Optum

Coding &
Payment Guide

Physical Therapy/ Rehabilitation/ Physical Medicine

For physical, occupational and speech therapy, rehabilitation and physical medicine

2025

optumcoding.com

Contents

Getting Started with Coding and Payment Guide

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

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

CPT/HCPCS Codes

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

Resequencing of CPT Codes

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

ICD-10-CM

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

Appendix Codes and Descriptions

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

CCI Edits, RVUs, and Other Coding Updates

The *Optum Coding and Payment Guide* includes the list of codes from the official Centers for Medicare and Medicaid Services' *National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from the version 29.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is https://www.optumcoding.com/ ProductUpdates/. The 2025 edition password is: **XXXXXX**. Log in frequently to ensure you receive the most current updates.

Index

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

For example:

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

Ankle
Strapping, 29540

or

Strapping
Ankle, 29540

General Guidelines

Providers

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

Sample Page and Key

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

94660

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

Explanation

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

Coding Tips

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

Documentation Tips

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

Reimbursement Tips

Coverage may be limited to therapists specializing in the care of pulmonary patients in specific settings. 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
J44.81	Bronchiolitis obliterans and bronchiolitis obliterans syndrome
J44.89	Other specified chronic obstructive pulmonary disease
J44.9	Chronic obstructive pulmonary disease, unspecified
J80	Acute respiratory distress syndrome
J81.0	Acute pulmonary edema
J95.87	Transfusion-associated dyspnea (TAD)
J96.01	Acute respiratory failure with hypoxia
J96.02	Acute respiratory failure with hypercapnia
M96.A4	Flail chest associated with chest compression and cardiopulmonary resuscitation
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
P28.31	Primary central sleep apnea of newborn
P28.32	Primary obstructive sleep apnea of newborn
P28.33	Primary mixed sleep apnea of newborn
P28.41	Central neonatal apnea of newborn
P28.42	Obstructive apnea of newborn
P28.43	Mixed neonatal apnea of newborn
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** 2022,Dec; 2022,Jun; 2022,Jan; 2020,Dec; 2019,Aug; 20 r

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
94660	0.76	1.06	0.06	1.88
Facility RVU	**Work**	**PE**	**MP**	**Total**
94660	0.76	0.27	0.06	1.09

	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

BiPAP. Bilevel positive airway pressure. Noninvasive mechanical ventilation. BiPAP consists of continuous positive airway pressure (CPAP) and pressure support ventilation.

CPAP. Continuous positive airway pressure. Respiratory modality used in the treatment of breathing difficulties or lung disease. Constantly pressurized air and oxygen are delivered to the lungs by a nasal cannula, facemask, or endotracheal tube, and may be administered with or without a ventilator. The lungs are kept partially inflated between breaths, making breathing less difficult.

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).

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding and Payment Guide for Physical Therapy/Rehabilitation/Physical Medicine* is updated with CPT codes for year 2024. The following icons are used in the *Coding and Payment Guide*:

- ● This CPT code is new for 2024.
- ▲ This CPT code description is revised for 2024.
- ✚ This CPT code is an add-on code.
- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services.
- [ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same provider on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice. The 97000 series contains the codes most often used by physical/occupational therapists and physical/occupational therapist assistants, many of which are timed codes (each 15 minutes) that do not include add-on codes. Physical/occupational therapists also use codes outside the 97000 series that do use add-on codes. Other rehabilitation/physical medicine providers may also use these 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 Therapy/Rehabilitation/Physical Medicine*, a step-by-step clinical description of the procedure is provided, in simple terms. Technical language that might be used by the physical/occupational therapist or speech-language pathologist is included and defined. *Coding and Payment Guide for Physical Therapy/Rehabilitation/Physical Medicine* describes the most common method of performing each procedure.

3. Coding Tips

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

4. Documentation Tips

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

5. Reimbursement Tips

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

6. ICD-10-CM Diagnostic Codes

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

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

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

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

7. Associated HCPCS Codes

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

8. AMA References

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

9. Relative Value Units/Medicare Edits

The 2024 Medicare edits were not available at the time this book went to press. Updated 2024 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2025 edition password is **XXXXXX**.

