Optum

APTA American Physical Therapy Association

Coding & Payment Guide

Physical Therapist

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

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2023

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Contents

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Getting Started with Coding and Payment Guide

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

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

CPT/HCPCS Codes

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

Resequencing of CPT Codes

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

ICD-10-CM

Overall, in the 10th revision of the ICD-10-CM codes, conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. Features include icons to identify newborn, pediatric, adult, male only, female only, and laterality. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features. A sample is shown on page 2. The black boxes with numbers in them correspond to the information on the page following the sample.

Appendix Codes and Descriptions

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

CCI Edits and Other Coding Updates

The *Optum 360 Coding and Payment Guide* includes the list of codes from the official Centers for Medicare and Medicaid Services' *National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from the version XX.X, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The CCI edits are located in a section at the back of the book. As other CPT (including COVID-related vaccine and administration codes) and ICD-10-CM codes relevant to your specialty are released, updates will be posted to the Optum360 website. The website address is https://www.optum360coding.com/ProductUpdates/. The 2023 edition password is: **XXXXX**. Log in frequently to ensure you receive the most current updates.

Index

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

For example:

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

Ankle
Strapping, 29540

Strapping
Ankle, 29540

General Guidelines

Providers

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

Sample Page and Key

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

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94660

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

Explanation

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

Coding Tips

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

Documentation Tips

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

Reimbursement Tips

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

ICD-10-CM Diagnostic Codes

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

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

Associated HCPCS Codes

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

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

Relative Value Units/Medicare Edits

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

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

* with documentation

Terms To Know

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

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

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

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

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1. CPT/HCPCS Codes and Descriptions

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

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

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

2. Explanation

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

3. Coding Tips

Coding tips provide information on how the code should be used, provides related procedure codes, and offers help concerning common billing errors and modifier usage. This information comes from consultants and subject matter experts at Optum360 and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

4. Documentation Tips

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

5. Reimbursement Tips

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

6. ICD-10-CM Diagnostic Codes

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

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

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

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

7. Associated HCPCS Codes

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

8. AMA References

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

9. Relative Value Units/Medicare Edits

Relative Value Units

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

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

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

Medicare Follow-Up Days (FUD)

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

Status

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

A	Active code—separate payment may be made
B	Bundled code—payment is bundled into other service
C	Carrier priced—individual carrier will price the code
I	Not valid—Medicare uses another code for this service
N	Non-covered—service is not covered by Medicare
R	Restricted—special coverage instructions apply
T	Injections—separately payable if no other services on same date

