



Dear Customer:

The 2015 edition of the *South Carolina Workers' Compensation Medical Services Provider Manual* has been updated as follows:

*NOTE: Underlined text has been added; text with ~~strikethrough~~ has been deleted.*

**On page ii, the Contents has been updated to reflect the additions on pages 65, 69, and 499.**

**On page 32, the following text has been deleted:**

~~Non-physician practitioners (nurse practitioners, physician assistants, or certified nurse specialists) may not provide the initial encounter with a patient.~~

**On page 65, the following text has been added:**

**NON-PHYSICIAN PRACTITIONERS**

When authorized by the employer or insurance carrier, a nurse practitioner or physician assistant may provide services to injured workers. Payment to these non-physician practitioners is determined by multiplying the maximum allowable payment (MAP) amounts listed in the Schedule by a service level adjustment factor (SLAF) of .85. Incident-to guidelines are not applicable to services rendered under the 2015 *South Carolina Workers' Compensation Medical Services Provider Manual*.

When a service is provided by a nurse practitioner, physician assistant, or certified nurse specialist, the service must be reported by adding state-specific modifier AL to the appropriate CPT code.

**On page 69, the following text has been added:**

**SOUTH CAROLINA STATE-SPECIFIC MODIFIER**

**AL Nurse practitioner, physician assistant, or certified nurse specialist**

When the service was provided by a nurse practitioner, physician assistant, or certified nurse specialist, modifier AL must be added to the CPT code for the service rendered.

**On page 434 are the following deletions and additions:**

Due to the nature of drug pricing, the prices of some HCPCS drug codes are updated quarterly at the Commission's website:

**<http://www.wcc.sc.gov/insurance/Pages/MedicalServicesDivision.aspx>**

**AS Physician Assistant**

~~When the service was provided by a physician assistant, modifier must be added to the CPT code for the service rendered.~~

**AS Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist Services for Assistant at Surgery**

*South Carolina Specific Instruction: When a certified physician assistant, nurse practitioner, or certified nurse specialist acts as a surgical assistant, the service must be identified by adding modifier AS. Reimbursement is made at 17 percent of the MAP.*

**On page 499, the following underlined text should be added below the existing text:**

For muscle testing, range of joint motion, or electromyography, use CPT codes 95831–95875. (See Section 6, Medicine for more information.) For biofeedback training by EMG use code 90901 (Section 8, subsection Psychological and Biofeedback Services). For TENS use code 64550.

**MULTIPLE PROCEDURE REDUCTION**

Multiple procedure reduction guidelines do not apply to the codes in the Physical Medicine section. It is inappropriate to report the physical medicine codes with modifier 51 or to reduce the MAP amount for second and subsequent procedures reported on the same or different dates of service.

Replacement pages that can be inserted into your book can be downloaded from:  
<https://www.optumcoding.com/ProductUpdates/>

With appreciation,

Optum360

# Contents

**Part I..... 1**

**Chapter I. Overview and Guidelines ..... 3**

Introduction ..... 3

Healthcare Common Procedure Coding System ..... 3

Providers Covered by the Manual ..... 3

Services Listed in Part II ..... 4

Services Not Listed in this Schedule ..... 4

Maximum Allowable Payment (MAP) Amounts ..... 5

Determining Payment ..... 5

Providers Filing Claims ..... 5

Claims Review and Reduction ..... 6

**Chapter II. General Policy ..... 7**

Employer Responsibilities ..... 7

Authorization to Treat ..... 7

Referrals ..... 7

Non-Physician Providers ..... 7

Provider Self-Referral Law ..... 7

Medical Necessity ..... 7

Documenting Services Rendered ..... 8

Medical Records ..... 8

Narrative Documentation ..... 8

Release of Information ..... 8

Copies of Records and Reports ..... 9

**Chapter III. Billing Policy ..... 11**

Billing Information ..... 11

Balance Billing and Pursuing Collection from the Claimant ..... 11

Missed Appointments ..... 11

Medical Claim Forms ..... 11

Service Codes ..... 11

Injectable Pharmaceuticals, Supplies, and Durable Equipment ..... 11

Modifiers ..... 12

Submitting Claims for Payment ..... 12

Collecting Medical Fees ..... 12

Explanation of Benefits (EOB) ..... 12

**Chapter IV. Payment Policy ..... 13**

General Payment Policy ..... 13

Timeliness ..... 13

Information Submitted to Commission ..... 13

Medical Services Rendered in Another State ..... 13

Out-of-State Injuries or Work-Related Illnesses Treated in South Carolina ..... 13

Payer Responsibilities ..... 13

National Correct Coding Initiative ..... 13

Medically Unlikely Edits ..... 14

Add-on Code Edits ..... 14

Reviewing for Correct Coding ..... 14

Services Not Substantiated by Documentation ..... 14

Services Not Accurately Coded ..... 14

Determining Payment for Services Listed as Individual Consideration (IC) ..... 14

