Optum

Coding &
Payment Guide

Physical Therapy/ Rehabilitation/ Physical Medicine

An essential coding, billing and reimbursement guide for physical, occupational and speech therapy, rehabilitation and physical medicine

2027

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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 CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT/HCPCS code description, followed by an easy-to-understand explanation, relative value units, and Medicare edits. The Relative Value Unit/Medicare Edits table will not be included with any CPT/HCPCS code with a "0" (zero) value.

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

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 32.3, 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 2027 edition password is: **XXXXX**. Log in frequently to ensure you receive the most current updates.

Index

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

For example:

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

Ankle
Strapping, 29540

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.**

Telehealth/Telemedicine Services

Telehealth/telemedicine services are identified by CPT with the ★ icon at the code level. The Centers for Medicare and Medicaid Services (CMS) identifies services that may be performed via telehealth. These

CMS-approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's home, and modifier 93 or 95 appended. If specialized equipment is used at the originating site, code Q3014 may be reported. Individual payers should be contacted foradditional or different guidelines regarding telehealth/telemedicine services.

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

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** 2024,Jan; 2022,Dec; 2022,Jun; 2022,Jan; 2020,Dec; 2019,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
94660	0.76	1.12	0.06	1.94
Facility RVU	**Work**	**PE**	**MP**	**Total**
94660	0.76	0.28	0.06	1.1

	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 2027. The following icons are used in the *Coding and Payment Guide*:

- ● This CPT code is new for 2027.
- ▲ This CPT code description is revised for 2027.
- ✚ 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.

Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

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
- ☑ Laterality

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

7. Associated HCPCS Codes

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

8. AMA References

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

9. Relative Value Units/Medicare Edits

Relative Value Units

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

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

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

Medicare Follow-Up Days (FUD)

Information on the Medicare global period is provided here, even though it is not relevant to 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

Documentation

The American Medical Association's (AMA) Physicians' Current Procedural Terminology (CPT®) and HCPCS Level II codes were developed specifically to define and describe services and procedures. They can be used by payers in combination with ICD-10-CM codes to analyze and describe practice patterns related to specific diagnoses and to project costs of procedures for diagnosis groups. Correct use of the procedure codes requires accurate and specific documentation of the evaluation and treatment provided.

To substantiate the CPT codes used, documentation at a minimum should describe:

- Evaluation and treatment interventions performed
- Responses observed
- Total time taken to provide the total visit, as well as the time spent in performing direct contact procedures

For information tailored to therapy services, see the chapter on procedure coding in this Coding and Payment Guide.

Outpatient therapy services must be furnished under a plan of care that is certified by the physician or nonphysician practitioner (qualified provider). The medical record must contain the therapy plan of care. The plan of care is established by a qualified provider (consultation with the treating therapist is recommended) or the therapist who will provide services. The plan of care at minimum should include the therapy goals; diagnoses; and the type, amount, duration and frequency of therapy services, as well as the expected outcomes and anticipated discharge plans. The plan of care should also be authenticated including the signature, professional credential (e.g., PT or MD), and the date.

Changes may be made to the plan of care. Any revisions should be documented in the medical record and authenticated. If the revisions are made at the request of the physician or other appropriate qualified provider, he or she should include either the written revision or a verbal approval.

Under Medicare guidelines, the patient's plan of care must be certified by a physician or other qualified provider to indicate the provider's approval of the plan of care.

Certification can be for whatever duration of treatment the qualified provider determines is appropriate, for the outpatient therapy plan of care up to a maximum of 90 calendar days, and must occur within 30 days of the initial therapy treatment. Acceptable documentation of the plan of care may include:

- The qualified provider's progress note
- A signed and dated referral from the qualified provider
- A plan of care dated and signed by the qualified provider

According to CMS, the initial certification should be completed "as soon as possible" but within 30 days of the initial therapy treatment and covers up to a 90-day duration from the initial therapy treatment. Recertifications that document the need for continued or modified therapy should be signed whenever the need for a significant modification of the plan becomes evident, or at least every 90 days after initiation of treatment under that plan of care. A delayed certification is acceptable when the physician or other health care professional makes a certification accompanied by a reason for the delay.

