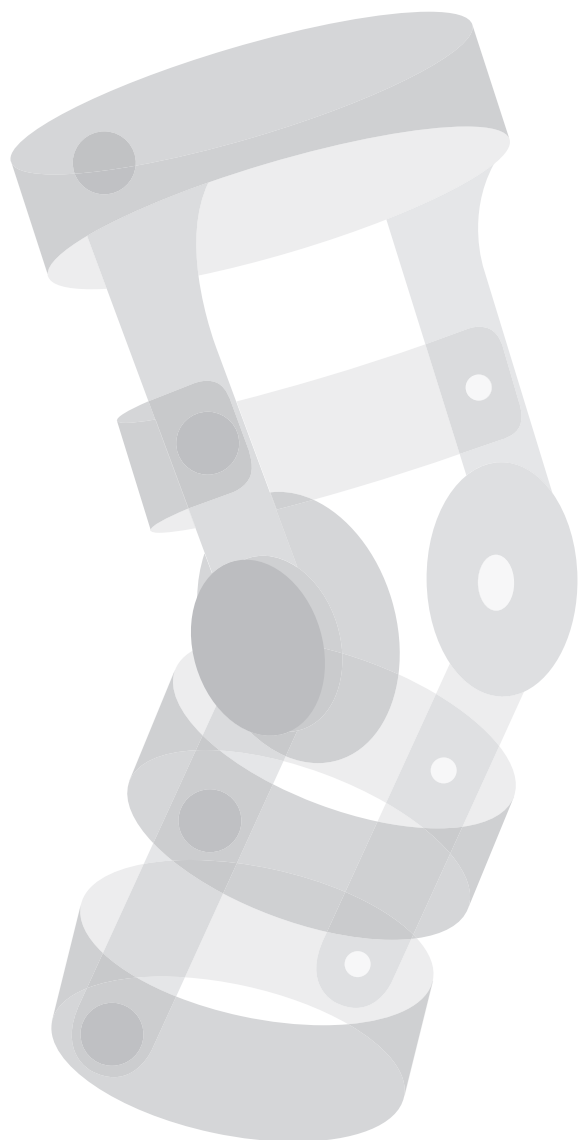


Coding and Billing for
**Physical Therapy/
Physical Medicine**

A Comprehensive and Illustrative Specialty Guide



2011

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Upper limb tension test (ULTT) – Considered an analogue to the straight leg raise test for the lower limb, it assesses pain responses consequent upon passive movements of the upper limb and neck. The traditional ULTT produces strain on the brachial plexus by a combination of movements involving shoulder girdle depression, shoulder abduction, external rotation of the shoulder, elbow extension, forearm supination and wrist/finger extension. Cervical spine ipsilateral and contralateral lateral flexion are also important to differentiate. This traditional test provides bias to the median nerve. Variations have developed, over the years, to address the other nerves of the upper limb, including the radial nerve and ulnar nerve.

Valgus deformity – Refers to a lateral inclination of a distal bone, of a joint, from the midline.

Varus deformity – Refers to medial inclination of a distal bone, of a joint, from the midline.

Vastus intermedius – This forms part of the quadriceps mechanism. The fibres lie in a plane parallel with the anterior aspect of the shaft of the femur.

Vastus lateralis – Forms the middle layer of the quadriceps group, providing stability rather than fast movement.

Vastus medialis – Located on the anteromedial aspect of the thigh. Recently been investigated for its role in patellar stability, with particular reference to patellofemoral dysfunction.

Vertebra – One of the 33 bones of the spinal column. A cervical, thoracic, or lumbar vertebra has a cylindrically-shaped bony anteriorly and a neural arch posteriorly (composed primarily of the laminae and pedicles as well as the other structures in the posterior aspect of the vertebra) that protects the spinal cord. The plural of vertebra is vertebrae.

Vertebral artery testing – Performed to assess the relationship between cervical spine movement and symptoms which may be vertebrobasilar in origin. If the subjective examination suggests that blood flow may be affected (with complaints of dizziness, tinnitus, diplopia, dysphagia, dysarthria or drop attacks), then vertebral artery testing must be performed. The tests that are advocated are: sustained rotation, left and right; sustained extension; sustained rotation and extension, left and right; and any position that is described, by the patient, that elicits dizziness.

Wobble board – An apparatus used for the re-education of proprioception and balance.

Yergason's test – A test for biceps tendon subluxation, at the shoulder. It is performed with the Therapist resisting shoulder flexion, elbow flexion and forearm supination. Palpating the biceps tendon is integral, to feel for the subluxation. May also be used to detect biceps tendinitis, but it will be pain in the bicipital groove noted and not instability of the tendon.

Zygapophyseal joint – Formed between the superior articular process, of the lower vertebra, and the inferior articular process, of the upper vertebra. They are described as plain synovial joints.

Abbreviations

The following definitions are medical terms commonly seen while coding/billing for Physical Therapy/Physical Medicine:

a	before meals
A	without, lack of, apathy; apnea; aphasia; anemia
A & P	anterior and posterior; auscultation and percussion
A & O	alert and oriented
AA	Atlanto-axial
ABD	Abduction
Abds	Abdominals
ABG	arterial blood gas
ABPB	abductor pollicis brevis (also APB)
ABPL	abductor pollicis longus (also APL)
AC	before meals
AC	Acromioclavicular
ACJ	acromioclavicular joint (also AC joint)
ACL	Anterior Cruciate Ligament
Ad	to, toward, near to, adductor; adhesion; adnexia; adrenal
Ad Lib	at pleasure, as needed or desired
ADD	Adduction
ADL	Activities of Daily Living
AI	Alternating Isometrics
AIN	anterior interosseous nerve
AK	above knee
AKA	Above-the-Knee Amputee
ALS	Amyotrophic Lateral Sclerosis
AM	anteromedial
AMA	against medical advice
Amb	Ambulation
Ambi	both, ambidextrous); ambilaterally
ANTE	before
AO	Alanto-occipital
APB	abductor pollicis brevis (also ABPB)
APL	abductor pollicis longus (also ABPL)
Apo	from, away from aponeurosis; apochromatic
APTA	American Physical Therapy Association
AROM	Active Range of Motion
ASIS	Anterior Superior Iliac Spine
AT	achilles tendon (also TA)
BAPS	Biomechanical Ankle Platform
Bi	twice, double biarticulate; bifocal; bifurcation
BID	Twice a day
BILAT	bilateral
BKA	Below-the-Knee Amputee
BP	Blood Pressure

of Diseases, 10th Edition (ICD-10). To view these Mappings, refer to the following link:

http://www.contextodata.com/2010ICD10CMMappings/2010_I9Gem.txt
http://www.contextodata.com/2010ICD10CMMappings/2010_I10Gem.txt

ICD-10-CM Code Set Improvements

The clinical modification of ICD-10 represents a significant improvement over ICD-9-CM. Some of the specific organizational improvements that provide greater specificity in code assignment include:

- The addition of information relevant to ambulatory and managed care encounters
- Expanded injury codes, grouped by anatomical site rather than injury category
- The creation of combination diagnosis/symptom or manifestation codes to reduce the number of codes needed to fully describe a condition as well as combination codes for poisonings and external causes
- The addition of 6th and 7th characters with the seventh digit extensions representing visit encounter or sequelae for injuries and external causes
- Added laterality
- Full code titles for all codes with the incorporation of common 4th and 5th digit subclassifications (no more referring back to common fourth and fifth digits to understand the full code)
- V and E codes are no longer supplemental classifications
- Postoperative complications have been grouped within a procedure-specific body system chapter

Official Coding Guideline Differences

In order to code more effectively, the Official Guidelines for Coding and Reporting should be reviewed. Below are examples of the ICD-9-CM and ICD-10-CM Guidelines placed side-by-side and the differences between the two become readily apparent. Because the format and structure of ICD-10-CM has undergone a number of changes, there is additional information as well as the changes.

ICD-9-CM General Coding Guidelines	ICD-10-CM General Coding Guidelines
Locating a Code in ICD-9-CM	Locating a Code in ICD-10-CM
Locate each term in the Alphabetic Index and verify the code selected in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.	To select a code in the classification that corresponds to a diagnosis or reason for visit documented in a medical record, first locate the term in the Index, and then verify the code in the Tabular List. Read and be guided by instructional notations that appear in both the Index and the Tabular List. It is essential to use both the Index and Tabular List when locating and assigning a code. The Index does not always provide the full code. Selection of the full code, including laterality and any applicable 7th character can only be done in the Tabular List. A dash (-) at the end of an Index entry indicates that additional characters are required. Even if a dash is not included at the Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required.

ICD-9-CM General Coding Guidelines	ICD-10-CM General Coding Guidelines
Level of Detail in Coding	Level of Detail in Coding
ICD-9-CM diagnosis codes are composed of codes with 3, 4, or 5 digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater detail.	ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6, or 7 digits. Codes with three digits are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater detail.
A three digit code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code.	A three-digit code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.
Codes from 001.0 through V91.99	Codes from A00.0 through T88.9, Z00-Z99.89
The appropriate code or codes from 001.0 through V91.99 must be used to identify problems, complaints or other reason(s) for the encounter/visit.	The appropriate code or codes from A00.0 through T88.9, Z00-Z99.89 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.
Signs and Symptoms	Signs and Symptoms
Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0-799.9) contains many, but not all codes for symptoms.	Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0-R99) contains many, but not all codes for symptoms.

Physical Therapy Specific ICD-10-CM Coding Information

Example:

Condition	ICD-9-CM	ICD-10-CM
Encounter for rehabilitation services for crush injury to right lower leg sustained in an automobile accident	V57.1 Care involving other physical therapy E819.9 Motor vehicle traffic accident of unspecified nature injuring unspecified person	S87.81xD Crushing injury of right lower leg, subsequent encounter V89.2xxD Person injured in unspecified motor-vehicle accident, traffic, subsequent encounter

Introduction to ICD-10-PCS

As new procedures are developed, the structure of ICD-10-PCS should allow them to be easily incorporated as unique codes.