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)

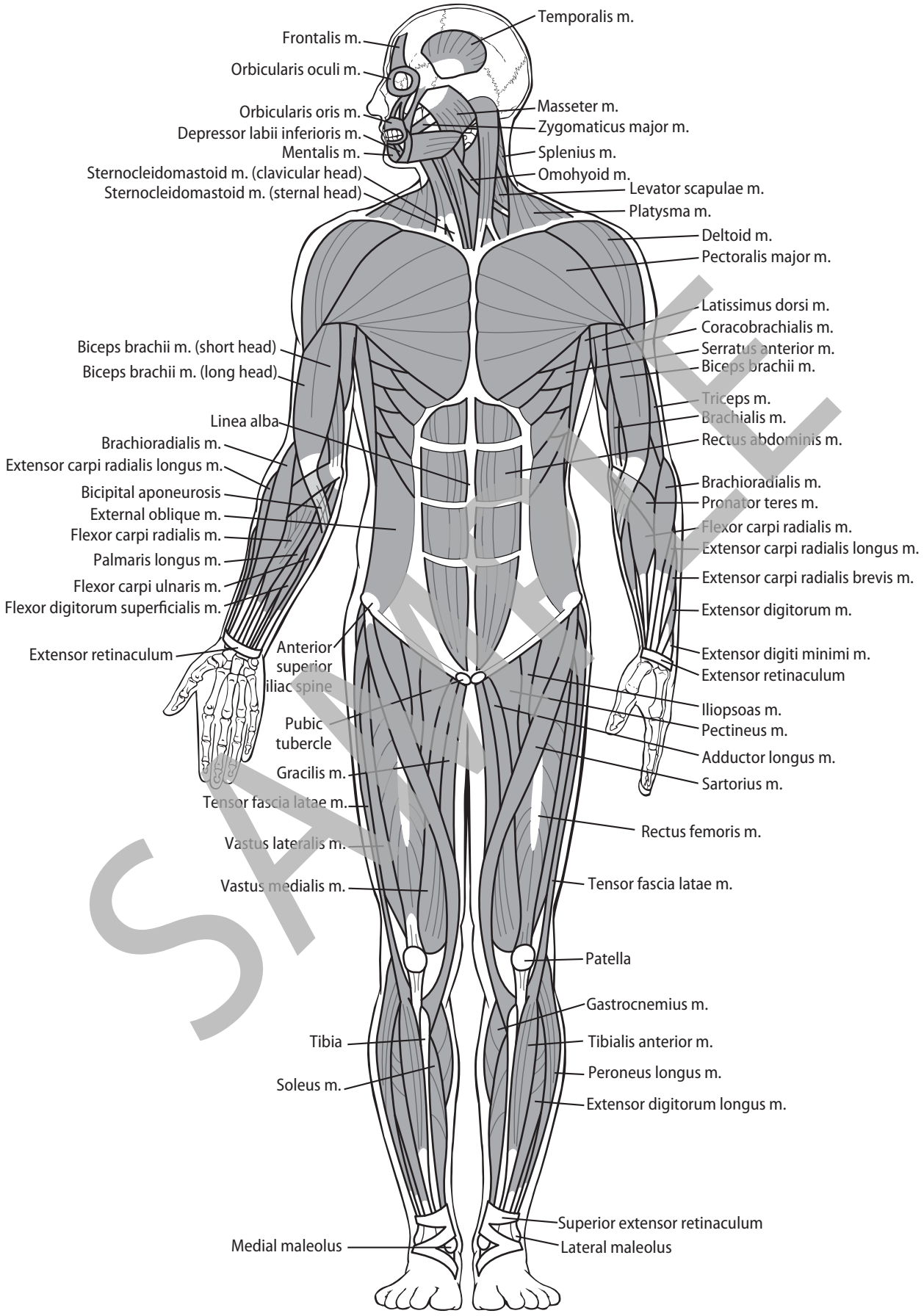
Information on the Medicare global period is provided here, even though it is not relevant to therapists' coding. These services, then, have a value of 0. The global period includes all the necessary services normally furnished before, during, and after a procedure. This includes preoperative visits 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
- X Statutory exclusion—no RVUs or payment