Multiple Patient Visits Per Day ..... 15

Separate Procedures ..... 15

Total Procedures Billed Separately ..... 15

Paying for Supplies ..... 15

Claims Review and Reduction ..... 15

Explanation of Benefits (EOB) ..... 15

Formal Disputes Only..... 16

Payment Dispute Resolution Process ..... 16

Timely Payment..... 16

Payment Reconsideration..... 17

Request a State of South Carolina Secure Email ..... 17

Medical Bill Dispute Form ..... 18

Approved Reviewers Submitting Claims to the Commission for Review ..... 18

**Chapter V. Completing and Submitting Claims ..... 23**

Claims Prepared by a Billing Service ..... 23

Copies of Office Notes, Operative Reports, and Records ..... 23

Instructions for Completing the CMS-1500 Claim Form ..... 23

**Part II ..... 27**

**Fee Schedule ..... 29**

Fee Schedule Layout ..... 29

Icons ..... 29

Resequenced Codes ..... 29

Maximum Allowable Payment ..... 29

Surgical Assistant ..... 30

Follow-up Days ..... 30

Part II Organization ..... 30

Services Not Listed in this Schedule ..... 30

**Section 1. Evaluation and Management (E/M) Services ..... 31**

Levels of E/M Services ..... 31

Evaluation and Management Time ..... 31

New and Established Patient..... 31

Preoperative Evaluation and Management Services ..... 31

Non-Physician Practitioners ..... 32

Consultation Services ..... 32

Consultation with a Nurse Case Manager ..... 32

Hospital Discharge Day Management ..... 32

Physical Therapy Services ..... 32

Injectable Pharmaceuticals ..... 32

Chiropractors ..... 32

Travel Reimbursement ..... 32

Supplies and Materials (CPT 99070) ..... 33

Impairment Ratings ..... 33

Independent Medical Evaluation (IME) ..... 33

Alternating Physicians ..... 33

Follow-up Days ..... 33

Modifiers..... 33

CPT Modifiers ..... 34

HCPCS Modifiers ..... 34

South Carolina State-Specific Modifier..... 34

**Section 2. Anesthesia ..... 53**  
 General Information and Overview ..... 53  
 Anesthesia Maximum Allowable Payment (AMAP) ..... 53  
     Determining the Basic MAP Amount ..... 53  
     Determining the Time Value Amount (TVA) ..... 53  
 Services Rendered by a CRNA ..... 53  
 CPT Codes for Anesthesia Services ..... 53  
 Anesthesia by Surgeon ..... 54  
 CPT Codes for Medical or Surgical Services ..... 54  
 Modifiers ..... 54  
     CPT Modifiers ..... 54  
     HCPCS Modifiers ..... 54  
     Time Value Chart ..... 54

**Section 3. Surgery ..... 63**  
 General ..... 63  
 Global Payment ..... 63  
 Anesthesia by Surgeon ..... 64  
 Surgical Supplies ..... 64  
 Multiple Procedures ..... 64  
     Exceptions ..... 64  
     Separate Procedures ..... 64  
     Distinct Procedural Services ..... 64  
     Bilateral Procedures ..... 64  
 Services Rendered by More Than One Physician ..... 65  
 Two Surgeons ..... 65  
 Surgery by a Resident in a Teaching Setting ..... 65  
 Non-physician Practitioners ..... 65  
 Wound Repair and Suture Removal ..... 66  
 Burns, Local Treatment ..... 66  
 Musculoskeletal System ..... 66  
     Application of Casts and Strapping ..... 66  
 Diagnostic or Therapeutic Nerve Blocks ..... 67  
 Microsurgical Procedures ..... 67  
 Modifiers ..... 67  
     CPT Modifiers ..... 67  
     HCPCS Modifiers ..... 69  
     South Carolina State-Specific Modifier ..... 69

**Section 4. Radiology ..... 251**  
 General Information ..... 251  
 Separate Procedures ..... 251  
 Contrast Media ..... 251  
 X-Ray Consultation (CPT 76140) ..... 251  
 Billing Radiology Services ..... 251  
     Number of Views ..... 251  
     Billing a Total Procedure (Professional and Technical Component) ..... 251  
     Billing the Professional Component (Modifier 26) ..... 251  
     Billing the Technical Component (Modifier TC) ..... 251  
 Billing for Radiological Supervision and Interpretation ..... 252  
 Payment ..... 252  
 Modifiers ..... 252  
     CPT Modifiers ..... 252  
     HCPCS Modifier ..... 252

**Section 5. Pathology and Laboratory Services ..... 319**  
 Pathology and Laboratory Codes ..... 319  
 Drug Screening ..... 319  
 Modifiers ..... 320  
     CPT Modifiers ..... 320  
     HCPCS Modifier ..... 320

**Section 6. Medicine and Injections ..... 431**  
 Non-Physician Providers (Nurse Practitioners and Physician Assistants) ..... 431

