pressure, temperature, and muscle tension. Monitors of various types are used to indicate body responses, which the patient learns to associate with related stimuli and also control in serial sessions. Code 90901 applies to any of several modalities of biofeedback training. Code 90911 applies to biofeedback training that uses the monitoring of the anus and/or rectum or urethra, including electromyography and manometry.

**Coding Tips**

Payment for coverage of biofeedback is determined by the payer. Because of this, a provider often must request prior authorization before providing this service. Under Medicare, use of biofeedback as part of a physical therapy plan of care is covered only when it is reasonable and necessary for the individual patient for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and more conventional treatments (heat, cold, massage, exercise, support) have not been successful. Biofeedback is covered for the treatment of stress and/or urge incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training. A failed trial of PME training is defined as no clinically significant improvement in urinary incontinence after completing up to four weeks of an ordered plan of PME to increase pelvic muscle strength. This therapy is not covered for treatment of ordinary muscle tension states or for psychosomatic conditions. Do not use codes 90875 or 90876; these codes are for individual psychophysiological therapy. Treatment of incontinence by pulsed magnetic neuromodulation should be reported using 53899.

**ICD-9-CM Diagnostic Codes**

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<td>342.01</td>
<td>Flaccid hemiplegia affecting dominant side</td>
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<td>342.02</td>
<td>Flaccid hemiplegia affecting nondominant side</td>
</tr>
<tr>
<td>342.11</td>
<td>Spastic hemiplegia affecting dominant side</td>
</tr>
<tr>
<td>342.12</td>
<td>Spastic hemiplegia affecting nondominant side</td>
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<td>344.01</td>
<td>Quadriplegia and quadriparesis, C1-C4, complete</td>
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<td>344.02</td>
<td>Quadriplegia and quadriparesis, C1-C4, incomplete</td>
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<tr>
<td>344.03</td>
<td>Quadriplegia and quadriparesis, C5-C7, complete</td>
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**Procedure Codes**

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<td>Diplegia of upper limbs</td>
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<td>344.60</td>
<td>Cauda equina syndrome without mention of neurogenic bladder</td>
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<td>564.01</td>
<td>Slow transit constipation</td>
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<td>Outlet dysfunction constipation</td>
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<td>564.6</td>
<td>Anal spasm</td>
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<td>596.4</td>
<td>Atony of bladder — (Use additional code to identify urinary incontinence: 625.6, 788.30-788.39)</td>
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<td>Hypertonicity of bladder — (Use additional code to identify urinary incontinence: 625.6, 788.30-788.39)</td>
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<td>596.55</td>
<td>Detrusor sphincter dyssynergia — (Use additional code to identify urinary incontinence: 625.6, 788.30-788.39)</td>
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<td>599.81</td>
<td>Urethral hypermobility — (Use additional code to identify urinary incontinence: 625.6, 788.30-788.39)</td>
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<td>Intrinsic (urethral) sphincter deficiency (ISD) — (Use additional code to identify urinary incontinence: 625.6, 788.30-788.39)</td>
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<td>728.85</td>
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<td>728.87</td>
<td>Muscle weakness (generalized)</td>
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<td>Rhabdomyolysis</td>
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<td>V48.2</td>
<td>Mechanical and motor problems with head</td>
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<td>V48.3</td>
<td>Mechanical and motor problems with neck and trunk</td>
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<td>V49.1</td>
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<td>V49.2</td>
<td>Motor problems with limbs</td>
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Please note that this list of associated ICD-9-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.

**IOM References**

100-2,16,10; 100-4,10.2; 100-5,40.7

**CCI Version 20.0**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour

92605 (92618)

92605 
Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour

92618 
each additional 30 minutes (List separately in addition to code for primary procedure)

Explanation
The assessment for the appropriate non-speech-generating augmentative and alternative communication (AAC) device is highly variable and dependent on the patient's age, ability, and motivation. Motor skills, hearing, vision, cognitive abilities, language comprehension, and general health are evaluated to determine the suitability of a high-tech or low-tech device. Once these are evaluated, an appropriate AAC device is prescribed. Report 92605 for the first hour spent face-to-face with the patient. Report 92618 for each additional 30 minutes.

Coding Tips
Code 92618 is a resequenced code and will not display in numeric order. As an add-on code, 92618 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as stand-alone codes.

A therapeutic procedure may be reported on the same day as an evaluation or reevaluation (97001–97002) when the medical record documentation supports the medical necessity of both services. Most payers consider these procedures to be speech pathology services and coverage can vary depending on the patient's contractual agreement with the payer. In most instances, these services must be reasonable and necessary to the treatment of the individual's illness or injury or must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state. Speech pathology is considered medically appropriate treatment for mental retardation when disorders such as aphasia or dysarthria are exhibited. The diagnosis and treatment of swallowing disorders (dysphagia) are also medically necessary regardless of the presence of a communication disability.

ICD-9-CM Diagnostic Codes

Expressive language disorder 315.31
Mixed receptive-expressive language disorder 315.32
Speech and language developmental delay due to hearing loss 318.5
Disorders of acoustic nerve 388.5
Aphasia due to cerebrovascular disease — (Use additional code to identify presence of hypertension) 438.12
Dysphasia due to cerebrovascular disease — (Use additional code to identify presence of hypertension) 744.1
Congenital anomalies of accessory auricle 744.23
Microtia 744.41
Congenital branchial cleft sinus or fistula 744.42
Congenital branchial cleft cyst 744.43
Congenital cervical auricle 744.46
Congenital preauricular sinus or fistula 744.47
Congenital preauricular cyst 744.81
Macrocheilia 744.82
Microcheilia 744.83
Macrostomia 744.84
Microstomia 748.0
Congenital choanal atresia 748.1
Other congenital anomaly of nose 748.2
Congenital web of larynx 784.41
Aphonia V10.01
Personal history of malignant neoplasm of tongue V10.20
Personal history of malignant neoplasm of unspecified respiratory organ V10.21
Personal history of malignant neoplasm of unspecified respiratory organ V10.22
Mechanical and motor problems with head V48.2
Mechanical and motor problems with neck and trunk V48.3
Sensory problem with head V48.4
Sensory problem with neck and trunk V48.5
Disfigurements of head V48.6
Disfigurements of neck and trunk V48.7
Fitting and adjustment of other specified prosthetic device V52.8
Fitting and adjustment of other devices related to nervous system and special senses V53.09

Please note that this list of associated ICD-9-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.

IOM References
100-2,15,230.3; 100-3,50.2; 100-4,5,10.2

CCI Version 20.0
31575, 76120-76125, 92507-92508, 92511, 92520, 92610-92611, 92613, 92614, 97755

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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**92607-92608**

**92607**  
Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour

**92608**  
each additional 30 minutes (List separately in addition to code for primary procedure)

**Explanation**

The patient is evaluated face to face by a specialist to determine the motor skills, hearing, cognitive abilities, comprehension, natural speech, esophageal and pharyngeal air flow, general health, and patient motivation for prescription of speech-generating augmentative and alternative communication (AAC) device. Once these are evaluated, an appropriate speech-generating device is prescribed. Report 92607 for the first hour and 92608 for each additional 30 minutes.

**Coding Tips**

As an add-on code, 92608 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same provider on the same date of service as the primary service/procedure, and must never be reported as stand-alone codes. Code 92608 should be reported once per 30 minutes.

The assessment can include the use of such tools as pictures on the lapboard, basic signs and gestures, and vocalizations. The medical record should also indicate the review of available medical records. A pertinent history is obtained including related educational background (e.g., history, current status, and learning style), as well as the types of devices previously used (low and high technology). Communication and/or medically related behaviors are evaluated.

Most payers consider these procedures to be speech pathology services and coverage can vary depending on the patient’s contractual agreement with the payer. The majority of payers break speech pathology coverage into two categories: evaluation (diagnostic) and therapeutic services. In most instances, these services must be reasonable and necessary to the treatment of the individual’s illness or injury or must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state.

Speech pathology is considered medically appropriate treatment for mental retardation when disorders such as aphasia or dysarthria are exhibited. The diagnosis and treatment of swallowing disorders (dysphagia) are also medically necessary regardless of the presence of a communication disability.

**ICD-9-CM Diagnostic Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>315.31</td>
<td>Expressive language disorder</td>
</tr>
<tr>
<td>315.32</td>
<td>Mixed receptive-expressive language disorder</td>
</tr>
<tr>
<td>315.34</td>
<td>Speech and language developmental delay due to hearing loss</td>
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</table>

<table>
<thead>
<tr>
<th>Code</th>
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<tr>
<td>388.5</td>
<td>Disorders of acoustic nerve</td>
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<td>389.05</td>
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<td>389.13</td>
<td>Neural hearing loss, unilateral</td>
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<td>389.14</td>
<td>Central hearing loss</td>
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<tr>
<td>389.15</td>
<td>Sensorineural hearing loss, unilateral</td>
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<tr>
<td>389.16</td>
<td>Sensorineural hearing loss, asymmetrical</td>
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<td>389.17</td>
<td>Sensory hearing loss, unilateral</td>
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<td>389.21</td>
<td>Mixed hearing loss, unilateral</td>
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<td>389.22</td>
<td>Mixed hearing loss, bilateral</td>
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<tr>
<td>438.11</td>
<td>Aphasia due to cerebrovascular disease — (Use additional code to identify presence of hypertension)</td>
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<tr>
<td>438.12</td>
<td>Dysphasia due to cerebrovascular disease — (Use additional code to identify presence of hypertension)</td>
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<tr>
<td>744.03</td>
<td>Congenital anomaly of middle ear, except ossicles, causing impairment of hearing</td>
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<tr>
<td>744.04</td>
<td>Congenital anomalies of ear ossicles</td>
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<tr>
<td>744.05</td>
<td>Congenital anomalies of inner ear</td>
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<tr>
<td>744.41</td>
<td>Congenital branchial cleft sinus or fistula</td>
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<tr>
<td>744.43</td>
<td>Congenital cervical auricle</td>
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<tr>
<td>744.46</td>
<td>Congenital preauricular sinus or fistula</td>
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<tr>
<td>748.0</td>
<td>Congenital choanal atresia</td>
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<tr>
<td>748.2</td>
<td>Congenital web of larynx</td>
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<tr>
<td>784.41</td>
<td>Aphonia</td>
</tr>
<tr>
<td>V52.8</td>
<td>Fitting and adjustment of other specified prosthetic device</td>
</tr>
<tr>
<td>V53.09</td>
<td>Fitting and adjustment of other devices related to nervous system and special senses</td>
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</table>

Please note that this list of associated ICD-9-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.

**IOM References**

100-2,15,230.3; 100-3,50.1; 100-3,50.2; 100-4,5,10.2; 100-4,5,10.6

**CCI Version 20.0**

97755

Also not with 92607: 92507-92508, 92521-92524, 92597, 92609

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Therapeutic services for the use of speech-generating device, including programming and modification

**Explanation**

This code includes therapeutic services associated with the use of speech generating devices. Services differ according to the device used. Electronic equipment may require routine maintenance, programming, or modification. Speech generating devices may require some patient therapeutic, rehabilitation, or occupational training.

**Coding Tips**

Most payers consider these procedures to be speech pathology services and coverage can vary depending on the patient's contractual agreement with the payer. The majority of payers break speech pathology coverage into two categories: evaluation (diagnostic) and therapeutic services. In most instances, these services must be reasonable and necessary to the treatment of the individual's illness or injury or must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state.

Speech pathology is considered medically appropriate treatment for mental retardation when disorders such as aphasia or dysarthria are exhibited. The diagnosis and treatment of swallowing disorders (dysphagia) are also medically necessary regardless of the presence of a communication disability.

**ICD-9-CM Diagnostic Codes**

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
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<tr>
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<tr>
<td>315.34</td>
<td>Speech and language developmental delay due to hearing loss</td>
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<tr>
<td>388.11</td>
<td>Acoustic trauma (explosive) to ear</td>
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<td>388.12</td>
<td>Noise-induced hearing loss</td>
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<td>388.2</td>
<td>Unspecified sudden hearing loss</td>
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<td>Disorders of acoustic nerve</td>
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<td>389.05</td>
<td>Conductive hearing loss, unilateral</td>
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<td>389.06</td>
<td>Conductive hearing loss, bilateral</td>
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<td>Sensory hearing loss, bilateral</td>
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<td>Neural hearing loss, unilateral</td>
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<td>438.19</td>
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<td>744.01</td>
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<td>744.03</td>
<td>Congenital anomaly of middle ear, except ossicles, causing impairment of hearing</td>
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<td>744.43</td>
<td>Congenital cervical auricle</td>
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<td>744.46</td>
<td>Congenital preauricular sinus or fistula</td>
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<td>Microstomia</td>
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<td>Congenital choanal atresia</td>
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<td>Other congenital anomaly of nose</td>
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<td>748.2</td>
<td>Congenital web of larynx</td>
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<td>748.3</td>
<td>Other congenital anomaly of larynx, trachea, and bronchus</td>
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<td>784.41</td>
<td>Aphonia</td>
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<tr>
<td>V52.8</td>
<td>Fitting and adjustment of other specified prosthetic device</td>
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<tr>
<td>V53.09</td>
<td>Fitting and adjustment of other devices related to nervous system and special senses</td>
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</table>

Please note that this list of associated ICD-9-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.

**IOM References**

100-2,15,230.3; 100-3,50.1; 100-3,50.2

**CCI Version 20.0**

92507-92508, 92521-92524, 97755

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

<table>
<thead>
<tr>
<th>Work Value</th>
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</table>
92610 Evaluation of oral and pharyngeal swallowing function

Explanation
The patient is evaluated to determine the oral and pharyngeal swallowing function. Assessment of the oral cavity includes the size, position, resting tone, range of motion and development of the tongue, lips, and palate. Palpation of the thyroid notch or cricoid arch with swallowing is used to determine elevation of the pharynx. Using a curved probe, sensation of the oral cavity may be assessed. An inventory of cranial nerves must also be included.

Coding Tips
Only one unit may be billed for this code per day, regardless of the amount of time taken to render the service. Most payers consider these procedures to be speech pathology services and coverage can vary depending on the patient's contractual agreement with the payer.

The majority of payers break speech pathology coverage into two categories: evaluation (diagnostic) and therapeutic services. In most instances, these services must be reasonable and necessary to the treatment of the individual's illness or injury or must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state.

Speech pathology is considered medically appropriate treatment for mental retardation when disorders such as aphasia or dysarthria are exhibited. The diagnosis and treatment of swallowing disorders (dysphagia) are also medically necessary regardless of the presence of a communication disability. Assigning a code from category 438 is inappropriate in cases of past history of cerebrovascular disease that resulted in no neurological deficits. The appropriate code assignment would be V12.54 Transient ischemic attack (TIA), and cerebral infarction without residual deficits.

Terms To Know

Cranial nerve. Twelve paired bundles of nerves connected to the brain that control ocular, auditory, and nasal senses; facial muscles; and oral and throat muscles.

ICD-9-CM Diagnostic Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>438.11</td>
<td>Aphasia due to cerebrovascular disease — (Use additional code to identify presence of hypertension)</td>
</tr>
<tr>
<td>438.12</td>
<td>Dysphagia due to cerebrovascular disease — (Use additional code to identify presence of hypertension)</td>
</tr>
<tr>
<td>438.82</td>
<td>Dysphagia due to cerebrovascular disease — (Use additional code to identify presence of hypertension)</td>
</tr>
<tr>
<td>507.0</td>
<td>Pneumonitis due to inhalation of food or vomitus — (Use additional code to identify infectious organism)</td>
</tr>
<tr>
<td>783.3</td>
<td>Feeding difficulties and mismanagement</td>
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<tr>
<td>787.20</td>
<td>Dysphagia, unspecified</td>
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<tr>
<td>787.21</td>
<td>Dysphagia, oral phase</td>
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<tr>
<td>787.22</td>
<td>Dysphagia, oropharyngeal phase</td>
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IOM References
100-2,15,230.3; 100-4,5,10.6

CCI Version 20.0
92511
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Motion fluoroscopic evaluation of swallowing function by cine or video recording

Explanation
Motion fluoroscopic examinations are done of the swallowing function by cine or video recording. The patient is seated upright in a normal eating posture. Small amounts of liquid barium and barium-coated foods of varying consistencies, textures, and flavors are administered allowing visualization of the swallowing function by fluoroscopy. The patient is given liquids, pastes, and solid foods that are visually followed from the oral cavity to the pharynx and the cervical esophagus. A portion of this test is usually repeated with the patient in a horizontal position.

Coding Tips
Most payers consider these procedures to be speech pathology services and coverage can vary depending on the patient’s contractual agreement with the payer. The majority of payers break speech pathology coverage into two categories: diagnosis, and evaluation and therapeutic services. In most instances, these services must be reasonable and necessary to the treatment of the individual’s illness or injury or must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state.

Speech pathology is considered medically appropriate treatment for mental retardation when disorders such as aphasia or dysarthria are exhibited. The diagnosis and treatment of swallowing disorders (dysphagia) are also medically necessary regardless of the presence of a communication disability.

Assigning a code from category 438 is inappropriate in cases of past history of cerebrovascular disease that resulted in no neurological deficits. The appropriate code assignment would be V12.54 Transient ischemic attack (TIA), and cerebral infarction without residual deficits.

Terms To Know
- cine. Movement usually related to motion pictures.

ICD-9-CM Diagnostic Codes
- 438.11 Aphasia due to cerebrovascular disease — (Use additional code to identify presence of hypertension)
- 438.12 Dysphasia due to cerebrovascular disease — (Use additional code to identify presence of hypertension)
- 438.82 Dysphagia due to cerebrovascular disease — (Use additional code to identify presence of hypertension)
- 507.0 Pneumonitis due to inhalation of food or vomitus — (Use additional code to identify infectious organism)
- 783.3 Feeding difficulties and mismanagement
- 787.20 Dysphagia, unspecified
- 787.21 Dysphagia, oral phase
- 787.22 Dysphagia, oropharyngeal phase
- 778.23 Dysphagia, pharyngeal phase
- 787.24 Dysphagia, pharyngoesophageal phase
- 787.29 Other dysphagia
- 933.1 Foreign body in larynx
- 934.0 Foreign body in trachea
- 934.1 Foreign body in main bronchus
- 934.8 Foreign body in other specified parts of trachea, bronchus, and lung
- 934.9 Foreign body in respiratory tree, unspecified
- V48.3 Mechanical and motor problems with neck and trunk

Please note that this list of associated ICD-9-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.

IOM References
100-2,15,230.3

CCI Version 20.0
70370-70371, 76120-76125, 92511, 92610
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
episode of care when the history does not mention a previous infarction. Assign the appropriate fourth digit to indicate the wall site (inferior, lateral, posterior, etc.). Assign the appropriate fifth digit to indicate a new AMI or a patient admitted within eight weeks of an AMI. A myocardial infarction of greater than eight weeks' duration with persistent symptoms is coded to 414.8.

Terms To Know

cardiac arrest. Sudden, unexpected cessation of cardiac action, including absence of heart sounds and/or blood pressure.

ICD-9-CM Diagnostic Codes

414.8 Other specified forms of chronic ischemic heart disease — (Use additional code to identify presence of hypertension: 401.0-405.9)

427.5 Cardiac arrest

518.51 Acute respiratory failure following trauma and surgery

518.52 Other pulmonary insufficiency, not elsewhere classified, following trauma and surgery

518.53 Acute and chronic respiratory failure following trauma and surgery

518.81 Acute respiratory failure

518.84 Acute and chronic respiratory failure

Please note that this list of associated ICD-9-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.

CCI Version 20.0


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report

93015 supervision only, without interpretation and report
93016 tracing only, without interpretation and report
93017 interpretation and report only

Explanation
A continuous recording of electrical activity of the heart is acquired by an assistant supervised by a qualified health care provider while the patient is exercising on a treadmill or bicycle and/or given medicines. The stress on the heart during the test is monitored. Code 93015 includes the test, supervision, and interpretation of the report; 93016 applies only to the supervision of the test; 93017 includes performing the test only; 93018 applies to the interpretation of a previously performed test's report.

Coding Tips
Some physical therapists specializing in the area of cardiopulmonary care administer maximum graded exercise tests, rehabilitate acutely ill patients in the intensive care unit, design exercise programs to restore endurance and function for patients with organ transplants, and enable patients with acute and chronic heart or lung problems to resume functional activities. Some of the programs require a team of specialists (cardiac rehabilitation, pulmonary rehabilitation). The patient may be seen for more than an hour a day, progressing in a multiple intervention program including exercise, bronchopulmonary hygiene, and education concerning cardiovascular fitness. For treatment codes, the physical therapist should select a code based on the outcome of the care (e.g., therapeutic exercise [97110] for strengthening).

When billing Medicare, the technical component of these procedures is subject to the Multiple Procedure Payment Reduction policy. Under Medicare, physical therapy is not covered when furnished in connection with cardiac rehabilitation exercise program services unless there also is a diagnosed noncardiac condition requiring therapy (e.g., where a patient who is recuperating from an acute phase of heart disease had a stroke which requires physical therapy). While the cardiac rehabilitation exercise program may be considered by some a form of physical therapy, it is a specialized program with separately defined coverage and payment guidelines conducted and/or supervised by specially trained personnel whose services are performed under the direct supervision of a physician. Restrictions on coverage of physical therapy do not affect rules regarding coverage or noncoverage of such services when furnished in a hospital inpatient or outpatient setting. Check with other payers for their program policies.

When coding an acute myocardial infarction (AMI), identify the site as determined by the EKG. AMI is coded as initial episode of care when the history does not mention a previous infarction. Assign the appropriate fourth digit to indicate the wall site (inferior, lateral, posterior, etc.). Assign the appropriate fifth digit to indicate a new AMI or a patient admitted within eight weeks of an AMI. A myocardial infarction of greater than eight weeks' duration with persistent symptoms is coded to 414.8.

Terms To Know
myocardial infarction. Obstruction of circulation to the heart, resulting in necrosis.
rehabilitation. Restoration of physical and mental functions to allow the usual daily activities of life.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,60.3

CCI Version 20.0
0178T-0179T, 0180T, 36000, 36410, 93000-93010, 93040-93042, 96372, 96374-96376, 99201-99223, 99231-99236, 99241-99255, 99455-99466, 99468-99480, 99485
Also not with 93015: 93016-93018, 94760-94761, 96360, 96365
Also not with 93016: 94760-94761, 96360, 96365
Also not with 93017: 93278, 94760-94761, 96413
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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94010 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

Explanation
A spirometer in a pulmonary lab is used to measure functions of the lungs including the amount of air contained in the lungs, the rate of expiration, and the volume of air a patient respires. The qualified health care professional interprets the results of the spirometry and a graphic record is obtained. This code includes laboratory procedures and interpretations of test results.

Coding Tips
Assign the appropriate evaluation or re-evaluation (97001–97002) when the medical record documentation supports the medical necessity of both services.

Do not report 94010 in addition to bronchospasm provocation evaluation (94070), vital capacity (94150), maximum breathing capacity (94200), respiratory flow volume loop (94375), or air resistance by impulse oscillometry (94728).

Chronic bronchitis combined with obstructive lung disease (491.2x) is defined as a persistent cough with sputum production occurring on most days for at least three months of the year for at least two years.

Obstructive lung disease is defined as a chronic or recurrent reduction in expiratory airflow within the lung. Obstructive chronic bronchitis is characterized by an increased mass of mucous glands in the lung, resulting in an increase in the thickness of the bronchial mucosa. Its most common etiology is cigarette smoking, but it may also be caused by environmental pollution or inhalation of irritant chemicals. Assign a fifth digit '0' to indicate obstructive chronic bronchitis without mention of acute exacerbation, 491.20, and fifth digit '1' for obstructive chronic bronchitis with acute exacerbation, 491.21. Acute exacerbation of chronic obstructive bronchitis is not the same as acute bronchitis, code 466.0. Do not assign 466.0 as an additional code or substitute code for 491.22. However, when the condition causing the acute exacerbation is known, it may be listed as an additional code.