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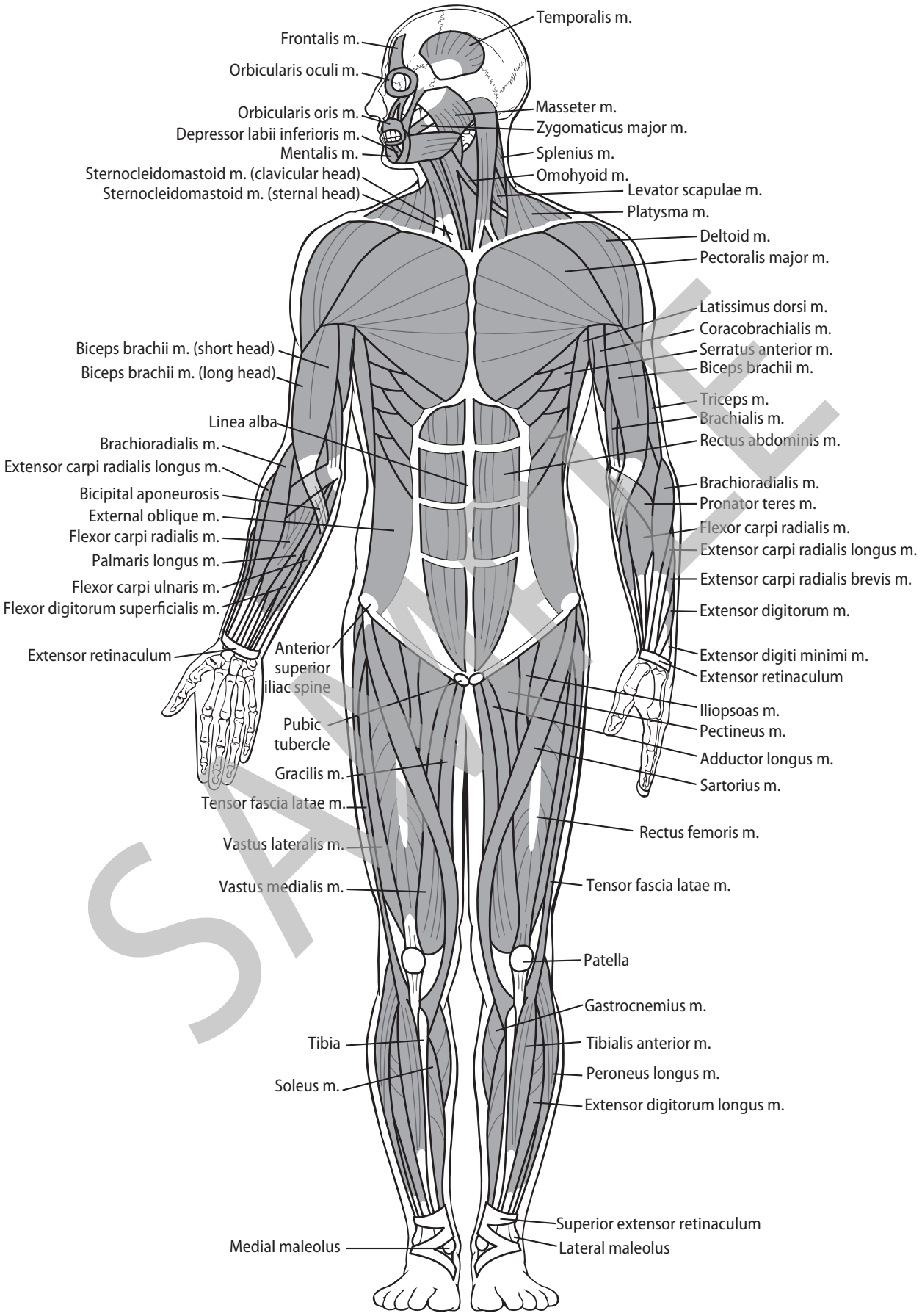
Muscles



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Procedure Codes

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

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

Appropriate Codes for Physical Therapists

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

The physical therapist in general practice will find the most relevant codes in the physical medicine and rehabilitation (PM&R) subsection of the medicine section (codes in the 97010–97799 range). Other services physical therapists provide, particularly those in specialty areas, are described under their appropriate body system within the medicine or surgery section.

For example, the neurological procedures most often performed by physical therapists, including range of motion testing (95851-95852) or electromyography (EMG) (95860-95887), are located in the neurology subsection of the medicine section, while burn care codes (16000–16030) are located in the integumentary subsection of the surgery section. None of the codes for these procedures are listed in the PM&R subsection, although they accurately describe services provided by a physical therapist.

In addition, new for 2022, PTs and PTAs are permitted to use remote therapeutic monitoring codes, which describe a mode of delivery rather than an intervention applied to a body system.

Although codes within the PM&R series (97010–97799) are most easily recognized by third-party payers as services provided by physical therapists they do not describe all physical therapy procedures. As noted above, some physical therapy services are described in other sections of the manual. Physical therapists should select the code that most closely describes the services being provided regardless of location of the code in the CPT book as long as the code represents a service within the physical therapist's scope of practice and is not expressly excluded in payer policy. However, payment policy may affect the payment of some codes when reported by a physical therapist.

CPT Symbols

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

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

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

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

Modifiers

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

- Procedures that have both a technical and professional component were performed
- More than one provider or setting was involved in the service
- Only part of a service was performed
- Unusual events occurred
- Two timed procedures were performed consecutively (versus concurrently)

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29520-29550

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

Explanation

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

Coding Tips

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

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

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

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

Documentation Tips

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

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

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

Reimbursement Tips

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

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

ICD-10-CM Diagnostic Codes

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

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

Associated HCPCS Codes

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

AMA: **29520** 2018,Jan,8; 2018,Jan,3; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **29530** 2018,Jan,8; 2018,Jan,3; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **29540**

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© 2022 Optum360, LLC N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only CPT © 2022 American Medical Association. All Rights Reserved.