Multiaxial

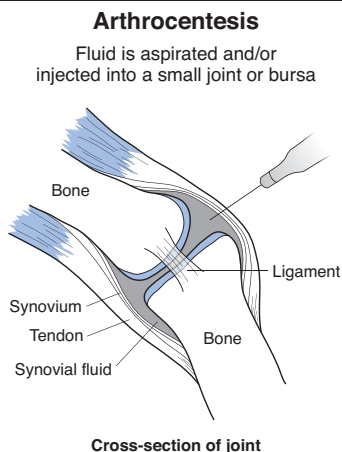
ICD-10-PCS codes should consist of independent characters, with each individual axis retaining its meaning across broad ranges of codes to the extent possible.

20600-20610

- 20600** Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)
- 20605** Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)
- 20610** Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)

Plain English Description

Arthrocentesis and/or aspiration is performed to remove fluid from a joint or bursa in order to diagnose the cause of joint effusion and/or to reduce pain caused by the excess fluid. Injection of a joint or bursa may be performed in conjunction with the arthrocentesis procedure and is typically performed using an anti-inflammatory medication such as a steroid to reduce inflammation of the joint or bursa. The skin over the joint is cleansed. A local anesthetic is injected as needed. A needle with a syringe attached is inserted into the affected joint or bursa. Fluid is removed and sent for separately reportable laboratory analysis. This may be followed by a separate injection of medication into the joint or bursa. Use 20600 for a small joint or bursa, such as the fingers or toes. Use 20605 for an intermediate joint or bursa, such as the temporomandibular, acromioclavicular, wrists, elbow, or ankle joint or the olecranon bursa. Use 20610 for a major joint or bursa, such as the shoulder, knee or hip joint or the subacromial bursa.



ICD-9-CM Diagnostic Codes (commonly used)

- 274** Gout
- 274.00** Gouty arthropathy, unspecified
- 274.01** Acute gouty arthropathy
- 274.02** Chronic gouty arthropathy without mention of tophus (tophi)
- 277.88** Tumor lysis syndrome
- 354.0** Carpal tunnel syndrome
- 355.0** Lesion of sciatic nerve
- 355.2** Other lesion of femoral nerve
- 355.3** Lesion of lateral popliteal nerve
- 355.4** Lesion of medial popliteal nerve
- 355.8** Mononeuritis of lower limb, unspecified
- 524.60** Temporomandibular joint disorders, unspecified
- 524.61** Temporomandibular joint disorders, adhesions and ankylosis (bony or fibrous)
- 524.62** Temporomandibular joint disorders, arthralgia of temporomandibular joint
- 711.01** Pyogenic arthritis involving shoulder region
- 711.03** Pyogenic arthritis involving forearm
- 711.04** Pyogenic arthritis involving hand
- 711.06** Pyogenic arthritis involving lower leg
- 711.07** Pyogenic arthritis involving ankle and foot
- 714.0** Rheumatoid arthritis
- 715.11** Osteoarthritis, localized, primary, involving shoulder region
- 715.15** Osteoarthritis, localized, primary, involving pelvic region and thigh

- 715.16** Osteoarthritis, localized, primary, involving lower leg
- 715.21** Osteoarthritis, localized, secondary, involving shoulder region
- 715.25** Osteoarthritis, localized, secondary, involving pelvic region and thigh
- 715.26** Osteoarthritis, localized, secondary, involving lower leg
- 715.31** Osteoarthritis, localized, not specified whether primary or secondary, involving shoulder region
- 716.14** Traumatic arthropathy involving hand
- 716.16** Traumatic arthropathy involving lower leg
- 716.17** Traumatic arthropathy involving ankle and foot
- 716.84** Other specified arthropathy involving hand
- 717.85** Old disruption of other ligaments of knee
- 717.89** Other internal derangement of knee
- 717.9** Unspecified internal derangement of knee
- 718.81** Other joint derangement, not elsewhere classified, involving shoulder region
- 718.86** Other joint derangement, not elsewhere classified, involving lower leg
- 719.01** Effusion of joint of shoulder region
- 719.02** Effusion of upper arm joint
- 719.03** Effusion of forearm joint
- 719.04** Effusion of hand joint
- 719.06** Effusion of lower leg joint
- 719.07** Effusion of ankle and foot joint
- 719.08** Effusion of joint of other specified sites
- 719.11** Hemiarthritis involving shoulder region
- 719.13** Hemiarthritis involving forearm
- 719.14** Hemiarthritis involving hand
- 719.16** Hemiarthritis involving lower leg
- 719.17** Hemiarthritis involving ankle and foot
- 719.41** Pain in joint involving shoulder region
- 719.44** Pain in joint involving hand
- 719.46** Pain in joint involving lower leg
- 719.47** Pain in joint involving ankle and foot
- 726.0** Adhesive capsulitis of shoulder
- 726.10** Disorders of bursae and tendons in shoulder region, unspecified
- 726.11** Calcifying tendinitis of shoulder
- 726.12** Bicipital tenosynovitis
- 726.5** Enthesopathy of hip region
- 726.60** Enthesopathy of knee, unspecified
- 726.69** Other enthesopathy of knee

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
20600	0.66	0.41	0.84	0.07	1.14	1.57	000	A
20605	0.68	0.44	0.94	0.08	1.20	1.70	000	A
20610	0.79	0.55	1.36	0.12	1.46	2.27	000	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
20600	1	2	0	0	1
20605	1	2	0	0	1
20610	1	2	0	0	1

CCI

- 20600** *There are too many associated CCI codes to list. Refer to Appendix A for complete list.*
- 20605** *There are too many associated CCI codes to list. Refer to Appendix A for complete list.*
- 20610** *There are too many associated CCI codes to list. Refer to Appendix A for complete list.*

Pub 100

No Pub 100 references apply to this code or code range.

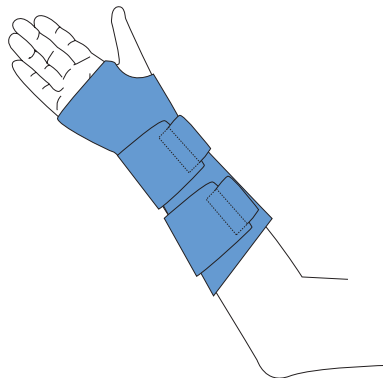
29125-29126

- 29125** Application of short arm splint (forearm to hand); static
- 29126** Application of short arm splint (forearm to hand); dynamic

Plain English Description

A static splint (29125) is applied to stabilize an injury by decreasing movement and providing support to the posterior aspect of the forearm, wrist, and hand. A stockinette is applied over the arm from the elbow to the wrist followed by padding over the stockinette. Plaster sheets cut to the appropriate length are then immersed in water and saturated. Excess water is gently squeezed out of the plaster. The plaster is applied to the posterior aspect of the forearm, wrist, and hand. The plaster is smoothed and molded. An elastic bandage is wrapped around the arm to secure the splint. The forearm may be placed in a sling. In 29126, a dynamic splint is applied. A dynamic splint allows movement of the forearm and wrist by placing a gentle sustained force on the wrist. The patient can tighten tubing on the outside of the splint to stretch the forearm and wrist, which improves flexibility of the joints.

Application of short arm splint



The physician puts the arm in a splint from just below the elbow to the hand.

ICD-9-CM Diagnostic Codes (commonly used)

- 354.0** Carpal tunnel syndrome
- 715.04** Osteoarthritis, generalized, involving hand
- 715.13** Osteoarthritis, localized, primary, involving forearm
- 715.14** Osteoarthritis, localized, primary, involving hand
- 715.23** Osteoarthritis, localized, secondary, involving forearm
- 715.33** Osteoarthritis, localized, not specified whether primary or secondary, involving forearm
- 715.93** Osteoarthritis, unspecified whether generalized or localized, involving forearm
- 715.94** Osteoarthritis, unspecified whether generalized or localized, involving hand
- 716.13** Traumatic arthropathy involving forearm
- 716.43** Transient arthropathy involving forearm
- 716.53** Unspecified polyarthropathy or polyarthritis involving forearm
- 716.63** Unspecified monoarthritis involving forearm
- 716.83** Other specified arthropathy involving forearm
- 716.93** Unspecified arthropathy involving forearm
- 718.03** Articular cartilage disorder involving forearm
- 718.23** Pathological dislocation of forearm joint
- 718.33** Recurrent dislocation of forearm joint
- 718.73** Developmental dislocation of joint forearm
- 718.74** Developmental dislocation of joint hand
- 718.83** Other joint derangement, not elsewhere classified, involving forearm
- 718.84** Other joint derangement, not elsewhere classified, involving hand
- 718.93** Unspecified derangement of forearm joint
- 718.94** Unspecified derangement of hand joint
- 719.33** Palindromic rheumatism involving forearm
- 719.83** Other specified disorders of forearm joint
- 719.84** Other specified disorders of hand joint
- 719.93** Unspecified disorder of forearm joint
- 726.4** Enthesopathy of wrist and carpus

- 727.05** Other tenosynovitis of hand and wrist
- 727.63** Nontraumatic rupture of extensor tendons of hand and wrist
- 727.64** Nontraumatic rupture of flexor tendons of hand and wrist
- 729.81** Swelling of limb
- 730.03** Acute osteomyelitis involving forearm
- 730.13** Chronic osteomyelitis involving forearm
- 730.23** Unspecified osteomyelitis involving forearm
- 730.33** Periostitis without mention of osteomyelitis involving forearm
- 730.73** Osteopathy resulting from poliomyelitis involving forearm
- 730.74** Osteopathy resulting from poliomyelitis involving hand
- 732.8** Other specified forms of osteochondropathy
- 733.12** Pathological fracture of distal radius and ulna
- 736.00** Unspecified deformity of forearm excluding fingers
- 736.03** Valgus deformity of wrist (acquired)
- 736.04** Varus deformity of wrist (acquired)
- 736.05** Wrist drop (acquired)
- 736.09** Other acquired deformities of forearm, excluding fingers
- 813.00** Closed fracture of upper end of forearm, unspecified
- 813.04** Other and unspecified closed fractures of proximal end of ulna (alone)
- 813.05** Fracture of head of radius, closed
- 813.06** Fracture of neck of radius, closed
- 813.07** Other and unspecified closed fractures of proximal end of radius (alone)
- 813.08** Fracture of radius with ulna, upper end (any part), closed
- 813.10** Open fracture of upper end of forearm, unspecified
- 813.15** Fracture of head of radius, open
- 813.16** Fracture of neck of radius, open
- 813.17** Other and unspecified open fractures of proximal end of radius (alone)
- 813.18** Fracture of radius with ulna, upper end (any part), open
- 813.20** Fracture of shaft of radius or ulna, unspecified, closed
- 813.21** Fracture of shaft of radius (alone), closed
- 813.22** Fracture of shaft of ulna (alone), closed