Emphysema classified to category 492 refers to pulmonary emphysema only.

Asthma (category 493) is a narrowing of the airways due to increased responsiveness of the trachea and bronchi to various stimuli. Asthma is reversible, changing in severity either spontaneously or as a result of treatment. Asthma is associated with bronchospasm and pathologic features such as increased mucous secretion, mucosal edema and hyperemia, hypertrophy of bronchial smooth muscle, and acute inflammation. Asthma has been classified as extrinsic, intrinsic, or unspecified. This differentiation is considered archaic by many clinicians because manifestations of both extrinsic and intrinsic disease commonly occur in the same patient. Status asthmaticus is defined as a severe episode of asthma that does not respond to normal therapeutic measures. The following fifth-digit assignment is based upon whether or not the patient presents with acute exacerbation.

COPD (496) or chronic airway obstruction, not elsewhere classified, is defined as a nonspecific condition characterized by a chronic or recurrent reduction in expiratory airflow within the lung. COPD and chronic obstructive lung disease (COLD) are the two most common descriptive diagnostic terms assigned to this code category. COPD, not elsewhere classified (496), may not be used with any of the codes from categories 491–493. Also, this category excludes COPD with allergic alveolitis (495.0–495.9), and bronchiectasis (494).

Terms To Know
spirometry Measurement of the lungs' breathing capacity.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0
00520, 0243T-0244T, 94150, 94200, 94375, 94728, 95070-95071, 99201-99215, 99241-99245, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
94011-94012

94011 Measurement of spirometric forced expiratory flows in an infant or child two years of age

94012 Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child two years of age

Explanation

A spirometer is an instrument that measures and records the volume of inhaled and exhaled air and is used to assess pulmonary function. This range of codes reports the measurement of spirometric forced expiratory flow in a patient two years of age or younger. Patients of this age often require sedation for testing in order to retain relaxed breathing. In one method, the child is positioned on a specialized bed. A qualified health care professional places a mask over the child’s mouth and nose. A loose jacket-type bag is fitted around the chest and upper abdomen. After the child takes a few breaths, the jacket bag inflates, giving the chest a gentle squeeze and forcing the air from the child’s lungs. In order to measure lung size, the provider closes the upper portion of the bag and air flow through the mask is briefly discontinued. The resultant change in air pressure allows the computer to measure lung size. Report 94011 for measurements obtained without the use of bronchodilators and 94012 for those obtained before and after the use of a bronchodilator. These codes include laboratory procedures and the interpretation of test results.

Coding Tips

Assign the appropriate evaluation or reevaluation (97001-97002) when the medical record documentation supports the medical necessity of both services.

Chronic bronchitis combined with obstructive lung disease (491.2x) is defined as a persistent cough with sputum production occurring on most days for at least three months of the year for at least two years. Obstructive lung disease is defined as a chronic or recurrent reduction in expiratory airflow within the lung. Obstructive chronic bronchitis is characterized by an increased mass of mucus glands in the lung, resulting in an increase in the thickness of the bronchial mucosa. Its most common etiology is cigarette smoking, but it also may be caused by environmental pollution or inhalation of irritant chemicals. Assign a fifth digit “0” to indicate obstructive chronic bronchitis without mention of acute exacerbation, 491.20, and fifth digit “1” for obstructive chronic bronchitis with acute exacerbation, 491.21. Acute exacerbation of chronic obstructive bronchitis is not the same as acute bronchitis, code 466.0. Do not assign 466.0 as an additional code or substitute code for 491.22. However, when the condition causing the acute exacerbation is known, it may be listed as an additional code.

Emphysema classified to category 492 refers to pulmonary emphysema only.

Asthma (category 493) is a narrowing of the airways due to increased responsiveness of the trachea and bronchi to various stimuli. Asthma is reversible, changing in severity spontaneously or as a result of treatment. Asthma is associated with bronchospasm and pathologic features such as increased mucus secretion, mucosal edema and hyperemia, hypertrophy of bronchial smooth muscle, and acute inflammation. Asthma has been classified as extrinsic, intrinsic, or unspecified. This differentiation is considered archaic by many clinicians because manifestations of both extrinsic and intrinsic disease commonly occur in the same patient. Status asthmaticus is defined as a severe episode of asthma that does not respond to normal therapeutic measures. The following fifth-digit assignment is to be used with codes 493.0-493.2 and 493.9: 0 unspecified, 1 with status asthmaticus, 2 with (acute) exacerbation.

Bronchospasm is an integral part of the asthmatic episode and should not be coded separately. Subcategory 493.8 Other forms of asthma, includes exercise induced bronchospasm and cough variant asthma.

Bronchiectasis (category 494) is acquired dilated bronchi as a result of destructive chronic lung infection due to foreign body aspiration, cystic fibrosis, or bronchial tumors. Bronchiectasis is also called acquired bronchiectasis or congenital bronchiectasis (although it is rarely congenital). Symptoms include chronic cough, coughing up blood, shortness of breath, weight loss, fatigue, clubbing of fingers, rales, wheezing, palpitations, headache, and paleness of skin coloration. Fifth-digit assignment is based upon whether or not the patient presents with acute exacerbation.

COPD (496) or chronic airway obstruction, not elsewhere classified, is defined as a nonspecific condition characterized by a chronic or recurrent reduction in expiratory airflow within the lung. COPD and chronic obstructive lung disease (COLD) are the two most common descriptive diagnostic terms assigned to this code category. COPD, not elsewhere classified (496), may not be used with any of the codes from categories 491-493. Also, this category excludes COPD with allergic alveolitis (495.0-495.9), and bronchiectasis (494).

Terms To Know

**spirometry.** Measurement of the lungs’ breathing capacity.

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**CCI Version 20.0**

0243T-0244T, 94200, 94375, 94728, 99143-99145, 99201-99215, 99241-99245, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350

Also not with 94011: 94010

Also not with 94012: 36000, 36410, 94010-94011, 96360, 96365, 96372, 96374-96376

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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94013

Measurement of lung volumes (i.e., functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV]) in an infant or child through 2 years of age

Explanation

This code reports the measurement of lung volumes in children 2 years of age or younger. These measurements are useful in the evaluation of patients with respiratory symptoms and are typically limited to periods of sleep so that maneuvers such as face mask positioning, short occlusions of the airway, and application of an inflatable jacket can be more easily tolerated. Functional residual capacity (FRC) refers to the volume of air contained in the lung at end-tidal expiration and can be determined by gas dilution techniques or whole body plethysmography. Forced vital capacity (FVC) measures the total volume of air exhaled, and expiratory reserve volume (ERV) is the amount of additional air that can be exhaled following normal expiration. This code includes laboratory procedures and interpretations of test results.

Coding Tips

Assign the appropriate evaluation or reevaluation (97001–97002) when the medical record documentation supports the medical necessity of both services.

Chronic bronchitis combined with obstructive lung disease (491.2x) is defined as a persistent cough with sputum production occurring on most days for at least three months of the year for at least two years. Obstructive lung disease is defined as a chronic or recurrent reduction in expiratory airflow within the lung. Obstructive chronic bronchitis is characterized by an increased mass of mucous glands in the lung, resulting in an increase in the thickness of the bronchial mucosa. Its most common etiology is cigarette smoking, but it also may be caused by environmental pollution or inhalation of irritating chemicals. Assign a fifth digit “0” to indicate obstructive chronic bronchitis without mention of acute exacerbation, 491.20, and fifth digit “1” for obstructive chronic bronchitis with acute exacerbation, 491.21. Acute exacerbation of chronic obstructive bronchitis is not the same as acute bronchitis, code 466.0. Do not assign 466.0 as an additional code or substitute code for 491.22. However, when the condition causing the acute exacerbation is known, it may be listed as an additional code.

Emphysema classified to category 492 refers to pulmonary emphysema only.

Asthma (category 493) is a narrowing of the airways due to increased responsiveness of the trachea and bronchi to various stimuli. Asthma is reversible, changing in severity either spontaneously or as a result of treatment. Asthma is associated with bronchospasm and pathologic features such as increased mucus secretion, mucosal edema and hyperemia, hypertrophy of bronchial smooth muscle, and acute inflammation. Asthma has been classified as extrinsic, intrinsic, or unspecified. This differentiation is considered archaic by many clinicians because manifestations of both extrinsic and intrinsic disease commonly occur in the same patient. Status asthmaticus is defined as a severe episode of asthma that does not respond to normal therapeutic measures. The following fifth-digit assignment is to be used with codes 493.0–493.2 and 493.9: 0 unspecified, 1 with status asthmaticus, 2 with (acute) exacerbation.

Bronchospasm is an integral part of the asthmatic episode and should not be coded separately. Subcategory 493.8 Other forms of asthma, includes exercise induced bronchospasm and cough variant asthma.

Bronchiectasis (category 494) is acquired dilated bronchi as a result of destructive chronic lung infection due to foreign body aspiration, cystic fibrosis, or bronchial tumors. Bronchiectasis is also called acquired bronchiectasis or congenital bronchiectasis (although it is rarely congenital). Symptoms include chronic cough, coughing up blood, shortness of breath, weight loss, fatigue, clubbing of fingers, rales, wheezing, palpitations, headache, and paleness of skin coloration. Fifth-digit assignment is based upon whether or not the patient presents with acute exacerbation.

Terms To Know

hyperemia. Excessive blood enclosed within an organ or body part.
plethysmography. Recording of the volume changes in an organ or body part, particularly related to the amount of blood circulating through it.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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features such as increased mucous secretion, mucosal edema and treatment. Asthma is associated with bronchospasm and pathologic responsiveness of the trachea and bronchi to various stimuli. Asthma (category 493) is a narrowing of the airways due to increased inflammation. Asthma has been classified as extrinsic, intrinsic, or unspecified. This differentiation is considered archaic by many clinicians because manifestations of both extrinsic and intrinsic disease commonly occur in the same patient. Status asthmaticus is defined as a severe episode of asthma that does not respond to normal therapeutic measures. The following fifth-digit assignment is to be used with codes 493.0–493.2 and 493.9: 0 unspecified, 1 with status asthmaticus, 2 with (acute) exacerbation.

Bronchospasm is an integral part of the asthmatic episode and should not be coded separately. Subcategory 493.8 Other forms of asthma, includes exercise induced bronchospasm and cough variant asthma. Bronchiectasis (category 494) is acquired dilated bronchi as a result of destructive chronic lung infection due to foreign body aspiration, cystic fibrosis, or bronchial tumors. Bronchiectasis is also called acquired bronchiectasis or congenital bronchiectasis (although it is rarely congenital). Symptoms include chronic cough, coughing up blood, shortness of breath, weight loss, fatigue, clubbing of fingers, rales, wheezing, palpitations, headache, and paleness of skin coloration.

Fifth-digit assignment is based upon whether or not the patient presents with acute exacerbation. COPD (496) or chronic airway obstruction, not elsewhere classified, is defined as a nonspecific condition characterized by a chronic or recurrent reduction in expiratory airflow within the lung. COPD and chronic obstructive lung disease (COLD) are the two most common descriptive diagnostic terms assigned to this code category. COPD, not elsewhere classified, 496, may not be used with any of the codes from categories 491–493. Also, this category excludes COPD with allergic alveolitis (495.0–495.9), and bronchiectasis (494).

Terms To Know
congenital. Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.
hyperemia. Excessive blood enclosed within an organ or body part.
separate procedures. Services commonly carried out as a fundamental part of a total service and, as such, do not usually warrant separate identification. These services are identified in CPT with the parenthetical phrase (separate procedure) at the end of the description and are payable only when performed alone.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0
99201-99215, 99241-99245, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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**Explanation**
This procedure measures the largest volume of air a patient can expire from his lungs. The patient amount of air inhaled and exhaled is measured and calculated with body size to determine the capacity of the lungs. This test is important for determining the threshold of capacity needed for vitality in patients with compromised respiration. For men, this is typically four to five liters; for women, this is normally three to four liters. It is normally performed as a part of a larger procedure and should only be billed separately when performed alone. This code includes laboratory procedures and interpretations of test results.

**Coding Tips**
This separate procedure, by definition, is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59 Distinct procedural service.

Do not report 94150 in addition to spirometry (94010), bronchodilation responsiveness (94060), or airway resistance by impulse oscilometry (94728).

Assign the appropriate evaluation or re-evaluation (97001–97002) when the medical record documentation supports the medical necessity of both services.

Chronic bronchitis combined with obstructive lung disease (491.2x) is defined as a persistent cough with sputum production occurring on most days for at least three months of the year for at least two years. Obstructive lung disease is defined as a chronic or recurrent reduction in expiratory airflow within the lung. Obstructive chronic bronchitis is characterized by an increased mass of mucous glands in the lung, resulting in an increase in the thickness of the bronchial mucosa. Its most common etiology is cigarette smoking, but it also may be caused by environmental pollution or inhalation of irritant chemicals. Assign a fifth digit "0" to indicate obstructive chronic bronchitis without mention of acute exacerbation, 491.20, and fifth digit "1" for obstructive chronic bronchitis with acute exacerbation, 491.21. Acute exacerbation of chronic obstructive bronchitis is not the same as acute bronchitis, code 466.0. Do not assign 466.0 as an additional code or substitute code for 491.22. However, when the condition causing the acute exacerbation is known, it may be listed as an additional code.

Emphysema classified to category 492 refers to pulmonary emphysema only.

Asthma (category 493) is a narrowing of the airways due to increased responsiveness of the trachea and bronchi to various stimuli. Asthma is reversible, changing in severity either spontaneously or as a result of treatment. Asthma is associated with bronchospasm and pathologic features such as increased mucous secretion, mucosal edema and hyperemia, hypertrophy of bronchial smooth muscle, and acute
94200

94200  Maximum breathing capacity, maximal voluntary ventilation

Explanation
This code applies to measuring maximum breathing capacity or maximal voluntary ventilation (the largest volume of air that a patient can inhale and exhale in 60 seconds). The patient inhales to the maximum vital capacity and exhales into a spirometer. The physician measures the maximal expiratory flow at 50 percent of expired vital capacity and at 75 percent of expired vital capacity. This code includes laboratory procedures and interpretations of test results.

Coding Tips
If a separately identifiable evaluation or re-evaluation is performed, the appropriate code from range 97001–97002 should also be reported.

Do not report 94200 in addition to spirometry (94010) or bronchodilator responsiveness (94060).

Chronic bronchitis combined with obstructive lung disease (491.2x) is defined as a persistent cough with sputum production occurring on most days for at least three months of the year for at least two years.

Obstructive lung disease is defined as a chronic or recurrent reduction in expiratory airflow within the lung. Obstructive chronic bronchitis is characterized by an increased mass of mucus glands in the lung, resulting in an increase in the thickness of the bronchial mucosa. Its most common etiology is cigarette smoking, but it also may be caused by environmental pollution or inhalation of irritant chemicals. Assign a fifth digit "0" to indicate obstructive chronic bronchitis without mention of acute exacerbation, 491.20, and fifth digit "1" for obstructive chronic bronchitis with acute exacerbation, 491.21. Acute exacerbation of chronic obstructive bronchitis is not the same as acute bronchitis, code 466.0. Do not assign 466.0 as an additional code or substitute code for 491.22. However, when the condition causing the acute exacerbation is known, it may be listed as an additional code.

Emphysema classified to category 492 refers to pulmonary emphysema only.

Asthma (category 493) is a narrowing of the airways due to increased responsiveness of the trachea and bronchi to various stimuli. Asthma is reversible, changing in severity either spontaneously or as a result of treatment. Asthma is associated with bronchospasm and pathologic features such as increased mucus secretion, mucosal edema, and hyperemia, hypertrophy of bronchial smooth muscle, and acute inflammation. Asthma has been classified as extrinsic, intrinsic, or unspecified. This differentiation is considered archaic by many clinicians because manifestations of both extrinsic and intrinsic disease commonly occur in the same patient. Status asthmaticus is defined as a severe episode of asthma that does not respond to normal therapeutic measures. The following fifth-digit assignment is to be used with codes 493.0–493.2 and 493.9: 0 unspecified, 1 with status asthmaticus, 2 with (acute) exacerbation. Bronchospasm is an integral part of the asthmatic episode and should not be coded separately. Subcategory 493.8 Other forms of asthma, includes exercise induced bronchospasm and cough variant asthma.

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Bronchiectasis (category 494) is acquired dilated bronchi as a result of destructive chronic lung infection due to foreign body aspiration, cystic fibrosis, or bronchial tumors. Bronchiectasis is also called acquired bronchiectasis or congenital bronchiectasis (although it is rarely congenital). Symptoms include chronic cough, coughing up blood, shortness of breath, weight loss, fatigue, clubbing of fingers, rales, wheezing, palpitations, headache, and paleness of skin coloration. Fifth-digit assignment is based upon whether or not the patient presents with acute exacerbation.

COPD (496) or chronic airway obstruction, not elsewhere classified, is defined as a nonspecific condition characterized by a chronic or recurrent reduction in expiratory airflow within the lung. COPD and chronic obstructive lung disease (COLD) are the two most common descriptive diagnostic terms assigned to this code category. COPD, Not elsewhere classified, 496, may not be used with any of the codes from categories 491–493. Also, this category excludes COPD with allergic alveolitis (495.0–495.9), and bronchiectasis (494).

Terms To Know
edema. Swelling due to fluid accumulation in the intercellular spaces.
hypermia. Excessive blood enclosed within an organ or body part.
hypertrophy. Overgrowth or enlargement of normal cells in tissue.
spirometry. Measurement of the lungs' breathing capacity.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0
99201-99215, 99241-99245, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
94250

Expired gas collection, quantitative, single procedure (separate procedure)

Explanation

Pulmonary function testing 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 in the lung after a patient exhales. The provider interprets results. This code applies to collecting and, in a separately reportable procedure, evaluating expired air.

Coding Tips

This separate procedure, by definition, is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59 Distinct procedural service.

Chronic bronchitis combined with obstructive lung disease (491.2x) is defined as a persistent cough with sputum production occurring on most days for at least three months of the year for at least two years. Obstructive lung disease is defined as a chronic or recurrent reduction in expiratory airflow within the lung. Obstructive chronic bronchitis is characterized by an increased mass of mucus glands in the lung, resulting in an increase in the thickness of the bronchial mucosa. Its most common etiology is cigarette smoking, but it also may be caused by environmental pollution or inhalation of irritant chemicals. Assign a fifth digit "0" to indicate obstructive chronic bronchitis without mention of acute exacerbation, 491.20, and fifth digit "1" for obstructive chronic bronchitis with acute exacerbation, 491.21. Acute exacerbation of chronic obstructive bronchitis is not the same as acute bronchitis, code 466.0. Do not assign 466.0 as an additional code or substitute code for 491.22. However, when the condition causing the acute exacerbation is known, it may be listed as an additional code.

Emphysema classified to category 492 refers to pulmonary emphysema only.

Asthma (category 493) is a narrowing of the airways due to increased responsiveness of the trachea and bronchi to various stimuli. Asthma is reversible, changing in severity either spontaneously or as a result of treatment. Asthma is associated with bronchospasm and pathologic features such as increased mucous secretion, mucosal edema, and hyperemia, hypertrophy of bronchial smooth muscle, and acute inflammation. Asthma has been classified as extrinsic, intrinsic, or unspecified. This differentiation is considered archaic by many clinicians because manifestations of both extrinsic and intrinsic disease commonly occur in the same patient. Status asthmaticus is defined as a severe episode of asthma that does not respond to normal therapeutic measures. The following fifth-digit assignment is to be used with codes 493.0-493.2 and 493.9: 0 unspecified, 1 with status asthmaticus, 2 with (acute) exacerbation. Bronchospasm is an integral part of the asthmatic episode and should not be coded separately. Subcategory 493.8 Other forms of asthma, includes exercise induced bronchospasm and cough variant asthma.

COPD (496) or chronic airway obstruction, not elsewhere classified, is defined as a nonspecific condition characterized by a chronic or recurrent reduction in expiratory airflow within the lung. COPD and chronic obstructive lung disease (COLD) are the two most common descriptive diagnostic terms assigned to this code category. COPD, not elsewhere classified, 496, may not be used with any of the codes from categories 491.493. Also, this category excludes COPD with allergic alveolitis (495.0-495.9), and bronchiectasis (494).

Terms To Know

edema. Swelling due to fluid accumulation in the intercellular spaces.

inflammation. Cytologic and chemical reactions that occur in affected blood vessels and adjacent tissues in response to injury or abnormal stimulation from a physical, chemical, or biologic agent.

separate procedures. Services commonly carried out as a fundamental part of a total service and, as such, do not usually warrant separate identification. These services are identified in CPT with the parenthetical phrase (separate procedure) at the end of the description and are payable only when performed alone.

spirometry. Measurement of the lungs' breathing capacity.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0

99201-99215, 99241-99245, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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**Respiratory flow volume loop**

**Explanation**
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 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 (97001-97002), report additionally.

Do not report 94150 in addition to spirometry (94010) or airway resistance by impulse oscillometry (94728).

Chronic bronchitis combined with obstructive lung disease (491.2x) is defined as a persistent cough with sputum production occurring on most days for at least three months of the year for at least two years.

Obstructive lung disease is defined as a chronic or recurrent reduction in expiratory airflow within the lung. Obstructive chronic bronchitis is characterized by an increased mass of mucous glands in the lung, resulting in an increase in the thickness of the bronchial mucosa. Its most common etiology is cigarette smoking, but it also may be caused by environmental pollution or inhalation of irritant chemicals. Assign a fifth digit "0" to indicate obstructive chronic bronchitis without mention of acute exacerbation, 491.20, and fifth digit "1" for obstructive chronic bronchitis with acute exacerbation, 491.21. Acute exacerbation of chronic obstructive bronchitis is not the same as acute bronchitis, code 466.0. Do not assign 466.0 as an additional code or substitute code for 491.22. However, when the condition causing the acute exacerbation is known, it may be listed as an additional code.

Emphysema classified to category 492 refers to pulmonary emphysema only.

Asthma (category 493) is a narrowing of the airways due to increased responsiveness of the trachea and bronchi to various stimuli. Asthma is reversible, changing in severity either spontaneously or as a result of treatment. Asthma is associated with bronchospasm and pathologic features such as increased mucus secretion, mucosal edema and hyperemia, hypertrophy of bronchial smooth muscle, and acute inflammation. Asthma has been classified as extrinsic, intrinsic, or unspecified. This differentiation is considered archaic by many clinicians because manifestations of both extrinsic and intrinsic disease commonly occur in the same patient. Status asthmaticus is defined as a severe episode of asthma that does not respond to normal therapeutic measures. The following fifth-digit assignment is to be used with codes 493.0-493.2 and 493.9: 0 unspecified, 1 with status asthmaticus, 2 with (acute) exacerbation. Bronchospasm is an integral part of the asthmatic episode and should not be coded separately. Subcategory 493.8 Other forms of asthma, includes exercise induced bronchospasm and cough variant asthma.

**Bronchiectasis** (category 494) is acquired dilated bronchi as a result of destructive chronic lung infection due to foreign body aspiration, cystic fibrosis, or bronchial tumors. Bronchiectasis is also called acquired bronchiectasis or congenital bronchiectasis (although it is rarely congenital). Symptoms include chronic cough, coughing up blood, shortness of breath, weight loss, fatigue, clubbing of fingers, rales, wheezing, palpitations, headache, and paleness of skin coloration. Fifth-digit assignment is based upon whether or not the patient presents with acute exacerbation.

COPD (496) or chronic airway obstruction, not elsewhere classified, is defined as a nonspecific condition characterized by a chronic or recurrent reduction in expiratory airflow within the lung. COPD and chronic obstructive lung disease (COLD) are the two most common descriptive diagnostic terms assigned to this code category. COPD, not elsewhere classified, 496, may not be used with any of the codes from categories 491-493. Also, this category excludes COPD with allergic alveolitis (495.0-495.9), and bronchiectasis (494).