M51.06 Intervertebral disc disorders with myelopathy, lumbar region
M51.15 Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16 Intervertebral disc disorders with radiculopathy, lumbar region
M51.17 Intervertebral disc disorders with radiculopathy, lumbosacral region
M53.2X7 Spinal instabilities, lumbosacral region
M53.2X8 Spinal instabilities, sacral and sacrococcygeal region
M53.3 Sacrococcygeal disorders, not elsewhere classified
M54.11 Radiculopathy, occipito-atlanto-axial region
M54.12 Radiculopathy, cervical region
M54.13 Radiculopathy, cervicothoracic region
M54.15 Radiculopathy, thoracolumbar region
M54.16 Radiculopathy, lumbar region
M54.17 Radiculopathy, lumbosacral region
M54.18 Radiculopathy, sacral and sacrococcygeal region
M79.601 Pain in right arm ☑
M79.604 Pain in right leg ☑
M79.621 Pain in right upper arm ☑
M79.631 Pain in right forearm ☑
M79.641 Pain in right hand ☑
M79.644 Pain in right finger(s) ☑
M79.651 Pain in right thigh ☑
M79.661 Pain in right lower leg ☑
M79.671 Pain in right foot ☑
M79.674 Pain in right toe(s) ☑

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

AMA: **95905** 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
95905	0.05	1.32	0.02	1.39
Facility RVU	**Work**	**PE**	**MP**	**Total**
95905	0.05	1.32	0.02	1.39

	FUD	Status	MUE	Modifiers				IOM Reference
95905	N/A	A	2(3)	N/A	N/A	N/A	80*	None

* with documentation

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.

95907-95909

95907 Nerve conduction studies; 1-2 studies

95908 3-4 studies

95909 5-6 studies

Explanation

Three types of nerve conduction studies are 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 are 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 on site 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 95907 for up to two studies; 95908 for three or four studies; 95909 for five or six studies; 95910 for seven or eight studies.

Coding Tips

To report seven or eight studies, see code 95910; code 95911 for nine or 10 studies; code 95912 for 11 or 12 studies; or code 95913 for 13 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 (SNCT) testing 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.

Reimbursement Tips

These procedures have both a technical and professional component. To report only the professional component, append modifier 26. To report only the technical component, append modifier TC. To report the complete procedure (i.e., both the professional and technical components), submit without a modifier.

ICD-10-CM Diagnostic Codes

G04.82 Acute flaccid myelitis
M35.06 Sjögren syndrome with peripheral nervous system involvement
M47.011 Anterior spinal artery compression syndromes, occipito-atlanto-axial region
M47.012 Anterior spinal artery compression syndromes, cervical region
M47.013 Anterior spinal artery compression syndromes, cervicothoracic region
M47.014 Anterior spinal artery compression syndromes, thoracic region
M47.015 Anterior spinal artery compression syndromes, thoracolumbar region
M47.016 Anterior spinal artery compression syndromes, lumbar region

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97016

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

Explanation

The qualified health care provider 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.

According to the American Medical Association, this code should be reported once for each distinct procedure performed.

The modalities identified by codes 97010–97028 require supervision by the physical therapist 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.

Documentation Tips

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

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

Reimbursement Tips

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.

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 modifier 51 exempt or as an add-on code in the CPT book.

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

This service is considered an "always-therapy" service. The following three modifiers refer only to services provided under plans of care for physical therapy, occupational therapy, and speech-language pathology services, and should only be reported with codes on the list of applicable therapy codes:

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

GO Services delivered under an outpatient occupational therapy plan of care

GP Services delivered under an outpatient physical therapy plan of care

Claims for services above the $2,150 threshold require the use of modifier KX. When appending modifier KX, the physical therapist indicates that the service thresholds are reasonable and medically necessary, and that there is documentation of medical necessity for the services in the patient's medical record. Services exceeding modifier KX thresholds for outpatient therapy and do not have modifier KX appended are denied by Medicare contractors.

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

ICD-10-CM Diagnostic Codes

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

AMA: **97016** 2018,May,5; 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
97016	0.18	0.16	0.01	0.35
Facility RVU	**Work**	**PE**	**MP**	**Total**
97016	0.18	0.16	0.01	0.35

	FUD	Status	MUE	Modifiers				IOM Reference
97016	N/A	A	1(3)	N/A	N/A	N/A	80*	None

* with documentation

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 blood stream.

lymphedema. Defect in which excessive lymph fluid accumulates in the tissues and causes the legs to swell.