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
29125	0.59	0.56	1.26	0.10	1.25	1.95	000	A
29126	0.77	0.65	1.35	0.11	1.53	2.23	000	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
29125	1	2	0	0	1
29126	1	2	0	0	1

CCI

29125	0213T ⁰ , 0216T ⁰ , 0228T ⁰ , 0230T ⁰ , 12001 ¹ , 12002 ¹ , 12032 ¹ , 12042 ¹ , 12044 ¹ , 13121 ¹ , 13132 ¹ , 29130 ¹ , 29260 ¹ , 36000 ¹ , 36400 ¹ , 36405 ¹ , 36406 ¹ , 36410 ¹ , 36420 ¹ , 36425 ¹ , 36430 ¹ , 36440 ¹ , 36600 ¹ , 36640 ¹ , 37202 ¹ , 43752 ¹ , 51701 ¹ , 51702 ¹ , 51703 ¹ , 62310 ⁰ , 62311 ⁰ , 62318 ⁰ , 62319 ⁰ , 64400 ⁰ , 64402 ⁰ , 64405 ⁰ , 64408 ⁰ , 64410 ⁰ , 64412 ⁰ , 64413 ⁰ , 64415 ⁰ , 64416 ⁰ , 64417 ⁰ , 64418 ⁰ , 64420 ⁰ , 64421 ⁰ , 64425 ⁰ , 64430 ⁰ , 64435 ⁰ , 64445 ⁰ , 64446 ⁰ , 64447 ⁰ , 64448 ⁰ , 64449 ⁰ , 64450 ⁰ , 64479 ⁰ , 64483 ⁰ , 64490 ⁰ , 64493 ⁰ , 64505 ⁰ , 64508 ⁰ , 64510 ⁰ , 64517 ⁰ , 64520 ⁰ , 64530 ⁰ , 69990 ⁰ , 93000 ¹ , 93005 ¹ , 93010 ¹ , 93040 ¹ , 93041 ¹ , 93042 ¹ , 93318 ¹ , 94002 ¹ , 94200 ¹ , 94250 ¹ , 94680 ¹ , 94681 ¹ , 94690 ¹ , 94770 ¹ , 95812 ¹ , 95813 ¹ , 95816 ¹ , 95819 ¹ , 95822 ¹ , 95829 ¹ , 95955 ¹ , 96360 ¹ , 96365 ¹ , 96372 ¹ , 96374 ¹ , 96375 ¹ , 96376 ¹ , 99148 ⁰ , 99149 ⁰ , 99150 ⁰ , G0168 ¹
29126	0213T ⁰ , 0216T ⁰ , 0228T ⁰ , 0230T ⁰ , 36000 ¹ , 36400 ¹ , 36405 ¹ , 36406 ¹ , 36410 ¹ , 36420 ¹ , 36425 ¹ , 36430 ¹ , 36440 ¹ , 36600 ¹ , 36640 ¹ , 37202 ¹ , 43752 ¹ , 51701 ¹ , 51702 ¹ , 51703 ¹ , 62310 ⁰ , 62311 ⁰ , 62318 ⁰ , 62319 ⁰ , 64400 ⁰ , 64402 ⁰ , 64405 ⁰ , 64408 ⁰ , 64410 ⁰ , 64412 ⁰ , 64413 ⁰ , 64415 ⁰ , 64416 ⁰ , 64417 ⁰ , 64418 ⁰ , 64420 ⁰ , 64421 ⁰ , 64425 ⁰ , 64430 ⁰ , 64435 ⁰ , 64445 ⁰ , 64446 ⁰ , 64447 ⁰ , 64448 ⁰ , 64449 ⁰ , 64450 ⁰ , 64479 ⁰ , 64483 ⁰ , 64490 ⁰ , 64493 ⁰ , 64505 ⁰ , 64508 ⁰ , 64510 ⁰ , 64517 ⁰ , 64520 ⁰ , 64530 ⁰ , 69990 ⁰ , 93000 ¹ , 93005 ¹ , 93010 ¹ , 93040 ¹ , 93041 ¹ , 93042 ¹ , 93318 ¹ , 94002 ¹ , 94200 ¹ , 94250 ¹ , 94680 ¹ , 94681 ¹ , 94690 ¹ , 94770 ¹ , 95812 ¹ , 95813 ¹ , 95816 ¹ , 95819 ¹ , 95822 ¹ , 95829 ¹ , 95955 ¹ , 96360 ¹ , 96365 ¹ , 96372 ¹ , 96374 ¹ , 96375 ¹ , 96376 ¹ , 99148 ⁰ , 99149 ⁰ , 99150 ⁰

Pub 100

Pub 100-4, 4, 120.1

** See Appendix for CCI information

* See Appendix for Modifier Rules

● New Code

▲ Revised Code

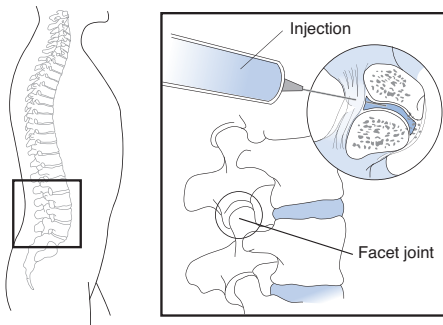
64493-64495

- 64493** Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
- 64494** Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
- 64495** Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)

Plain English Description

Paravertebral facet joints, also called zygapophyseal joints, are located on the back (posterior) of the spine on each side of the vertebra at the point where one vertebra overlaps the next. Facet joint pain may be associated with post laminectomy syndrome or other spine surgery due to destabilization of the spinal joints, scar tissue formation, or recurrent disc herniation. Other causes include spondylosis, spondylolisthesis, and arthritis. Using fluoroscopic or CT guidance, a diagnostic or therapeutic facet joint injection or injection of nerves innervating the joint is performed. The skin overlying the facet joint is prepped and a local anesthetic injected. A spinal needle is directed into the facet joint space until bone or cartilage is encountered. A small amount of contrast material is injected to verify that the needle is correctly positioned. This is followed by injection of a local anesthetic and/or steroid. Diagnostic facet joint injection uses a local anesthetic to identify the specific area generating the pain. If the patient experiences pain relief for a significant period of time following a diagnostic injection, the physician will perform a therapeutic injection on a subsequent date of service using a long acting local anesthetic in conjunction with a steroid. Use 64493 for a single lumbar or sacral facet joint injection; use 64494 for the second level; use 64495 for the third and any additional lumbar or sacral levels injected.

Injection, diagnostic or therapeutic agent, paravertebral facet joint, lumbar or sacral



Single lumbar or sacral facet joint injection (64493); second level (64494); third and any additional levels (64495)

ICD-9-CM Diagnostic Codes (commonly used)

- 338.0** Central pain syndrome
- 338.4** Chronic pain syndrome
- 721.0** Cervical spondylosis without myelopathy
- 721.1** Cervical spondylosis with myelopathy
- 721.2** Thoracic spondylosis without myelopathy
- 721.3** Lumbosacral spondylosis without myelopathy
- 721.41** Spondylosis with myelopathy thoracic region
- 721.42** Spondylosis with myelopathy lumbar region
- 722.0** Displacement of cervical intervertebral disc without myelopathy
- 722.10** Displacement of lumbar intervertebral disc without myelopathy
- 722.11** Displacement of thoracic intervertebral disc without myelopathy
- 722.31** Schmorl's nodes of thoracic region
- 722.32** Schmorl's nodes of lumbar region
- 722.4** Degeneration of cervical intervertebral disc
- 722.51** Degeneration of thoracic or thoracolumbar intervertebral disc

- 722.52** Degeneration of lumbar or lumbosacral intervertebral disc
- 722.71** Intervertebral disc disorder with myelopathy, cervical region
- 722.72** Intervertebral disc disorder with myelopathy, thoracic region
- 722.73** Intervertebral disc disorder with myelopathy, lumbar region
- 722.83** Postlaminectomy syndrome of lumbar region
- 722.91** Other and unspecified disc disorder of cervical region
- 722.92** Other and unspecified disc disorder of thoracic region
- 722.93** Other and unspecified disc disorder of lumbar region
- 723.0** Spinal stenosis in cervical region
- 723.1** Cervicalgia
- 724.01** Spinal stenosis of thoracic region
- ▲ 724.02** Spinal stenosis of lumbar region, without neurogenic claudication
- 724.1** Pain in thoracic spine
- 724.2** Lumbago
- 724.3** Sciatica
- 724.4** Thoracic or lumbosacral neuritis or radiculitis, unspecified
- 724.6** Disorders of sacrum
- 733.90** Disorder of bone and cartilage, unspecified

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
64493	1.52	1.10	3.50	0.14	2.76	5.16	000	A
64494	1.00	0.49	1.51	0.08	1.57	2.59	ZZZ	A
64495	1.00	0.52	1.54	0.08	1.60	2.62	ZZZ	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
64493	1	2	0	0	2
64494	1	0	0	0	2
64495	1	0	0	0	2