Separate Procedures ..... 431  
 Travel Reimbursement ..... 431  
 Independent Medical Evaluation ..... 431  
 Chiropractors and Osteopaths ..... 432  
 Audiologic Function Tests ..... 432  
 Psychological Services ..... 432  
     Services Rendered by a Clinical Social Worker ..... 432  
     Billing ..... 432  
 Biofeedback ..... 432  
 Over-the-Counter Preparations ..... 432  
 Consultation Services ..... 432  
 Neurology and Neuromuscular Services ..... 433  
 Extremity Testing, Muscle Testing, and Range of Motion (ROM) Measurements ..... 433  
 Electromyography (EMG) ..... 433  
 Nerve Conduction Studies (CPT Codes 95905–95913) ..... 433  
 Ophthalmological Services ..... 433  
     Payment of Ophthalmologic Supplies ..... 433  
 Injectable Pharmaceuticals ..... 433  
 Modifiers ..... 434  
     CPT Modifiers ..... 434  
     HCPCS Modifiers ..... 434  
     South Carolina State-Specific Modifier ..... 435

**Section 7. Physical Medicine ..... 497**  
 Eligible Providers ..... 497  
 Chiropractors and Osteopaths ..... 497  
 Osteopathic Manipulative Treatment (OMT) ..... 497  
 Chiropractic Manipulative Treatment (CMT) ..... 497  
 Authorization to Treat ..... 497  
 Plan of Care ..... 498  
 Initial Assessment ..... 498  
 Functional Capacity Assessment ..... 498  
 Work Hardening and Work Conditioning ..... 498  
 Transcutaneous Electrical Nerve Stimulation ..... 498  
 Hot and Cold Packs ..... 498  
 Medical Supplies ..... 498  
 Billing Guidelines ..... 498  
 Multiple Procedure Reduction ..... 499  
 Modifiers ..... 499  
     CPT Modifiers ..... 499

**Section 8. Special Reports and Services ..... 503**  
 Special Reports ..... 503  
 Copies of Reports and Records ..... 503  
 Travel Reimbursement ..... 503  
 Medical Testimony ..... 504

**Section 9. HCPCS Level II ..... 507**  
 Billing ..... 507  
 Coding ..... 507  
 Modifiers ..... 507  
     HCPCS Modifiers ..... 507

**Section 10. Pharmacy ..... 707**

**Part III ..... 709**

**Appendix A. Workers' Compensation Medical Laws and Regulations Referenced ..... 711**

**Appendix B. Exceptions to the Multiple Surgical Procedures Policy ..... 719**

**Appendix C. Reviewer Approval ..... 721**

**Appendix D. Abbreviations ..... 723**

---

# Section 1. Evaluation and Management (E/M) Services

This section stipulates the policies and procedures that are unique to Evaluation and Management Services. Additional policies and procedures that apply to all providers are found in Part I of this *Medical Services Provider Manual*.

## LEVELS OF E/M SERVICES<sup>1</sup>

Evaluation and Management codes are grouped into broad categories such as office visits, hospital visits and consultations. Most of the categories are further divided into two or more subcategories of services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of services that are identified by specific codes. This classification is important because the nature of physician work varies by type of service, place of service, and the patient's status.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified. Third, the content of the service is defined, for example, comprehensive history and comprehensive examination. Fourth the nature of the presenting problem(s) usually associated with a given level is described, and fifth, the time typically required to provide the service is specified.

### **Documentation must support the level of E/M service reported.**

For complete instructions on identifying and billing E/M services, please refer to the Evaluation and Management Services Guidelines of the 2015 CPT® book.

E/M service descriptors have seven components. These components are: history, examination, medical decision-making, counseling, coordination of care, nature of presenting problem, and time.

---

1. Adapted from the AMA 2015 CPT book, pp 1–10.

## **Evaluation and Management Time**

The times listed in the code descriptors are averages. Actual time spent by the provider may be slightly higher or lower depending upon the actual clinical circumstances; however, providers should select the CPT code that best describes the amount of time actually spent. For office visits and other outpatient visits, time is based on the amount of time spent face to face and not the time the patient is in an examining room. For inpatient hospital care, time is based on unit floor time. This includes the time the physician is present on the patient's hospital unit and at the bedside rendering services. This also includes time spent reviewing the patient's chart, writing additional notes, and communicating with other professionals and/or the patient's family.

Time is used as the controlling factor to select a level of service when more than 50 percent of the patient encounter is spent in counseling and coordination of care. Time spent counseling and the extent of the counseling and/or coordination of care must be documented.

## **New and Established Patient**

A new patient is one who has not received professional face-to-face services from the provider or another provider of the same specialty in the same practice for three years. A new patient is also defined as a patient who is being seen and evaluated for a new workers' compensation related illness or injury. An established patient has been seen within the last three years by the same provider or a provider of the same specialty in the same practice within the last three years.

Refer to the decision tree in the CPT book to help determine if the patient is new or established.

## **Preoperative Evaluation and Management Services**

The E/M service where the decision was made to perform surgery is billable. This visit can be identified with modifier 57 Decision for surgery. Subsequent visits for the express purpose of completing the facility-required history and physical are not separately reported.