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97032

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

Explanation

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

Coding Tips

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

Documentation Tips

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

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

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

Reimbursement Tips

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

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

This service is considered an "always-therapy" service. The following three modifiers refer only to services provided under plans of care for physical therapy, occupational therapy, and speech-language pathology services, and should only be reported with codes on the list of applicable therapy codes:

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

GO Services delivered under an outpatient occupational therapy plan of care

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Claims for services above the $2,150 threshold require the use of modifier KX. When appending modifier KX, the physical therapist indicates that the service thresholds are reasonable and medically necessary, and that there is documentation of medical necessity for the services in the patient's medical record. Services exceeding modifier KX thresholds for outpatient therapy and do not have modifier KX appended are denied by Medicare contractors.

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

ICD-10-CM Diagnostic Codes

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

Associated HCPCS Codes

A4595	Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)
E0720	Transcutaneous electrical nerve stimulation (TENS) device, two-lead, localized stimulation
E0730	Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation

AMA: **97032** 2019,Jul,10; 2018,Oct,11; 2018,Oct,8; 2018,May,5; 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

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

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

* with documentation

Terms To Know

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

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A Codes: Medical and Surgical Supplies (A0021–A9999)

This section covers a wide variety of medical and surgical supplies, as well as some DME-related supplies and accessories. Medicare generally covers DME-related supplies, accessories, maintenance, and repair under the prosthetic devices provision.

A4265 Paraffin, per pound

MED: Pub. 100-3, Section 280.1

Coding Tip
Portable paraffin bath units and supplies may be covered when the patient has undergone a successful trial period of paraffin therapy ordered by a provider and the patient's condition is expected to be relieved by long-term use of this modality.

Additional Miscellaneous Supplies

A4290 Sacral nerve stimulation test lead, each

A4436 Irrigation supply; sleeve, reusable, per month

A4437 Irrigation supply; sleeve, disposable, per month

A4450 Tape, non-waterproof, per 18 sq in

MED: Pub. 100-2, Chapter 15, Section 120

A4452 Tape, waterproof, per 18 sq in

MED: Pub. 100-2, Chapter 15, Section 120

A4455 Adhesive remover or solvent (for tape, cement or other adhesive), per ounce

MED: Pub. 100-2, Chapter 15, Section 120

A4456 Adhesive remover, wipes, any type, each

A4461 Surgical dressing holder, nonreusable, each

A4463 Surgical dressing holder, reusable, each

A4465 Nonelastic binder for extremity

A4467 Belt, strap, sleeve, garment, or covering, any type

A4490 Surgical stocking above knee length, each

MED: Pub. 100-2, Chapter 15, Section 100, 130; Pub. 100-3, Section 280.1

A4495 Surgical stocking thigh length, each

MED: Pub. 100-2, Chapter 15, Section 100, 130; Pub. 100-3, Section 280.1

A4500 Surgical stocking below knee length, each

MED: Pub. 100-2, Chapter 15, Section 100, 130; Pub. 100-3, Section 280.1

A4510 Surgical stocking full length, each

MED: Pub. 100-2, Chapter 15, Section 100 , 130; Pub. 100-3, Section 280.1

A4556 Electrodes (e.g., Apnea monitor), per pair

A4558 Conductive gel or paste, for use with electrical device (e.g., TENS, NMES), per ounce

A4559 Coupling gel or paste, for use with ultrasound device, per ounce

A4565 Slings

A4566 Shoulder sling or vest design, abduction restrainer, with or without swathe control, prefabricated, includes fitting and adjustment

Coding Tip
The initial casting of the fracture is considered part of the fracture care, inherent in the fracture care code. The sling, however, is not included in the global package for fracture care. Some contractors will pay for this additional patient care item; some will not. If the provider ordered the sling secondary to high probability of patient self-harm with a flailing, casted limb, or if the patient is a child who requires immobilization of the casted limb to avert further injury, reimbursement may be considered by some contractors. Clear evidence of these situations must be reflected in the medical documentation and should be submitted with the claim. In any case, it would be prudent to secure an advance beneficiary notice of noncoverage (ABN) from the patient in case a medical necessity denial is received.