**Terms To Know**
- **acute.** Sudden, severe.
- **aspiration.** Drawing fluid out by suction.
- **chronic.** Persistent, continuing, or recurring.
- **foreign body.** Any object or substance found in an organ and tissue that does not belong under normal circumstances.

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**CCI Version 20.0**
00520, 94728, 99201-99215, 99241-99245, 99281-99285, 99304-99310, 99315-99328, 99334-99337, 99341-99350

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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ICD-9-CM Diagnostic Codes

491.0 Simple chronic bronchitis — (Use additional code to identify infectious organism)
491.1 Mucopurulent chronic bronchitis — (Use additional code to identify infectious organism)
491.20 Obstructive chronic bronchitis, without exacerbation — (Use additional code to identify infectious organism)
491.21 Obstructive chronic bronchitis, with (acute) exacerbation — (Use additional code to identify infectious organism)
492.0 Emphysematous bleb
493.01 Extrinsic asthma with status asthmaticus
493.02 Extrinsic asthma, with (acute) exacerbation
493.11 Intrinsic asthma with status asthmaticus
493.12 Intrinsic asthma, with (acute) exacerbation
493.21 Chronic obstructive asthma with status asthmaticus
493.22 Chronic obstructive asthma, with (acute) exacerbation
493.81 Exercise induced bronchospasm
493.82 Cough variant asthma
494.0 Bronchiectasis without acute exacerbation — (Use additional code to identify infectious organism)
494.1 Bronchiectasis with acute exacerbation — (Use additional code to identify infectious organism)

Explanation
A pulmonary exercise stress test is done to test how much air moves in and out of the lungs during exercise and to determine where breathing problems are occurring, since they may be in the lungs, heart, or circulation. A simple exercise stress test is done with the patient riding a stationary bike (ergometer) or walking on a treadmill. Heart rate, breathing, and blood pressure are monitored before beginning the exercise. Basic ventilation studies are performed with a spirometer and recording device in a simple exercise test (94620) as the patient breathes through a mouthpiece and connecting tube while a nose clip prevents nasal breathing. The patient’s oxygen level is monitored with pulse oximetry. Complex testing (94621) uses electrodes 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 during exercise.

Coding Tips
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 94761.

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Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (e.g., with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)

Explanation
A pressurized or nonpressurized inhalation treatment is applied for an acute obstruction of the airway, preventing the patient from taking in sufficient air on his or her own, or for sputum induction for diagnostic purposes. This is done with an aerosol generator, nebulizer, metered dose inhaler, or intermittent positive pressure breathing (IPPB) device.

Coding Tips
Append modifier 76 Repeat procedure or service by same physician, to this code when more than one treatment is performed on the same date of service.

ICD-9-CM Diagnostic Codes
491.1 Mucopurulent chronic bronchitis — (Use additional code to identify infectious organism)
491.20 Obstructive chronic bronchitis, without exacerbation — (Use additional code to identify infectious organism)
491.21 Obstructive chronic bronchitis, with (acute) exacerbation — (Use additional code to identify infectious organism)
492.0 Emphysematous bleb
492.8 Other emphysema
493.01 Extrinsic asthma with status asthmaticus
493.02 Extrinsic asthma, with (acute) exacerbation
493.10 Intrinsic asthma, unspecified
493.11 Intrinsic asthma with status asthmaticus
493.12 Intrinsic asthma, with (acute) exacerbation
493.21 Chronic obstructive asthma with status asthmaticus
493.22 Chronic obstructive asthma, with (acute) exacerbation
493.81 Exercise induced bronchospasm
493.82 Cough variant asthma
494.0 Bronchiectasis without acute exacerbation — (Use additional code to identify infectious organism)
494.1 Bronchiectasis with acute exacerbation — (Use additional code to identify infectious organism)
495.1 Bagassosis — (Use additional code to identify infectious organism)
495.2 Bird-fanciers' lung — (Use additional code to identify infectious organism)
495.3 Suberosis — (Use additional code to identify infectious organism)
495.4 Malt workers' lung — (Use additional code to identify infectious organism)
495.5 Mushroom workers' lung — (Use additional code to identify infectious organism)
495.6 Maple bark-strippers' lung — (Use additional code to identify infectious organism)
495.7 Ventilation pneumonitis — (Use additional code to identify infectious organism)
496 Chronic airway obstruction, not elsewhere classified — (Note: This code is not to be used with any code from 491-493)
501 Asbestosis — (Use additional code to identify infectious organism)
506.0 Bronchitis and pneumonitis due to fumes and vapors — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
506.1 Acute pulmonary edema due to fumes and vapors — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
506.2 Upper respiratory inflammation due to fumes and vapors — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
506.4 Chronic respiratory conditions due to fumes and vapors — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
508.0 Acute pulmonary manifestations due to radiation — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
508.2 Respiratory conditions due to smoke inhalation — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
518.81 Acute respiratory failure

Please note that this list of associated ICD-9-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.

CCI Version 20.0
89220, 94664, 99201-99215, 99241-99245, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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**94642**

**Aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis**

**Explanation**
An antimicrobial medication called pentamidine is given in cases of pneumocystis carinii pneumonia treatment or prophylaxis in high risk groups. Even though the condition is more commonly referred to as Pneumocystis carinii pneumonia (PCP), the organism causing the condition has subsequently been renamed Pneumocystis jiroveci. The patient breathes the aerosolized medication into the lungs.

**Coding Tips**
Append modifier 76 Repeat procedure or service by same physician, to this code when more than one treatment is performed on the same date of service.

Code 042 is sequenced first when a patient is seen for an HIV infection or complication due to the presence of the HIV infection. Additional codes are used to identify associated complications.

**Terms To Know**
- **aerosol**: Atomized particles or microorganisms suspended in air.
- **complication**: Condition arising after the beginning of observation and treatment that modifies the course of the patient's illness or the medical care required, or an undesired result or misadventure in medical care.
- **pentamidine isethionate**: Inhalation solution used as a preventive treatment for pneumoocystis carinii pneumonia, a serious form of pneumonia commonly occurring in those with impaired immune systems. Supply is reported with HCPCS Level II code J2545. May be sold as brand name Nebupent.
- **prophylaxis**: Intervention or protective therapy intended to prevent a disease.

**ICD-9-CM Diagnostic Codes**

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>042</td>
<td>Human immunodeficiency virus [HIV] — (Use additional code(s) to identify all manifestations of HIV. Use additional code to identify HIV-2 infection: 079.53)</td>
</tr>
<tr>
<td>079.53</td>
<td>Human immunodeficiency virus, type 2 (HIV 2), in conditions classified elsewhere and of unspecified site — (Note: This code is to be used as an additional code to identify the viral agent in diseases classifiable elsewhere and viral infection of unspecified nature or site)</td>
</tr>
<tr>
<td>136.3</td>
<td>Pneumocystosis</td>
</tr>
<tr>
<td>V08</td>
<td>Asymptomatic human immunodeficiency virus (HIV) infection status — (This code is only to be used when no HIV infection symptoms or conditions are present. If any HIV infection symptoms or conditions are present, see code 042)</td>
</tr>
</tbody>
</table>

Please note that this list of associated ICD-9-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.

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</table>

CCI Version 20.0

00520, 99201-99215, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour

Each additional hour (List separately in addition to code for primary procedure)

**Explanation**

This treatment is often called a nebulized wet aerosol (NWA). A continuous aerosol inhalation treatment is applied for an acute obstruction of the airway that prevents the patient from taking in sufficient air on his or her own. This is done employing an aerosol generator. Report 94644 for the first hour of treatment and 94645 for each additional hour.

**Coding Tips**

As an add-on procedure, 94645 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same provider on the same date of service and the primary service or procedure, and must never be reported as stand-alone codes. Code 94645 must be used in conjunction with 96444.

**Terms To Know**

- *empyema*: Accumulation of pus within the respiratory, or pleural, cavity.
- *fistula*: Abnormal tube-like passage between two body cavities or organs or from an organ to the outside surface.
- *inhalation*: Act of drawing in by breathing.
- *nebulizer*: Latin for mist, a device that converts liquid into a fine spray and is commonly used to deliver medicine to the upper respiratory, bronchial, and lung areas.

**ICD-9-CM Diagnostic Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>464.4</td>
<td>Croup — (Use additional code to identify infectious organism)</td>
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<tr>
<td>478.6</td>
<td>Edema of larynx</td>
</tr>
<tr>
<td>478.71</td>
<td>Cellulitis and perichondritis of larynx — (Use additional code to identify infectious organism)</td>
</tr>
<tr>
<td>478.74</td>
<td>Stenosis of larynx</td>
</tr>
<tr>
<td>478.75</td>
<td>Laryngeal spasm</td>
</tr>
<tr>
<td>488.01</td>
<td>Influenza due to identified avian influenza virus with pneumonia — (Use additional code to identify the type of pneumonia: 480.0-480.9, 481, 482.0-482.9, 483.0-483.8, 485)</td>
</tr>
<tr>
<td>488.02</td>
<td>Influenza due to identified avian influenza virus with other respiratory manifestations</td>
</tr>
<tr>
<td>488.11</td>
<td>Influenza due to identified 2009 H1N1 influenza virus with pneumonia — (Use additional code to identify the type of pneumonia: 480.0-480.9, 481, 482.0-482.9, 483.0-483.8, 485)</td>
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<tr>
<td>488.12</td>
<td>Influenza due to identified 2009 H1N1 influenza virus with other respiratory manifestations</td>
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<tr>
<td>488.81</td>
<td>Influenza due to identified novel influenza A virus with pneumonia — (Use additional code to identify the type of pneumonia: 480.0-480.9, 481, 482.0-482.9, 483.0-483.8, 485)</td>
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<tr>
<td>488.82</td>
<td>Influenza due to identified novel influenza A virus with other respiratory manifestations</td>
</tr>
<tr>
<td>490</td>
<td>Bronchitis, not specified as acute or chronic — (Use additional code to identify infectious organism)</td>
</tr>
<tr>
<td>508.1</td>
<td>Chronic and other pulmonary manifestations due to radiation — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81)</td>
</tr>
<tr>
<td>508.8</td>
<td>Respiratory conditions due to other specified external agents — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81)</td>
</tr>
<tr>
<td>508.9</td>
<td>Respiratory conditions due to unspecified external agent — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81)</td>
</tr>
<tr>
<td>510.0</td>
<td>Empyema with fistula — (Use additional code to identify infectious organism: 041.00-041.9)</td>
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<td>510.9</td>
<td>Empyema without mention of fistula — (Use additional code to identify infectious organism: 041.00-041.9)</td>
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<tr>
<td>511.0</td>
<td>Pleurisy without mention of effusion or current tuberculosis — (Use additional code to identify infectious organism)</td>
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<td>511.1</td>
<td>Pleurisy with effusion, with mention of bacterial cause other than tuberculosis — (Use additional code to identify infectious organism)</td>
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<td>511.9</td>
<td>Unspecified pleural effusion — (Use additional code to identify infectious organism)</td>
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<td>Abscess of mediastinum — (Use additional code to identify infectious organism)</td>
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<td>518.83</td>
<td>Chronic respiratory failure</td>
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<tr>
<td>518.84</td>
<td>Acute and chronic respiratory failure</td>
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Please note that this list of associated ICD-9-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.
CCI Version 20.0
99201-99215, 99241-99245, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350
Also not with 94644: 94640-94642

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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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.

**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.

**ICD-9-CM Diagnostic Codes**
464.4 Croup — (Use additional code to identify infectious organism)
478.6 Edema of larynx
478.71 Cellulitis and perichondritis of larynx — (Use additional code to identify infectious organism)
478.74 Stenosis of larynx
478.75 Laryngeal spasm
478.79 Other diseases of larynx — (Use additional code to identify infectious organism)
490 Bronchitis, not specified as acute or chronic — (Use additional code to identify infectious organism)
508.1 Chronic and other pulmonary manifestations due to radiation — (Use additional code to identify infectious organism. Use additional E code to identify associated respiratory conditions: 518.81.)
508.8 Respiratory conditions due to other specified external agents — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
508.9 Respiratory conditions due to unspecified external agent — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
510.0 Empyema with fistula — (Use additional code to identify infectious organism: 041.00-041.9)
510.9 Empyema without mention of fistula — (Use additional code to identify infectious organism: 041.00-041.9)
511.0 Pleurisy without mention of effusion or current tuberculosis — (Use additional code to identify infectious organism)
511.1 Pleurisy with effusion, with mention of bacterial cause other than tuberculosis — (Use additional code to identify infectious organism)
511.89 Other specified forms of effusion, except tuberculous
511.9 Unspecified pleural effusion — (Use additional code to identify infectious organism)
513.0 Abscess of lung — (Use additional code to identify infectious organism)
513.1 Abscess of mediastinum — (Use additional code to identify infectious organism)
518.83 Chronic respiratory failure
518.84 Acute and chronic respiratory failure
518.89 Other diseases of lung, not elsewhere classified — (Use additional code to identify infectious organism)
786.03 Apnea
786.07 Wheezing
786.52 Painful respiration

Please note that this list of associated ICD-9-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.

**IOM References**
100-3,240.4

**CCI Version 20.0**
99201-99215, 99241-99245, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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94662

Continuous negative pressure ventilation (CNP), 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 negative pressure breathing uses negative pressure during the inspiration phase of breathing. This code applies to subsequent evaluation or application of continuous negative airway pressure for ventilation assistance with negative pressure during inspiration and exhalation.

Coding Tips

Code 94662 is considered to be a part of critical care services, when provided, and is not reported separately when provided with these services.

Terms To Know

effusion. Escape of fluid from within a body 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.

ICD-9-CM Diagnostic Codes

464.4 Croup — (Use additional code to identify infectious organism)
478.6 Edema of larynx
478.70 Unspecified disease of larynx
478.71 Cellulitis and perichondritis of larynx — (Use additional code to identify infectious organism)
478.74 Stenosis of larynx
478.75 Laryngeal spasm
478.79 Other diseases of larynx — (Use additional code to identify infectious organism)
490 Bronchitis, not specified as acute or chronic — (Use additional code to identify infectious organism)
508.0 Acute pulmonary manifestations due to radiation — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: S18.81.)
508.1 Chronic and other pulmonary manifestations due to radiation — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: S18.81.)
508.8 Respiratory conditions due to other specified external agents — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: S18.81.)
508.9 Respiratory conditions due to unspecified external agent — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: S18.81.)
510.0 Empyema with fistula — (Use additional code to identify infectious organism: 041.00-041.9)
510.9 Empyema without mention of fistula — (Use additional code to identify infectious organism: 041.00-041.9)
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513.0 Abscess of lung — (Use additional code to identify infectious organism)
513.1 Abscess of mediastinum — (Use additional code to identify infectious organism)
518.83 Chronic respiratory failure
518.84 Acute and chronic respiratory failure
518.89 Other diseases of lung, not elsewhere classified — (Use additional code to identify infectious organism)
786.03 Apnea
786.04 Cheyne-Stokes respiration
786.05 Shortness of breath
786.06 Tachypnea
786.07 Wheezing
786.52 Painful respiration

Please note that this list of associated ICD-9-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.

CCI Version 20.0

94660, 99201-99215, 99241-99245, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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</table>
Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device

Explanation
A demonstration is done for the patient on how to use an aerosol generator, nebulizer, metered dose inhaler, or intermittent positive pressure breathing device (IPPB) and/or the patient’s utilization is evaluated.

Coding Tips
Report 94664 only once per date of service.

ICD-9-CM Diagnostic Codes
478.71 Cellulitis and perichondritis of larynx — (Use additional code to identify infectious organism)
478.74 Stenosis of larynx
478.75 Laryngeal spasm
490 Bronchitis, not specified as acute or chronic — (Use additional code to identify infectious organism)
491.0 Simple chronic bronchitis — (Use additional code to identify infectious organism)
491.1 Mucopurulent chronic bronchitis — (Use additional code to identify infectious organism)
491.20 Obstructive chronic bronchitis, without exacerbation — (Use additional code to identify infectious organism)
491.21 Obstructive chronic bronchitis, with (acute) exacerbation — (Use additional code to identify infectious organism)
492.0 Emphysematous bleb
493.01 Extrinsic asthma with status asthmaticus
493.02 Extrinsic asthma, with (acute) exacerbation
493.11 Intrinsic asthma with status asthmaticus
493.12 Intrinsic asthma, with (acute) exacerbation
493.21 Chronic obstructive asthma with status asthmaticus
493.22 Chronic obstructive asthma, with (acute) exacerbation
493.81 Exercise induced bronchospasm
494.0 Bronchiectasis without acute exacerbation — (Use additional code to identify infectious organism)
494.1 Bronchiectasis with acute exacerbation — (Use additional code to identify infectious organism)
495.7 Ventilation pneumonitis — (Use additional code to identify infectious organism)
496 Chronic airway obstruction, not elsewhere classified — (Note: This code is not to be used with any code from 491-493)
501 Asbestosis — (Use additional code to identify infectious organism)
506.0 Bronchitis and pneumonitis due to fumes and vapors — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
506.1 Acute pulmonary edema due to fumes and vapors — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
506.2 Upper respiratory inflammation due to fumes and vapors — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
506.4 Chronic respiratory conditions due to fumes and vapors — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
508.0 Acute pulmonary manifestations due to radiation — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
508.1 Chronic and other pulmonary manifestations due to radiation — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
510.0 Empyema with fistula — (Use additional code to identify infectious organism: 041.00-041.9)
510.9 Empyema without mention of fistula — (Use additional code to identify infectious organism: 041.00-041.9)
511.0 Pleurisy without mention of effusion or current tuberculosis — (Use additional code to identify infectious organism)
511.1 Pleurisy with effusion, with mention of bacterial cause other than tuberculosis — (Use additional code to identify infectious organism)
513.0 Abscess of lung — (Use additional code to identify infectious organism)
513.1 Abscess of mediastinum — (Use additional code to identify infectious organism)
518.83 Chronic respiratory failure
518.84 Acute and chronic respiratory failure

Please note that this list of associated ICD-9-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.

CCI Version 20.0
00520, 99201-99215, 99241-99245, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
94667-94668

94667  Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation

94668  subsequent

Explanation
A physical therapist manipulates the chest wall—cupping, vibration, and percussion—to mobilize secretions and improve breathing for some lung disorders. Code 94667 applies to initial evaluation and treatment, code 94668 applies to subsequent treatment.

Coding Tips
These services are not subject to the Medicare outpatient physical therapy cap. When performed mechanically, see 94669.

Terms To Know
acute. Sudden, severe.
manipulate. Treatment by hand.

ICD-9-CM Diagnostic Codes
277.00  Cystic fibrosis without mention of meconium ileus — (Use additional code to identify any associated intellectual disabilities)
277.01  Cystic fibrosis with meconium ileus — (Use additional code to identify any associated intellectual disabilities)
466.0   Acute bronchitis — (Use additional code to identify infectious organism)
466.11  Acute bronchiolitis due to respiratory syncytial virus (RSV) — (Use additional code to identify infectious organism)
466.19  Acute bronchiolitis due to other infectious organisms — (Use additional code to identify infectious organism)
491.0   Simple chronic bronchitis — (Use additional code to identify infectious organism)
491.1   Mucopurulent chronic bronchitis — (Use additional code to identify infectious organism)
491.20  Obstructive chronic bronchitis, without exacerbation — (Use additional code to identify infectious organism)
491.21  Obstructive chronic bronchitis, with (acute) exacerbation — (Use additional code to identify infectious organism)
491.8   Other chronic bronchitis — (Use additional code to identify infectious organism)
492.0   Emphysematous bleb
492.8   Other emphysema
493.00  Extrinsic asthma, unspecified
493.01  Extrinsic asthma with status asthmaticus
493.10  Intrinsic asthma, unspecified
493.11  Intrinsic asthma with status asthmaticus
493.20  Chronic obstructive asthma, unspecified

Please note that this list of associated ICD-9-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.

IOM References
100-3,150.1; 100-3,240.7

CCI Version 20.0
00520, 97124, 99201-99215, 99241-99245, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350

Also not with 94668: 94667

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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<th>Work Value</th>
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**94669**

**Mechanical chest wall oscillation to facilitate lung function, per session**

**Explanation**

Mechanical percussion techniques help to clear mucus in the tracheobronchial passages in patients who cannot clear their airways themselves due to a disease process such as cystic fibrosis, emphysema, asthma, etc. An oscillation device is applied to the patient’s chest. The device may be a vest or a belt. Pneumatically driven air, mechanical vibrators and/or direct mechanical compression are applied to the chest wall via the device. Treatment results in an increased expulsion of mucus from the bronchioles and clearing of the airways.

**Coding Tips**

This code is new for 2014. To report cupping, percussing, or vibration of the chest wall in order to facilitate lung function, see 94667 (initial) or 94668 (subsequent).

**Terms To Know**

broncho-. Relating to the trachea.

**ICD-9-CM Diagnostic Codes**

- 277.00 Cystic fibrosis without mention of meconium ileus — (Use additional code to identify any associated intellectual disabilities)
- 277.01 Cystic fibrosis with meconium ileus — (Use additional code to identify any associated intellectual disabilities)
- 466.0 Acute bronchitis — (Use additional code to identify infectious organism)
- 466.11 Acute bronchiolitis due to respiratory syncytial virus (RSV) — (Use additional code to identify infectious organism)
- 466.19 Acute bronchiolitis due to other infectious organisms — (Use additional code to identify infectious organism)
- 491.0 Simple chronic bronchitis — (Use additional code to identify infectious organism)
- 491.1 Mucopurulent chronic bronchitis — (Use additional code to identify infectious organism)
- 491.20 Obstructive chronic bronchitis, without exacerbation — (Use additional code to identify infectious organism)
- 491.21 Obstructive chronic bronchitis, with (acute) exacerbation — (Use additional code to identify infectious organism)
- 491.8 Other chronic bronchitis — (Use additional code to identify infectious organism)
- 492.0 Emphysematous bleb
- 492.8 Other emphysema
- 493.00 Extrinsic asthma, unspecified
- 493.01 Extrinsic asthma with status asthmaticus
- 493.10 Intrinsic asthma, unspecified
- 493.11 Intrinsic asthma with status asthmaticus
- 493.20 Chronic obstructive asthma, unspecified
- 493.21 Chronic obstructive asthma with status asthmaticus
- 493.81 Exercise induced bronchospasm
- 493.82 Cough variant asthma
- 493.90 Asthma, unspecified, unspecified status
- 493.91 Asthma, unspecified with status asthmaticus
- 494.0 Bronchiectasis without acute exacerbation — (Use additional code to identify infectious organism)
- 494.1 Bronchiectasis with acute exacerbation — (Use additional code to identify infectious organism)

Please note that this list of associated ICD-9-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.

**CCI Version 20.0**

00520, 97124, 99201-99215, 99241-99245, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
measures. The following fifth-digit assignment is to be used with codes

- Code 491.22. However, when the condition causing the acute exacerbation is known, it may be listed as an additional code.
- Do not assign 466.0 as an additional code or substitute code 466.0 for acute exacerbation of chronic obstructive bronchitis or obstructive chronic bronchitis without acute exacerbation. Code 466.0 is used to report the collection of expired air and evaluation of oxygen update using indirect methods during rest.

Explanation
Pulmonary testing supervised by a physician in a lab measures functions of the lungs. Code 94680 applies to collecting expired air and evaluating oxygen uptake using direct methods during rest and exercise. Code 94681 applies to collecting expired air and evaluating oxygen uptake, carbon dioxide output, and percentage oxygen extracted. Code 94690 is used to report the collection of expired air and evaluation of oxygen uptake using indirect methods during rest.

Coding Tips
Note that 94690, a separate procedure by definition, is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59 Distinct procedural service.