## NON-PHYSICIAN PRACTITIONERS

When authorized by the employer or insurance carrier, a nurse practitioner or physician assistant may provide services to injured workers. Payment to these non-physician practitioners is determined by multiplying the maximum allowable payment (MAP) amounts listed in the Schedule by a service level adjustment factor (SLAF) of .85. For example, to bill for a basic evaluation (CPT code 99212 valued at \$58.00 in the non-facility setting) performed by a nurse practitioner or physician assistant, payment would be calculated as follows:

$$\$58.00 \times .85 = \$49.30$$

When a service is provided by a nurse practitioner, physician assistant, or certified nurse specialist, the service must be reported by adding state-specific modifier AL to the appropriate CPT code. All services provided by nurse practitioners, physician assistants, or certified nurse specialists are subject to the SLAF. Incident-to guidelines are not applicable to services rendered under the *2015 South Carolina Workers' Compensation Medical Services Provider Manual*.

## CONSULTATION SERVICES

A consultation includes services rendered by a physician whose opinion or advice is requested by another physician or other appropriate source for the further evaluation and/or management of the patient. A consultant may initiate diagnostic or therapeutic services at the request of the attending physician. There must be documentation to the attending physician of the recommended course of action and that the treatment has been initiated upon the attending physician's request. A copy of a consultation report must be submitted with the bill in order for payment to be made.

Payment for a consultation includes payment for the report. When a physician performs consultative services and subsequently becomes the treating physician for either total or partial care, payment for the consultative services should not be denied by the carrier. The subsequent services must be billed and paid under the appropriate visit codes, not consultation codes.

### Consultation with a Nurse Case Manager

A consultation with a nurse case manager may be billed and paid only when the consultation service meets all requirements listed in the descriptor of the CPT consultation code billed. The medical record pertaining to the consultation must specify the time spent in consultation and must be included with the claim for payment.

## HOSPITAL DISCHARGE DAY MANAGEMENT

Payment must not be made for this service in addition to another hospital visit billed by the same physician on the same day for the same patient.

## PHYSICAL THERAPY SERVICES

A treating physician who sees an injured worker for the single purpose of monitoring the outcome of physical therapy may be paid for only one E/M service per week. If the E/M office note can substantiate that a separately identifiable service was provided, the provider may be paid. An E/M service may be provided on the same day as the therapeutic modality application. Physical therapists must not be paid for E/M services.

## INJECTABLE PHARMACEUTICALS

If the injection is part of an office visit where other services are provided and an office visit is billed, the physician will be paid only for the cost of the pharmaceutical but not for the injection fee. The injectable pharmaceutical must be billed using the appropriate HCPCS A, C, J, or Q code as listed in Section 9, HCPCS Level II.

If the single purpose of an office visit is for the injection, the physician may be paid for the cost of the injectable pharmaceutical plus a fee for the injection but cannot be paid for an office visit. (See "Injectable Pharmaceuticals" in Section 6, Medicine, for complete information on billing for injections.)

## CHIROPRACTORS

In addition to payments for physical medicine and x-ray services, a chiropractor who is the treating physician may also be paid for one office visit per week. Office visit codes may not be substituted for manipulation codes.

## TRAVEL REIMBURSEMENT

Physicians may be reimbursed for travel associated with depositions or other medical testimony. Travel by public transportation, subsistence, and lodging are reimbursed at actual cost. Travel by personal auto is paid per mile as follows:

Effective Date	Amount Per Mile
January 1, 2015	\$0.575

primary procedure and add modifier 50. Payment will be made at the lesser of 150 percent of the MAP amount or the provider's charge. If the bilateral procedure is performed in addition to another procedure and is not the primary procedure, then payment is made at the lesser of billed charges or 75 percent of the MAP amount.

## SERVICES RENDERED BY MORE THAN ONE PHYSICIAN

**Consultant Services:** When a patient's condition requires the services of a consultant in addition to the services of the attending physician, the consultant's continuing services may be paid only for as long as they are medically necessary.

**Surgical Assistant:** When medically necessary and approved by the employer or carrier, a surgical assistant may be paid separately for assisting at surgery. The surgical assistant must submit a separate claim that includes a copy of the operative report, and must identify his/her services by using the appropriate modifier(s) as described below.

**Assistant Surgeon:** When a physician assists at surgery, payment will be made at 20 percent of the MAP for the applicable surgical procedure or the provider's charge, whichever is less. Modifier 80 must be added to the surgical procedure code to identify the surgical assistant.

**Certified Physician Assistant, Nurse Practitioner, or Certified Nurse Specialist as Surgical Assistant:** When a certified physician assistant assists at surgery payment will be made at the lesser of billed charges or 17 percent of the MAP for the applicable surgical procedure (85 percent of the amount allowed for a physician assisting at surgery) or the provider's charge, whichever is less. Modifier AS must be added to the surgical procedure code to identify the certified physician assistant, nurse practitioner, or certified nurse specialist.

## TWO SURGEONS

Under certain circumstances, two surgeons (usually with different skills) may be required in the management of a specific surgical procedure. Under such circumstances, the separate services may be identified by adding modifier 62 to the procedure code used by each surgeon for reporting the procedure(s). Each surgeon must submit an individual billing form for the services rendered along with an operative report documenting the specific surgical procedure(s) provided. Payment must not be made to either surgeon until the carrier has received each surgeon's individual operative report and claim form.

Payment for co-surgeons follows the same logic as for a surgeon-assistant surgeon team except that the payment will be divided equally among the two surgeons. When co-surgeons perform a single procedure, each will be paid the lesser of billed charges or 60 percent of the MAP for the procedure.