Muscles



Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

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

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

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

Classification of Evaluation and Management (E/M) Services

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

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

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

New and Established Patients

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

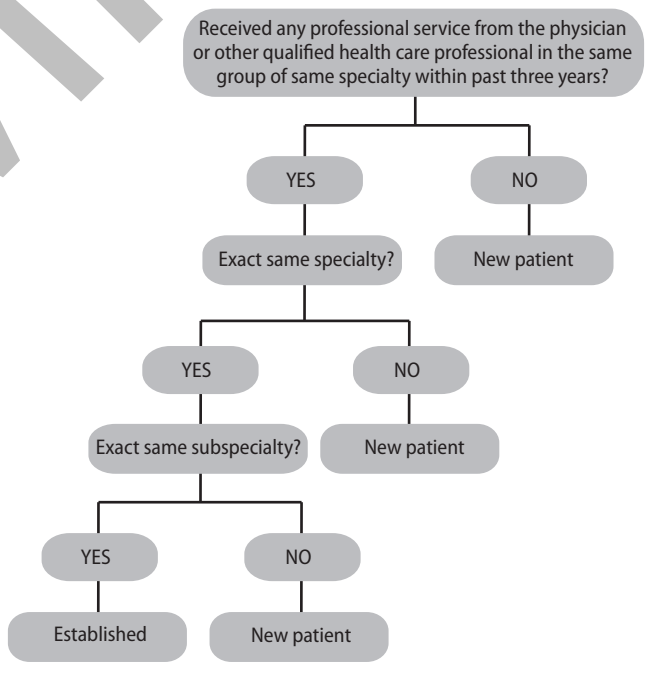
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the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

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

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

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

Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or

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

▶ ◀ = Contains new or revised text

99202-99205

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

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

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

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

Explanation

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

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternatively, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. Medicare and the CPT code book have identified these codes as telehealth/telemedicine services. Telemedicine services may be reported by the performing provider by adding modifier 95 to the procedure code and/or using the appropriate place-of-service (POS) indicator; POS 02 for telehealth when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. For prolonged services applicable to 99205, see 99417; for Medicare, see G2212. Medicare and commercial payers should be contacted regarding their coverage guidelines. For office or other outpatient services for an established patient, see 99211–99215.

Documentation Tips

Medicare allows only the medically necessary portion of the visit. Although not used to determine code selection, the history and exam performed should be documented. Medical decision making performed should be documented, and only the necessary services for the condition of the patient at the time of the visit can be considered in determining the level of an E/M code. Medical necessity must be clearly stated and support the level of service reported.

Reimbursement Tips

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

ICD-10-CM Diagnostic Codes

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

AMA: **99202** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99203** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99204** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99205** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun

 ● New ▲ Revised + Add On ★ Telemedicine AMA: CPT Assist [Resequenced] ☑ Laterality

20550-20551

20550 Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")

20551 single tendon origin/insertion

Explanation

The practitioner injects a therapeutic agent into a single tendon sheath, or ligament, aponeurosis such as the plantar fascia in 20550 and into a single tendon origin/insertion site in 20551. The practitioner identifies the injection site by palpation or radiographs (reported separately) and marks the injection site. The needle is inserted and the medicine is injected. After the needle is withdrawn, the patient is monitored for reactions to the therapeutic agent.

Coding Tips

Report 20550 and 20551 one time only for single or multiple injections to a single tendon sheath, ligament, aponeurosis, or tendon origin/insertion. For trigger point injections, see 20552–20553. For aspiration or injection of a ganglion cyst, see 20612. When documentation indicates that the physician injected a Morton's neuroma, see 64455 or 64632. Never use codes 20550–20551 to indicate "dry needling"; see 20560–20561. Do not report 20550 or 20551 with 0232T or 0481T. Report the drug used with the appropriate HCPCS Level II code when performed in the physician office.