CCI

- 64493** 0178T¹, 0179T¹, 0180T¹, 0199T⁰, 01992⁰, 0213T⁰, 0214T⁰, 0215T⁰, 0216T⁰, 0217T⁰, 0218T⁰, 20550¹, 20551¹, 20552¹, 20553¹, 20600¹, 20605¹, 20610¹, 36140¹, 51701¹, 51702¹, 51703¹, 69990⁰, 72275¹, 76000¹, 76001¹, 76800¹, 76998¹, 77001¹, 77002¹, 77003¹, 77012¹, 77021¹, 90862¹, 92585⁰, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 94002¹, 94200¹, 94250¹, 94680¹, 94681¹, 94690¹, 94770¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822⁰, 95829⁰, 95860⁰, 95861⁰, 95867⁰, 95868⁰, 95870⁰, 95900⁰, 95904⁰, 95920⁰, 95925⁰, 95926⁰, 95927⁰, 95928⁰, 95929⁰, 95930⁰, 95933⁰, 95934⁰, 95936⁰, 95937⁰, 95955¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 99148⁰, 99149⁰, 99150⁰, J0670¹, J2001¹
- 64494** 0213T⁰, 0214T⁰, 0215T⁰, 0216T⁰, 0217T⁰, 0218T⁰, 51701¹, 51702¹, 51703¹, 69990⁰, 76000¹, 76001¹, 76800¹, 76998¹, 77001¹, 77003¹, 77012¹, 77021¹, 92585⁰, 95822⁰, 95860⁰, 95861⁰, 95867⁰, 95868⁰, 95870⁰, 95900⁰, 95904⁰, 95920⁰, 95925⁰, 95926⁰, 95927⁰, 95928⁰, 95929⁰, 95930⁰, 95933⁰, 95934⁰, 95936⁰, 95937⁰, J0670¹, J2001¹
- 64495** 0213T⁰, 0214T⁰, 0215T⁰, 0216T⁰, 0217T⁰, 0218T⁰, 51701¹, 51702¹, 51703¹, 69990⁰, 76000¹, 76001¹, 76800¹, 76998¹, 77001¹, 77003¹, 77012¹, 77021¹, 92585⁰, 95822⁰, 95860⁰, 95861⁰, 95867⁰, 95868⁰, 95870⁰, 95900⁰, 95904⁰, 95920⁰, 95925⁰, 95926⁰, 95927⁰, 95928⁰, 95929⁰, 95930⁰, 95933⁰, 95934⁰, 95936⁰, 95937⁰, J0670¹, J2001¹

Pub 100

No Pub 100 references apply to this code or code range.

** See Appendix for CCI information

* See Appendix for Modifier Rules

● New Code

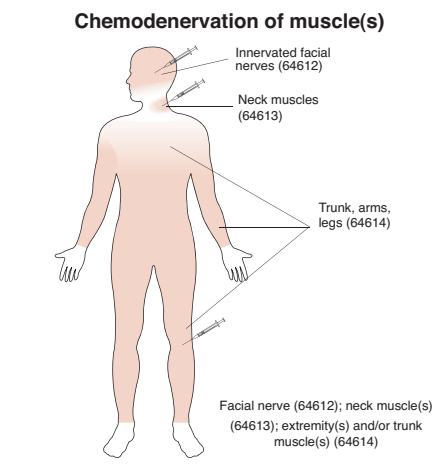
▲ Revised Code

64612-64614

- 64612** Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)
- 64613** Chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)
- 64614** Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)

Plain English Description

Chemodenervation is performed on muscles innervated by the facial nerve (64612), for spasmodic torticollis (64613), or on muscles of the extremities and/or trunk (64614). Chemodenervation involves injection of type A botulinum toxin directly into a muscle to treat dystonia, spasticity, cerebral palsy, multiple sclerosis, muscles spasms, and spinal cord injuries. Injecting botulinum toxin produces temporary muscle paralysis by blocking the release of acetylcholine at the peripheral nerve endings which interrupts neuromuscular transmission. In 64612, muscles innervated by the facial nerve are injected with botulinum toxin to treat conditions such as blepharospasm or hemifacial pain. The site to be injected is prepped. The muscle group is injected along its course. One or more injections may be required to accomplish the denervation. In 64613, the functional muscle group in the neck is injected to treat spasmodic torticollis. In 64614, the functional muscle group in the trunk, arm, or leg is injected. Multiple injections are performed along each muscle and several muscles are typically injected.



ICD-9-CM Diagnostic Codes (commonly used)

- 332.0** Paralysis agitans
- 333.6** Genetic torsion dystonia
- 333.71** Athetoid cerebral palsy
- 333.72** Acute dystonia due to drugs
- 333.79** Other acquired torsion dystonia
- 333.81** Blepharospasm
- 333.82** Orofacial dyskinesia
- 333.83** Spasmodic torticollis
- 333.89** Other fragments of torsion dystonia
- 340** Multiple sclerosis
- 342.10** Spastic hemiplegia and hemiparesis, affecting unspecified side
- 342.11** Spastic hemiplegia and hemiparesis, affecting dominant side
- 342.12** Spastic hemiplegia and hemiparesis, affecting nondominant side
- 343.8** Other specified infantile cerebral palsy
- 343.9** Infantile cerebral palsy, unspecified
- 346.11** Common migraine, with intractable migraine, so stated
- 351.8** Other facial nerve disorders
- 351.9** Facial nerve disorder, unspecified
- 478.79** Other diseases of larynx
- 723.1** Cervicalgia
- 723.2** Cervicocranial syndrome
- 728.85** Spasm of muscle
- 729.1** Myalgia and myositis, unspecified
- 767.5** Facial nerve injury due to birth trauma

- 781.0** Abnormal involuntary movements
- 781.94** Facial weakness
- 784.0** Headache
- 784.49** Other voice and resonance disorders
- 951.4** Injury to facial nerve

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
64612	2.01	1.93	2.39	0.65	4.59	5.05	010	A
64613	2.01	1.69	2.24	0.58	4.28	4.83	010	A
64614	2.20	1.86	2.54	0.42	4.48	5.16	010	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
64612	1	2	0	0	1
64613	1	2	0	0	1
64614	1	2	0	0	1

CCI

64612	0213T ⁰ , 0216T ⁰ , 0228T ⁰ , 0230T ⁰ , 36000 ¹ , 36400 ¹ , 36405 ¹ , 36406 ¹ , 36410 ¹ , 36420 ¹ , 36425 ¹ , 36430 ¹ , 36440 ¹ , 36600 ¹ , 36640 ¹ , 37202 ¹ , 43752 ¹ , 51701 ¹ , 51702 ¹ , 51703 ¹ , 62310 ⁰ , 62311 ⁰ , 62318 ⁰ , 62319 ⁰ , 64400 ⁰ , 64402 ⁰ , 64405 ⁰ , 64408 ⁰ , 64410 ⁰ , 64412 ⁰ , 64413 ⁰ , 64415 ⁰ , 64416 ⁰ , 64417 ⁰ , 64418 ⁰ , 64420 ⁰ , 64421 ⁰ , 64425 ⁰ , 64430 ⁰ , 64435 ⁰ , 64445 ⁰ , 64446 ⁰ , 64447 ⁰ , 64448 ⁰ , 64449 ⁰ , 64450 ⁰ , 64479 ⁰ , 64483 ⁰ , 64490 ⁰ , 64493 ⁰ , 64505 ⁰ , 64508 ⁰ , 64510 ⁰ , 64517 ⁰ , 64520 ⁰ , 64530 ⁰ , 69990 ⁰ , 92585 ⁰ , 93000 ¹ , 93005 ¹ , 93010 ¹ , 93040 ¹ , 93041 ¹ , 93042 ¹ , 93318 ¹ , 94002 ¹ , 94200 ¹ , 94250 ¹ , 94680 ¹ , 94681 ¹ , 94690 ¹ , 94770 ¹ , 95812 ¹ , 95813 ¹ , 95816 ¹ , 95819 ¹ , 95822 ¹ , 95829 ¹ , 95860 ¹ , 95861 ⁰ , 95863 ⁰ , 95864 ⁰ , 95867 ⁰ , 95868 ⁰ , 95869 ⁰ , 95870 ⁰ , 95900 ⁰ , 95904 ⁰ , 95920 ⁰ , 95925 ⁰ , 95926 ⁰ , 95927 ⁰ , 95928 ⁰ , 95929 ⁰ , 95930 ⁰ , 95933 ⁰ , 95934 ⁰ , 95936 ⁰ , 95937 ⁰ , 95955 ¹ , 96360 ¹ , 96365 ¹ , 96372 ¹ , 96374 ¹ , 96375 ¹ , 96376 ¹ , 99148 ⁰ , 99149 ⁰ , J2001 ¹
64613	0213T ⁰ , 0216T ⁰ , 0228T ⁰ , 0230T ⁰ , 36000 ¹ , 36400 ¹ , 36405 ¹ , 36406 ¹ , 36410 ¹ , 36420 ¹ , 36425 ¹ , 36430 ¹ , 36440 ¹ , 36600 ¹ , 36640 ¹ , 37202 ¹ , 43752 ¹ , 51701 ¹ , 51702 ¹ , 51703 ¹ , 62310 ⁰ , 62311 ⁰ , 62318 ⁰ , 62319 ⁰ , 64400 ⁰ , 64402 ⁰ , 64405 ⁰ , 64408 ⁰ , 64410 ⁰ , 64412 ⁰ , 64413 ⁰ , 64415 ⁰ , 64416 ⁰ , 64417 ⁰ , 64418 ⁰ , 64420 ⁰ , 64421 ⁰ , 64425 ⁰ , 64430 ⁰ , 64435 ⁰ , 64445 ⁰ , 64446 ⁰ , 64447 ⁰ , 64448 ⁰ , 64449 ⁰ , 64450 ⁰ , 64479 ⁰ , 64483 ⁰ , 64490 ⁰ , 64493 ⁰ , 64505 ⁰ , 64508 ⁰ , 64510 ⁰ , 64517 ⁰ , 64520 ⁰ , 64530 ⁰ , 69990 ⁰ , 92585 ⁰ , 93000 ¹ , 93005 ¹ , 93010 ¹ , 93040 ¹ , 93041 ¹ , 93042 ¹ , 93318 ¹ , 94002 ¹ , 94200 ¹ , 94250 ¹ , 94680 ¹ , 94681 ¹ , 94690 ¹ , 94770 ¹ , 95812 ¹ , 95813 ¹ , 95816 ¹ , 95819 ¹ , 95822 ¹ , 95829 ¹ , 95860 ¹ , 95861 ⁰ , 95863 ⁰ , 95864 ⁰ , 95865 ¹ , 95867 ⁰ , 95868 ⁰ , 95869 ⁰ , 95870 ⁰ , 95900 ⁰ , 95904 ⁰ , 95920 ⁰ , 95925 ⁰ , 95926 ⁰ , 95927 ⁰ , 95928 ⁰ , 95929 ⁰ , 95930 ⁰ , 95933 ⁰ , 95934 ⁰ , 95936 ⁰ , 95937 ⁰ , 95955 ¹ , 96360 ¹ , 96365 ¹ , 96372 ¹ , 96374 ¹ , 96375 ¹ , 96376 ¹ , 99148 ⁰ , 99149 ⁰ , 99150 ⁰ , J2001 ¹
64614	0213T ⁰ , 0216T ⁰ , 0228T ⁰ , 0230T ⁰ , 36000 ¹ , 36400 ¹ , 36405 ¹ , 36406 ¹ , 36410 ¹ , 36420 ¹ , 36425 ¹ , 36430 ¹ , 36440 ¹ , 36600 ¹ , 36640 ¹ , 37202 ¹ , 43752 ¹ , 51701 ¹ , 51702 ¹ , 51703 ¹ , 62310 ⁰ , 62311 ⁰ , 62318 ⁰ , 62319 ⁰ , 64400 ⁰ , 64402 ⁰ , 64405 ⁰ , 64408 ⁰ , 64410 ⁰ , 64412 ⁰ , 64413 ⁰ , 64415 ⁰ , 64416 ⁰ , 64417 ⁰ , 64418 ⁰ , 64420 ⁰ , 64421 ⁰ , 64425 ⁰ , 64430 ⁰ , 64435 ⁰ , 64445 ⁰ , 64446 ⁰ , 64447 ⁰ , 64448 ⁰ , 64449 ⁰ , 64450 ⁰ , 64479 ⁰ , 64483 ⁰ , 64490 ⁰ , 64493 ⁰ , 64505 ⁰ , 64508 ⁰ , 64510 ⁰ , 64517 ⁰ , 64520 ⁰ , 64530 ⁰ , 69990 ⁰ , 92585 ⁰ , 93000 ¹ , 93005 ¹ , 93010 ¹ , 93040 ¹ , 93041 ¹ , 93042 ¹ , 93318 ¹ , 94002 ¹ , 94200 ¹ , 94250 ¹ , 94680 ¹ , 94681 ¹ , 94690 ¹ , 94770 ¹ , 95812 ¹ , 95813 ¹ , 95816 ¹ , 95819 ¹ , 95822 ¹ , 95829 ¹ , 95860 ¹ , 95861 ⁰ , 95863 ⁰ , 95864 ⁰ , 95866 ¹ , 95867 ⁰ , 95868 ⁰ , 95869 ⁰ , 95870 ⁰ , 95900 ⁰ , 95904 ⁰ , 95920 ⁰ , 95925 ⁰ , 95926 ⁰ , 95927 ⁰ , 95928 ⁰ , 95929 ⁰ , 95930 ⁰ , 95933 ⁰ , 95934 ⁰ , 95936 ⁰ , 95937 ⁰ , 95955 ¹ , 96360 ¹ , 96365 ¹ , 96372 ¹ , 96374 ¹ , 96375 ¹ , 96376 ¹ , 99148 ⁰ , 99149 ⁰ , 99150 ⁰