## SURGERY BY A RESIDENT IN A TEACHING SETTING

Because there are a number of teaching hospitals in South Carolina where residents are trained in surgery under the direction and supervision of an attending physician, it may occur that an injured worker undergoes surgery by a resident-attending physician team. This practice is permissible under the following conditions:

1. the attending physician must be fully qualified for the specialty in which the resident is being trained;
2. prior to surgery, authorization must be obtained from the employer or insurance carrier for the surgery to be performed by a resident under the supervision of an attending physician;
3. the attending physician must participate in the surgery, which includes direct supervision and control of the procedure; or
4. the operative note must identify the resident surgeon as a resident and must indicate in the narrative that the attending surgeon was present during the entire procedure.

When the surgery is performed by a resident-attending physician team under these conditions, the attending physician may bill and be paid for the surgery. Modifier GC or GR should be appended in this circumstance.

## NON-PHYSICIAN PRACTITIONERS

When authorized by the employer or insurance carrier, a nurse practitioner or physician assistant may provide services to injured workers. Payment to these non-physician practitioners is determined by multiplying the maximum allowable payment (MAP) amounts listed in the Schedule by a service level adjustment factor (SLAF) of .85. Incident-to guidelines are not applicable to services rendered under the 2015 *South Carolina Workers' Compensation Medical Services Provider Manual*.

When a service is provided by a nurse practitioner, physician assistant, or certified nurse specialist, the service must be reported by adding state-specific modifier AL to the appropriate CPT code.

## WOUND REPAIR AND SUTURE REMOVAL

Payment for wound repair includes the evaluation, routine debridement, materials normally required to perform the procedure (e.g., suture tray), and suture removal. In the rare event that the suture removal is performed by another physician not associated with the initial physician, that physician may be paid for the office visit at the appropriate level of service.

The following policies for reporting wound repairs were adapted from the American Medical Association's CPT book.

Wound repairs are classified as simple, intermediate, or complex.

**Simple Repair:** When a wound involves only the skin and/or superficial tissues and requires simple suturing. (For closure with adhesive strips, only the appropriate office visit is paid.)

**Intermediate Repair:** When a wound involves deeper layers and requires layer closure.

**Complex Repair:** When a wound is more complicated and requires more than layered closure.

The repaired wound(s) should be measured and recorded in centimeters, regardless of configuration such as curved, angular or stellate.

When multiple wounds of the same classification (see above) and anatomic grouping are repaired, add together the lengths of those wounds and report them as a single repair. When multiple wounds of more than one classification or anatomic grouping are repaired, list the more complicated repair as the primary procedure; report the less complicated repair as the secondary procedure by listing it separately and adding modifier 51.

Debridement is considered a separate procedure only when gross contamination requires:

- prolonged cleansing not normally encountered;
- when appreciable amounts of devitalized or contaminated tissue are removed from the wound; or
- when debridement is provided without other definitive procedures.

For extensive debridement of soft tissue and/or bone, see CPT codes 11042–11047.

Report repair of nerves, blood vessels and tendons using codes from the appropriate system (Nervous, Cardiovascular, Musculoskeletal). The repair of these structures include wound repair unless it qualifies as a complex wound, in which case modifier 51 should be appended as appropriate.

## BURNS, LOCAL TREATMENT

1. Procedure code 16000 must be used when billing for treatment of first degree burns when no more than local treatment of the burned surfaces is required.
2. Procedure codes 16020–16030 must be used only when billing for treatment of second and third degree burns.

Major debridement of foreign bodies, grease, epidermis, or necrotic tissue may be billed separately using CPT codes 11000–11047.

In order to accurately identify the proper CPT code (codes 16020–16030) and substantiate the descriptor for billing, the exact percentage of the body surface involved and the degree of the burn must be specified in the proper section on the billing form. Percentage of body surface burned is defined as follows:

- “Small” means less than 5 percent of the body area
- “Medium” means 5–10 percent of the body area (e.g., whole face or whole extremity)
- “Large” means greater than 10 percent of the body area (e.g., more than one extremity)

Any claim submitted that does not indicate the degree of burn and exact percentage of body area involved must be returned to the physician for completion. Grafting of burned areas must be billed separately under the appropriate skin grafting procedures. (See procedure codes 15050–15261.)

## MUSCULOSKELETAL SYSTEM

### Application of Casts and Strapping

The casting and strapping codes are reported:

- for initial treatment to stabilize or protect a fracture, injury, or dislocation;
- when additional restorative treatment not performed at that visit;
- replacement of cast or strapping; or
- patient comfort.

Restorative treatment or procedure(s) rendered by another physician following the application of the initial cast/splint/strap may be reported with a treatment of fracture and/or dislocation code.

A physician who applies the initial cast, strap, or splint and provides all fracture, dislocation, or injury care cannot separately report the application of casts and strapping codes. The first cast/splint or strap application is included in the treatment of a fracture and/or dislocation. Preoperative care does not include temporary casting/splinting and is not



separately reported. Significantly identifiable evaluation and management services provided at the time of the cast application or strapping may be reported.