Chronic bronchitis combined with obstructive lung disease (491.2x) is defined as a persistent cough with sputum production occurring on most days for at least three months of the year for at least two years. Obstructive lung disease is defined as a chronic or recurrent reduction in expiratory airflow within the lung. Obstructive chronic bronchitis is characterized by an increased mass of mucus glands in the lung, resulting in an increase in the thickness of the bronchial mucosa. Its most common etiology is cigarette smoking, but it also may be caused by environmental pollution or inhalation of irritant chemicals. Assign a fifth digit "0" to indicate obstructive chronic bronchitis without mention of acute exacerbation, 491.20, and fifth digit "1" for obstructive chronic bronchitis with acute exacerbation, 491.21. Acute exacerbation of chronic obstructive bronchitis is not the same as acute bronchitis, code 466.0. Do not assign 466.0 as an additional code or substitute code for 491.22. However, when the condition causing the acute exacerbation is known, it may be listed as an additional code.

Emphysema classified to category 492 refers to pulmonary emphysema only.

Asthma (category 493) is a narrowing of the airways due to increased responsiveness of the trachea and bronchi to various stimuli. Asthma is reversible, changing in severity either spontaneously or as a result of treatment. Asthma is associated with bronchospasm and pathologic features such as increased mucous secretion, mucosal edema and hyperemia, hypertrophy of bronchial smooth muscle, and acute inflammation. Asthma has been classified as extrinsic, intrinsic, or unspecified. This differentiation is considered archaic by many clinicians because manifestations of both extrinsic and intrinsic disease commonly occur in the same patient. Status asthmaticus is defined as a severe episode of asthma that does not respond to normal therapeutic measures. The following fifth-digit assignment is to be used with codes 493.0-493.2 and 493.9: 0 unspecified, 1 with status asthmaticus, 2 with (acute) exacerbation. Bronchospasm is an integral part of the asthmatic episode and should not be coded separately. Subcategory 493.8 Other forms of asthma, includes exercise induced bronchospasm and cough variant asthma.

Bronchiectasis (category 494) is acquired dilated bronchi as a result of destructive chronic lung infection due to foreign body aspiration, cystic fibrosis, or bronchial tumors. Bronchiectasis is also called acquired bronchiectasis or congenital bronchiectasis (although it is rarely congenital). Symptoms include chronic cough, coughing up blood, shortness of breath, weight loss, fatigue, clubbing of fingers, rales, wheezing, palpitations, headache, and paleness of skin coloration. Fifth-digit assignment is based upon whether or not the patient presents with acute exacerbation.

COPD (496) or chronic airway obstruction, not elsewhere classified, is defined as a nonspecific condition characterized by a chronic or recurrent reduction in expiratory airflow within the lung. COPD and chronic obstructive lung disease (COLD) are the two most common descriptive diagnostic terms assigned to this code category. COPD, not elsewhere classified, 496, may not be used with any of the codes from categories 491-493. Also, this category excludes COPD with allergic alveolitis (495.0-495.9), and bronchiectasis (494).

Terms To Know
- separate procedures. Services commonly carried out as a fundamental part of a total service and, as such, do not usually warrant separate identification. These services are identified in CPT with the parenthetical phrase (separate procedure) at the end of the description and are payable only when performed alone.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

ICM References
- 100-4,4,320.1; 100-4,4,320.2

CCI Version 20.0
- 99201-99215, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350, 99446-99449, J1644

Also not with 94681: 94250, 94680-94690

Also not with 94681: 94250, 94680, 94690

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Terms To Know
- separate procedures. Services commonly carried out as a fundamental part of a total service and, as such, do not usually warrant separate identification. These services are identified in CPT with the parenthetical phrase (separate procedure) at the end of the description and are payable only when performed alone.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

ICM References
- 100-4,4,320.1; 100-4,4,320.2

CCI Version 20.0
- 99201-99215, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350, 99446-99449, J1644

Also not with 94680: 94250, 94681-94690

Also not with 94681: 94250, 94690

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Terms To Know
- separate procedures. Services commonly carried out as a fundamental part of a total service and, as such, do not usually warrant separate identification. These services are identified in CPT with the parenthetical phrase (separate procedure) at the end of the description and are payable only when performed alone.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

ICM References
- 100-4,4,320.1; 100-4,4,320.2

CCI Version 20.0
- 99201-99215, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350, 99446-99449, J1644

Also not with 94680: 94250, 94681-94690

Also not with 94681: 94250, 94690

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

## Coding and Payment Guide for the Physical Therapist

### Procedure Codes

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<th>Code</th>
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</table>
ICD-9-CM Diagnostic Codes

163.0 Malignant neoplasm of parietal pleura
163.1 Malignant neoplasm of visceral pleura
335.20 Amyotrophic lateral sclerosis
344.1 Paraplegia
416.1 Kyphoscoliotic heart disease
416.8 Other chronic pulmonary heart diseases
428.1 Left heart failure — (Code, if applicable, heart failure due to hypertension first: 402.0-402.9, with fifth-digit 1 or 404.0-404.9 with fifth digit 1 or 3)
519.8 Other diseases of respiratory system, not elsewhere classified — (Use additional code to identify infectious organism)
710.0 Systemic lupus erythematosus — (Use additional code to identify manifestation: 424.91, 581.81, 582.81, 583.81)

94726-94728

94726 Plethysmography for determination of lung volumes and, when performed, airway resistance
94727 Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes
94728 Airway resistance by impulse oscillometry

Explanation

Pulmonary function testing the lungs’ volume, airway resistance, and diffusing capacity is performed in multiple ways. In 94726, the lung volume and possibly the airway resistance are evaluated using a variety of methods. In the oldest method, the patient is enclosed in a pressurized small room and the volume of air and air resistance are measured as the patient breathes. In a newer method, two belts with sensors are wrapped around the patient at the rib cage and the abdomen to measure the lung volumes, referred to as respiratory inductance plethysmography. In 94727, lung volumes are tested 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 in the lung after a patient exhales. The physician interprets results. This code applies to the distribution of inspired gas using multiple breath nitrogen washout curves and including alveolar nitrogen or helium equilibration time. In 94728, the patient breathes into an apparatus called a pneumotachograph. This device uses sound waves to detect and analyze airway changes. In 94729, diffusing capacity is tested. In this test, the patient takes a deep breath, holds it for 10 seconds, and releases the first half. The second half is collected and analyzed for the amount of carbon dioxide it contains.

Coding Tips

Do not report code 94726 in addition to gas dilution or washout (94727) or airway resistance by impulse oscillometry (94748). Do not report code 94728 in addition to spirometry (94010), respiratory flow volume loop (94375), or plethysmography (94726).

Also not with 94728: 94150
Also not with 94727: J0670, J2001
Also not with 94726: 94727-94728, J0670, J2001
Also not with 99315-99318, 99324-99328, 99334-99337, 99341-99350, 00520, 99201-99215, 99241-99245, 99281-99285, 99304-99310, CCI Version 20.0

late effect of adverse effect of drug, medical or biological substance
987.0 Toxic effect of liquefied petroleum gases — (Use additional code to specify the nature of the toxic effect)
987.1 Toxic effect of other hydrocarbon gas — (Use additional code to specify the nature of the toxic effect)
987.2 Toxic effect of nitrogen oxides — (Use additional code to specify the nature of the toxic effect)
987.3 Toxic effect of sulfur dioxide — (Use additional code to specify the nature of the toxic effect)
987.4 Toxic effect of freon — (Use additional code to specify the nature of the toxic effect)
987.5 Toxic effect of lacrimogenic gas — (Use additional code to specify the nature of the toxic effect)
987.6 Toxic effect of chlorine gas — (Use additional code to specify the nature of the toxic effect)
987.7 Toxic effect of hydrocyanic acid gas — (Use additional code to specify the nature of the toxic effect)
987.8 Toxic effect of other specified gases, fumes, or vapors — (Use additional code to specify the nature of the toxic effect)
987.9 Toxic effect of unspecified gas, fume, or vapor — (Use additional code to specify the nature of the toxic effect)
V12.60 Personal history, unspecified disease of respiratory system
V12.61 Personal history, Pneumonia (recurrent)
V12.69 Personal history, Other diseases of respiratory system
V42.1 Heart replaced by transplant

Please note that this list of associated ICD-9-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.

CCI Version 20.0

00520, 99201-99215, 99241-99245, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350
Also not with 94726: 94727-94728, J0670, J2001
Also not with 94727: J0670, J2001
Also not with 94728: 94150
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
**94760-94761**

94760  Noninvasive ear or pulse oximetry for oxygen saturation; single determination

94761  multiple determinations (eg, during exercise)

**Explanation**
A sensor is placed on the earlobe or finger to measure arterial oxygen saturation levels in the blood for a pulse oximetry. A light shines through the capillary bed for the measurement. Code 94760 applies to a single measurement, 94761 applies to multiple measurements.

**Coding Tips**
Code 94760 is considered to be a part of critical care services, when provided, and is not reported separately when provided with these services.

For blood gas testing, see 82803-82810.

Pulse oximetry is commonly used in a large variety of inpatient and outpatient settings. Often called the “fifth” vital sign along with blood pressure, heart rate, respiration rate, and temperature, this service is most often considered to be incidental to another primary service provided on the same date of service. Not only is it used for monitoring during diagnostic cardiac and pulmonary studies, it is used for pulmonary rehabilitation, as well as for patients on long-term oxygen therapy. Medicare considers the service to be technical only, with no physician component, which renders it not separately payable in any facility setting. Guidelines from other payers vary widely, however, with regards to coverage and payment.

**Terms To Know**

**ABG.** Arterial blood gas. Diagnostic service used to evaluate the gas exchange in the lungs. Measurements include partial pressure of oxygen (PaO2), partial pressure of carbon dioxide (PaCO2), pH to measure the acid-base level of the blood or the hydrogen ion (H+) concentration, oxygen content (O2CT), oxygen saturation (O2Sat), and bicarbonate (HCO3−). Correct code assignment is dependent upon the number and type of analytes; reported with CPT codes 82803-82810.

**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).

**Pulmonary collapse.** Condition in which all or part of a lung remains airless and cannot completely expand and fill with air.

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**
100-4,32,130; 100-4,32,130.1
95831-95834

95831  Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk
95832  hand, with or without comparison with normal side
95833  total evaluation of body, excluding hands
95834  total evaluation of body, including hands

Explanation
Muscles or muscle groups are tested for strength. Code 95831 applies to manually testing the arm, leg, or trunk; 95832 applies to manually testing the hands; 95833 applies to manually testing the body exclusive of the hands; 95834 applies to manually testing the body inclusive of the hands.

Coding Tips
These services are considered separate procedures and are usually a component of a more complex service and are not identified separately. When performed alone or with other unrelated procedures/services, they may be reported. If performed alone, list the code; if performed with other unrelated procedures/services, list the code and append modifier 59 Distinct procedural service.

These codes are not to be reported for every muscle test. Rather, each of these codes is to be reported only one time for each extremity or area of the body designated by the code descriptor. Some aspects of manual muscle testing usually are included in the physical therapy evaluation/reevaluation (97001-97002). If reporting 95831-95834, the evaluator is required to prepare a signed and documented separate report that identifies the specific muscles tested, the grade of strength and scale used to measure, and comparative muscle grades if applicable. If such a report is not prepared and included in the medical record as a separate billable procedure, then the appropriate evaluation or reevaluation code (97001-97002) should be used, or 97750 also can be used to report manual muscle testing as a separate procedure from an evaluation or re-evaluation. Documentation to support 97750 includes a description of the protocol for the procedure, the specific area(s) of the body being tested/measured, the purpose of the procedure, and the outcome as well as impact on the individual’s plan of care.

These services may be billed in addition to the standard evaluation. Note that because these codes are outside the physical medicine series of codes it is advisable for the physical therapist to obtain payment information or prior authorization from the payer before rendering the service.

Terms To Know
myelopathy. Pathological or functional changes in the spinal cord, often resulting from nonspecific and noninflammatory lesions.
neuropathy. Abnormality, disease, or malfunction of the nerves.

<table>
<thead>
<tr>
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<th>Fac PE</th>
<th>Malpractice</th>
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**95851-95852**

**95851**  
Range of motion measurements and report (separate procedure);  
each extremity (excluding hand) or each trunk section (spine)

**95852**  
hand, with or without comparison with normal side

**Explanation**
Testing determines active and passive range of motion for extremities  
and joints. Code 95851 applies to manually testing each arm or leg or  
sections of the spine in a separately reported procedure. Code 95852  
applies to manually testing the hands.

**Coding Tips**
A more appropriate code for a physical therapist to bill for muscle  
testing, based on the procedure preformed, may be 97750 Physical  
performance test or measurement.

Note that 95851 and 95852, separate procedures by definition, are  
usually each components of a more complex service and are not  
identified separately. When performed alone or with other unrelated  
procedures/services they may be reported. If performed alone, list the  
code; if performed with other procedures/services, list the code and  
append modifier 59 Distinct procedural service.

Medical record documentation for codes 95851 and 95852 must  
include a separate, distinctly identifiable report that is also signed by  
the PT. Report 95851 once for each extremity or section of trunk (i.e.,  
cervical, thoracic, lumbar) measured.

These services may be billed in addition to the standard evaluation.  
Note that because these codes are outside the physical medicine series  
of codes it is advisable for the physical therapist to obtain payment  
information or prior authorization from the payer before rendering the  
service.

**Terms To Know**
- **contracture.** Shortening of muscle or connective tissue.
- **dorsiflexion.** Position of being bent toward the extensor side of a limb.
- **flexion.** Act of bending or being bent.
- **range of motion.** Action of a body part throughout its extent of natural  
  movement, measured in degrees of a circle.
- **separate procedures.** Services commonly carried out as a fundamental  
  part of a total service and, as such, do not usually warrant separate identification.  
  These services are identified in CPT with the parenthetical phrase (separate  
  procedure) at the end of the description and are payable only when performed  
  alone.

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present  

**IOM References**
100-2,15,230.4; 100-4,5,10.2

<table>
<thead>
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<th>Work Value</th>
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<td>0.47</td>
<td>0.17</td>
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</table>
1) The PT is certified by the American Board of Physical Therapist criteria:

When performed by a PT who meets the following modifier.

To report the complete procedure component, append modifier 26. To report only the technical and professional component. To report only the professional providing data for future claims. These codes have both a technical keep track of experiences with each insurance company and policy, insurers require physical therapists to bill services. Therapists should keep track of experiences with each insurance company and policy, providing data for future claims.

Coding Tips

Single-fiber EMG testing is the innervation of one or more nerve cell(s) 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.

When no nerve conduction studies are performed on the same date of service, the appropriate EMG code (95860–95864 and 95866–95870) should be reported. To report nerve conduction studies, see 95907–95913.

Physical therapists in private practice may bill for the technical and professional component of certain diagnostic tests in the 9560–95937 code range, such as electromyograms and nerve conduction studies. 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 try 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.

Terms To Know

- **atrophy**: Reduction in size or activity in an anatomic structure, due to wasting away from disease or other factors.
- **electromyography**: (EMG). Examining and recording the electrical activity of a muscle.
- **myositis**: Inflammation of a muscle with voluntary movement.
- **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.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-2,15,230.4; 100-4,5,10.2

CCI Version 20.0

95869-95870, 95873-95874, 95885-95886, 95907-95913, 99446-99449

Also not with 95861: 95860

Also not with 95863: 95860-95861

Also not with 95864: 95860-95863

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

### 95860-95864

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<td>Needle electromyography; 1 extremity with or without related paraspinal areas</td>
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<td>2 extremities with or without related paraspinal areas</td>
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<td>4 extremities with or without related paraspinal areas</td>
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<td>0.08</td>
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Needle electromyography; hemidiaphragm

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 the 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
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 the complete procedure (i.e., both the professional and technical components), submit without a modifier.

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

1) The PT is certified by the American Board of Physical Therapist Specialties (ABPTS) as a clinical electrophysiologic-certified specialist
2) The PT is personally supervised by an ABPTS-certified PT; only the certified PT may bill for the service

Medicare will permit a PT without ABPTS certification to provide certain electromyography services if that PT 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.

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.

These codes can be used in addition to the standard evaluation. These codes do not include nerve conduction studies. When needle electromyography with nerve conduction, amplitude and latency/velocity is performed, see code 95857.

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

electromyography. (EMG). 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.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0
90901, 95867, 95870, 95873-95874, 99446-99449
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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**Needle electromyography; cranial nerve supplied muscle(s), unilateral**

**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 the muscle at rest, and during contraction. These codes are specific to the 12 nerves that emerge from or enter the cranium. Report 95867 for unilateral studies and 95868 for bilateral studies.

**Coding 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 the complete procedure (i.e., both the professional and technical components), submit without a modifier.

When no nerve conduction studies are performed on the same date of service, the appropriate EMG code (95860–95864 and 95866–95870) should be reported. To report nerve conduction studies, see 95907–95913.

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

1) The PT is certified by the American Board of Physical Therapist Specialties (ABPTS) as a clinical electrophysiologic-certified specialist

2) The PT is personally supervised by an ABPTS-certified PT; only the certified PT may bill for the service.

Medicare will permit a PT without ABPTS certification to provide certain electromyography services if that PT 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.

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. These codes can be used in addition to the standard evaluation.

<table>
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<th>Work Value</th>
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**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**

100-2,15,230.4; 100-4,5,10.2

**CCI Version 20.0**

95869-95870, 95873-95874, 95887, 95907-95913, 99446-99449

Also not with 95868: 92265, 95866-95867

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)

limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters

Explanation
Needle electromyography (EMG) records the electrical properties of thoracic paraspinal muscles, excluding T1 or T12 (95869) using an oscilloscope. Recordings, which may be amplified and heard through a loudspeaker, are made during needle insertion, with the muscle at rest, and during contraction. Report 95870 for a limited study of muscles in one extremity or non-limb (axial) muscles other than thoracic paraspinal or cranial supplied muscles or sphincters.

Coding Tips
Code 95870 should be used to report a needle EMG study of a limb that has fewer than five muscles tested per limb. Report this code once, or once per each extremity examined. Append modifier 59 Distinct procedural service, to any subsequent codes reported. Report 95870 once when performed on the cervical or lumbar paraspinal muscles, report 95870 only once regardless of the number of levels examined or if performed bilaterally.

When no nerve conduction studies are performed on the same date of service, the appropriate EMG code (95860–95864 and 95866–95870) should be reported. To report nerve conduction studies, see 95907–95913.

Do not report code 95870 in addition to code 95860, 95861, 95863, or 95864 since the testing of paraspinal muscles corresponding to an extremity are included in these codes. However, when a different limb is tested, append modifier 59 Distinct procedural service, to indicate the involvement of the second limb.

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 the complete procedure (i.e., both the professional and technical components), submit without a modifier.

Terms To Know
electromyography. (EMG). Examining and recording the electrical activity of a muscle.
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.

Synonym(s): TC.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,230.4; 100-4,5,10.2

CCI Version 20.0
95873-95874, 95907-95913, 99446-99449
Also not with 95869: 90901, 95870, 95887
Also not with 95870: 95885-95887
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied.

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 the muscle at rest, and during contraction. This procedure uses a single fiber electrode to obtain additional information on specific muscles, including quantitative measurement of jitter, blocking, and/or fiber density.

Coding 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 the complete procedure (i.e., both the professional and technical components), submit without a modifier.

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

1) The PT is certified by the American Board of Physical Therapist Specialties (ABPTS) as a clinical electrophysiologic-certified specialist
2) The PT is personally supervised by an ABPTS-certified PT; only the certified PT may bill for the service

Medicare will permit a PT without ABPTS certification to provide certain electromyography services if that PT 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.

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. These codes can be used in addition to the standard evaluation.

Terms To Know

electromyography. (EMG). Examining and recording the electrical activity of a muscle.

oscilloscope. Instrument in which a varying electrical signal (y) vertically deflects an electron beam impinging on a fluorescent screen, while some other function (x or time) deflects the beam horizontally. The result is a visual graph of y plotted against x or time with negligible distortion by inertia.

quantitative. To determine the amount and nature of the components of a substance.

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.

Synonym(s): TC.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-2,15,230.4

CCI Version 20.0

99446-99449

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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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 the muscle at rest, and during contraction. Report 95885 per limited study of an extremity and 95886 for a complete (five or more muscles) study of an extremity. Codes 95885-95886 can be reported for a total of four units if all extremities are tested.

**Coding Tips**

These are resequenced codes and will not display in numeric order. As add-on codes, these codes are not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as stand-alone codes.

Codes 95985 and 95986 may be reported with 95907–95913 for nerve conduction studies. Do not report nerve conduction studies (95907–95913), needle EMG of cranial and paraspinal nerves (95867–95869), limited muscle EMG (95870), or motor and/or sensory nerve conduction (95905) with 95887.

Codes 95885 and 95886 for electromyography with nerve conduction studies may not be reported with 95860–95864, 95870 (electromyography without nerve conduction studies), or 95905 (motor and/or sensory nerve conduction).

Codes 95885 and 95886 may be reported once per extremity tested. Both may be reported at the same time when all four extremities are tested up to a total of four units of service.

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.
Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)

**Explanation**
This procedure tests electrical properties of ischemic limb during exercise and includes lactic acid determination using a muscle biopsy technique.

**Coding 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 the complete procedure (i.e., both the professional and technical components), submit without a modifier. A complete list of the nerves considered for a separate study may be found in appendix J of the CPT manual.

The professional component is covered by Medicare as outpatient physical therapy when performed by a PT who meets the following criteria:
1) The PT is certified by the American Board of Physical Therapist Specialties (ABPTS) as a clinical electrophysiology-certified specialist
2) The PT is personally supervised by an ABPTS-certified PT; only the certified PT may bill for the service

Medicare will permit a PT without ABPTS certification to provide certain electromyography services if that PT 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.

Chronic total occlusion of an extremity artery usually develops over a long period of time, although partial occlusion is initially present. Symptoms vary, but may include intermittent claudication when the lower extremity arteries are affected. The presence of a collateral blood supply can cause a wide variation in symptoms and may actually allow worsening of an occlusion even though symptoms may be relatively less. Since a total occlusion is more difficult to cross than a partial occlusion, treatment with angioplasty and/or stenting is significantly more complex. These conditions are classified to subcategory 440.4 Chronic total arterial occlusion of the extremities.

ICD-9-CM subcategory 728.8 includes muscle weakness (728.87), excluding generalized weakness, which is coded to 780.79, and rhabdomyolysis (728.88). Rhabdomyolysis is a common disorder which may result from hereditary diseases, or by trauma or toxic insults to skeletal muscle. Rhabdomyolysis results from an injury damaging the integrity of the skeletal muscle. This results in pain, weakness, tenderness, and contractures, or even muscle necrosis and the release of potentially toxic muscle cell components into the circulation causing potential life-threatening complications to arise, including acute renal failure, hyperkalemia, and cardiac arrest.

**Terms To Know**
- **contracture.** Shortening of muscle or connective tissue.
- **ischemia.** Deficiency in blood supply causing tissues to be deprived of oxygen, resulting from trauma, mechanical or functional constriction of blood vessels, or a physical obstruction.
- **oscilloscope.** Instrument in which a varying electrical signal (y) vertically deflects an electron beam impinging on a fluorescent screen, while some other function (x or time) deflects the beam horizontally. The result is a visual graph of y plotted against x or time with negligible distortion by inertia.

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**
100-2,15,230.4

**CCI Version 20.0**
36000, 36410, 95860, 95869, 96360, 96365, 96372, 96374-96376, 99446-99449
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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</tbody>
</table>

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95905

**Explanation**

Nerve testing uses sensors to measure and record nerve functions including conduction, amplitude, and latency/velocity. Nerves are stimulated with electric shocks along the course of the nerve. The time required to initiate contraction is measured and recorded. Measurements of distal latency (the time required for an impulse to travel a measured length of nerve) are also recorded. Code 95905 reports motor and/or sensory nerve conduction tests performed using preconfigured electrode arrays. It includes F-wave study, when performed, as well as interpretation and report. Report 95905 only once for each limb studied.