Pub 100

No Pub 100 references apply to this code or code range.

** See Appendix for CCI information

* See Appendix for Modifier Rules

● New Code

▲ Revised Code

96374-96376

- 96374** Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
- 96375** Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)
- 96376** Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)

Plain English Description

A therapeutic, prophylactic, or diagnostic injection is administered by intravenous push (IVP) technique. The specified substance or drug is injected using a syringe directly into an injection site of an existing intravenous line or intermittent infusion set (saline lock). The injection is given over a short period of time, usually less than 15 minutes. Use 96374 for a single or initial substance or drug. Use 96375 as an add-on code for each additional sequential push of a new substance or drug provided through the same venous access site. Use 96376 for the facility component for each additional sequential intravenous push of the same substance/drug when the interval between each administration is 30 minutes or more.

ICD-9-CM Diagnostic Codes (commonly used)

There are too many codes to list. Refer to the ICD-9-CM book for associated diagnostic codes.

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
96374	0.18	1.44	1.44	0.03	1.65	1.65	XXX	A
96375	0.10	0.56	0.56	0.01	0.67	0.67	ZZZ	A
96376	0.10	0.52	0.52	0.04	0.64	0.64	ZZZ	X

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
96374	0	0	0	0	0
96375	0	0	0	0	0
96376	9	9	9	9	9

CCI

- 96374** 36000¹, 96372¹, 96523⁰, 99201¹, 99202¹, 99203¹, 99204¹, 99205¹, 99211⁰, 99212¹, 99213¹, 99214¹, 99215¹, 99455¹, 99456¹
- 96375** 36000¹, 96523⁰
- 96376** 36000¹, 96523⁰

Pub 100

Pub 100-02, 15, 80

97001

97001 Physical therapy evaluation

Plain English Description

Physical therapy (PT) evaluation of patient by the therapist, including history, tests, and measurements. Therapist report, including prognosis and treatment plan, included.

ICD-9-CM Diagnostic Codes (commonly used)

- 715.16** Osteoarthritis, localized, primary, involving lower leg
- 715.96** Osteoarthritis, unspecified whether generalized or localized, involving lower leg
- 719.41** Pain in joint involving shoulder region
- 719.45** Pain in joint involving pelvic region and thigh
- 719.46** Pain in joint involving lower leg
- 722.52** Degeneration of lumbar or lumbosacral intervertebral disc
- 723.1** Cervicalgia
- ▲ **724.02** Spinal stenosis of lumbar region, without neurogenic claudication
- **724.03** Spinal stenosis, lumbar region, with neurogenic claudication
- 724.2** Lumbago
- 724.4** Thoracic or lumbosacral neuritis or radiculitis, unspecified
- 726.10** Disorders of bursae and tendons in shoulder region, unspecified
- 729.5** Pain in limb
- 733.96** Stress fracture of femoral neck
- 733.97** Stress fracture of shaft of femur
- 733.98** Stress fracture of pelvis
- 780.72** Functional quadriplegia
- 781.2** Abnormality of gait
- 840.4** Rotator cuff (capsule) sprain
- V46.3** Wheelchair dependence

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
97001	1.20	0.89	0.89	0.05	2.14	2.14	XXX	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
97001	0	5	0	0	0

CCI

- 97001** 0213T¹, 0216T¹, 0228T¹, 0229T¹, 0230T¹, 0231T¹, 62310¹, 62311¹, 62318¹, 62319¹, 64400¹, 64402¹, 64405¹, 64408¹, 64410¹, 64412¹, 64413¹, 64415¹, 64416¹, 64417¹, 64418¹, 64420¹, 64421¹, 64425¹, 64430¹, 64435¹, 64445¹, 64446¹, 64447¹, 64448¹, 64449¹, 64450¹, 64479¹, 64480¹, 64483¹, 64484¹, 64490¹, 64493¹, 64505¹, 64508¹, 64510¹, 64517¹, 64520¹, 64530¹, 95831⁰, 95832⁰, 95833⁰, 95834⁰, 95851⁰, 95852⁰, 96101¹, 96102¹, 96103¹, 96105¹, 96118¹, 96119¹, 96120¹, 96125¹, 96150⁰, 96151⁰, 96152⁰, 96153⁰, 96154⁰, 97750⁰, 97755⁰, 97762⁰, 97802⁰, 97803⁰, 97804⁰, 99201¹, 99202¹, 99203¹, 99204¹, 99205¹, 99211¹, 99212¹, 99213¹, 99214¹, 99215¹, 99217¹, 99218¹, 99219¹, 99220¹, 99221¹, 99222¹, 99223¹, 99224¹, 99225¹, 99226¹, 99231¹, 99232¹, 99233¹, 99234¹, 99235¹, 99236¹, 99238¹, 99239¹, 99291¹, 99292¹, 99304¹, 99305¹, 99306¹, 99307¹, 99308¹, 99309¹, 99310¹, 99315¹, 99316¹, 99318¹, 99324¹, 99325¹, 99326¹, 99327¹, 99328¹, 99334¹, 99335¹, 99336¹, 99337¹, 99341¹, 99342¹, 99343¹, 99344¹, 99345¹, 99347¹, 99348¹, 99349¹, 99350¹, 99354¹, 99355¹, 99356¹, 99357¹, 99455¹, 99456¹, 99460¹, 99461¹, 99462¹, 99463¹, 99465¹, 99466¹, 99468¹, 99469¹, 99471¹, 99472¹, 99475¹, 99476¹, 99477¹, 99478¹, 99479¹, 99480¹, 99605¹, 99606¹, G0270⁰, G0271⁰, G0406¹, G0407¹, G0408¹, G0425¹, G0426¹, G0427¹

Pub 100

100-02, 15, 80.3

CPT® Procedural Coding

97036

97036 Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes

Plain English Description

This code reports the use of a Hubbard tank, which is large enough to immerse the entire body in warm water. Often used to aid in debridement (removal of dead tissue or other matter from a wound) or general cleansing.