A4570 Splint

MED: Pub. 100-2, Chapter 15, Section 100

A4580 Cast supplies (e.g., plaster)

MED: Pub. 100-2, Chapter 15, Section 100

A4590 Special casting material (e.g., fiberglass)

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

MED: Pub. 100-3, Section 270.3

A4600 Sleeve for intermittent limb compression device, replacement only, each

A4630 Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient

A4635 Underarm pad, crutch, replacement, each

A4636 Replacement, handgrip, cane, crutch, or walker, each

A4637 Replacement, tip, cane, crutch, walker, each

A4649 Surgical supply; miscellaneous

Coding Tip
Determine if an alternative national HCPCS Level II code better describes the supply being reported. Code A4649 should be used only if a more specific code is unavailable.

A5113 Leg strap; latex, replacement only, per set

MED: Pub. 100-2, Chapter 15, Section 120

A5114 Leg strap; foam or fabric, replacement only, per set

MED: Pub. 100-2, Chapter 15, Section 120

Dressings

Medicare claims fall under the jurisdiction of the durable medical equipment Medicare administrative contractor (DME MAC) unless otherwise noted.

A6000 Non-contact wound warming wound cover for use with the non-contact wound warming device and warming card

MED: Pub. 100-3, Section 270.2

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L1001 **Cervical thoracic lumbar sacral orthosis, immobilizer, infant size, prefabricated, includes fitting and adjustment**

L1005 **Tension based scoliosis orthosis and accessory pads, includes fitting and adjustment**

L1600–L2999 Orthotic Devices, Lower Limb

The procedures in L1600–L2999 are considered base or basic procedures and may be modified by listing procedures from the additions sections and adding them to the base procedures. For Medicare, file claims for codes in this section with DME MAC.

L1600 **Hand orthosis, abduction control of hip joints, flexible, Frejka type with cover, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise**

L1610 **Hand orthosis, abduction control of hip joints, flexible, (Frejka cover only), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise**

L1620 **Hand orthosis, abduction control of hip joints, flexible, (Pavlik harness), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise**

L1650 **Hand orthosis, abduction control of hip joints, static, adjustable (Ilfled type), prefabricated, includes fitting and adjustment**

L1652 **Hand orthosis, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, includes fitting and adjustment, any type**

L1660 **Hand orthosis, abduction control of hip joints, static, plastic, prefabricated, includes fitting and adjustment**

L1686 **Hand orthosis, abduction control of hip joint, postoperative hip abduction type, prefabricated, includes fitting and adjustments**

L1690 **Combination, bilateral, lumbo-sacral, hip, femur orthosis providing adduction and internal rotation control, prefabricated, includes fitting and adjustment**

L1810 **Knee orthosis, elastic with joints, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise**

L1812 **Knee orthosis, elastic with joints, prefabricated, off-the-shelf**

L1820 **Knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment**

L1830 **Knee orthosis, immobilizer, canvas longitudinal, prefabricated, off-the-shelf**

L1831 **Knee orthosis, locking knee joint(s), positional orthosis, prefabricated, includes fitting and adjustment**

L1832 **Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise**

L1833 **Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf**

L1836 **Knee orthosis, rigid, without joint(s), includes soft interface material, prefabricated, off-the-shelf**

L1843 **Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise**

L1845 **Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise**

L1847 **Knee orthosis, double upright with adjustable joint, with inflatable air support chamber(s), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise**

L1848 **Knee orthosis, double upright with adjustable joint, with inflatable air support chamber(s), prefabricated, off-the-shelf**

L1850 **Knee orthosis, Swedish type, prefabricated, off-the-shelf**

L1851 **Knee orthosis (ko), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf**

L1852 **Knee orthosis (ko), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf**

L1902 **Ankle foot orthosis, ankle gauntlet, prefabricated, off-the-shelf**

L1906 **Ankle foot orthosis, multiligamentus ankle support, prefabricated, off-the-shelf**

L1910 **Ankle foot orthosis, posterior, single bar, clasp attachment to shoe counter, prefabricated, includes fitting and adjustment**

L1930 **Ankle foot orthosis, plastic or other material, prefabricated, includes fitting and adjustment**

L1932 **Ankle foot orthosis, rigid anterior tibial section, total carbon fiber or equal material, prefabricated, includes fitting and adjustment**

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