**Coding Tips**

This service should be reported only once per extremity studied. This code is used to indicate nerve conduction studies performed with preconfigured electrodes that are customized to a particular anatomic site.

Do not report 95905 in conjunction with needle EMG with nerve conduction amplitude and latency/velocity studies (95885–95886), nerve conduction, amplitude and latency/velocity studies, or H reflex studies (95907–95913).

This code includes the interpretation, recording, and preparation of the report.

**Terms To Know**

amplitude. Size, extent, abundance, fullness, or amount of movement.

latency. Hidden, concealed, or dormant.

nerve conduction study. Diagnostic test performed to assess muscle or nerve damage. Nerves are stimulated with electric shocks along the course of the muscle. Sensors are utilized to measure and record nerve functions, including conduction and velocity.

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**CCI Version 20.0**

95885-95887, 95938-95940, 99446-99449, G0453

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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### Coding and Payment Guide for the Physical Therapist

#### Procedure Codes

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#### Coding and Payment Guide for the Physical Therapist

**95907-95909**

95907  Nerve conduction studies; 1-2 studies
95908  3-4 studies
95909  5-6 studies

**Explanation**

There are three types of nerve conduction studies represented by these codes: sensory conduction, motor conduction (with or without an F wave test) or an H-reflex test. Electrodes are placed directly over the nerve, in sensory conduction testing, or over the motor point of a specific muscle in motor conduction testing. Electrical stimulation is applied. The latency, amplitude and conduction velocity of the stimulation is measured. Adjustments to any of the testing elements (stimulus site, recording site, ground site, filtered settings) are made to minimize unintended stimulation of adjacent nerves. A report is generated onsite that interprets the numerous test results at each site tested. Each type of study is reported only once regardless of the number of times performed on the same nerve in different areas. Report code 95907 for up to two studies; code 95908 for three or four studies; code 95909 for five or six studies.

**CPT Coding Tips**

To report seven or eight studies see code 95910; code 95911 for nine or ten studies; code 95912 for eleven or twelve studies; or code 95913 for thirteen or more studies. Appropriate code selection is determined by the number of studies performed. When nerve conduction studies are performed with needle electromyography, report also codes 95885-95887 as appropriate. It is appropriate to report these codes for sensory nerve conduction threshold testing (SNCT) since information on the nerve conduction, amplitude, latency, and velocity are provided. Sensory conduction testing, motor conduction testing (with or without F wave testing) or H-reflex testing are each considered a single conduction study and for coding purposes, are considered to be distinct when determining the number of studies to be reported.

Each nerve conduction study is reported only once per nerve even when multiple sites of the same nerve are studied. Do not report motor and/or sensory nerve conduction studies (95905) separately when performed during the same encounter.

Acute transverse myelitis (ATM) is a focal inflammatory condition of the spinal cord, resulting in motor, sensory, and autonomic dysfunction. "Transverse" indicates dysfunction at a specific level across the spinal cord, with altered function below this level and normal function above it. The cause of about 60 percent of TM cases is unknown, and so is referred to as idiopathic. Other cases can be linked to certain associated diseases. The most optimal treatment of ATM is dependent upon a timely and accurate diagnosis. Because acute transverse myelopathies are comparatively rare, delayed and incomplete work ups often occur.

Myotonia, a neuromuscular disorder characterized by the slow relaxation of the muscles following contraction, may be inherited or acquired. Caused by an abnormality in the muscle membrane, it can affect all muscle groups. The most common form is myotonic muscular dystrophy (MMD, Steinert’s disease), which is often manifested by weakness and wasting of the voluntary muscles generally noticed at the age of 2 to 3 years. Muscle stiffness, especially in the legs, may be brought on by sudden activity after rest. Muscle enlargement may occur and muscle strength may be increased. Myotonic chondrodystrophy is a rare genetic disorder characterized by joint contractures, bone dysplasia, myotonic myopathy, and growth delays resulting in dwarfism. Treatment options for the various myotonic disorders may include anticonvulsant drugs, physical therapy, and other rehabilitative measures designed to improve muscle function.

**Terms To Know**

- **Nerve conduction study**: Diagnostic test performed to assess muscle or nerve damage. Nerves are stimulated with electric shocks along the course of the muscle. Sensors are utilized to measure and record nerve functions, including conduction and velocity.
- **H-reflex**: Involuntary action, movement, or activity brought about by triggering the corresponding stimulus.

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**

100-2,15,230.4; 100-4,5,10.2

**CCI Version 20.0**

99446-99449

Also not with 95907: 95905
Also not with 95908: 95905-95907
Also not with 95909: 95905-95908

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Acute transverse myelitis (ATM) is a focal inflammatory condition of the spinal cord, resulting in motor, sensory, and autonomic dysfunction. "Transverse" indicates dysfunction at a specific level across the spinal cord, with altered function below this level and normal function above it. The cause of about 60 percent of TM cases is unknown, and so is the underlying condition. Idiopathic transverse myelitis is now uniquely identified by code 341.22.

Myotonia, a neuromuscular disorder characterized by the slow relaxation of the muscles following contraction, may be inherited or acquired. Caused by an abnormality in the muscle membrane, it can affect all muscle groups. The most common form is myotonic muscular dystrophy (MMD, Steinert’s disease), which is often manifested by weakness and wasting of the voluntary muscles generally noticed at the age of 2 to 3 years. Muscle stiffness, especially in the legs, may be brought on by sudden activity after rest. Muscle enlargement may occur and muscle strength may be increased. Myotonic chondrodystrophy is a rare genetic disorder characterized by joint contractures, bone dysplasia, myotonic myopathy, and growth delays resulting in dwarfism. Treatment options for the various myotonic disorders may include anticonvulsant drugs, physical therapy, and other rehabilitative measures designed to improve muscle function.

Terms To Know

nerve conduction study. Diagnostic test performed to assess muscle or nerve damage. Nerves are stimulated with electric shocks along the course of the muscle. Sensors are utilized to measure and record nerve functions, including conduction and velocity.

reflex. Involuntary action, movement, or activity brought about by triggering the corresponding stimulus.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-2,15,230.4

CCI Version 20.0

99446-99449
Also not with 95910: 95905-95909
Also not with 95911: 95905-95910
Also not with 95912: 95905-95911
Also not with 95913: 95905-95912

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day

Explanation
Benign paroxysmal positional vertigo (BPPV) is an inner ear problem caused by crystals (canalith) floating in the fluid of the inner ear. With a change in position, these crystals may stimulate a portion of the inner ear, resulting in short periods of dizziness. The physical therapist treats benign positional vertigo with a series of repositioning movements known as Epley or Semont maneuvers. The patient is placed in various planned positions during the maneuver, which may cause temporary dizziness. The physical therapist provides instructions to the patient immediately following the procedure to ensure safe and appropriate home maintenance. Report 95992 once for each day of treatment.

Coding Tips
As exempt from modifier 51, 95992 has not been designated in CPT as an add-on service or procedure. However, codes identified as exempt from modifier 51 are not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied.

Because CMS bundles code 95992 with codes for which physical therapists do not bill, Medicare policy permits PTs to use code 97112 to bill for canalith reposition services. Some private payers allow PTs to use 95992; check with payers for individual policies.

Codes 92531 and/or 92532 should not be reported in addition to 95992.

Terms To Know
BPPV. Benign positional paroxysmal vertigo. Common cause of dizziness that may be idiopathic or caused by neuritis, stroke, or trauma. BPPV is reported with ICD-9-CM code 386.11.

Epley maneuver. Also called the canalith repositioning procedure, this maneuver decreases or eliminates the symptoms of benign paroxysmal positional vertigo (BPPV) by moving debris out of the sensitive area in the ear canal. It involves sequential moving of the head into four positions. The patient starts in a seated position, progresses to a supine position, followed by sequential changes to head and neck positions. After the maneuver, the patient is provided additional instructions aimed at reducing the chance that the debris might fall back into the sensitive area of the ear canal. This procedure is reported with CPT code 95992.

Semont maneuver. Also called the liberatory maneuver, this procedure decreases or eliminates the symptoms of benign paroxysmal positional vertigo (BPPV) by moving debris out of the sensitive area in the ear canal. It involves moving the patient briskly from lying on one side to lying on the other side. After the maneuver, the patient is provided additional instructions aimed at reducing the chance that the debris might fall back into the sensitive area of the ear canal. This procedure is reported with CPT code 95992.

Vertigo. Sensation of movement, either of one's own body or the environment rotating or spinning, due to a disturbance of the inner ear, vestibular centers, or pathways in the central nervous system. This condition often causes nausea and vomiting.

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96000-96001

9600  Comprehensive computer-based motion analysis by video-taping and 3D kinematics
96001  with dynamic plantar pressure measurements during walking

Explanation
Human motion analysis has several applications including biomedical and athletic performance. To conduct a biomedical analysis, patient movements are recorded, digitized, copied on computer, and processed. For example, when calculating net joint moments, the joint center is calculated using a local coordinate system created from body markers. When tracking markers in 3D using video, as in 96000, two or more cameras are used to identify the markers. After all parameters are found (e.g., linear acceleration, angular acceleration, ground reaction forces) and gathered using stereo X-rays or MRI techniques, the resultant net joint forces and moments can be calculated. In 3-D kinematics, joint centers are digitized for the first few frames of the sequence recorded. Linear parameters of movement can be measured to assess horizontal and vertical motion. Also, angular parameters can measure the degrees of movement of the joints to analyze specific joint motion. In 96001, while taking dynamic plantar pressure measurements, data is collected using a pressure sensor platform positioned on a walkway. The patient walks along the walkway so pressure data can be analyzed in areas of the foot (i.e., the heel, metatarsal heads, and the hallux). The peak pressure is determined in all areas and the highest pressure of all sites (i.e., peak pressure foot) is measured. Report 96004 in addition to each of these codes for physician review and interpretation of results, which includes the physical therapist's written report.

Coding Tips
These codes are used to report services that are performed as part of a therapeutic or diagnostic patient evaluation and are provided in a dedicated motion analysis laboratory using sophisticated videotaping, computerized 3-D kinematics, and dynamic electromyography equipment. To report needle electromyography, the appropriate code from 95860-95870, 95872, or 95885-95887 should be indicated on the claim.

Hemiplegia and hemiparesis (category 342) codes are to be used when hemiplegia (complete) (incomplete) is reported without further specification, or is stated to be old or long standing but of unspecified cause. The category is also used for multiple coding to identify these types of hemiplegia resulting from any cause.

Hemiplegia and hemiparesis resulting from cerebrovascular disease is classified to category 438. Fifth-digit assignment identifies the affected side. Assigning a code from the 438 category is inappropriate in cases of past history of cerebrovascular disease that resulted in no neurological deficits. The appropriate code assignment would be V12.54 Transient ischemic attack (TIA), and cerebral infarction without residual deficits. Code 434.91 is assigned for the nonspecific diagnosis of stroke or CVA, not otherwise specified.

Osteoarthritis (category 715) is a degenerative, rather than inflammatory, disease of one or more joints. Also known as osteoarthritis and degenerative joint disease, osteoarthritis is most conspicuous in the large joints and is initiated by local deterioration of the articular cartilage. It progressively destroys the cartilage, remodels the subchondral bone, and causes a secondary inflammation of the synovial membrane. Assignment of the fourth digit to codes in this category is based on whether the disease is localized or generalized and whether it is primary or secondary. In these subcategories, localized includes unilateral involvement of the same site. Assign a fourth digit as follows: 0 Generalized; 1 Localized, primary; 2 Localized, secondary; 3 Localized, not specified whether primary or secondary; 8 Involving, or with mention of more than one site, but not specified as generalized; 9 Unspecified whether generalized or localized

A fifth digit must also be assigned to specify the site as follows: 0 Site unspecified: 1 Shoulder region (not valid for 715.0, 715.8, 715.9); 2 Upper arm (not valid for 715.0, 715.8, 715.9); 3 Forearm (not valid for 715.0, 715.8, 715.9); 4 Hand (not valid for 715.0, 715.8, 715.9); 5 Pelvic region and thigh (not valid for 715.0, 715.8, 715.9); 6 Lower leg (not valid for 715.0, 715.8, 715.9); 7 Ankle and foot (not valid for 715.0, 715.8, 715.9); 8 Other specified sites (not valid for 715.0, 715.8, 715.9); 9 Multiple sites (not valid for 715.1, 715.2, 715.3, 715.9).

Terms To Know
ataxia. Defect in muscular coordination, seen especially when voluntary muscular movements are attempted.
coordination disorder. Disorders in which the main feature is a serious impairment in the development of motor coordination that is not explicable in terms of general intellectual retardation and is commonly associated with perceptual difficulties.
kinetics. Motion or movement.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,230.4

CCI Version 20.0
97116, 97750
Also not with 96001: 96000
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles

Explanation
Electrodes placed on the muscle belly, parallel to the grain of the muscle fiber, detects an electrical signal that comes from active muscles (the patient is in motion during the test). The strength and pattern of the signal is seen on a computer screen and the data is collected in a software program that is able to run various analyses of the data to create useful reports regarding muscle function. For example, gait analysis allows the clinician to analyze time normal activation patterns separately for stance and swing phases between conditions or against data base values. Report 96002 for a study of one to 12 muscles. Report 96004 in addition to this code for physician review and interpretation of results, which includes the physical therapist's written report.

Coding Tips
Codes 95860–95866, 95869–95872, and 95885–95887 should not be used to report motion analysis or reported with codes 96002–96003 for motion analysis. This code is used to report services that are performed as part of a therapeutic or diagnostic patient evaluation and are provided in a dedicated motion analysis laboratory using sophisticated videotaping, computerized 3-D kinematics, and dynamic electromyography equipment.

Do not use a code from category V49 as a principal diagnosis for inpatient admissions. Also, avoid indiscriminate reporting of conditions influencing health status as secondary codes. All secondary diagnoses in this code range are susceptible to the same tests of relevance and timeliness as defined by the Uniform Hospital Discharge Data Set (UHDDS) definition for "other diagnoses." The UHDDS defines "other diagnoses" as disease that coexists at the time of encounter and has a bearing on the management of the patient requiring any of the following: clinical evaluation, therapeutic treatment, diagnostic studies, or monitoring.

Osteoarthrosis (category 715) is a degenerative, rather than inflammatory, disease of one or more joints. Also known as osteoarthritis and degenerative joint disease, osteoarthritis is most conspicuous in the large joints and is initiated by local deterioration of the articular cartilage. It progressively destroys the cartilage, remodels the subchondral bone, and causes a secondary inflammation of the synovial membrane. Assignment of the fourth digit to codes in this category is based on whether the disease is generalized or localized and whether it is primary or secondary. In these subcategories, localized includes bilateral involvement of the same site. Assign a fourth digit as follows: 0 Generalized; 1 Localized, primary; 2 Localized, secondary; 3 Localized, not specified whether primary or secondary; 8 Involving, or with mention of more than one site, but not specified as generalized; 9 Unspecified whether generalized or localized

A fifth digit must also be assigned to specify the site as follows: 0 Site unspecified: 1 Shoulder region (not valid for 715.0, 715.8, 715.9); 2 Upper arm (not valid for 715.0, 715.8, 715.9); 3 Forearm (not valid for 715.0, 715.8, 715.9); 4 Hand (not valid for 715.0, 715.8, 715.9); 5 Pelvic region and thigh (not valid for 715.0, 715.8, 715.9); 6 Lower leg (not valid for 715.0, 715.8, 715.9); 7 Ankle and foot (not valid for 715.0, 715.8, 715.9); 8 Other specified sites (not valid for 715.0, 715.8); 9 Multiple sites (not valid for 715.1, 715.2, 715.3, 715.9).

Terms To Know

gait. Manner in which a person walks. The phases of the gait cycle include loading, response, mid-stance, terminal stance, pre-swing, initial, mid-swing, and push off.

kinetics. Motion or movement.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,230.4

CCI Version 20.0
95860-95866, 95869-95872, 95885-95887, 97116, 97750
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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96003

Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle

Explanation
Electrodes placed in the muscle belly, parallel to the grain of the muscle fiber, detects an electrical signal that comes from active muscles (the patient is in motion during the test). The strength and pattern of the signal is seen on a computer screen and the data is collected in a software program that is able to run various analyses of the data to create useful reports regarding muscle function. For example, gait analysis allows the clinician to analyze time normal activation patterns separately for stance and swing phases between conditions or against data base values. Report 96002 for a study of one to 12 muscles. Use 96003 to report dynamic fine wire electromyography for one muscle.

Coding Tips
Codes 95860–95866, 95869–95872, and 95885–95887 should not be used to report motion analysis or reported with codes 96002–96003 for motion analysis. This code is used to report services that are performed as part of a therapeutic or diagnostic patient evaluation and are provided in a dedicated motion analysis laboratory using sophisticated videotaping, computerized 3-D kinematics, and dynamic electromyography equipment.

There are three code choices for generalized arthritis or osteoarthrosis: unspecified site (715.00), the hand (715.04), or multiple sites (715.09). Localized osteoarthrosis is a disease confined to a limited number of sites. The distinction between generalized and localized can be difficult for the clinician because the disease may be generalized, but detectable in only one or two of the larger weight-bearing joints such as the hip or knee. The provider must document localized or generalized, or the coder should assign the unspecified code, 715.9 Osteoarthrosis, unspecified whether generalized or localized. Often, the medical record indicates osteoarthritis of multiple sites without stating "generalized." Coders should assign 715.89 Osteoarthrosis involving, or with mention of more than one site, but not specified as generalized, multiple sites for this diagnosis. Fifth digit 9 indicating multiple sites may not be used for osteoarthritis unspecified as generalized or localized.

Terms To Know
- electromyography. (EMG). Examining and recording the electrical activity of a muscle.
- kinematics. Motion or movement.
- stance phase of gait. Period of time when the foot is in contact with the ground.
- swing phase of gait. Period of time when all portions of the foot are in forward motion; usually when the foot is not in contact with the ground, but also in cases where the foot never leaves the ground (foot drag).

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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Review and interpretation by physician or other qualified health care professional of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report

**Explanation**

The physical therapist reviews and interprets computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography performed using codes 96000, 96001, 96002, and 96003 to report the service.

**Coding Tips**

Report code 96004 only one time no matter how many studies are reviewed and interpreted. Hemiplegia and hemiparesis (category 342) codes are to be used when hemiplegia (complete) (incomplete) is reported without further specification, or is stated to be old or long standing but of unspecified cause. The category is used also for multiple coding to identify these types of hemiplegia resulting from any cause. Hemiplegia and hemiparesis resulting from cerebrovascular disease is classified to category 438. Assigning a code from the 438 category is inappropriate in cases of past history of cerebrovascular disease that resulted in no neurological deficits. The appropriate code assignment would be V12.54 Transient ischemic attack (TIA), and cerebral infarction without residual deficits. Code 434.91 is assigned for the nonspecific diagnosis of stroke or CVA, not otherwise specified.

**Terms To Know**

cerebrovascular accident. Disruption in blood flow to the brain caused by an embolism, thrombosis, or other occlusion, resulting in a lack of perfusion and infarction of brain tissue. Current CVAs are reported with codes from the 434 rubric of ICD-9-CM with a fifth digit of 1 to indicate that cerebral infarction has occurred. An impending CVA is reported as an unspecified transient ischemic attack (TIA), 435.9, in which intermittent ischemia of the brain tissue occurs. When a cerebrovascular accident occurs postoperatively, report 997.02. Sequelae or late effects of CVA can include paralysis, weakness, speech problems, and aphasia, and are reported within the 438 category reserved for late effects of cerebrovascular disease. A healed or old cerebral infarction is coded to V12.59, a personal history of circulatory system disease. Synonym(s): CVA, stroke.

electromyography. (EMG). Examining and recording the electrical activity of a muscle.

hemiplegia. Paralysis of one side of the body.

kinetics. Motion or movement.

neuromyopathy. Disease or disorder affecting both the nerves and the muscles, particularly a muscular disease of nervous origin. Report this condition with a code from ICD-9-CM category 358.

TIA. Transient ischemic attack. Intermittent or brief cerebral dysfunction from lack of oxygenation with no persistent neurological deficits; associated with occlusive vascular disease.

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96105
Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour

Explanation
The physical therapist administers tests to measure communication problems such as speech and writing in an aphasic patient. This code applies to each hour of testing.

Coding Tips
Report this code once per hour of testing. A written report must be generated. The interpretation and report are included in the service. Aphasia due to late effects of cerebrovascular disease should be reported using code 438.11. Use 315.31 when developmental aphasia is documented.

Terms To Know
aphasia. Partial or total loss of the ability to comprehend language or communicate through speaking, the written word, or sign language. Aphasia may result from stroke, injury, Alzheimer's disease, or other disorder. Common types of aphasia include expressive, receptive, anomic, global, and conduction. Aphasia is reported with ICD-9-CM code 784.3. Other codes apply when specified as developmental, late effect, or from tertiary syphilis. Synonym(s): logagnosia, logamnesia, logasthenia.
cognitive. Being aware by drawing from knowledge, such as judgment, reason, perception, and memory.

ICD-9-CM Diagnostic Codes
313.83 Academic underachievement disorder of childhood or adolescence
313.89 Other emotional disturbance of childhood or adolescence
313.9 Unspecified emotional disturbance of childhood or adolescence
314.00 Attention deficit disorder of childhood without mention of hyperactivity
314.01 Attention deficit disorder of childhood with hyperactivity
314.1 Hyperkinesia of childhood with developmental delay — (Use additional code to identify any associated neurological disorder)
314.2 Hyperkinetic conduct disorder of childhood
314.8 Other specified manifestations of hyperkinetic syndrome of childhood
314.9 Unspecified hyperkinetic syndrome of childhood
315.00 Developmental reading disorder, unspecified
315.01 Alexia
315.02 Developmental dyslexia
315.09 Other specific developmental reading disorder
315.1 Mathematics disorder
315.2 Other specific developmental learning difficulties
315.31 Expressive language disorder
315.32 Mixed receptive-expressive language disorder
315.34 Speech and language developmental delay due to hearing loss
315.39 Other developmental speech or language disorder
315.4 Developmental coordination disorder
315.5 Mixed development disorder
315.8 Other specified delay in development
315.9 Unspecified delay in development
316 Psychic factors associated with diseases classified elsewhere — (Use additional code to identify the associated physical condition as: 259.4, 427.2, 493.9, 531.0-531.9, 532.0-532.9, 556, 564.9, 691.8, 692.9, 708.0-708.9)
317 Mild intellectual disabilities — (Use additional code(s) to identify any associated psychiatric or physical condition(s))
318.0 Moderate intellectual disabilities — (Use additional code(s) to identify any associated psychiatric or physical condition(s))
318.1 Severe intellectual disabilities — (Use additional code(s) to identify any associated psychiatric or physical condition(s))
318.2 Profound intellectual disabilities — (Use additional code(s) to identify any associated psychiatric or physical condition(s))
319 Unspecified intellectual disabilities — (Use additional code(s) to identify any associated psychiatric or physical condition(s))
438.11 Aphasia due to cerebrovascular disease — (Use additional code to identify presence of hypertension)
783.40 Lack of normal physiological development, unspecified
783.42 Delayed milestones
784.3 Aphasia

Please note that this list of associated ICD-9-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.

IOM References
100-1,3,30.1; 100-2,15,80.2; 100-2,15,230.4; 100-4,5,10.2; 100-4,5,10.6; 100-4,12,150; 100-4,12,160; 100-4,12,170; 100-4,12,170.1

CCI Version 20.0
96110-96111, 96125, G0451

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Developmental screening, with interpretation and report, per standardized instrument form

Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report

Explanation
The physical therapist performs developmental screening to determine whether the patient needs additional work up for a developmental disorder or at periodic intervals throughout infancy and adolescent years (96110), or performs developmental testing of cognitive, motor, social, language, adaptive, and/or cognitive abilities (96111) on a provider standardized form (meeting industry standards). Standardized testing (meeting industry standards) via written, oral, or combined format testing is used. These codes include the interpretation of the findings and preparation of the report.