ICD-9-CM Diagnostic Codes (commonly used)

- 337.00 Idiopathic peripheral autonomic neuropathy, unspecified
- 715.09 Osteoarthritis, generalized, involving multiple sites
- 715.11 Osteoarthritis, localized, primary, involving shoulder region
- 715.16 Osteoarthritis, localized, primary, involving lower leg
- 719.41 Pain in joint involving shoulder region
- 719.45 Pain in joint involving pelvic region and thigh
- 719.47 Pain in joint involving ankle and foot
- 722.0 Displacement of cervical intervertebral disc without myelopathy
- 722.52 Degeneration of lumbar or lumbosacral intervertebral disc
- 724.2 Lumbago
- 724.3 Sciatica
- 729.5 Pain in limb
- 739.1 Nonalopathic lesions of cervical region, not elsewhere classified
- 739.2 Nonalopathic lesions of thoracic region, not elsewhere classified
- 739.3 Nonalopathic lesions of lumbar region, not elsewhere classified
- 780.72 Functional quadriplegia
- V46.3 Wheelchair dependence

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
97036	0.28	0.57	0.57	0.01	0.86	0.86	XXX	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
97036	0	5	0	0	0

CCI

97036 0213T¹, 0216T¹, 0228T¹, 0229T¹, 0230T¹, 0231T¹, 62310¹, 62311¹, 62318¹, 62319¹, 64400¹, 64402¹, 64405¹, 64408¹, 64410¹, 64412¹, 64413¹, 64415¹, 64416¹, 64417¹, 64418¹, 64420¹, 64421¹, 64425¹, 64430¹, 64435¹, 64445¹, 64446¹, 64447¹, 64448¹, 64449¹, 64450¹, 64479¹, 64480¹, 64483¹, 64484¹, 64490¹, 64493¹, 64505¹, 64508¹, 64510¹, 64517¹, 64520¹, 64530¹, 97002¹, 97004¹

Pub 100

Pub 100-3, 1, 10.3-10.4; 100-4, 5, 20-20.3

97110-97112

97110 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

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

Plain English Description

Therapeutic exercise of one or more areas to develop strength, endurance, and flexibility. Code once for each 15 minutes of treatment. Code 97112 if the physician exercises one or more areas to rehabilitate patient movement, coordination, and balance, etc.

ICD-9-CM Diagnostic Codes (commonly used)

- 715.16 Osteoarthritis, localized, primary, involving lower leg
- 715.96 Osteoarthritis, unspecified whether generalized or localized, involving lower leg
- 719.41 Pain in joint involving shoulder region
- 719.45 Pain in joint involving pelvic region and thigh
- 719.46 Pain in joint involving lower leg
- 722.52 Degeneration of lumbar or lumbosacral intervertebral disc
- 723.1 Cervicalgia
- ▲ **724.02** Spinal stenosis of lumbar region, without neurogenic claudication
- **724.03** Spinal stenosis, lumbar region, with neurogenic claudication
- 724.2 Lumbago
- 724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified
- 726.10 Disorders of bursae and tendons in shoulder region, unspecified
- 728.2 Muscular wasting and disuse atrophy, not elsewhere classified
- 728.85 Spasm of muscle
- 729.5 Pain in limb
- 739.3 Nonalopathic lesions of lumbar region, not elsewhere classified
- 780.72 Functional quadriplegia
- 781.2 Abnormality of gait
- 781.3 Lack of coordination
- 840.4 Rotator cuff (capsule) sprain
- V46.3 Wheelchair dependence

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
97110	0.45	0.42	0.42	0.01	0.88	0.88	XXX	A
97112	0.45	0.45	0.45	0.01	0.91	0.91	XXX	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
97110	0	5	0	0	0
97112	0	5	0	0	0

CCI

97110 0213T¹, 0216T¹, 0228T¹, 0229T¹, 0230T¹, 0231T¹, 62310¹, 62311¹, 62318¹, 62319¹, 64400¹, 64402¹, 64405¹, 64408¹, 64410¹, 64412¹, 64413¹, 64415¹, 64416¹, 64417¹, 64418¹, 64420¹, 64421¹, 64425¹, 64430¹, 64435¹, 64445¹, 64446¹, 64447¹, 64448¹, 64449¹, 64450¹, 64479¹, 64480¹, 64483¹, 64484¹, 64490¹, 64493¹, 64505¹, 64508¹, 64510¹, 64517¹, 64520¹, 64530¹, 93040¹, 93041¹, 93042¹, 97002¹, 97004¹

97112 0213T¹, 0216T¹, 0228T¹, 0229T¹, 0230T¹, 0231T¹, 62310¹, 62311¹, 62318¹, 62319¹, 64400¹, 64402¹, 64405¹, 64408¹, 64410¹, 64412¹, 64413¹, 64415¹, 64416¹, 64417¹, 64418¹, 64420¹, 64421¹, 64425¹, 64430¹, 64435¹, 64445¹, 64446¹, 64447¹, 64448¹, 64449¹, 64450¹, 64479¹, 64480¹, 64483¹, 64484¹, 64490¹, 64493¹, 64505¹, 64508¹, 64510¹, 64517¹, 64520¹, 64530¹, 97002¹, 97004¹, 97022¹, 97036¹

Pub 100

100-02, 15, 80.3

** See Appendix for CCI information

* See Appendix for Modifier Rules

● New Code

▲ Revised Code

98925-98929

- 98925** Osteopathic manipulative treatment (OMT); 1-2 body regions involved
- 98926** Osteopathic manipulative treatment (OMT); 3-4 body regions involved
- 98927** Osteopathic manipulative treatment (OMT); 5-6 body regions involved
- 98928** Osteopathic manipulative treatment (OMT); 7-8 body regions involved
- 98929** Osteopathic manipulative treatment (OMT); 9-10 body regions involved

Plain English Description

Osteopathic manipulative treatment (OMT), which treats certain bone and joint disorders by manipulating the effected regions. Code this code if one or two body regions are treated. Code 98926 if three to four body regions are involved. Code 98927 if five to six body regions are involved. Code 98928 if seven to eight body regions are involved. Code 98929 if nine to ten body regions are involved.

ICD-9-CM Diagnostic Codes (commonly used)

- 401.1** Benign essential hypertension
- 401.9** Unspecified essential hypertension
- 715.00** Osteoarthritis, generalized, involving unspecified site
- 719.46** Pain in joint involving lower leg
- 722.52** Degeneration of lumbar or lumbosacral intervertebral disc
- 723.1** Cervicalgia
- 724.1** Pain in thoracic spine
- 724.2** Lumbago
- 724.5** Backache, unspecified
- 728.85** Spasm of muscle
- 729.1** Myalgia and myositis, unspecified
- 729.5** Pain in limb
- 739.0** Nonallopathic lesions of head region, not elsewhere classified
- 739.1** Nonallopathic lesions of cervical region, not elsewhere classified
- 739.2** Nonallopathic lesions of thoracic region, not elsewhere classified
- 739.3** Nonallopathic lesions of lumbar region, not elsewhere classified
- 739.4** Nonallopathic lesions of sacral region, not elsewhere classified
- 739.5** Nonallopathic lesions of pelvic region, not elsewhere classified
- 739.6** Nonallopathic lesions of lower extremities, not elsewhere classified
- 739.8** Nonallopathic lesions of rib cage, not elsewhere classified
- 739.9** Nonallopathic lesions of abdomen and other sites, not elsewhere classified
- 847.0** Neck sprain

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
98925	0.45	0.18	0.41	0.03	0.66	0.89	000	A
98926	0.65	0.26	0.52	0.03	0.94	1.20	000	A
98927	0.87	0.33	0.64	0.04	1.24	1.55	000	A
98928	1.03	0.39	0.73	0.05	1.47	1.81	000	A
98929	1.19	0.45	0.84	0.07	1.71	2.10	000	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
98925	0	0	0	0	0
98926	0	0	0	0	0
98927	0	0	0	0	0
98928	0	0	0	0	0
98929	0	0	0	0	0

CCI

98925 00640⁰, 0213T⁰, 0216T⁰, 0228T⁰, 0229T⁰, 0230T⁰, 0231T⁰, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64479⁰, 64480⁰, 64483⁰, 64484⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 97140⁰, 98940⁰, 98941⁰, 98942⁰, 99148⁰, 99149⁰, 99150⁰, 99201¹, 99202¹, 99203¹, 99204¹, 99205¹, 99211¹, 99212¹, 99213¹, 99214¹, 99215¹, 99217¹, 99218¹, 99219¹, 99220¹, 99221¹, 99222¹, 99223¹, 99224¹, 99225¹, 99226¹, 99231¹, 99232¹, 99233¹, 99234¹, 99235¹, 99238¹, 99239¹, 99281¹, 99282¹, 99283¹, 99284¹, 99285¹, 99291¹, 99304¹, 99305¹, 99306¹, 99307¹,

99308¹, 99309¹, 99310¹, 99315¹, 99316¹, 99318¹, 99324¹, 99325¹, 99326¹, 99327¹, 99328¹, 99334¹, 99335¹, 99336¹, 99337¹, 99341¹, 99342¹, 99343¹, 99344¹, 99345¹, 99347¹, 99348¹, 99349¹, 99350¹, 99354¹, 99356¹, 99360¹, 99455¹, 99456¹, 99460¹, 99461¹, 99462¹, 99463¹, 99464¹, 99465¹, 99466¹, 99468¹, 99469¹, 99471¹, 99472¹, 99475¹, 99476¹, 99477¹, 99478¹, 99479¹, 99480¹, G0380¹, G0381¹, G0382¹, G0383¹, G0384¹, G0406¹, G0407¹, G0408¹, G0425¹, G0426¹, G0427¹