Casting or strapping without other definitive treatment is reported in addition to the documented level of evaluation and management. The casting or strapping supplies may be reported with the appropriate HCPCS Level II code from Section 9 or code 99070.

Casting and strapping codes include removal of cast or strapping.

## DIAGNOSTIC OR THERAPEUTIC NERVE BLOCKS

When a nerve block is performed for diagnostic or therapeutic purposes, select the appropriate code from CPT codes 62310–62319 or 64400–64530.

## MICROSURGICAL PROCEDURES

When a magnifying loupe or magnifying binoculars are used during a surgical procedure, no additional payment will be made for the use of the magnifying instrument. Only microsurgical techniques requiring the use of operating microscopes may be paid.

## MODIFIERS

The following modifiers are used when reporting surgical services. See *CPT 2015 Appendix A* for a full list of CPT modifiers.

### CPT Modifiers

#### 26 Professional Component

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

#### 47 Anesthesia by Surgeon

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia) **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures.

#### 50 Bilateral Procedure

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

**South Carolina Specific Instruction:** The second (bilateral) procedure is identified by adding modifier 50 to the procedure code.

#### 51 Multiple Procedures

When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated “add-on” codes.

**South Carolina Specific Instruction:** This modifier may be used to report multiple medical procedures performed at the same session, as well as a combination of medical and surgical procedures, or several surgical procedures performed at the same operative session. The second and each subsequent procedure should be valued at the lesser of billed charges or 50 percent of its listed MAP value.

#### 53 Discontinued Procedure

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

#### 58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional 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 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 (eg, unanticipated clinical condition), see modifier 78.

**59 Distinct Procedural Service**

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

**62 Two Surgeons**

When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

**South Carolina Specific Instruction:** Each provider is reimbursed at the lesser of billed charges or 60 percent of the MAP for a total of 120 percent of the MAP.

**66 Surgical Team**

Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professionals, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating

individual with the addition of modifier 66 to the basic procedure number used for reporting services.

**76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional**

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

**77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional**

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

**78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period**

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

**79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period**

The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

**80 Assistant Surgeon**

Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

## HCPCS Modifiers

### **AS Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery**

**South Carolina Specific Instruction:** When a certified physician assistant, nurse practitioner, or certified nurse specialist acts as a surgical assistant, the service must be identified by adding the modifier AS in addition to the modifier 80 to the surgery procedure code. Reimbursement is made at 17 percent of the MAP.

### **GC This service has been performed in part by a resident under the direction of a teaching physician**

### **GR This service was performed in whole or in part by a resident in a department of veterans affairs medical center or clinic, supervised in accordance with VA policy**

### **TC Technical Component**

Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number.

### **XE Separate encounter, a service that is distinct because it occurred during a separate encounter.**

### **XP Separate practitioner, a service that is distinct because it was performed by a different practitioner.**

### **XS Separate structure, a service that is distinct because it was performed on a separate organ/structure.**

### **XU Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.**

## South Carolina State-Specific Modifier

### **AL Nurse practitioner, physician assistant, or certified nurse specialist**

When the service was provided by a nurse practitioner, physician assistant, or certified nurse specialist, modifier AL must be added to the CPT code for the service rendered.

**SURGERY****10021–69990****Medical Fee Schedule****Effective September 1, 2015**

	<b>CODE</b>	<b>DESCRIPTION</b>	<b>MAP NON FAC</b>	<b>MAP FAC</b>	<b>FUD</b>	<b>ASST</b>	
	<b>10021</b>	Fine needle aspiration; without imaging guidance	196.50	95.00	000	0	
	<b>10022</b>	with imaging guidance	187.50	91.00	000	0	
⊙	<b>10030</b>	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous	1016.00	214.00	000	0	
	<b>10040</b>	Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)	134.50	118.00	010	1	
	<b>10060</b>	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	155.00	130.00	010	1	
	<b>10061</b>	complicated or multiple	272.66	238.71	010	1	
	<b>10080</b>	Incision and drainage of pilonidal cyst; simple	235.00	138.00	010	1	
	<b>10081</b>	complicated	354.50	229.00	010	1	
	<b>10120</b>	Incision and removal of foreign body, subcutaneous tissues; simple	198.20	136.88	010	1	
	<b>10121</b>	complicated	361.50	250.50	010	1	
	<b>10140</b>	Incision and drainage of hematoma, seroma or fluid collection	216.00	159.00	010	1	
	<b>10160</b>	Puncture aspiration of abscess, hematoma, bulla, or cyst	172.00	129.00	010	1	
	<b>10180</b>	Incision and drainage, complex, postoperative wound infection	324.00	239.00	010	1	
	<b>11000</b>	Debridement of extensive eczematous or infected skin; up to 10% of body surface	72.50	39.50	000	1	
+	<b>11001</b>	each additional 10% of the body surface, or part thereof (List separately in addition to code for primary procedure)	28.00	19.50	000	1	
	<b>11004</b>	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum	791.00	791.00	000	1	
	<b>11005</b>	abdominal wall, with or without fascial closure	1063.00	1063.00	000	0	
	<b>11006</b>	external genitalia, perineum and abdominal wall, with or without fascial closure	957.50	957.50	000	1	
+	<b>11008</b>	Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)	374.00	374.00	000	0	
	<b>11010</b>	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues	647.00	378.00	010	1	
	<b>11011</b>	skin, subcutaneous tissue, muscle fascia, and muscle	695.50	403.00	000	1	
	<b>11012</b>	skin, subcutaneous tissue, muscle fascia, muscle, and bone	936.00	573.50	000	1	
	<b>11042</b>	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	107.31	64.61	000	1	
	<b>11043</b>	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less	343.00	297.75	000	1	
	<b>11044</b>	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	473.32	409.97	000	1	
+	#	<b>11045</b>	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	55.00	35.50	000	0
+	#	<b>11046</b>	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	97.00	76.00	000	0
+		<b>11047</b>	each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	165.50	135.00	000	0