Documentation Tips

Medical record documentation should include the location of the injection to identify it as a tendon sheath, ligament, aponeurosis, or tendon origin/insertion. The medical record should indicate the drug that was injected and the dosage.

Reimbursement Tips

Coverage of this procedure varies by payer. Some payers limit the number of injections that can be performed within a specified time period. Check with the payer for specific coverage guidelines.

ICD-10-CM Diagnostic Codes

D86.86 Sarcoid arthropathy
D86.87 Sarcoid myositis
G89.0 Central pain syndrome
G89.11 Acute pain due to trauma
G89.12 Acute post-thoracotomy pain
G89.21 Chronic pain due to trauma
G89.22 Chronic post-thoracotomy pain
G89.4 Chronic pain syndrome
M04.1 Periodic fever syndromes
M04.2 Cryopyrin-associated periodic syndromes
M25.511 Pain in right shoulder ☑
M25.521 Pain in right elbow ☑
M25.531 Pain in right wrist ☑
M25.541 Pain in joints of right hand ☑
M25.551 Pain in right hip ☑
M25.561 Pain in right knee ☑
M25.571 Pain in right ankle and joints of right foot ☑
M65.011 Abscess of tendon sheath, right shoulder ☑
M65.021 Abscess of tendon sheath, right upper arm ☑
M65.031 Abscess of tendon sheath, right forearm ☑
M65.041 Abscess of tendon sheath, right hand ☑
M65.051 Abscess of tendon sheath, right thigh ☑
M65.061 Abscess of tendon sheath, right lower leg ☑
M65.071 Abscess of tendon sheath, right ankle and foot ☑
M65.08 Abscess of tendon sheath, other site
M65.221 Calcific tendinitis, right upper arm ☑
M65.231 Calcific tendinitis, right forearm ☑
M65.241 Calcific tendinitis, right hand ☑
M65.251 Calcific tendinitis, right thigh ☑
M65.261 Calcific tendinitis, right lower leg ☑
M65.271 Calcific tendinitis, right ankle and foot ☑
M65.311 Trigger thumb, right thumb ☑
M65.321 Trigger finger, right index finger ☑
M65.331 Trigger finger, right middle finger ☑
M65.341 Trigger finger, right ring finger ☑
M65.351 Trigger finger, right little finger ☑
M65.4 Radial styloid tenosynovitis [de Quervain]
M66.211 Spontaneous rupture of extensor tendons, right shoulder ☑
M66.221 Spontaneous rupture of extensor tendons, right upper arm ☑
M66.231 Spontaneous rupture of extensor tendons, right forearm ☑
M66.241 Spontaneous rupture of extensor tendons, right hand ☑
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 ☑
M66.28 Spontaneous rupture of extensor tendons, other site
M66.29 Spontaneous rupture of extensor tendons, multiple sites
M66.311 Spontaneous rupture of flexor tendons, right shoulder ☑
M66.321 Spontaneous rupture of flexor tendons, right upper arm ☑
M66.331 Spontaneous rupture of flexor tendons, right forearm ☑
M66.341 Spontaneous rupture of flexor tendons, right hand ☑
M66.351 Spontaneous rupture of flexor tendons, right thigh ☑
M66.361 Spontaneous rupture of flexor tendons, right lower leg ☑
M66.371 Spontaneous rupture of flexor tendons, right ankle and foot ☑
M66.38 Spontaneous rupture of flexor tendons, other site
M66.39 Spontaneous rupture of flexor tendons, multiple sites
M66.811 Spontaneous rupture of other tendons, right shoulder ☑
M66.821 Spontaneous rupture of other tendons, right upper arm ☑
M66.831 Spontaneous rupture of other tendons, right forearm ☑
M66.841 Spontaneous rupture of other tendons, right hand ☑
M66.851 Spontaneous rupture of other tendons, right thigh ☑
M66.861 Spontaneous rupture of other tendons, right lower leg ☑
M66.871 Spontaneous rupture of other tendons, right ankle and foot ☑
M66.88 Spontaneous rupture of other tendons, other sites
M66.89 Spontaneous rupture of other tendons, multiple sites
M67.311 Transient synovitis, right shoulder ☑
M67.321 Transient synovitis, right elbow ☑
M67.331 Transient synovitis, right wrist ☑
M67.341 Transient synovitis, right hand ☑
M67.351 Transient synovitis, right hip ☑
M67.361 Transient synovitis, right knee ☑
M67.371 Transient synovitis, right ankle and foot ☑
M67.38 Transient synovitis, other site
M67.39 Transient synovitis, multiple sites
M70.031 Crepitant synovitis (acute) (chronic), right wrist ☑