98926

00640⁰, 0213T⁰, 0216T⁰, 0228T⁰, 0229T⁰, 0230T⁰, 0231T⁰, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64479⁰, 64480⁰, 64483⁰, 64484⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 97140⁰, 98925⁰, 98941⁰, 98942⁰, 99148⁰, 99149⁰, 99150⁰, 99201¹, 99202¹, 99203¹, 99204¹, 99205¹, 99211¹, 99212¹, 99213¹, 99214¹, 99215¹, 99217¹, 99218¹, 99219¹, 99220¹, 99221¹, 99222¹, 99223¹, 99224¹, 99225¹, 99226¹, 99231¹, 99232¹, 99233¹, 99234¹, 99235¹, 99236¹, 99238¹, 99239¹, 99281¹, 99282¹, 99283¹, 99284¹, 99285¹, 99291¹, 99304¹, 99305¹, 99306¹, 99307¹, 99308¹, 99309¹, 99310¹, 99315¹, 99316¹, 99318¹, 99324¹, 99325¹, 99326¹, 99327¹, 99328¹, 99334¹, 99335¹, 99336¹, 99337¹, 99341¹, 99342¹, 99343¹, 99344¹, 99345¹, 99347¹, 99348¹, 99349¹, 99350¹, 99354¹, 99356¹, 99360¹, 99455¹, 99456¹, 99460¹, 99461¹, 99462¹, 99463¹, 99464¹, 99465¹, 99466¹, 99468¹, 99469¹, 99471¹, 99472¹, 99475¹, 99476¹, 99477¹, 99478¹, 99479¹, 99480¹, G0380¹, G0381¹, G0382¹, G0383¹, G0384¹, G0406¹, G0407¹, G0408¹, G0425¹, G0426¹, G0427¹

98927

00640⁰, 0213T⁰, 0216T⁰, 0228T⁰, 0229T⁰, 0230T⁰, 0231T⁰, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64479⁰, 64480⁰, 64483⁰, 64484⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 97140⁰, 98925⁰, 98926⁰, 98942⁰, 99148⁰, 99149⁰, 99150⁰, 99201¹, 99202¹, 99203¹, 99204¹, 99205¹, 99211¹, 99212¹, 99213¹, 99214¹, 99215¹, 99217¹, 99218¹, 99219¹, 99220¹, 99221¹, 99222¹, 99223¹, 99224¹, 99225¹, 99226¹, 99231¹, 99232¹, 99233¹, 99234¹, 99235¹, 99236¹, 99238¹, 99239¹, 99281¹, 99282¹, 99283¹, 99284¹, 99285¹, 99291¹, 99304¹, 99305¹, 99306¹, 99307¹, 99308¹, 99309¹, 99310¹, 99315¹, 99316¹, 99318¹, 99324¹, 99325¹, 99326¹, 99327¹, 99328¹, 99334¹, 99335¹, 99336¹, 99337¹, 99341¹, 99342¹, 99343¹, 99344¹, 99345¹, 99347¹, 99348¹, 99349¹, 99350¹, 99354¹, 99356¹, 99360¹, 99455¹, 99456¹, 99460¹, 99461¹, 99462¹, 99463¹, 99464¹, 99465¹, 99466¹, 99468¹, 99469¹, 99471¹, 99472¹, 99475¹, 99476¹, 99477¹, 99478¹, 99479¹, 99480¹, G0380¹, G0381¹, G0382¹, G0383¹, G0384¹, G0406¹, G0407¹, G0408¹, G0425¹, G0426¹, G0427¹

98928

00640⁰, 0213T⁰, 0216T⁰, 0228T⁰, 0229T⁰, 0230T⁰, 0231T⁰, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64479⁰, 64480⁰, 64483⁰, 64484⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 97140⁰, 98925⁰, 98926⁰, 98927⁰, 99148⁰, 99149⁰, 99150⁰, 99201¹, 99202¹, 99203¹, 99204¹, 99205¹, 99211¹, 99212¹, 99213¹, 99214¹, 99215¹, 99217¹, 99218¹, 99219¹, 99220¹, 99221¹, 99222¹, 99223¹, 99224¹, 99225¹, 99226¹, 99231¹, 99232¹, 99233¹, 99234¹, 99235¹, 99236¹, 99238¹, 99239¹, 99281¹, 99282¹, 99283¹, 99284¹, 99285¹, 99291¹, 99304¹, 99305¹, 99306¹, 99307¹, 99308¹, 99309¹, 99310¹, 99315¹, 99316¹, 99318¹, 99324¹, 99325¹, 99326¹, 99327¹, 99328¹, 99334¹, 99335¹, 99336¹, 99337¹, 99341¹, 99342¹, 99343¹, 99344¹, 99345¹, 99347¹, 99348¹, 99349¹, 99350¹, 99354¹, 99356¹, 99360¹, 99455¹, 99456¹, 99460¹, 99461¹, 99462¹, 99463¹, 99464¹, 99465¹, 99466¹, 99468¹, 99469¹, 99471¹, 99472¹, 99475¹, 99476¹, 99477¹, 99478¹, 99479¹, 99480¹, G0380¹, G0381¹, G0382¹, G0383¹, G0384¹, G0406¹, G0407¹, G0408¹, G0425¹, G0426¹, G0427¹

98929

There are too many associated CCI codes to list. Refer to Appendix A for complete list.

Pub 100

No Pub 100 references apply to this code or code range.

Volume 2 – Alphabetic Index

The Alphabetic Index also makes use of certain instructional conventions to help guide the user in appropriate code selection and sequencing.

Special Instruction Notes

The “see” instruction directs the user to another main term to find the correct code.

Example:**Crisis**

Vascular – see Disease, cerebrovascular, acute

The “see also” instruction directs the user to also refer to the suggested main term for additional information on the condition or disease.

Example:

Crohn’s disease (see also Enteritis, regional) 555.9

Punctuation

[/] Slanted brackets identify situations when more than one code is needed to correctly code the condition. The index lists the codes in sequencing order with the secondary code in brackets.

Example:

Mononeuropathy (see also Mononeuritis) 355.9
diabetic NEC 250.6x [355.9]

() Parentheses enclose nonessential modifiers which may or may not be used with the diagnosis or condition listed in the index. These nonessential modifiers may help in clarifying the documentation, but the presence or absence of any of them does not change the code number selection.

Example:

Cyst (mucus) (retention) (serous) (simple)

ICD-9-CM Coding

ICD-9-CM diagnostic coding is a necessity when submitting claims to payers for reimbursement. It also identifies the reason for the patient’s visit to the provider and will indicate the medical necessity of the services rendered by the provider. The following are guidelines that instruct on ICD-9-CM diagnostic coding:

1. Consult Volume 2, Alphabetic Index to ICD-9-CM, first. Locate the main entry term. The Alphabetic Index is arranged by condition.
2. Refer to Volume 1 of the ICD-9-CM, locating the selected code in the Tabular List. Review any exclusion notes or other instructions for proper coding before final selection of codes. Also, refer to the addenda for any new diagnostic codes or corrections.
3. Read and apply all other conventions used in the Tabular List and Alphabetic Index.
4. Code only confirmed diagnoses. Do not code “suspected,” “rule out” or “probable” diagnoses. If there is not a confirmed diagnosis for outpatient service, code the symptom(s). For inpatient, short-term, acute care, and long term care coding, if only a “suspected,” “rule-out,” or “probable” diagnosis is listed, it should be coded as if it existed or was established.
5. Code only the confirmed diagnoses if both the diagnoses and symptoms are documented in the medical record, except

when the diagnoses and symptoms are not related, then code both.

6. Code to the level of highest specificity. Check to see if the diagnostic code consists of three, four, or five numbers. Truncated codes will be denied if a claim is submitted without all of the digits.
7. Chronic diseases and conditions treated on an ongoing basis may be coded as many times as the patient receives treatment and care for the condition(s).
8. Code all documented conditions that coexist at the time of the patient encounter that require or affect patient care, treatment, or management.

2011 Physical Therapy/Physical Medicine Diagnostic Code Index**Abnormal, nonspecific, findings**

radiological and other examinations
musculoskeletal system 793.7
other body structure 793.99

Affections, shoulder region, other 726.2**Aftercare**

fracture
pathologic
arm, NOS V54.20
lower V54.22
upper V54.21
bone, other V54.29
hip V54.23
leg, NOS V54.24
lower V54.26
upper V54.25
vertebrae V54.27
traumatic
arm, NOS V54.10
lower V54.12
upper V54.11
bone, other V54.19
hip V54.13
leg, NOS V54.14
lower V54.16
upper V54.15
vertebrae V54.17
internal fixation device, other V54.09
joint replacement V54.81
orthopedic, other V54.89

Algoneurodystrophy 733.7**Amyotrophy, neuralgic 353.5****Ankylosis, joint**

ankle 718.57
foot 718.57
forearm 718.53
hand 718.54
lower leg 718.56
pelvic region, thigh 718.55
shoulder region 718.51

Jurisdiction D Information

Claims, Correspondence, Redetermination Requests, Refunds, FOIA, etc.

Noridian Administrative Services

PO Box 6727
Fargo ND 58108-6727
Electronic Funds Transfer (EFT) Forms

Noridian Administrative Services

PO Box 6728
Fargo ND 58108-6728

Benefit Protection**Noridian Administrative Services**

PO Box 6736
Fargo ND 58108-6736

Advance Determination of Medicare Coverage (ADMC)**IntegriGuard, LLC**

2301 N 117 Ave Suite 200
Omaha NE 68164
Fax: 1-402-498-2306

Reconsiderations/Administrative Law Judge (ALJ) Hearing Requests**RiverTrust Solutions**

PO Box 180208
Chattanooga, TN 37401-7208

ALJ Status Inquiries**Office of Medicare Hearings and Appeals (OMHA)**

BP Tower & Garage
200 Public Square Suite 1300
Cleveland OH 44114-2316

Jurisdiction D Durable Medical Equipment**Benefit Integrity Support Center (DME-BISC)**

Richard Kensic, Benefit Integrity Manager
DME-BISC
PO Box 51152
Los Angeles CA 90051-5452
www.integriguard.org/gov/psc/dme-bisc.html

Additional Resources**Supplier Enrollment/Inquiries**

National Supplier Clearinghouse
PO Box 100142
Columbia SC 29202-3142

Overnight Mailing Address**National Supplier Clearinghouse**

2300 Springdale Drive Bldg 1
Camden SC 29020
Phone: 1-866-238-9652
www.palmettogba.com/nsc

The supplier enrollment form, CMS 855S, is available at www.cms.gov/cmsforms/downloads/cms855S.pdf

Coding Assistance**Statistical Analysis Durable Medical Equipment Regional Contractor (SADMERC)**

Palmetto Government Benefits Administrators
Medicare SADMERC Operations
PO Box 100143
Columbia SC 29202-3143
Phone: 1-877-735-1326
www.palmettogba.com/sadmerc

2011 Physical Therapy/Physical Medicine HCPCS Level II Code Index**Adhesive remover A4455****Bandage**

adhesive, first-aid type A6413
compression
padding S8430
roll S8431
conforming
non-sterile
greater than/equal to 5 in A6444
greater than 3 in, less than 5 in A6443
less than 3 in A6442
sterile
greater than/equal to 5 in A6447
greater than 3 in, less than 5 in A6446
less than 3 in A6445
self-adherent elastic
less than 3 in A6453
3 to 5 in A6454
greater than 5 in A6455

Bar, abduction rotation, foot

including shoes L3140
without shoes L3150

Belt

extremity E0945
pelvic E0944
thoracic, rib L0210
custom fabricated L0220

Benesch boot

child L3213
infant L3212
junior L3214

Body sock L0984**Boot/shoe, surgical L3260**

child L3209
infant L3208
junior L3211

Cane, all materials E0100

handgrip, replacement A4636

Cardiac rehabilitation, intensive G0422-G0423**Cast**

long leg splint
fiberglass
adult Q4042
pediatric Q4044

- ❶ In some hospitals with residency programs, Medicare pays through the medical program or graduate medical education (GME) program. Because of this, they will not reimburse for a resident when they are used as an assistant surgeon. Although under special circumstances, payment may be made if there is a emergent situation that is life-threatening.