## NEUROLOGY AND NEUROMUSCULAR SERVICES

Neurologic services are typically consultation services and any of the five levels of consultation may be appropriate.

Diagnostic studies (nerve conduction tests, electromyograms, electroencephalograms, etc.) may be paid in addition to the office visit or consultative service. A diagnostic study includes both a technical component (equipment, technical personnel, supplies, etc.) and a professional component (interpreting test results, written report, etc.).

When the professional and technical components are performed separately, use modifier 26 to indicate the professional component, or modifier TC to indicate the technical component. Billing the CPT neurological and neuromuscular service codes with no modifier indicates that the complete service (professional and technical components) was provided.

When diagnostic services are provided at a hospital or ambulatory surgical center (ASC), that will be billing for the technical component, the professional service must be billed with the modifier 26. The physician will be paid only for the professional component.

## EXTREMITY TESTING, MUSCLE TESTING, AND RANGE OF MOTION (ROM) MEASUREMENTS

See Section 7, Physical Medicine for complete details.

## ELECTROMYOGRAPHY (EMG)

Payment for electromyography (EMG) services includes the initial set of electrodes and all supplies necessary to perform the service. Additional sets of electrodes and supplies and materials provided by the physician over and above those usually included with the service may be paid. Use the appropriate code from Section 9, HCPCS Level II, to report the supply. In the event that a supply cannot be identified using the codes listed in Section 9, use CPT code 99070 and price the item at actual cost plus 20 percent. (See Supplies in Chapters III and IV for additional information.)

When a physician provides only the interpretation of an EMG performed in a hospital or other facility that will be billing for the technical services, modifier 26 must be added to the service code signifying that the physician is billing only for the professional component of the procedure.

Physicians may be paid for both an initial (new patient) visit or consultation and an EMG performed on the same day. When an EMG is performed on the same day as a follow-up (established patient) visit or consultation, payment may be made for the visit only when documentation of medical

necessity substantiates the need for the E/M services in addition to the EMG.

## NERVE CONDUCTION STUDIES (CPT CODES 95905–95913)

A nerve conduction study is the assessment of the motor and sensory functions of a nerve in an extremity. Nerve conduction studies may include comparison studies when documented as medically necessary.

Providers may be paid for all procedures that are necessary to complete a single nerve conduction study.

Physicians may be paid for both an initial (new patient) visit/consultation and nerve conduction studies performed at the same visit. When a nerve conduction study is performed on the same day as a follow-up (established patient) visit/consultation, payment for the visit/consultation may be made only when documentation of medical necessity substantiates the need for the visit services in addition to the nerve conduction study.

## OPHTHALMOLOGICAL SERVICES

Ophthalmological services cover numerous highly specialized procedures for the treatment of workers with on-the-job injuries or work-related illnesses. Included are prescriptive and diagnostic services and specific supplies and materials that may be required in treatment.

If the service provided does not equal the scope of the descriptor for a specific ophthalmology service code, the provider should use a general medicine service code or surgical service code that more clearly describes the service provided.

### Payment of Ophthalmologic Supplies

The provision of spectacles or contact lenses, including the prescription, the fitting, and the supply of materials, may be paid only when the spectacles/contacts were damaged or lost as the result of an on-the-job injury or accident, or are required for the treatment of an on-the-job injury or work-related illness. The provision of replacement frames is limited to frames of comparable quality to the original frames.

## INJECTABLE PHARMACEUTICALS

Payment for injection codes includes the supplies usually required to perform the procedure, but not the medications. Injections are classified as either subcutaneous, intramuscular, or intravenous. Subcutaneous (SC) injections and intramuscular (IM) injections are billed using CPT code 96372; and intravenous (IV) injections are billed using CPT

code 96374. Each of these CPT codes has been assigned a basic MAP amount, as listed in the Schedule.

When an injection is given during an E/M service, the cost of providing the injection is included in the payment for the E/M service and must not be billed or paid separately. The cost of the injectable pharmaceutical may be billed using the appropriate HCPCS code listed in this section. If a HCPCS code for the injectable pharmaceutical does not exist, use CPT code 99070 and price the drug at its average wholesale price (AWP) as contained in the current edition of *Medi-Span* published by Wolters Kluwer Health.