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

29130-29131

29130 Application of finger splint; static

29131 dynamic

Explanation

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

Coding Tips

According to CPT guidelines, the application and removal of the first cast, splint, or traction device are included in the codes that appear in the Musculoskeletal System section of the CPT book. Supplies may be reported separately. Modifier 56 should not be reported for preoperative management of a fracture. Removal of a cast by a provider, other than the provider who applied the cast, can be reported with cast removal codes 29700, 29705, and 29710. Cast, splint, or strapping (29000-29750) and/or traction device (20690, 20692) replacement during or after the global period of a procedure may be reported separately.

The Musculoskeletal System section of the CPT book is generally arranged according to body region. Physical/occupational 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 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 second and subsequent therapy services is paid at 50 percent. The "always therapy services" have modified guidelines; 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 reported separately.

ICD-10-CM Diagnostic Codes

M20.001 Unspecified deformity of right finger(s) ☑
M20.011 Mallet finger of right finger(s) ☑
M20.021 Boutonniere deformity of right finger(s) ☑
M20.031 Swan-neck deformity of right finger(s) ☑
M20.091 Other deformity of right finger(s) ☑
M24.444 Recurrent dislocation, right finger ☑
M24.841 Other specific joint derangements of right hand, not elsewhere classified ☑
M65.311 Trigger thumb, right thumb ☑
M65.321 Trigger finger, right index finger ☑
M65.331 Trigger finger, right middle finger ☑
M65.341 Trigger finger, right ring finger ☑
M65.351 Trigger finger, right little finger ☑
M72.0 Palmar fascial fibromatosis [Dupuytren] A
M80.041A Age-related osteoporosis with current pathological fracture, right hand, initial encounter for fracture A ☑
M84.341A Stress fracture, right hand, initial encounter for fracture ☑
M84.344A Stress fracture, right finger(s), initial encounter for fracture ☑
M84.441A Pathological fracture, right hand, initial encounter for fracture ☑
S63.280A Dislocation of proximal interphalangeal joint of right index finger, initial encounter ☑
S63.282A Dislocation of proximal interphalangeal joint of right middle finger, initial encounter ☑
S63.284A Dislocation of proximal interphalangeal joint of right ring finger, initial encounter ☑
S63.286A Dislocation of proximal interphalangeal joint of right little finger, initial encounter ☑
S63.290A Dislocation of distal interphalangeal joint of right index finger, initial encounter ☑
S63.292A Dislocation of distal interphalangeal joint of right middle finger, initial encounter ☑
S63.294A Dislocation of distal interphalangeal joint of right ring finger, initial encounter ☑
S63.296A Dislocation of distal interphalangeal joint of right little finger, initial encounter ☑
S63.621A Sprain of interphalangeal joint of right thumb, initial encounter ☑
S63.630A Sprain of interphalangeal joint of right index finger, initial encounter ☑
S63.632A Sprain of interphalangeal joint of right middle finger, initial encounter ☑
S63.634A Sprain of interphalangeal joint of right ring finger, initial encounter ☑
S63.636A Sprain of interphalangeal joint of right little finger, initial encounter ☑
S63.638A Sprain of interphalangeal joint of other finger, initial encounter
S63.641A Sprain of metacarpophalangeal joint of right thumb, initial encounter ☑
S63.650A Sprain of metacarpophalangeal joint of right index finger, initial encounter ☑
S63.652A Sprain of metacarpophalangeal joint of right middle finger, initial encounter ☑
S63.654A Sprain of metacarpophalangeal joint of right ring finger, initial encounter ☑

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

64450

64450 Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch

Explanation

The practitioner injects one or more anesthetic agents and/or steroids near an affected peripheral nerve or branch to control pain and inflammation or to aid in diagnosis and treatment. The practitioner draws an anesthetic agent and/or steroid into a syringe and injects it into the targeted area. This code is used to report nerve blocks of other nerves not specifically listed in this section.