90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

- ❶ Check with payers to determine if the provider may bill for the laboratory procedure if not performed by the provider.

91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of the modifier 91.

Note: This modifier may not be used when tests are rerun to confirm initial results due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

92 Alternative Laboratory Platform Testing

When laboratory testing is performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the laboratory procedure code (HIV testing 86701-86703). The test does not require permanent dedicated space, hence by its design may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of testing is not in itself determinative of the use of this modifier.

99 Multiple Modifiers

Under certain circumstances, two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

- ❶ Check with payers to determine if this modifier is necessary when reporting multiple modifiers.

Approved Modifiers For Ambulatory Surgery Center (ASC) Hospital Outpatient Use

There are some differences in modifiers for professional and ASC hospital use. The following list consists of the only approved modifiers that can be used in an ASC/hospital setting:

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M

service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This service may be reported by adding modifier 25 to the appropriate level of E/M service.

Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

- ❶ According to Medicare, modifier 25 may be appended to an Emergency Department Services E/M code (99281-99285) if provided on the same day as a diagnostic or therapeutic procedure.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding the modifier 27 to each appropriate level outpatient and/or emergency department code(s). This modifier provides a means of reporting circumstances involving E/M services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic).

Note: This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient E/M services provided by the same physician on the same date and performed in multiple outpatient setting(s) (e.g., hospital emergency department, clinic), see Evaluation and Management, Emergency Department, or Preventive Medicine services codes.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding the modifier 50 to the appropriate 5-digit code.

- ❶ Reported on procedures performed at the same operative session, this modifier should be reported only once as a one-line item for Medicare, with the modifier appended to the end of the code.
- ❶ Some payers may accept the bilateral procedures as two-line items, with HCPCS Level II modifiers LT and RT appended to the end of the codes.

52 Reduced Services

Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstance or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

- ❶ Procedures reported with modifier 52 are typically billed at a reduced amount. Most payers do not require documentation to support the use of modifier 52 and will reimburse the procedure at a reduced level.

58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned or anticipated (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure.

Note: For treatment of a problem that requires a return to the operating/procedure room (e.g., unanticipated clinical condition), see modifier 78.

Evaluation and Management Services

Physical Therapy Evaluation and Management

For physical therapy evaluation and management (E/M), most payers accept the following codes instead of the standard E/M codes:

97001 Physical therapy evaluation

Included in these codes are a comprehensive history, physical exam and systems review, and the performance of tests and measures to develop a plan for the course of treatment. Therapists examine patients' medical histories and test and measure strength, range of motion, balance and coordination, posture, muscle performance, respiration, and motor function. The plan is to restore function, improve mobility, relieve pain, and prevent or limit permanent physical disabilities of patients suffering from injuries or disease.

97002 Physical therapy re-evaluation

The physical therapist re-examines the patient and documents the progress, and modifies treatment(s) when necessary. Therapists re-examine patients' medical histories and test and measure strength, range of motion, balance and coordination, posture, muscle performance, respiration, and motor function, if needed.

Physical therapists may use electrical stimulation, hot packs or cold compresses, and ultrasound to relieve pain and reduce swelling. They also may use traction or deep-tissue massage to relieve pain. For a list of these modalities, see the CPT chapter in this book.

Case Management Services

Some payers allow case management services to be reported by a physical therapist. Case management services consists of physical therapists consulting and practicing with a variety of other professionals, such as physicians, nurses, educators, social workers, occupational therapists, speech-language pathologists, and audiologists, etc.

Team Conferences (99361-99362)

These medical conferences are a group of health professionals gathering to coordinate activities of patient care. Time needs to be documented to determine level of code(s) chosen.

Telephone Calls (98966-98968)

These codes are used to coordinate medical management of patients, which include reporting on tests and/or laboratory results, any new issues/problems related to patient care, and /or counseling sessions for seriously ill patient to coordinate complex the services of several different health professionals.

Occupational Therapy Evaluation and Management

For occupational therapy evaluation and management, the following E/M codes are typically used:

97003 Occupational therapy evaluation

Activities of daily living are examined to initiate a plan for the patient. They also determine patients' ability to be independent and reintegrate into the community or workplace after injury or illness.

97004 Occupational therapy re-evaluation

The patient is re-evaluated to determine progress. Any adjustments are made to the plan, if needed.

Other Evaluation and Management Services

The following evaluation and management information is not typically used by physical therapists but is included for other health care providers who may use them.

The Evaluation and Management (E/M) section in the CPT® book is divided into different types of services. There are broad categories, such as outpatient visits, hospital visits, or consultations. Many of these categories are further divided into two or more subcategories as appropriate for that service type: office visits have new and established patients, while hospital services have admissions, follow-up visits, and discharge services. Other E/M services are based on the health status of the patient while others may be based on location alone.

Many of the subcategories contain ranges of codes. For example, the Outpatient/New Patient section contains five CPT codes, 99201-99205, that range from low-intensity services to high-intensity services. The Established Patient codes also increase in provider intensity across the range of codes as the numbers increase.

Once the category and subcategory of E/M services are identified, the primary method of selecting the correct code is matching the level of actual provider work with those performance elements or service descriptors associated with the codes in that range. The most common E/M codes, such as office visits, are usually assigned based on the extent to which the provider performs or addresses the "key components" of history, physical exam, and medical decision-making.

The basic format of the levels of E/M services is the same for most categories:

- 1) the type and/or place of service is specified
- 2) a unique code number is listed
- 3) the content of the service is defined (based on key components)
- 4) the nature of the present problem(s) usually associated with a given level is described
- 5) the time associated with counseling or coordination care considerations for that code is listed

Since many of these codes represent varying degrees of provider work, and that work is benchmarked by the extent to which providers address certain components of the visit, it is reasonable that payers expect the medical record to contain documentation

supporting the code reported. They may request information to validate the following:

- documentation that services were provided consistent with the code reported
- documentation that supports medical necessity/appropriateness of the diagnostic and/or therapeutic services provided
- site of service

The CPT book contains certain definitions of codes and code components, but each payer may have specific requirements in terms of either performance or documentation of a given service. The Centers for Medicare and Medicaid Services (CMS) guidance is set forth as well as the American Medical Association (AMA) and general coding principles are provided to give a broad over-view of E/M code selection, performance, and documentation criteria.

The principles of medical record documentation are generally applicable to medical and surgical services in all settings. For E/M services, the nature and amount of provider work and documentation varies by type of service, place of service, the patient's medical status or other code criteria. The following general principles may be adapted to take into account these variable circumstances:

1. The medical record should be complete and legible
2. The documentation of each patient encounter should include:
 - reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results (if applicable)
 - assessment, clinical impression, or diagnosis
 - plan for care
 - date and legible identity of observer
3. Past and present diagnoses should be accessible to the treating and/or consulting physician
4. Appropriate health risk factors should be identified
5. The patient's progress, response to, and changes in treatment, and revision of diagnosis should be documented
6. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record

Note: Documentation guideline commentaries from the Federal Guidelines are identified by the characters "DG."

The descriptors for the levels of E/M services recognize seven components that are used in defining levels of E/M services. These components are:

- History
- Examination
- Medical Decision Making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

The first three of these components (history, examination, and medical decision making) are the key components in selecting the level of E/M services. In the case of visits that consist predominantly of counseling or coordination of care, time may be considered the key or controlling factor to qualify for a particular level of E/M service.

Typically, new or initial visits will require that all three components be met or exceeded, while some established or follow-up services require that only two of the three be addressed. Although neither the AMA or CMS specifically state that one component is more important than any other, one should remember that medical necessity is most closely linked with the medical decision-making component. That said, performance and documentation of one component at the highest level does not necessarily mean that the encounter qualifies for the highest level of E/M service in a given subcategory.

When selecting a level of service:

- Identify the category or subcategory of service
- Review the reporting instructions for the selected category or subcategory
- Review the level of E/M service descriptors and examples in the selected category or subcategory
- Determine the extent of history obtained
- Determine the extent of examinations performed
- Determine the complexity of medical decision making
- Select the appropriate level of E/M services

Specific Definitions and Guidance for History Elements

The History Component

The history component consists of the following elements:

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Review of systems (ROS)
- Past, family and/or social history (PFSH)

The extent of history of present illness, review of systems, and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

Federal guidance provides these general observations pertaining to the history:

DG: The CC, ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.

DG: An ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:

- describing any new ROS and/or PFSH information or noting there has been no change in the information; and
- noting the date and location of the earlier ROS and/or PFSH.

DG: The ROS and/or PFSH may be recorded by ancillary staffer on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

DG: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance, which precludes obtaining a history.