Coding Tips
These codes are used to report services provided during testing of cognitive function of the central nervous system. These codes are reported per hour of service. Information obtained through the assessment is interpreted and a written report is generated. These codes include interpretation of the findings and preparation of the report.

For neuropsychological testing, see codes from range 96118–96120.
For psychological testing, see codes from range 96101–96103.

Terms To Know
cognitive. Being aware by drawing from knowledge, such as judgment, reason, perception, and memory.
dyslexia. Serious impairment of reading skills such as word blindness and strephosymbolia (letter or word reversal) that is not explicable in terms of general intellectual retardation or of inadequate schooling.

ICD-9-CM Diagnostic Codes
315.00 Developmental reading disorder, unspecified
315.01 Alexia
315.02 Developmental dyslexia
315.09 Other specific developmental reading disorder
315.1 Mathematics disorder
315.2 Other specific developmental learning difficulties
315.31 Expressive language disorder
315.32 Mixed receptive-expressive language disorder
315.34 Speech and language developmental delay due to hearing loss
315.39 Other developmental speech or language disorder
315.4 Developmental coordination disorder
315.5 Mixed development disorder
315.8 Other specified delay in development
315.9 Unspecified delay in development

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

CCI Version 20.0
Also not with 9610: 96125

Note: These ICD-9-CM codes are 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.

IOM References
100-1,3,30; 100-1,3,30.1; 100-1,3,30.3; 100-2,15,80.2; 100-2,15,230.4; 100-4,12,150; 100-4,12,160; 100-4,12,170; 100-4,12,170.1

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Standardized cognitive performance testing (e.g., 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 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.

For the development of cognitive skills, see 97532 and 97533.

**Terms To Know**
cognitive. Being aware by drawing from knowledge, such as judgment, reason, perception, and memory.

**ICD-9-CM Diagnostic Codes**
306.7 Malfunction of organs of special sense arising from mental factors
306.8 Other specified psychophysiological malfunction
306.9 Unspecified psychophysiological malfunction
307.0 Adult onset fluency disorder
307.1 Anorexia nervosa
307.20 Tic disorder, unspecified
307.22 Chronic motor or vocal tic disorder
307.23 Tourette's disorder
307.3 Stereotypic movement disorder
310.0 Frontal lobe syndrome
310.2 Postconcussion syndrome — (Use additional code to identify associated post-traumatic headache, if applicable: 339.20-339.22)
315.31 Expressive language disorder
315.32 Mixed receptive-expressive language disorder
315.34 Speech and language developmental delay due to hearing loss
315.39 Other developmental speech or language disorder
315.4 Developmental coordination disorder
315.5 Mixed development disorder

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**CCI Version 20.0**
No CCI Edits apply to this code.
97001-97002
97001  Physical therapy evaluation
97002  Physical therapy re-evaluation

Explanation
Physical therapy evaluation (97001) is a dynamic process in which the physical therapist makes clinical judgments based on data gathered during examination. Examination includes taking a comprehensive history, performing a systems review and conducting tests and measures. Tests and measures include but are not limited to tests of range of motion, motor function, muscle performance, joint integrity, neuromuscular status and review of orthotic or prosthetic devices. The PT evaluates the examination findings, establish a physical therapy diagnosis, determine the prognosis, and develop a plan of care that includes goals and expected outcomes, interventions to be used and anticipated discharge plans. A physical therapy reevaluation (97002) should be reported when the PT reexamines the patient/client to evaluate the progress and to modify or redirect intervention and/or revise anticipated goals and expected outcomes. Reexamination may be indicated more than once during a plan of care. Tests and measures included but are not limited to those described above. The PT modifies the plan of care as indicated and support medical necessity of skilled intervention.

Coding Tips
These services can be performed at multiple places of service (e.g., patient’s home, physical therapist office, outpatient hospital). Be certain that the correct place of service is indicated on the claim form. See the claims processing chapter in this Coding and Payment Guide for more information regarding place-of-service codes.

A therapeutic procedure may be reported on the same day as an evaluation or re-evaluation (97001–97002) when the medical record documentation supports the medical necessity of both services.

Muscle and range of motion testing are reported with 95831–95852. Electromyography is reported with codes 95860–95872 which includes resequenced codes [95885, 95886, 95887]. If a separate procedure is provided and reported that includes performing a muscle or range-of-motion test, then these services would be reported with 95831–95832.

According to the CPT guidelines, these codes are not reported with modifier S1 but have not been designated as modifier S1 exempt or as add-on codes in the CPT book. Please see the beginning of this section for more information on the use of modifiers. A fifth digit is required when reporting spinal stenosis of the lumbar region. The fifth-digit subclassification indicates if neurogenic claudication is present.

Terms To Know
evaluation. Dynamic process in which the physical, occupational, sports, or other therapist makes clinical judgments based on data gathered during the examination.

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
97003-97004

97003  Occupational therapy evaluation
97004  Occupational therapy re-evaluation

Explanation

In 97003, the provider examines the patient. Various movements required for activities of daily living are examined. Dexterity, range of movement, and other elements may also be studied. In 97004, the provider re-evaluates the patient to gauge progress of therapy. Various movements required for activities of daily living are examined. Dexterity, range of movement, and other elements may also be studied.

Coding Tips

A therapeutic procedure may be reported on the same day as an evaluation or re-evaluation (97003–97004) when the medical record documentation supports the medical necessity of both services. These services can be performed at multiple places of service (e.g., patient’s home, provider’s office, outpatient hospital). Be certain that the correct place of service is indicated on the claim form. See the claims processing chapter in this Coding and Payment Guide for more information regarding place-of-service codes.

Muscle and range of motion testing are reported with 95831–95852. Electromyography is reported with codes 95860–95872, which includes resequenced codes [95885, 95886, 95887]. According to the CPT guidelines, these codes are not reported with modifier 51 but have not been designated as modifier 51 exempt or as add-on codes in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

Terms To Know

activities of daily living. Self-care activities often used to determine a patient’s level of function such as bathing, dressing, using a toilet, transferring in and out of bed or a chair, continence, eating, and walking.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-2,15,60.3; 100-2,15,230.4; 100-4,5,10; 100-4,5,10.2

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CCI Version 20.0


Also not with 9703: 99485
Also not with 9704: 97003

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
97005-97006

97005  Athletic training evaluation
97006  Athletic training re-evaluation

Explanation
In 97005, the provider examines the patient. The provider formulates an assessment, prognosis, and notes the anticipated intervention. In 97006, the provider re-examines the patient to obtain objective measures of progress toward stated goals. Tests include, but are not limited to, range of motion, motor function, muscle performance, joint integrity, and neuromuscular status. The provider modifies the treatment plan as is indicated to support medical necessity of skilled intervention.

Coding Tips
Codes 97005 and 97006 describe athletic training services and are not restricted to athletic trainers. However, payment may require review or authorization by a third party. For physical therapy evaluations and re-evaluations performed by those licensed to do so, use 97001 and 97002.

A therapeutic procedure may be reported on the same day as an evaluation or re-evaluation (97005–97006) when the medical record documentation supports the medical necessity of both services. These services can be performed at multiple places of service (e.g., patient’s home, provider’s office, or other outpatient hospital). Be certain that the correct place of service is indicated on the claim form. See the claims processing chapter of this Coding and Payment Guide for more information regarding place-of-service codes.

Muscle and range of motion testing are reported with 95831–95852. Electromyography is reported with codes 95860–95872, which includes resequenced codes [95885, 95886, 95887]. If a separate procedure is provided and reported that includes performing a muscle or range-of-motion test, then these services would be reported with 95831–95832.

According to the CPT guidelines, these codes are not reported with modifier S1 but have not been designated as modifier S1 exempt or add-on codes in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

Terms To Know
range of motion. Action of a body part throughout its extent of natural movement, measured in degrees of a circle.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,230.4; 100-4,5,10

CCI Version 20.0
No CCI Edits apply to this code.

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97010

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

Explanation
The physical therapist 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 day. However, when multiple separate treatment sessions are performed per day, it is appropriate to report one unit for each treatment session. See coding tip below for further guidance on reporting multiple treatment sessions.

Coding Tips
Report code 97010 once only when both cold and hot packs are provided during a single session. 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 code requires supervision by the provider but does not require direct patient contact (one-to-one).

According to the AAMA (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 a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

A fifth digit is required when reporting spinal stenosis of the lumbar region. The fifth-digit subclassification indicates if neurogenic claudication is present.

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.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-3,10.4; 100-3,160.17; 100-4,5,10; 100-4,5,10.2; 100-4,5,20.2

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CCI Version 20.0
No CCI Edits apply to this code.
97012

Explanation
The health care provider applies sustained or intermittent mechanical traction most often to the cervical and/or lumbar spine, but can be to any area. The mechanical force produces distraction between the vertebrae or joint, thereby relieving pain and increasing tissue flexibility. The treatment requires supervision and typically only one unit is billed per day. However, when multiple separate treatment sessions are performed per day, it is appropriate to report one unit for each treatment session.

Coding Tips
Modality is defined as any group of agents that may include thermal, acoustic, radiant, mechanical, or electrical energy to produce physiologic changes in tissues for therapeutic purposes. Codes included in this section do not include specific time increments as a requirement. The modalities identified by codes 97010-97028 require supervision by the provider but do not require direct patient contact (one-to-one). 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 a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

A fifth digit is required when reporting spinal stenosis of the lumbar region. The fifth-digit subclassification indicates if neurogenic claudication is present.

Terms To Know

autotraction. Using the body’s own weight to create traction force.

intermittent. Using a constant amount of force for the duration of the traction application.

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.

static. Alternating traction and relaxation periods throughout the traction application.

traction. Therapeutic use of manual or mechanical tension created by a pulling force to produce a combination of distraction and gliding to relieve pain and increase tissue flexibility.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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97014
97014 Application of a modality to 1 or more areas; electrical stimulation
(unattended)

Explanation
The physical therapist applies electrical stimulation to one or more areas
in order to stimulate muscle function, enhance healing, and alleviate
pain and/or edema. The clinician chooses which type of electrical
stimulation is appropriate. The treatment requires supervision and
typically only one unit is billed per day.

Coding Tips
Modality is defined as any group of agents that may include thermal,
aoustic, radiant, mechanical, or electrical energy to produce
physiologic changes in tissues for therapeutic purposes. Codes included
in this section do not include specific time increments as a requirement.
The modalities identified by codes 97010-97028 require supervision
by the provider but do not require direct patient contact (one-to-one).
Medicare requires that electrical stimulation for the treatment of wounds
or other applications be reported using HCPCS Level II codes
G0281-G0282 or G0283, respectively. Check with other third-party
payers for their requirements.

When billing for supplies, try to be as specific as possible. In addition
to the general supply and material CPT code (99070), there are HCPCS
Level II A, E, and L codes that may describe the specific supply provided.
Under Medicare payment guidelines, electrodes are included in the
practice-expense relative value units for this code and may not be billed
separately.

This code requires supervision by the provider but does not require
direct patient contact (one-to-one). 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 a modifier 51 exempt or an add-on
code in the CPT book. Please see the beginning of this section for more
information on the use of modifiers.

A fifth digit is required when reporting spinal stenosis of the lumbar
region. The fifth-digit subclassification indicates if neurogenic
claudication is present.

Terms To Know
Traction. Therapeutic use of manual or mechanical tension created by a pulling
force to produce a combination of distraction and gliding to relieve pain and
increase tissue flexibility.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present

IOM References
100-2,15,60.3; 100-2,15,230; 100-2,15,230.4; 100-3,160.12;
100-3,160.15

CCI Version 20.0
No CCI Edits apply to this code.
97016

97016 Application of a modality to 1 or more areas; vasopneumatic devices

Explanation

The physical therapist applies a vasopneumatic device to treat extremity edema (usually lymphedema). A pressurized sleeve is applied. Girth measurements are taken pre- and posttreatment. Typically only one unit is billed per day. However, when multiple separate treatment sessions are performed per day, it is appropriate to report one unit for each treatment session.

Coding Tips

Modality is defined as any group of agents that may include thermal, acoustic, radiant, mechanical, or electrical energy to produce physiologic changes in tissues for therapeutic purposes. Codes included in this section do not include specific time increments as a requirement. The modalities identified by codes 97010-97028 require supervision by the provider but do not require direct patient contact (one-to-one).

For coverage guidelines for the treatment of lymphedema and chronic venous insufficiency, see the Medicare national coverage decision 280.6 Pneumatic Compression Devices. Idiopathic cyclical edema is edema of unknown cause, occurring episodically over a period of years, usually affecting women, usually worse during the premenstrual cycle, and is associated with increased aldosterone secretion. Assign 782.3 Edema, for this condition.

This code requires supervision by the provider but does not require direct patient contact (one-to-one). 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 a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

Terms To Know

edema. Swelling due to fluid accumulation in the intercellular spaces.
idiopathic. Having no known cause.
insufficiency. Inadequate closure of the valve that allows abnormal backward blood flow.
lymph. Clear, sometimes yellow fluid that flows through the tissues in the body, through the lymphatic system, and into the bloodstream.
lymphedema. Defect in which excessive lymph fluid accumulates in the tissues and causes the legs to swell.

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ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-4,5,10

CCI Version 20.0

0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 97002, 97004, 97018, 97026

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
**97018**

**Explanation**
The physical therapist uses a paraffin bath to apply superficial heat to a part of an extremity. The part is repeatedly dipped into the paraffin forming a glove. Use of paraffin facilitates treatment of arthritis and other conditions that cause limitations in joint flexibility. Once the paraffin is applied and patient instruction provided, the procedure requires supervision. This code may be billed once regardless of the number of body areas or application times.

**Coding Tips**
Modality is defined as any group of agents that may include thermal, acoustic, radiant, mechanical, or electrical energy to produce physiologic changes in tissues for therapeutic purposes. Codes included in this section do not include specific time increments as a requirement. This code requires supervision by the provider but does not require direct patient contact (one-to-one). 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.

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.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

Rheumatoid arthritis (714.0) is a chronic, systemic, inflammatory disease of unknown etiology, characterized by a variable but prolonged course with exacerbations and remissions of joint pains and swelling. In early stages, the disease attacks the joints of the hands and feet. As the disease progresses, more joints become involved. Also known as primary progressive arthritis and proliferative arthritis, the disease often leads to progressive deformities, which may develop rapidly, and produce permanent disability. Onset, distribution, degree of severity, and rate of progressions, as clinical manifestations of rheumatoid arthritis are highly variable. Joint disease is the major manifestation; systemic involvement (spleen, liver, eyes, etc.) is rare. Use an additional code to identify manifestations of rheumatoid arthritis (714.0) such as myopathy (359.6) and polyneuropathy (357.1).

Osteoarthrosis (category 715) is a degenerative, rather than inflammatory, disease of one or more joints. Also known as osteoarthritis and degenerative joint disease, osteoarthrosis is most conspicuous in the large joints and is initiated by local deterioration of the articular cartilage. It progressively destroys the cartilage, remodels the subchondral bone, and causes a secondary inflammation of the synovial membrane. Assignment of the fourth digit in this category is based on whether the disease is generalized or localized and whether it is primary or secondary. A fifth digit must also be assigned to specify the site.

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**CCI Version 20.0**
0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 97002, 97004, 97022
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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97022

97022  Application of a modality to 1 or more areas; whirlpool

Explanation
The physical therapist uses a whirlpool to provide superficial heat and cold in an environment that facilitates range of motion and/or exercise. The physical therapist decides the appropriate water temperature, provides safety instruction, and supervises the treatment. The treatment requires supervision and typically only one unit is billed per day.

Coding Tips
If the whirlpool is used as a wound care treatment, see 97597 or 97598. Code 97022 may be reported with 97597 or 97598 only if used to treat a separately identifiable condition. For example, whirlpool therapy is used to treat an ankle sprain. Whirlpool is also employed to assist in the debridement of tissue from a burn on the wrist. In this example, codes 97022 and 97597 may both be reported.

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.

According to the CPT guidelines, this code is not reported with modifier S1 but has not been designated as a modifier S1 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

When billing for supplies, try to be as specific as possible. In addition to the general supply and material CPT code (99070), there are HCPCS Level II A, E, and L codes that may describe the specific supply provided.

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.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.4

CCI Version 20.0
0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 97002, 97004, 97602

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
97024

97024  Application of a modality to 1 or more areas; diathermy (eg, microwave)

**Explanation**
The physical therapist uses diathermy or microwave as a form of superficial heat for one or more body areas. After application and safety instructions have been provided, the clinician supervises the treatment. The treatment typically includes only one unit is billed per day.

**Coding Tips**
Modality is defined as any group of agents that may include thermal, acoustic, radiant, mechanical, or electrical energy to produce physiologic changes in tissues for therapeutic purposes. Codes included in this section do not include specific time increments as a requirement. The modalities identified by codes 97010-97028 require supervision by the provider but do not require direct one-to-one patient contact.

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.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

A fifth digit is required when reporting spinal stenosis of the lumbar region. The fifth-digit subclassification indicates if neurogenic claudication is present.

**Terms To Know**
diathermy. Application of heat to body tissues using high-frequency currents that are not intense enough to destroy or impair tissue. Diathermy is used to treat chronic arthritis, bursitis, fractures, and other conditions.

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.4; 100-3,150.5; 100-3,240.3

**CCI Version 20.0**
0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 97002, 97004, 97018, 97026

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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97026

Application of a modality to 1 or more areas; infrared

Explanation
The physical therapist uses infrared light as a form of superficial heat that will increase circulation to one or more localized areas. Once applied and safety instructions have been provided to the patient, the treatment is supervised.

Coding Tips
Modality is defined as any group of agents that may include thermal, acoustic, radiant, mechanical, or electrical energy to produce physiologic changes in tissues for therapeutic purposes. Codes included in this section do not include specific time increments as a requirement. The modalities identified by codes 97010-97028 require supervision by the provider but do not require direct patient contact (one-to-one). 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.

According to the CPT guidelines, this code is not reported with modifier S1 but has not been designated as a modifier S1 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

When billing for supplies, try to be as specific as possible. In addition to the general supply and material CPT code (99070), there are HCPCS Level II A, E, and L codes that may describe the specific supply provided.

A fifth digit is required when reporting spinal stenosis of the lumbar region. The fifth-digit subclassification indicates if neurogenic claudication is present.

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.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.3; 100-2,15,230.4; 100-4,5,10; 100-4,5,20.4

CCI Version 20.0
0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 97002, 97004, 97018, 97022.

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
97028
Application of a modality to 1 or more areas; ultraviolet

Explanation
The physical therapist applies ultraviolet light to treat dermatological problems. Once applied and safety instructions have been provided, the treatment is supervised.

Coding Tips
Modality is defined as any group of agents that may include thermal, acoustic, radiant, mechanical, or electrical energy to produce physiologic changes in tissues for therapeutic purposes. Codes included in this section do not include specific time increments as a requirement. The modalities identified by codes 97010-97028 require supervision by the provider but do not require direct patient contact (one-to-one).

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.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

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.
- **ultraviolet light**: Light source consisting of light rays with a higher frequency than those at the violet end of the visual spectrum.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-3,10.3; 100-4,5,10

CCI Version 20.0
0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64493, 64505-64530, 97002, 97004, 97018, 97022, 97026

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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97032

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

Explanation

The physical therapist 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 provider 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. 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.

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.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

For transcutaneous electrical modulation pain reprocessing (e.g., scrambler therapy), see 0278T.

A fifth digit is required when reporting spinal stenosis of the lumbar region. The fifth-digit subclassification indicates if neurogenic claudication is present.

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.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-2,15,60.3; 100-2,15,230; 100-2,15,230.4; 100-3,10.3; 100-3,10.4; 100-3,160.12; 100-3,160.15; 100-3,160.17; 100-4,5,20.2
**97033**

**Application of a modality to 1 or more areas; iontophoresis, each 15 minutes**

**Explanation**
The physical therapist uses electrical current to administer medication to one or more areas. Iontophoresis is usually prescribed for soft tissue inflammatory conditions and pain control. This code requires constant attendance by the clinician and is billed in multiple 15-minute units.

**Coding Tips**
This modality requires direct (one-to-one) patient contact by the provider 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. 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.

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.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

A fifth digit is required when reporting spinal stenosis of the lumbar region. The fifth-digit subclassification indicates if neurogenic claudication is present.

**Terms To Know**
- **Iontophoresis:** Method of localized transdermal medication delivery using a low-level electrical current applied to a drug solution in a patch. The drug ions are propelled through the skin into underlying tissue. Iontophoresis is used to alleviate joint or muscle pain in sports medicine. It is also the method used for introducing pilocarpine in the sweat test for cystic fibrosis and as a treatment for hyperhidrosis.
- **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.

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-4,5,10

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97034

97034  Application of a modality to 1 or more areas; contrast baths, each 15 minutes

Explanation
The physical therapist uses hot and cold baths in a repeated, alternating fashion to stimulate the vasomotor response of a localized body part. This code requires constant attendance and is billed in multiple in 15-minute units.

Coding Tips
This modality requires direct (one-to-one) patient contact by the provider 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. 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.

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.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

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.
vaso-. Relating to blood vessels.
vasomotor. Relationship of the nerves and muscles that cause blood vessels to constrict or dilate.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-4,5,10

CCI Version 20.0
0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 97002, 97004
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Application of a modality to 1 or more areas; ultrasound, each 15 minutes

Explanation
The physical therapist applies ultrasound to increase circulation to one or more areas. A water bath or some form of ultrasound lotion must be used as a coupling agent to facilitate the procedure. The delivery of corticosteroid medication via ultrasound is called phonophoresis and is reported using this code. The medication as a supply may or may not be paid by the payer. Ultrasound or phonophoresis requires constant attendance and is billed in multiple in 15-minute units.

Coding Tips
This modality requires direct (one-to-one) patient contact by the provider 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. 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.

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.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

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.
- **phonophoresis**. Use of ultrasound to increase the diffusion of a drug into the skin.
- **ultrasound**. Imaging using ultra-high sound frequency bounced off body structures.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-3,240.3

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CCI Version 20.0
0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 97002, 97004
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
97036
97036  Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes

Explanation
The Hubbard tank is utilized when it is necessary to fully immerse the areas that require treatment into water. Care of wounds and burns may require use of the Hubbard tank to facilitate tissue cleansing and debridement. This code requires constant attendance and is billed in multiple in 15-minute units.

Coding Tips
If the Hubbard tank is used as wound care treatment, see 97597 or 97598. Code 97036 can be reported on the same date of service as 97597, 97598, or 97602 when the Hubbard tank is used to treat an additional diagnosis separate from the condition that requires wound debridement. If provided, report both codes with modifier 59 Distinct procedural service. Documentation must support the use of this modifier identifying the separate service.

This modality requires direct (one-to-one) patient contact by the provider 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. 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.

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.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

Terms To Know
debidement. Removal of dead or contaminated tissue and foreign matter from a wound.

first-degree burn. Superficial partial-thickness burn in which only the epidermis or a portion of the dermis is involved, displaying redness but no blister formation.

second-degree burn. Deep partial-thickness burn with destruction of the epidermis, the upper portion of the dermis, possibly some deeper dermal tissues, and blistering of the skin with fluid exudate.

third-degree burn. Full-thickness burn with total destruction of the epidermis and dermis, while deeper underlying tissue may also be affected, including the loss of body parts (e.g., nose, ear, extremity).

wound. Injury to living tissue often involving a cut or break in the skin.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2

CCI Version 20.0
0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 97002, 97004

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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**97039**

97039  Unlisted modality (specify type and time if constant attendance)

**Explanation**
When the CPT book does not contain a code that accurately describes the physical medicine service provided that requires constant attendance, it is necessary to report the unlisted 97039 code. Medical record documentation should indicate the type of service performed, the reason the service was provided, if direct one-to-one patient contact was provided by the physical therapist, as well as total treatment time (as defined by all timed and untimed codes). Check with other third-party payers for their guidelines.