Coding Tips

Report imaging guidance and localization separately if utilized.

For anesthetic agent injection of nerves innervating the sacroiliac joint, see 64451.

This code should be reported only once for each nerve plexus, nerve, or branch, even if multiple injections are performed in the same area.

Documentation Tips

Medical record documentation should clearly indicate the nerve injected and the substance administered. If imaging guidance is used, the type of guidance should be documented.

Reimbursement Tips

Code 64450 describes a unilateral procedure. If the procedure is performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code, while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image).

ICD-10-CM Diagnostic Codes

G43.701	Chronic migraine without aura, not intractable, with status migrainosus
G43.709	Chronic migraine without aura, not intractable, without status migrainosus
G43.711	Chronic migraine without aura, intractable, with status migrainosus
G43.719	Chronic migraine without aura, intractable, without status migrainosus
G56.01	Carpal tunnel syndrome, right upper limb ☑
G56.02	Carpal tunnel syndrome, left upper limb ☑
G89.0	Central pain syndrome
G89.11	Acute pain due to trauma
G89.12	Acute post-thoracotomy pain
G89.18	Other acute postprocedural pain
G89.21	Chronic pain due to trauma
G89.22	Chronic post-thoracotomy pain
G89.28	Other chronic postprocedural pain
G89.29	Other chronic pain
G89.3	Neoplasm related pain (acute) (chronic)
G89.4	Chronic pain syndrome
M25.561	Pain in right knee ☑
M25.562	Pain in left knee ☑
M25.59	Pain in other specified joint
M54.2	Cervicalgia
M54.51	Vertebrogenic low back pain
M54.81	Occipital neuralgia

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: 64450 2023,Jan; 2022,Dec; 2022,Jul; 2022,May; 2021,Mar; 2021,Feb; 2019,Nov; 2018,Nov

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
64450	0.75	1.41	0.08	2.24
Facility RVU	**Work**	**PE**	**MP**	**Total**
64450	0.75	0.41	0.08	1.24

	FUD	Status	MUE	Modifiers				IOM Reference
64450	0	A	10(3)	51	50	N/A	N/A	None

* with documentation

Terms To Know

nerve block. Regional anesthesia/analgesia administered by injection that prevents sensory nerve impulses from reaching the central nervous system.

plexus. Bundle of nerves that serve a particular region of the body that lies relatively deep in the body as opposed to superficial nerves, which are close to the surface of the skin.

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

94150

94150 Vital capacity, total (separate procedure)

Explanation

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

Coding Tips

Laboratory procedures and interpretations of test results are included. Do not report 94150 in addition to spirometry (94010), bronchodilation responsiveness (94060), or airway resistance by impulse oscillometry (94728).

Assign the appropriate evaluation or re-evaluation code (97161–97164, 97165–97168, 97169–97172) when the medical record documentation supports the medical necessity of both services.

Documentation Tips

Documentation may include terms such as pink puffer (a descriptor for a patient with COPD and severe emphysema, who has a pink complexion and dyspnea) or blue bloater (a descriptor to indicate the appearance of a patient with COPD who has symptoms of chronic bronchitis). Verify the condition before assigning a code for emphysema.

Reimbursement Tips

Coverage may be limited to therapists specializing in the care of pulmonary patients in specific settings. Procedure 94150 has 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.