When the injection is provided without an E/M service, and only the injection will be billed for that date of service, the injection and the medication should be listed separately on the claim form. Report the injection by entering the appropriate CPT injection code, and report the medication as described in the paragraph above. The reimbursement for the injection is the lesser of billed charges or the MAP amount. The charge for the injectable pharmaceutical is determined by the HCPCS code or the average wholesale price (AWP) as published in the current edition of *Medi-Span*. Total reimbursement for the injection is the lesser of billed charges or the basic MAP amount plus the cost of the pharmaceutical.

Anesthetic agents such as Xylocaine and Carbocaine used for local infiltration are included in the payment for the procedure and will not be paid separately.

## MODIFIERS

The following modifiers are used when reporting medicine services. See *CPT 2015* Appendix A for a full list of CPT modifiers.

### CPT Modifiers

#### 26 Professional Component

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

#### 52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

#### 53 Discontinued Procedure

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

### HCPCS Modifiers

#### AH Clinical Psychologist

**South Carolina Specific Instruction:** When the service was rendered by a clinical psychologist or other non-Ph.D. provider, the modifier AH must be added to the CPT code for the service rendered.

#### AJ Clinical Social Worker

**South Carolina Specific Instruction:** When the service was rendered by a clinical social worker, the modifier AJ must be added to the CPT code for the service rendered.

#### AS Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist Services for Assistant at Surgery

**South Carolina Specific Instruction:** When a certified physician assistant, nurse practitioner, or certified nurse specialist acts as a surgical assistant, the service must be identified by adding modifier AS. Reimbursement is made at 17 percent of the MAP.

For muscle testing, range of joint motion, or electromyography, use CPT codes 95831–95875. (See Section 6, Medicine for more information.) For biofeedback training by EMG use code 90901 (Section 8, subsection Psychological and Biofeedback Services). For TENS use code 64550.

## MULTIPLE PROCEDURE REDUCTION

Multiple procedure reduction guidelines do not apply to the codes in the Physical Medicine section. It is inappropriate to report the physical medicine codes with modifier 51 or to reduce the MAP amount for second and subsequent procedures reported on the same or different dates of service.

## MODIFIERS

The following modifiers are used when reporting physical medicine services. See *CPT 2015* Appendix A for a full list of CPT modifiers.

### CPT Modifiers

#### 52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional.

Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

#### 53 Discontinued Procedure

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

## PHYSICAL MEDICINE

95831–95852, 97001–97546, 97750–97799, 98925–98943

## Medical Fee Schedule

Effective September 1, 2015

CODE	DESCRIPTION	MAP NON FAC	MAP FAC	FUD	ASST
95831	Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk	40.50	20.50	000	0
95832	hand, with or without comparison with normal side	40.00	22.00	000	0
95833	total evaluation of body, excluding hands	49.28	29.50	000	0
95834	total evaluation of body, including hands	65.70	43.00	000	0
95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)	24.50	10.50	000	0
95852	hand, with or without comparison with normal side	21.50	8.00	000	0
Ⓜ 97001	Physical therapy evaluation	101.00	101.00	000	0
Ⓜ 97002	Physical therapy re-evaluation	56.50	56.50	000	0
Ⓜ 97003	Occupational therapy evaluation	114.00	114.00	000	0
Ⓜ 97004	Occupational therapy re-evaluation	70.00	70.00	000	0
Ⓜ 97010	Application of a modality to 1 or more areas; hot or cold packs	NC	NC	000	9
Ⓜ 97012	traction, mechanical	21.50	21.50	000	0
Ⓜ 97014	electrical stimulation (unattended)	21.00	21.00	000	9
Ⓜ 97016	vasopneumatic devices	25.50	25.50	000	0
Ⓜ 97018	paraffin bath	14.24	14.24	000	0
Ⓜ 97022	whirlpool	30.50	30.50	000	0
Ⓜ 97024	diathermy (eg, microwave)	8.50	8.50	000	0
Ⓜ 97026	infrared	8.00	8.00	000	0
Ⓜ 97028	ultraviolet	10.00	10.00	000	0
Ⓜ 97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	25.50	25.50	000	0
Ⓜ 97033	iontophoresis, each 15 minutes	43.00	43.00	000	0
Ⓜ 97034	contrast baths, each 15 minutes	24.00	24.00	000	0
Ⓜ 97035	ultrasound, each 15 minutes	17.00	17.00	000	0
Ⓜ 97036	Hubbard tank, each 15 minutes	44.00	44.00	000	0
97039	Unlisted modality (specify type and time if constant attendance)	IC	IC	000	0
Ⓜ 97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	43.50	43.50	000	0
Ⓜ 97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	44.50	44.50	000	0
Ⓜ 97113	aquatic therapy with therapeutic exercises	57.00	57.00	000	0
Ⓜ 97116	gait training (includes stair climbing)	38.00	38.00	000	0
Ⓜ 97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	35.50	35.50	000	0
97139	Unlisted therapeutic procedure (specify)	IC	IC	000	0
Ⓜ 97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	40.00	40.00	000	0
Ⓜ 97150	Therapeutic procedure(s), group (2 or more individuals)	24.44	24.44	000	0
Ⓜ 97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	46.50	46.50	000	0
Ⓜ 97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes	36.00	36.00	000	0