**Coding Tips**
Reporting an unlisted code requires the submission of documentation, such as a procedure report, that provides a description of the procedure performed that includes the time, effort, and equipment necessary to provide the service, as well as the medical necessity of the procedure. AMA guidelines state that incremental intervals of treatment performed on the same session may be added together when determining total time.

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.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

A fifth digit is required when reporting spinal stenosis of the lumbar region. The fifth-digit subclassification indicates if neurogenic claudication is present.

**Terms To Know**
medical necessity. Medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and national medical practice guidelines regarding type, frequency, and duration of treatment; rendered in a cost-effective manner.

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2;
100-2,15,230.4; 100-4,5,10

**CCI Version 20.0**
0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435,
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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Visual impairment may range from total blindness to low vision and may be due to conditions such as glaucoma, retinitis pigmentosa, macular degeneration, or diabetes mellitus. A physical therapist must have provided a complete evaluation of the patient’s current level of functioning and implement a therapeutic plan of care that promotes safe independent living. Rehabilitation services provided to patients with primary visual impairments must be provided in accordance with a written plan of treatment that is established by a Medicare physician and implemented by approved Medicare providers or incident to physician services. It is expected that this service will be provided short-term, as maintenance therapy is not covered. Patients must have the potential for improvement and are expected to demonstrate significant improvement within a reasonable and fairly predictable amount of time. Covered services for beneficiaries with vision impairment include mobility, activities of daily living, and other rehabilitation goals that are medically necessary.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

A fifth digit is required when reporting spinal stenosis of the lumbar region. The fifth-digit subclassification indicates if neurogenic claudication is present.

### ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

### IOM References

- 100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2
- 100-2,15,230.4; 100-3,10.3; 100-3,10.4; 100-3,160.17; 100-4,5,10; 100-4,5,10.2; 100-4,5,20.2
- 0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 93040-93042, 97002, 97004

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

### Coding and Payment Guide for the Physical Therapist

#### Procedure Codes

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<tr>
<th>Procedure Code</th>
<th>Description</th>
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97112

97112 Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.

Explanation

The qualified health care professional, such as a physical therapist, is in direct contact with one patient using neuromuscular techniques to treat one or more body areas that facilitate reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception. This code requires direct contact with a physical therapist and is billed in multiple in 15-minute units.

Coding Tips

This code is time specific and is billed in 15-minute increments. 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. 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.

Documentation must support the skilled nature of the therapeutic procedures, the physical therapist’s interaction with the patient reflecting the skilled nature of the interventions and/or the need for design and establishment of an exercise program. Examples of the developmental goals include increased functional abilities in self-care, mobility, or patient safety. Goals should be developed to address improvement in functional abilities such as self care/activities of daily living (ADL), mobility and safety in performing any functional activities. Document the goals and type of procedures provided and/or exercise program established and the major muscle groups treated.

Submit claims when the neuromuscular reeducation, because of documented medical complications, the condition of the patient, or complexity of the neuromuscular reeducation employed, must be rendered by or under the supervision of a PT. Include the patient’s losses and/or dependencies in self-care, mobility, and safety in the daily tasks of work or home. Provide documentation that supports why skilled physical therapy is needed for the patient’s medical condition and/or safety. This information usually is supported by the patient’s evaluation and plan of care.

Submit claims that document establishment and design of a needed maintenance exercise program to fit the patient’s level of activities of daily living (ADL), function and needed instruction to the patient, and supportive personnel and/or family members to safely and effectively carry out the program.

Medicare beneficiaries who are blind or visually impaired may be eligible for rehabilitation services to improve performance of activities of daily living including self-care and home management skills, as well as mobility skills when provided by an approved health professional such as a physical therapist. Visual impairment may range from total blindness to low vision and may be due to conditions such as glaucoma, retinitis pigmentosa, macular degeneration, or diabetes mellitus.

A physical therapist must have provided a complete evaluation of the patient’s current level of functioning and implement a therapeutic plan of care that promotes safe independent living. Rehabilitation services provided to patients with primary visual impairments must be provided in accordance with a written plan of treatment that is established by a Medicare physician and implemented by approved Medicare providers or incident to physician services. It is expected that this service will be provided short-term, as maintenance therapy is not covered. Patients must have the potential for improvement and are expected to demonstrate significant improvement within a reasonable and fairly predictable amount of time. Covered services for beneficiaries with vision impairment include mobility, activities of daily living, and other rehabilitation goals that are medically necessary.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-4,5,10

CCI Version 20.0

0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 97002, 97004, 97022, 97036

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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A physical therapist must have provided a complete evaluation of the patient's current level of functioning and implement a therapeutic plan of care that promotes safe independent living. Rehabilitation services provided to patients with primary visual impairments must be provided in accordance with a written plan of treatment that is established by a Medicare physician and implemented by approved Medicare providers or incident to physician services. It is expected that this service will be provided short-term, as maintenance therapy is not covered. Patients must have the potential for improvement and are expected to demonstrate significant improvement within a reasonable and fairly predictable amount of time. Covered services for beneficiaries with vision impairment include mobility, activities of daily living, and other rehabilitation goals that are medically necessary.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-4,5,10

**CCI Version 20.0**
0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 97002, 97004, 97022, 97036, 97110

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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97116
97116 Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)

Explanation
The physical therapist trains the patient in specific activities that will facilitate ambulation and stair climbing with or without an assistive device. Proper gait sequencing and safety instructions are included when appropriate. This code requires direct contact with the physical therapist and is billed in multiple in 15-minute units.

Coding Tips
This code is time specific and is billed in 15-minute increments. 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. 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.

Documentation must support the skilled nature of the therapeutic procedures, the physical therapist’s interaction with the patient reflecting the skilled nature of the interventions and/or the need for design and establishment of an exercise program. Examples of the developmental goals include increased functional abilities in self-care, mobility, or patient safety. Goals should be developed to address improvement in functional abilities such as self care/activities of daily living (ADL), mobility and safety in performing any functional activities. Document the goals and type of procedures provided and/or exercise program established and the major muscle groups treated.

Submit claims when the gait training, because of documented medical complications, the condition of the patient, or complexity of the exercise employed, must be rendered by or under the supervision of a PT. Include the patient's losses and/or dependencies in self-care, mobility, and safety in the daily tasks of work or home. Provide documentation that supports why skilled physical therapy is needed for the patient’s medical condition and/or safety. This information usually is supported by the patient’s evaluation and plan of care.

Submit claims that document establishment and design of a needed maintenance exercise program to fit the patient’s level of activities of daily living (ADL), function and needed instruction to the patient, and supportive personnel and/or family members to safely and effectively carry out the program.

Medicare beneficiaries who are blind or visually impaired may be eligible for rehabilitation services to improve performance of activities of daily living including self-care and home management skills, as well as mobility skills when provided by an approved health professional such as a physical therapist. Visual impairment may range from total blindness to low vision and may be due to conditions such as glaucoma, retinitis pigmentosa, macular degeneration, or diabetes mellitus.

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A physical therapist must have provided a complete evaluation of the patient’s current level of functioning and implement a therapeutic plan of care that promotes safe independent living. Rehabilitation services provided to patients with primary visual impairments must be provided in accordance with a written plan of treatment that is established by a Medicare physician and implemented by approved Medicare providers or incident to physician services. It is expected that this service will be provided short-term, as maintenance therapy is not covered. Patients must have the potential for improvement and are expected to demonstrate significant improvement within a reasonable and fairly predictable amount of time. Covered services for beneficiaries with vision impairment include mobility, activities of daily living, and other rehabilitation goals that are medically necessary.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

A fifth digit is required when reporting spinal stenosis of the lumbar region. The fifth-digit subclassification indicates if neurogenic claudication is present.

Terms To Know
gait. Manner in which a person walks.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-4,5,10

CCI Version 20.0
0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 65505-65430, 97002, 97004
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Coding and Payment Guide for the Physical Therapist

97124

97124  Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, pettrissage and/or tapotement (stroking, compression, percussion).

Explanation

The physical therapist uses massage to provide muscle relaxation, increase localized circulation, soften scar tissue, or mobilize mucous secretions in the lung via tapotement and/or percussion. This code requires direct contact with the physical therapist and is billed in 15-minute units, regardless of number of body parts treated.

Coding Tips

This code is time specific and is billed in 15-minute increments. 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. 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 patient may be added together when determining total time. Check with other third-party payers for their guidelines. When these techniques are performed for postural drainage some payer policies may require the submission of other codes, such as 94667 or 94668. Check with the third-party payer to determine their specific requirements before submitting the claim.

Documentation must support the skilled nature of the therapeutic procedures, the physical therapist's interaction with the patient reflecting the skilled nature of the interventions and/or the need for design and establishment of an exercise program. Examples of the developmental goals include increased functional abilities in self-care, mobility, or patient safety. Goals should be developed to address improvement in functional abilities such as self care/activities of daily living (ADL), mobility and safety in performing any functional activities. Document the goals and type of procedures provided and/or exercise program established and the major muscle groups treated.

Submit claims when the therapeutic massage, because of documented medical complications, the condition of the patient, or complexity of the exercise employed, must be rendered by or under the supervision of a PT. Include the patient's losses and/or dependencies in self-care, mobility, and safety in the daily tasks of work or home. Provide documentation that supports why skilled physical therapy is needed for the patient's medical condition and/or safety. This information usually is supported by the patient's evaluation and plan of care.

Submit claims that document establishment and design of a needed maintenance exercise program to fit the patient's level of activities of daily living (ADL), function and needed instruction to the patient, and supportive personnel and/or family members to safely and effectively carry out the program.

Medicare beneficiaries who are blind or visually impaired may be eligible for rehabilitation services to improve performance of activities of daily living including self-care and home management skills, as well as mobility skills when provided by an approved health professional such as a physical therapist. Visual impairment may range from total blindness to low vision and may be due to conditions such as glaucoma, retinitis pigmentosa, macular degeneration, or diabetes mellitus.

A physical therapist must have provided a complete evaluation of the patient's current level of functioning and implement a therapeutic plan of care that promotes safe independent living. Rehabilitation services provided to patients with primary visual impairments must be provided in accordance with a written plan of treatment that is established by a Medicare physician and implemented by approved Medicare providers or incident to physician services. It is expected that this service will be provided short-term, as maintenance therapy is not covered. Patients must have the potential for improvement and are expected to demonstrate significant improvement within a reasonable and fairly predictable amount of time. Covered services for beneficiaries with vision impairment include mobility, activities of daily living, and other rehabilitation goals that are medically necessary.

According to the CPT guidelines, this code is not reported with modifier S1 but has not been designated as a modifier S1 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2;
100-2,15,230.4; 100-4,5,10

CCI Version 20.0

0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435,
64445-64450, 64479-64490, 64493, 64505-64530, 97002, 97004

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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© 2014 OptumInsight, Inc.  CPT © 2014 American Medical Association. All Rights Reserved.
97140 Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes

Explanation
The qualified health care professional, such as a physical therapist, performs manual therapy techniques including, but not limited to, soft tissue and joint mobilization, manipulation, manual traction, and/or manual lymphatic drainage to one or more areas. This code requires direct contact with the physical therapist and is billed in 15-minute units.

Coding Tips
This code is time specific and is billed in 15-minute increments. 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. 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.

Do not report this code in addition to those codes for the application of multilayer compression systems (29581-29584).

Documentation must support the skilled nature of the therapeutic procedures and/or the need for design and establishment of an exercise program. The goals should be to increase functional abilities in self-care, mobility, or patient safety. Document the goals and type of procedures provided and/or exercise program established and the major muscle groups treated.

Submit claims when the therapeutic exercise, because of documented medical complications, the condition of the patient, or complexity of the exercise employed, must be rendered by or under the supervision of a PT. Include the patient's losses and/or dependencies in self-care, mobility, and safety in the daily tasks of work or home. Provide documentation that supports why skilled physical therapy is needed for the patient's medical condition and/or safety. This information usually is supported by the patient's evaluation and plan of care.

Submit claims that document establishment and design of a needed maintenance exercise program to fit the patient's level of activities of daily living (ADL), function and needed instruction to the patient, and supportive personnel and/or family members to safely and effectively carry out the program.

Medicare beneficiaries who are blind or visually impaired may be eligible for rehabilitation services to improve performance of activities of daily living including self-care and home management skills, as well as mobility skills when provided by an approved health professional such as a physical therapist. Visual impairment may range from total blindness to low vision and may be due to conditions such as glaucoma, retinitis pigmentosa, macular degeneration, or diabetes mellitus.

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A physical therapist must have provided a complete evaluation of the patient's current level of functioning and implement a therapeutic plan of care that promotes safe independent living. Rehabilitation services provided to patients with primary visual impairments must be provided in accordance with a written plan of treatment that is established by a Medicare physician and implemented by approved Medicare providers or incident to physician services. It is expected that this service will be provided short-term, as maintenance therapy is not covered. Patients must have the potential for improvement and are expected to demonstrate significant improvement within a reasonable and fairly predictable amount of time. Covered services for beneficiaries with vision impairment include mobility, activities of daily living, and other rehabilitation goals that are medically necessary.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

A fifth digit is required when reporting spinal stenosis of the lumbar region. The fifth-digit subclassification indicates if neurogenic claudication is present.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-4,5,10; 100-4,5,10.2

CCI Version 20.0
0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 95851-95852, 97002, 97004, 97018, 97124, 97530, 97750

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Therapeutic procedure(s), group (2 or more individuals)

Explanation
The physical therapist or properly supervised support personnel provides direct contact services to two or more patients at the same time. Services in a group setting could include therapeutic exercise, therapeutic activities, aquatic therapy with therapeutic exercise, and neuromuscular reeducation. The patients/clients do not have to be performing the same activity simultaneously; however, the need for skilled intervention must be documented. This code can be reported once for each group participant.

Coding Tips
Code 97150 requires the provider to have direct contact with the group. This code is untimed and billed only once per date of service, unless billed with a modifier. Supervised exercise by a nonqualified provider is not coded as 97150. This code should be reported for each individual member of the group.

Use of the group therapy code (printed with permission from the American Physical Therapy Association [APTA]) supports the interpretation of the group therapy code for outpatient physical therapy services, as established by CMS and as clarified in the Carriers Manual Transmittal 1753. This longstanding policy states that outpatient physical therapy services provided simultaneously to two or more individuals by a practitioner constitutes group therapy services and should be billed as such. The individuals can be, but need not be, performing the same activity. The therapist involved in group therapy services must be in constant attendance and must provide skilled services to the group.

APTA supports the interpretation of the one-on-one codes as published by CMS. Language describing the appropriate use of one-on-one codes and the group code first appeared in the Federal Register in 1994 (12-8-94, Vol. 59, No. 235, p 63451). This same language was republished in the Federal Register in 1996 (11-22-96, Vol. 61, No. 227, p 59542).

CMS further clarified usage of the group code in Carriers Manual Transmittal 1753, dated May 17, 2002. The language, now published in the Medicare Benefit Policy Manual, chapter 15, section 230 states: "Group Therapy Services (Code 97150): Pay for outpatient physical therapy services (which includes speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services. The individuals can be, but need not be, performing the same activity. The therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required."

APTA recognizes that in certain situations it may be possible to add the time spent with each individual patient and bill for these services with an appropriate one-on-one code when the one-on-one time requirements are met. This also may be the most efficient approach. However, APTA also supports the interpretation that would allow these professional services to be billed under the group code, which is an untimed code, all other requirements for professional services having been met. The duration of the group session to which the code is applied should be sufficient to ensure that professional ("skilled") services are provided. Because the code is not a timed code, it can be used with other interventions provided on the same day of services, although modifiers may be required.

APTA does not interpret CMS Transmittal 1753 as prohibiting payment for a supervised (unattended) modality and a one-on-one service being delivered to two patients in the same time interval.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-4,5,20.4; 100-4,5,100.10

CCI Version 20.0
0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 95831, 95834, 95835, 97002, 97004, 97110-97113, 97116, 97124, 97140, 97530, 97532-97537, 97542, 97760-97761

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes

Explanation
The physical therapist uses dynamic therapeutic activities designed to achieve improved functional performance (e.g., lifting, pulling, bending). This code requires direct contact with the physical therapist and can be billed in 15-minute units.

Coding Tips
This code is time specific and is billed in 15-minute increments. 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. 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.

Code choices could include 97530 (performance of daily activities such as lifting, throwing, reaching) or 97535 (managing activities in the living environment, such as safely using adaptive equipment in the kitchen/bath/car).

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

A fifth digit is required when reporting spinal stenosis of the lumbar region. The fifth-digit subclassification indicates if neurogenic claudication is present.

Terms To Know
- dynamic: Manifesting motion in response to force.
- therapeutic procedure: Treatment of a pathological or traumatic condition through the use of activities performed to treat or heal the cause or to effect change through the application of clinical skills or services that attempt to improve function.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-4,5,10

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CCI Version 20.0
0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 95831-95834, 95851-95852, 97002, 97004, 97113, 97116, 97532-97537, 97542, 97750

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes

Explanation
The physical therapist works one-on-one with an individual to assist in the development of cognitive skills. Individuals with inherited learning disabilities or in individuals who have lost these skills as a result of illness or brain injury often need to develop compensatory methods of processing and retrieving information when disability, illness, or injury has affected these cognitive processes. Cognitive skill development includes mental exercises that assist the patient in areas such as attention, memory, perception, language, reasoning, planning, problem-solving, and related skills.

Coding Tips
This code requires direct (one-to-one) patient contact by the provider 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. 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.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

ICD-9-CM Diagnostic Codes
326 Late effects of intracranial abscess or pyogenic infection — (Use additional code to identify condition: 331.4, 342.0-342.9, 344.0-344.9)
330.0 Leukodystrophy — (Use additional code to identify associated intellectual disabilities)
330.1 Cerebral lipidoses — (Use additional code to identify associated intellectual disabilities)
330.2 Cerebral degeneration in generalized lipidoses — (Use additional code to identify associated intellectual disabilities. Code first underlying disease: 277.27)
330.3 Cerebral degeneration of childhood in other diseases classified elsewhere — (Use additional code to identify associated intellectual disabilities. Code first underlying disease: 277.5)
331.11 Pick’s disease — (Use additional code, where applicable, to identify dementia: 294.10, 294.11)
331.6 Corticobasal degeneration
332.0 Paralysis agitans

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Please note that this list of associated ICD-9-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.

IOM References
100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-4,5,10

CCI Version 20.0
0213T, 0216T, 0228T-0231T, 62310-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 97002, 97004

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes

**Explanation**

The physical therapist works one-on-one with an individual with sensory integration disorders to provide techniques for enhancing sensory processing and adapting to environmental demands. Sensory integration disorders may be the result of a learning disability, illness, or brain injury. Sensory experiences include touch, movement, body awareness, sight, sound, and the pull of gravity. The process of the brain organizing and interpreting this information is called sensory integration. Sensory integration provides a crucial foundation for later, more complex learning and behavior.

**Coding Tips**

This code requires direct (one-to-one) patient contact by the provider 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. 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.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

**ICD-9-CM Diagnostic Codes**

- **326** Late effects of intracranial abscess or pyogenic infection — (Use additional code to identify condition: 331.4, 342.0-342.9, 344.0-344.9)
- **330.0** Leukodystrophy — (Use additional code to identify associated intellectual disabilities)
- **330.1** Cerebral lipidoses — (Use additional code to identify associated intellectual disabilities)
- **330.2** Cerebral degeneration in generalized lipidoses — (Use additional code to identify associated intellectual disabilities. Code first underlying disease: 272.7)
- **330.3** Cerebral degeneration of childhood in other diseases classified elsewhere — (Use additional code to identify associated intellectual disabilities. Code first underlying disease: 277.5)
- **331.0** Alzheimer’s disease — (Use additional code, where applicable, to identify dementia: 294.10, 294.11)
- **331.11** Pick’s disease — (Use additional code, where applicable, to identify dementia: 294.10, 294.11)
- **332.0** Paralysis agitans
- **332.1** Secondary Parkinsonism — (Use additional E code to identify drug, if drug-induced)
- **332.4** Huntington’s chorea
- **334.0** Friedreich’s ataxia
- **334.2** Primary cerebellar degeneration
- **335.20** Amyotrophic lateral sclerosis
- **335.21** Progressive muscular atrophy
- **430** Subarachnoid hemorrhage — (Use additional code to identify presence of hypertension)
- **431** Intracerebral hemorrhage — (Use additional code to identify presence of hypertension)
- **432.0** Nontraumatic extradural hemorrhage — (Use additional code to identify presence of hypertension)
- **432.1** Subdural hemorrhage — (Use additional code to identify presence of hypertension)
- **438.0** Cognitive deficits due to cerebrovascular disease — (Use additional code to identify presence of hypertension)
- **438.11** Aphasia due to cerebrovascular disease — (Use additional code to identify presence of hypertension)
- **438.12** Dysphasia due to cerebrovascular disease — (Use additional code to identify presence of hypertension)
- **906.0** Late effect of open wound of head, neck, and trunk
- **906.4** Late effect of crushing
- **907.0** Late effect of intracranial injury without mention of skull fracture
- **907.1** Late effect of injury to cranial nerve
- **907.2** Late effect of spinal cord injury
- **V57.1** Other physical therapy — (Use additional code to identify the underlying condition)
- **V57.22** Encounter for vocational therapy — (Use additional code to identify the underlying condition)

Please note that this list of associated ICD-9-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.

**IOM References**

100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-4,5,10

**CCI Version 20.0**

0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 97002, 97004

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes

Explanation

The physical therapist instructs and trains the patients in self-care and home management activities (e.g., ADL and use of adaptive equipment in the kitchen, bath, and/or car). Direct contact with the physical therapist is required. This code is billed in 15-minute units.

Coding Tips

This code requires direct (one-to-one) patient contact by the provider 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. 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.

Describe the patient's current functional limitations in transfer ability that warrant skilled PT intervention. Include the special transfer training needed and rendered, and any training needed by supportive personnel and/or family members to safely and effectively carry it out. Transfer training may be approved only when documentation supports a skilled need for evaluation, design, and effective monitoring and instruction of the special transfer technique for safety and completion of the task. If documentation supports only repetitious carrying out of the transfer method, once established and monitored for safety and completion of the task, it will be considered noncovered care.

Code choices could include 97530 (performance of daily activities such as lifting, throwing, reaching) or 97535 (managing activities in the living environment, such as safely using adaptive equipment in the kitchen/bath/car).

Terms To Know

activities of daily living. Self-care activities often used to determine a patient's level of function such as bathing, dressing, using a toilet, transferring in and out of bed or a chair, continence, eating, and walking.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-4,5,10

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CCI Version 20.0

0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 97002, 97004, 97802-97804, G0270-G0271

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes

Explanation
The physical therapist instructs and trains the patient/client in community/work re-integration activities (e.g., work task analysis, money management, shopping, work environment modification, safe accessing of transportation, and the use of available assistive technology devices or adaptive equipment). This requires direct one-on-one contact with the patient by the physical therapist and is billed in 15-minute increments.

Coding Tips
This code requires direct (one-to-one) patient contact by the provider 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. 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.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

Terms To Know
workers’ compensation. State-governed system designated to administer and regulate the provision and cost of medical treatment and wage losses arising from a worker’s job-related injury or disease, regardless of who is at fault. In exchange, the employer is protected from being sued.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-4,5,10

CCI Version 20.0
97002, 97004, 97802-97804, G0270-G0271
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Wheelchair management (e.g., assessment, fitting, training), each 15 minutes

Explanation
The provider performs assessments, fitting and adjustments, and instructs and trains the patient in proper wheelchair skills (e.g., propulsion, safety techniques) in their home, facility, work, or community environment. This requires direct contact and may be billed in 15-minute units.