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

ICD-10-CM Diagnostic Codes

A15.0	Tuberculosis of lung
A15.4	Tuberculosis of intrathoracic lymph nodes
A15.7	Primary respiratory tuberculosis
B44.81	Allergic bronchopulmonary aspergillosis
B95.3	Streptococcus pneumoniae as the cause of diseases classified elsewhere
C34.01	Malignant neoplasm of right main bronchus ☑
C34.11	Malignant neoplasm of upper lobe, right bronchus or lung ☑
C34.2	Malignant neoplasm of middle lobe, bronchus or lung
C34.31	Malignant neoplasm of lower lobe, right bronchus or lung ☑
C34.81	Malignant neoplasm of overlapping sites of right bronchus and lung ☑
E84.0	Cystic fibrosis with pulmonary manifestations
J43.0	Unilateral pulmonary emphysema [MacLeod's syndrome]
J43.1	Panlobular emphysema
J43.2	Centrilobular emphysema
J43.8	Other emphysema
J44.0	Chronic obstructive pulmonary disease with (acute) lower respiratory infection
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J44.81	Bronchiolitis obliterans and bronchiolitis obliterans syndrome
J44.89	Other specified chronic obstructive pulmonary disease
J45.40	Moderate persistent asthma, uncomplicated
J45.41	Moderate persistent asthma with (acute) exacerbation
J45.42	Moderate persistent asthma with status asthmaticus
J45.50	Severe persistent asthma, uncomplicated
J45.51	Severe persistent asthma with (acute) exacerbation
J45.52	Severe persistent asthma with status asthmaticus
J82.81	Chronic eosinophilic pneumonia
J82.82	Acute eosinophilic pneumonia
J82.83	Eosinophilic asthma
J82.89	Other pulmonary eosinophilia, not elsewhere classified
J84.170	Interstitial lung disease with progressive fibrotic phenotype in diseases classified elsewhere
J84.178	Other interstitial pulmonary diseases with fibrosis in diseases classified elsewhere
J95.87	Transfusion-associated dyspnea (TAD)
M35.02	Sjögren syndrome with lung involvement
R05.1	Acute cough
R05.2	Subacute cough
R05.3	Chronic cough
R05.4	Cough syncope
R05.8	Other specified cough

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: **94150** 2020,Dec; 2019,Mar; 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
94150	0.07	0.65	0.02	0.74
Facility RVU	**Work**	**PE**	**MP**	**Total**
94150	0.07	0.65	0.02	0.74

	FUD	Status	MUE	Modifiers				IOM Reference
94150	N/A	B	0(3)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

COPD. Chronic obstructive pulmonary disease.

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

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

95905

95905 Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report

Explanation

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

Coding Tips

Do not report 95905 in addition to needle electromyography of the extremities with nerve conduction amplitude and latency/velocity studies (95885-95886) or nerve conduction studies (95907-95913).

This code includes interpretation of the findings and preparation of the report.

Documentation Tips

Indicate the specific nerve(s) studied.

Documentation should include the latency, amplitude, velocity, and evoked response even when normal.

Examples of motor function examination findings include:

- Dexterity, coordination, and agility
- Electrophysiological integrity
- Hand function
- Initiation, modification, and control of movement patterns and voluntary postures

Examples of muscle performance examination findings include:

- Electrophysiological integrity
- Muscle strength, power, and endurance during functional activities
- Muscle tension

Reimbursement Tips

As exempt from modifier 51, 95905 has not been designated in the CPT book as an add-on service or procedure. However, codes identified as exempt from modifier 51 are not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied.

This service is reported once for each extremity studied. The number of extremities (units) is identified in item 24G of the CMS-1500 claim form or in the appropriate loop of the 837P electronic claim submission.

ICD-10-CM Diagnostic Codes

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
M47.021 Vertebral artery compression syndromes, occipito-atlanto-axial region
M47.022 Vertebral artery compression syndromes, cervical region
M47.811 Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region
M47.812 Spondylosis without myelopathy or radiculopathy, cervical region
M47.813 Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814 Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815 Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816 Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817 Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818 Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M47.891 Other spondylosis, occipito-atlanto-axial region
M48.01 Spinal stenosis, occipito-atlanto-axial region
M48.02 Spinal stenosis, cervical region
M48.03 Spinal stenosis, cervicothoracic region
M48.05 Spinal stenosis, thoracolumbar region
M48.061 Spinal stenosis, lumbar region without neurogenic claudication
M48.062 Spinal stenosis, lumbar region with neurogenic claudication
M48.07 Spinal stenosis, lumbosacral region
M48.08 Spinal stenosis, sacral and sacrococcygeal region
M48.31 Traumatic spondylopathy, occipito-atlanto-axial region
M48.32 Traumatic spondylopathy, cervical region
M48.33 Traumatic spondylopathy, cervicothoracic region
M48.35 Traumatic spondylopathy, thoracolumbar region
M48.36 Traumatic spondylopathy, lumbar region
M48.37 Traumatic spondylopathy, lumbosacral region
M48.38 Traumatic spondylopathy, sacral and sacrococcygeal region
M50.01 Cervical disc disorder with myelopathy, high cervical region
M50.021 Cervical disc disorder at C4-C5 level with myelopathy
M50.022 Cervical disc disorder at C5-C6 level with myelopathy
M50.023 Cervical disc disorder at C6-C7 level with myelopathy
M50.03 Cervical disc disorder with myelopathy, cervicothoracic region
M50.11 Cervical disc disorder with radiculopathy, high cervical region
M50.121 Cervical disc disorder at C4-C5 level with radiculopathy
M50.122 Cervical disc disorder at C5-C6 level with radiculopathy
M50.123 Cervical disc disorder at C6-C7 level with radiculopathy
M50.13 Cervical disc disorder with radiculopathy, cervicothoracic region
M51.05 Intervertebral disc disorders with myelopathy, thoracolumbar region
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

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

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 reported in multiple 15-minute units.

Coding Tips

This modality requires direct (one-to-one) patient contact by the physical/occupational 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 reported. For transcutaneous magnetic stimulation of peripheral nerves, see 0766T–0767T.

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 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 therapist.

Medical record documentation should indicate the total amount of time for the direct one-to-one patient contact provided by the therapist, as well as total treatment time (as defined by all timed and untimed codes). AMA guidelines state that incremental intervals of treatment performed at 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 reported separately.

If two separate treatment sessions are provided on the same date of service (e.g., a.m. and p.m.), both may be reported, but they would require modifier 76 to indicate that the code is being reported for two separate sessions on the same date. Check with third-party payers as their guidelines may differ.

According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as 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 be reported only 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 $2,330 threshold require the use of modifier KX. When appending modifier KX, the therapist indicates that the service thresholds are reasonable and medically necessary and that medical necessity for the services is documented in the patient's medical record. Services exceeding modifier KX thresholds for outpatient therapy and that do not have modifier KX appended are denied by Medicare contractors.

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

ICD-10-CM Diagnostic Codes

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

Associated HCPCS Codes

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

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

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

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

Relative Value Units/Medicare Edits

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

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

* with documentation

Terms To Know

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

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

L0456 TLSO, flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L0457 TLSO, flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated, off-the-shelf

L0458 TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment

L0460 TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L0462 TLSO, triplanar control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment

L0464 TLSO, triplanar control, modular segmented spinal system, four rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment

L0466 TLSO, sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L0467 TLSO, sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated, off-the-shelf

L0468 TLSO, sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal, and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L0469 TLSO, sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated, off-the-shelf

L0470 TLSO, triplanar control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding extends from sacrococcygeal junction to scapula, lateral strength provided by pelvic, thoracic, and lateral frame pieces, rotational strength provided by subclavicular extensions, restricts gross trunk motion in sagittal, coronal, and transverse planes, provides intracavitary pressure to reduce load on the intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment

L0472 TLSO, triplanar control, hyperextension, rigid anterior and lateral frame extends from symphysis pubis to sternal notch with two anterior components (one pubic and one sternal), posterior and lateral pads with straps and closures, limits spinal flexion, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment

L0488 TLSO, triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, prefabricated, includes fitting and adjustment