Coding Tips
This modality requires direct (one-to-one) patient contact by the provider 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. 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.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

When reporting code V46.3 Wheelchair dependence, code first the cause of dependence, such as muscular dystrophy (359.1) or obesity (278.00, 278.01).

The ICD-9-CM codes describing overweight, obesity, and other hyperalimentation (category 278), provides information about a person’s weight, and is coded in accordance with the physician’s documentation and guidelines for assigning secondary diagnoses. Specific information regarding the severity of the condition is reported by assigning additional codes from category V85 Body mass index.

Functional quadriplegia (780.72) is the inability to move due to another condition (e.g., dementia, severe contractures, arthritis, etc.). Functionally, the patient is the same as a paralyzed person. The inability to move and perform routine daily tasks for themselves renders patients immobile. This state poses certain associated health risks such as pressure ulcers, contractures, and pneumonia. The amount and type of care required to attend to these patients is greater than that of a patient with a similar state of health but who is more mobile or has a greater degree of physical function.

Code 780.72 includes complete immobility due to severe physical disability or frailty. This code helps provide essential assessment data to report the level of service of long-term nursing care provided. Multiple exclusions are listed to code 780.72 for specific types of quadriplegia and paralysis that are more appropriately classified elsewhere, such as hysterical paralysis, (300.11), immobility syndrome (728.3), neurological quadriplegia (344.00-344.09, and quadriplegia NOS (344.00).

Terms To Know
assessment. Process of collecting and studying information and data, such as test values, signs, and symptoms.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-4,5,10

CCI Version 20.0
97002, 97004
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
97545-97546

97545 Work hardening/conditioning; initial 2 hours
97546 each additional hour (List separately in addition to code for primary procedure)

Explanation
This code is used for a procedure where the injured worker is put through a series of conditioning exercises and job simulation tasks in preparation for return to work. Endurance, strength, and proper body mechanics are emphasized. The patient is also educated in problem solving skills related to job task performance and employing correct lifting and positioning techniques. Key components of work hardening include job simulation and targeted education related to safe return to work. Key components of work conditioning include exercise targeted to returning to functional work activities. Report 97546 for each additional hour after the initial two hours.

Coding Tips
Third-party payers may limit reporting this code on the same day as a physical therapy evaluation or re-evaluation.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as a modifier 51 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

Terms To Know
work conditioning. Intensive, work-related, goal-oriented conditioning program designed specifically to restore systemic neuromusculoskeletal functions (e.g., strength, endurance, movement, flexibility, motor control) and cardiopulmonary functions. The objective of the work conditioning program is to restore physical capacity and function to enable the patient/client to return to work.

work hardening. Highly structured, goal-oriented, individualized treatment program designed to return the client to work. Work hardening programs, which are often interdisciplinary in nature, use real or simulated work activities designed to restore physical, behavioral, and vocational functions. Work hardening addresses issues of productivity, safety, physical tolerances, and worker behaviors.

workers’ compensation. State-governed system designated to administer and regulate the provision and cost of medical treatment and wage losses arising from a worker’s job-related injury or disease, regardless of who is at fault. In exchange, the employer is protected from being sued.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,60.3; 100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-4,5,10; 100-4,5,20.4

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CCI Version 20.0
Also not with 97545: 97002, 97004, 97140
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Skin loss.

- Stage II: Abrasion, blister, shallow open crater, or other partial thickness.
- Stage I: Nonblanching erythema (a reddened area on the skin).

Affected tissue may be painful and differ in temperature and texture from surrounding tissue. It may progress rapidly. Suspected deep tissue injury may be characterized by purple or maroon discoloration of the skin with or without blistering. Affected tissue may be painful and differ in temperature and texture from surrounding tissue.

- Stage III: Full-thickness skin loss involving damage or necrosis into subcutaneous soft tissues.
- Stage IV: Full-thickness skin loss with necrosis of soft tissues through to the muscle, tendons, or tissues around underlying bone.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-2,15,230.4; 100-4,200.9; 100-4,5,10.2

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<td>97597-97598</td>
<td>Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less</td>
</tr>
</tbody>
</table>
Skin loss.

• Stage I: Nonblanching erythema (a reddened area on the skin) from surrounding tissue. Affected tissue may be painful and differ in temperature and texture by purple or maroon discoloration of the skin with or without blistering. This can progress rapidly. Suspected deep tissue injury may be characterized in individuals with dark skin tones, and as such, evolution of the wound may progress to affect muscle and bone. Assign the appropriate code for the site of ulcer from subcategory 707.0 with an additional code from subcategory 707.2 to specify the stage of the ulcer.

When cellulitis occurs as a complication of a postoperative wound, code the cellulitis as a postoperative infection (998.39) with an additional code to specify the infection and a code to identify the infectious organism if known. When cellulitis occurs with chronic skin ulcer (category 707), code both conditions. When cellulitis occurs secondary to a superficial injury (e.g., frostbite or burn), two codes are required, sequenced according to the circumstances of the episode of care.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-2,15,230.4; 100-4,4,200.9; 100-4,5,10

CCI Version 20.0

Coding and Payment Guide for the Physical Therapist

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<td>97602</td>
<td>Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session</td>
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</table>

**Explanation**

The physical therapist performs wound care management to promote healing using nonselective debridement techniques to remove devitalized tissue. Nonselective debridement techniques, sometimes referred to as mechanical debridement, are those in which both necrotic and healthy tissue are removed and include wet-to-moist dressings, enzymatic chemicals, autolytic debridement, and abrasion. Wet-to-moist debridement involves allowing a dressing to proceed from wet to moist, and manually removing the dressing, which removes both the necrotic and healthy tissue. Chemical enzymes are fast acting products that produce slough of necrotic tissue. Autolytic debridement is accomplished using occlusive or semicocclusive dressings including hydrocolloids, hydrogels and transparent films that keep wound fluid in contact with the necrotic tissue. Abrasion involves scraping the wound surface with a tongue blade or similar blunt instrument.

**Coding Tips**

Do not report this code with debridement codes 11010–11047. When 97602 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51.

This procedure includes any application of dressings. Code 97602 is a bundled service under Medicare. It reports treatment provided during a session, no matter how many wounds or body areas are treated during the session. The physical therapist must provide direct, one-on-one patient contact when billing this procedure.

The National Pressure Ulcer Advisor Panel (NPUAP) has recently updated the definition and staging of pressure ulcers. A pressure ulcer is now defined as a "localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction."

Clinicians ordinarily characterize pressure ulcers by location, shape, depth, and healing status. The depth of the lesion or stage of ulcer is the most important element in quality measurement: depth, and healing status. The depth of the lesion or stage of ulcer is

**Work Value | Non-Fac PE | Fac PE | Malpractice | Non-Fac Total | Fac Total**

97602

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Fac Total

Non-Fac Total
Stage I: Nonblanching erythema (a reddened area on the skin). Affected tissue may be painful and differ in temperature and texture by purple or maroon discoloration of the skin with or without blistering. It may progress rapidly. Suspected deep tissue injury may be characterized in individuals with dark skin tones, and as such, evolution of the wound may be difficult to detect in nonremovable dressings, eschar, sterile blister, or suspected deep tissue injury in evolution. Deep tissue injury may be difficult to detect in the bed, evacuating wound fluid thereby reducing edema, and removing exudates and bacteria. Drainage from the wound(s) is collected in a canister. Report 97605 for a wound(s) with a total surface area less than or equal to 50 sq. cm. Report 97606 for a wound with a total surface area greater than 50 sq. cm.

Explanation
The physical therapist performs negative pressure wound therapy (NPWT) with vacuum assisted drainage collection to promote healing of a chronic nonhealing wound, including diabetic or pressure (decubitus) ulcer. This procedure includes topical applications to the wound, wound assessment, and patient or caregiver instruction related to on-going care per session. Negative pressure wound therapy uses controlled application of subatmospheric pressure to a wound. The subatmospheric pressure is generated using an electrical pump. The electrical pump conveys intermittent or continuous subatmospheric pressure through connecting tubing to a specialized wound dressing. The specialized wound dressing includes a porous foam dressing that covers the wound surface and an airtight adhesive dressing that seals the wound and contains the subatmospheric pressure at the wound site. Negative pressure wound therapy promotes healing by increasing local vascularity and oxygenation of the wound bed, evacuating wound fluid thereby reducing edema, and removing exudates and bacteria. The physical therapist must provide direct, one-on-one patient contact with education and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters.

Coding Tips
The physical therapist must provide direct, one-on-one patient contact when billing these procedures. See code 97610 when documentation indicates that low frequency, noncontact, nonthermal ultrasound is used for wound therapy.

The National Pressure Ulcer Advisor Panel (NPUAP) has recently updated the definition and staging of pressure ulcers. A pressure ulcer is now defined as a “localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.”

Clinicians ordinarily characterize pressure ulcers by location, shape, depth, and healing status. The depth of the lesion or stage of ulcer is the most important element in quality measurement:

- Stage I: Nonblanching erythema (a reddened area on the skin). A reddened area on the skin.
- Stage II: Abrasion, blister, shallow open crater, or other partial thickness skin loss.
- Stage III: Full-thickness skin loss involving damage or necrosis into subcutaneous soft tissues.
- Stage IV: Full-thickness skin loss with necrosis of soft tissues through to the muscle, tendons, or tissues around underlying bone.

Subclassification 707.0 reports conditions also known as bedsores or pressure sores. These lesions initially affect superficial tissues and, depending on the state of patient’s health and other circumstances, may progress to affect muscle and bone. Assign the appropriate code for the site of ulcer from subcategory 707.0 with an additional code from subcategory 707.2 to specify the stage of the ulcer.

When cellulitis occurs as a complication of a postoperative wound, code the cellulitis as a postoperative infection (998.59) with an additional code for the cellulitis to specify the infection.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

ICD-9-CM Diagnostic Codes

IOD References
100,2,15,230.4, 100-4,4,200.9

CCI Version 20.0


Also not with 97605: 97602, G0456-G0457

Also not with 97606: 97602-97605, G0456-G0457

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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<td>97605</td>
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<tr>
<td>97605</td>
<td>Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters</td>
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<tr>
<td>97606</td>
<td>Total wound(s) surface area greater than 50 square centimeters</td>
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97610

97610  Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day

Explanation

The physical therapist performs wound treatment using a device that produces low-frequency, ultrasound-generated mist. This noncontact, nonthermal modality promotes wound healing through cellular stimulation. Indicated for acute, chronic, and colonized wounds, as well as burns and ulcers, it provides wound cleansing, bacteria removal, and maintenance debridement of fibrin and tissue exudates. The device uses ultrasound technology to atomize saline, delivering a continuous mist to the treatment site. Multiple passes over the wound are made with the treatment head of the device for a predetermined treatment session. This code includes assessment of the wound, topical applications when performed, and ongoing care instructions. Report this code once per day for the duration of treatment.

Coding Tips

This code is new for 2014. To report negative pressure wound therapy, see codes 97605-97606. This code is reported once per day. Documentation should include wound assessment and ongoing care instructions when provided.

ICD-9-CM Diagnostic Codes

682.1 Cellulitis and abscess of neck — (Use additional code to identify organism, such as 041.1, etc.)
682.2 Cellulitis and abscess of trunk — (Use additional code to identify organism, such as 041.1, etc.)
682.3 Cellulitis and abscess of upper arm and forearm — (Use additional code to identify organism, such as 041.1, etc.)
682.4 Cellulitis and abscess of hand, except fingers and thumb — (Use additional code to identify organism, such as 041.1, etc.)
682.5 Cellulitis and abscess of buttock — (Use additional code to identify organism, such as 041.1, etc.)
682.6 Cellulitis and abscess of leg, except foot — (Use additional code to identify organism, such as 041.1, etc.)
682.7 Cellulitis and abscess of foot, except toes — (Use additional code to identify organism, such as 041.1, etc.)
686.01 Pyoderma gangrenosum — (Use additional code to identify any infectious organism: 041.0-041.8)
686.1 Pyogenic granuloma of skin and subcutaneous tissue — (Use additional code to identify any infectious organism: 041.0-041.8)
707.01 Pressure ulcer, elbow — (Use additional code to identify pressure ulcer stage: 707.20-707.25)
707.02 Pressure ulcer, upper back — (Use additional code to identify pressure ulcer stage: 707.20-707.25)
707.03 Pressure ulcer, lower back — (Use additional code to identify pressure ulcer stage: 707.20-707.25)
707.04 Pressure ulcer, hip — (Use additional code to identify pressure ulcer stage: 707.20-707.25)
707.05 Pressure ulcer, buttock — (Use additional code to identify pressure ulcer stage: 707.20-707.25)
707.06 Pressure ulcer, ankle — (Use additional code to identify pressure ulcer stage: 707.20-707.25)
707.07 Pressure ulcer, heel — (Use additional code to identify pressure ulcer stage: 707.20-707.25)
707.11 Ulcer of thigh — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)
707.12 Ulcer of calf — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)
707.13 Ulcer of ankle — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)
707.14 Ulcer of heel and midfoot — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)
707.15 Ulcer of other part of foot — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)
905.0 Late effect of fracture of skull and face bones
905.2 Late effect of fracture of upper extremities
905.3 Late effect of fracture of neck of femur
905.4 Late effect of fracture of lower extremities
906.0 Late effect of open wound of head, neck, and trunk
906.1 Late effect of open wound of extremities without mention of tendon injury
906.4 Late effect of crushing
906.5 Late effect of burn of eye, face, head, and neck
906.6 Late effect of burn of wrist and hand
906.7 Late effect of burn of other extremities
997.62 Infection (chronic) of amputation stump — (Use additional code to identify complications)
998.51 Infected postoperative seroma — (Use additional code to identify organism)

Please note that this list of associated ICD-9-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.

CCI Version 20.0

97035, 97602

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
97750

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

Explanation
The physical therapist, 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. 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.

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. According to the CPT guidelines, this code is not reported with modifier S1 but has not been designated as a modifier S1 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

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.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,230; 100-2,15,230.1; 100-2,15,230.2; 100-2,15,230.4; 100-3,10.4; 100-4,5,10; 100-4,5,10.2

CCI Version 20.0
95831-95834, 95851-95852, 97150
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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97755

Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes

Explanation
The physical therapist performs an assessment for the suitability and benefits of acquiring any assistive technology device that will help restore, augment, or compensate for the existing functional ability in the patient; or that will optimize functional tasks and/or maximize the patient's environmental accessibility and mobility. This includes the preparation of a written report. This code is billed in 15-minute increments.

Coding Tips
This code is time specific and is billed in 15-minute increments. 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. 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.

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. Report 97535–97537 for training in use of assistive technology.

According to the CPT guidelines, this code is not reported with modifier S1 but has not been designated as a modifier S1 exempt or an add-on code in the CPT book. Please see the beginning of this section for more information on the use of modifiers.

Terms To Know
evaluation. Dynamic process in which the physical, occupational, sports, or other therapist makes clinical judgments based on data gathered during the examination.

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.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,230.4

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Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes

Prosthetic training, upper and/or lower extremity(s), each 15 minutes

Checkout for orthotic/prosthetic use, established patient, each 15 minutes

Explanation
In 97760, the physical therapist assesses, fits and/or trains the patient in the use of an orthotic device for one or more body parts. In 97761, the qualified health care professional such as a physical therapist assesses, fits, and/or trains the patient in the use of a prosthetic device for one or more body parts. These include assessment for the appropriate type of orthotic or prosthetic device. These do not include fabrication time, if applicable, or cost of materials. In 97762, the qualified health care professional such as a physical therapist evaluates the effectiveness of an existing orthotic or prosthetic device and makes recommendations for changes, as appropriate.

Coding Tips
These codes are time specific and are billed in 15-minute increments. 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. 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.

Check with the payer about coding and billing procedures for orthotic supplies with respect to the distinction between fitting/training for the device and fabricating it.

A custom-fitted orthotic is a premanufactured orthotic that can be adjusted to fit the patient.

A custom-fabricated orthotic is made from basic materials on an individual basis by using actual measurements or positive molds of the patient. Generally, only the patient who was measured will be able to use a custom-fabricated orthotic.

Code 97760 Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s), and/or trunk, each 15 minutes was developed to include the training aspect of the management of a patient being assessed and fitted for an orthotic. If a HCPCS Level II code is reported and its description includes assessment and fitting, then documentation must also support the training aspect of the skilled services in order to also report CPT 97760.

Do not report code 97760 with gait training (97716), if performed on the same lower extremity. If however, the two services are performed on lower and upper extremities, each code may be reported and modifier 59 should be assigned indicating that two distinct services were performed.

The physical therapist must provide direct, one-on-one patient contact when billing these procedures.

Terms To Know

- **deformity**: Irregularity or malformation of the body.
- **orthotic**: Associated with the making and fitting of an orthosis(es).
- **prosthetic**: Device that replaces all or part of an internal body organ or body part, or that replaces part of the function of a permanently inoperable or malfunctioning internal body organ or body part.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-2, 15, 230.4

CCI Version 20.0
Also not with 97760: 0213T, 0216T, 0228T-0231T, 29044-29085, 29105-29200, 29240-29450, 29505-29584, 29700-29710, 29720-29750, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 97002, 97004, 97016, 97110-97112, 97116, 97124, 97140, 97762

Also not with 97761: 0213T, 0216T, 0228T-0231T, 62310-62319, 64400-64435, 64445-64450, 64479-64490, 64493, 64505-64530, 97002, 97004, 97016, 97110-97112, 97116, 97124, 97140, 97760, 97762

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient

without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)

with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient

with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)

Explanation

The qualified health care provider, such as a physical therapist who is also a licensed acupuncturist, performs acupuncture therapy by inserting one or more fine needles into the patient as dictated by acupuncture meridians for the relief of pain. The needles are twirled or manipulated by hand to generate therapeutic stimulation. No electrical stimulation is employed with 97810-97811. Report 97810 for the initial 15 minutes of personal one-on-one contact with the patient and 97811 for each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of the needle. In 97813-97814, the clinician applies acupuncture therapy by inserting one or more fine needles into the patient as dictated by acupuncture meridians for the relief of pain. The needles are energized by employing a micro-current for electrical stimulation. Report 97813 for the initial 15 minutes of personal one-on-one contact with the patient and 97814 for each additional 15 minutes of personal one-on-one contact with the patient, with reinsertion of the needle.

Coding Tips

As add-on codes, 97811 and 97814 are not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same provider on the same date of service as the primary service/procedure, and must never be reported as stand-alone codes. Use 97811 in conjunction with 97810 and 97813. Use 97814 in conjunction with 97813.

Do not report 97810 in conjunction with 97813.

Evaluation and reevaluation services (97001–97002) may be reported separately when documentation supports the medical necessity of the service in addition to the acupuncture services. The time of the evaluation service is not included in the time of the acupuncture service. Dry needling of a joint or cyst should not be reported as acupuncture.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.
**98960-98962**

**98960**  
Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient

**98961**  
2-4 patients

**98962**  
5-8 patients

**Explanation**

The qualified, nonphysician health care professional provides education and training using a standard curriculum. This training is prescribed by a physician to enable the patient to concurrently self-manage established illnesses or diseases with physical therapists. Report 98960 for education and training provided for an individual patient for each 30 minutes of service. Report 98961 for a group of two to four patients and 98962 for a group of five to eight patients.

**Coding Tips**

Codes within this range are used to report education and training of a patient when prescribed by a physician but performed by a nonphysician provider. Guidelines indicate that a standardized curriculum must be utilized and may be modified to meet individual patient needs. The focus of the training should be to teach the patient how to effectively manage the clinical condition. It may also include a patient’s caregiver. The service can be provided to a single patient (98960) or a group of patients (98961–98962).

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**

100-2, 15, 230.4

**CCI Version 20.0**

No CCI Edits apply to this code.

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98966-98968

98966  Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

98967  11-20 minutes of medical discussion

98968  21-30 minutes of medical discussion

Explanation
A qualified health care professional (nonphysician) provides telephone assessment and management services to a patient in a non-face-to-face encounter. These episodes of care may be initiated by an established patient or by the patient's guardian. These codes are not reported if the telephone service results in a decision to see the patient within 24 hours or at the next available urgent visit appointment; instead, the phone encounter is regarded as part of the pre-service work of the subsequent face-to-face encounter. These codes are also not reported if the telephone call is in reference to a service performed and reported by the qualified health care professional that occurred within the past seven days or within the postoperative period of a previously completed procedure. This applies both to unsolicited patient follow-up or that requested by the health care professional.

Coding Tips
Correct code assignment is dependent upon the time of the medical discussion. Report 98966 for telephone services requiring five to 10 minutes of medical discussion, 98967 for telephone services requiring 11 to 20 minutes of medical discussion, and 98968 for telephone services requiring 21 to 30 minutes of medical discussion. Medical record documentation should include the nature and total time of the discussion.

Do not report these codes with complex chronic care coordination (99487–99489) or transitional care management services (99495–99496).

Coverage of this service varies. Check with third-party payers for their coverage guidelines.

When performed by a physician, see 99441–99443.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,230.4; 100-4,12,30.6.16

CCI Version 20.0
No CCI Edits apply to this code.

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Online assessment and management service provided by a qualified nonphysician health care professional to an established patient or guardian, not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network.

**Explanation**

Online medical assessment and management services are those provided to an established patient, guardian, or physical therapist in response to a patient's online inquiry using internet resources in a non-face-to-face encounter. Code 98969 reports services provided by a qualified health care professional (nonphysician). In order for these services to be reportable, the health care professional must provide a personal, timely response to the inquiry and the encounter must be permanently stored via electronic means or hard copy. A reportable service includes all communication related to the online encounter, such as phone calls, provision of prescriptions, and orders for laboratory services. This code is not reported if the online evaluation is in reference to a service performed and reported by the same health care professional within the past seven days or within the postoperative period of a previously completed procedure. Rather, the online service is considered to be part of the previous service or procedure. This applies both to unsolicited patient follow-up or that requested by the health care professional.

**Coding Tips**

This code is used to report nonphysician services only. This code is reported once per a seven-day period regardless of the number of communications (e.g., related telephone calls, additional on-line communications).

Medical record documentation should include a permanent storage (electronic or hard paper copy) of the nature and total time of the discussion. Coverage of this service varies. Check with third-party payers for their coverage guidelines.

When performed by a physician, see 99444.

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**

100-2,15,230.4

**CCI Version 20.0**

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**Explanation**

Medical team conferences require the face-to-face participation of at least three participants of different disciplines providing direct care to the patient. The conference may also include the presence of the patient, patient’s family or other guardian or caregiver. Medical team conference participants must have provided direct face-to-face evaluation and/or treatment to the patient within 60 days previous to the conference. Documentation must include a record of participation in the conference, the information contributed by the provider and treatment recommendations provided from others. Only one provider from the same specialty may report a code for this service. If, by contractual agreement, a facility or other organization has agreed to provide a medical team conference, these services should not be billed separately. Team conference services provided by a physician with the patient or patient’s family present are billed using the appropriate evaluation and management codes.

**Coding Tips**

Some payers may not provide coverage if the patient or patient’s family is not present. Check with third-party payers for coverage guidelines.

Do not report these services when duration is less than 30 minutes.

When provided by a physician, code 99367 is reported.

Do not report medical team conference codes in the same month as complex chronic care coordination services (99487–99489) or transitional care management services (99495–99496).

Medicare will not provide benefits for team conferences or telephone calls as these services are considered to be a part of the associated billable service and cannot be reported separately.

**Terms To Know**

**coverage.** Services paid for by the insurance policy, as well as the amount that will be paid for those services.

**evaluation and management.** Assessment, counseling, and other services provided to a patient reported through CPT codes.

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**

100-2,15,230.4; 100-4,11,40.1.3; 100-4,12,30.6.16

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