Financial Limitations for Skilled Nursing Facility and Home Health Providers

As of October 1, 2019, payment for skilled nursing facilities (SNF) is made using the Patient-Driven Payment Model (PDPM) for Medicare beneficiaries. As of January 1, 2020, payment for home health agencies is paid under the Home Health Patient-Driven Groupings Model (PDGM). The need for physical therapy, occupational therapy, and speech-language pathology is part of the case-mix methodology that is used to determine reimbursement.

Reimbursement is based on correlation between the reported ICD-10-CM codes and the assigned groupings. Additional diagnoses and comorbidity codes also impact the final prospective payment classification.

These payment models, PDPM and PDGM, focus on patient needs, conditions, and characteristics rather than the former model relying on volume of services as reporting using time spent and number of services rendered. Reimbursement under these models is based on accurate ICD-10-CM coding. However, coverage criteria and documentation requirements will not change. Therapists still need to document the type, duration, and intensity of skilled therapies. Care and documentation guidelines remain unchanged.

Documentation of Time

Many of the services performed by physical/occupational therapists and therapist assistants are represented by "timed" codes. This means that the CPT code for the service indicates that a service was performed for a specific amount of time. For example, CPT code 97116 should be reported once for each 15 minutes that a provider provides gait training.

CMS guidelines to contractors indicate that the medical record documentation for therapy services must record time. The total amount of treatment time (including treatment provided and reported by timed codes and untimed codes) and the amount of time spent providing direct contact services, represented only by timed codes, should be documented.

Per CMS guideline, if more than one timed CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time. Medicare has established (based on the work values for these CPT codes) that a therapist's direct one-on-one patient contact time will average 15 minutes in length for each unit. CMS guidelines state that when only one service is provided in a day, providers should not bill for services performed for less than eight minutes. For any single timed CPT code in the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to eight minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes, through and including 37 minutes, then two units should be billed. For additional information, refer to the *Medicare Claims Processing Manual*, chapter 5. Payers outside of Medicare and other federal payers may require providers to report timed codes according to AMA's CPT method, as outlined in the AMA's CPT Professional Edition, which is to consider each code individually, using the number of minutes spent face-to-face with the patient for each code to determine how many units of that code are to be reported. Check with payers and state regulations to confirm which method to use.

99366-99368

99366 Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional

99367 Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician

99368 participation by nonphysician qualified health care professional

Explanation

A medical team conference is defined as a service where at least three qualified health care professionals from different specialties or disciplines, each of whom provides direct care to the patient, actively engage in the evolution, revision, coordination, and implementation of health care services needed by the patient. The conferences may or may not involve the presence of the patient, family members, community agencies, surrogate decision makers/legal guardians, and/or caregivers. Medical team clinicians should report the time spent in a team conference with the patient and/or family present with the appropriate E/M code, using time as a key controlling factor for selecting a code when counseling and/or coordination of care dominates the service. The individual clinician must be directly involved with rendering face-to-face services outside of the conference visit with other clinicians or agencies. All medical professionals participating on the medical team must document their own individual participation in the team conference, in addition to their contributed information and follow-up treatment recommendations. However, only one individual from the same specialty may report a code from this category at the same encounter. No individuals may report a code from range 99366-99368 if participation in the medical team conference is a part of a facility or organizational service contractually provided by the facility or organization. Team conferences commence upon review of the individual patient case and conclude once the review has come to a conclusion. Record keeping and report generation time is not reportable. The clinician must report all time for which he or she was present. Reportable time is not limited to the time that the clinician is communicating with other team members, the patient, and/or the patient's family. Note that time spent in medical team conferences should not be used toward determining other E/M services such as care plan oversight services, home, domiciliary, or rest home care plan oversight, prolonged services, psychotherapy, or any other E/M service. Nonphysician qualified health care professionals may report 99366, medical team conference, direct (face-to-face) contact with patient and/or family, when the patient is present for any or all of the medical conference with a duration of at least 30 minutes. This includes such providers as speech-language pathologists, physical therapists, occupational therapists, social workers, and dieticians. Medical conferences of less than 30 minutes duration are not reported. Codes 99367-99368 describe team conferences without direct, face-to-face patient and/or family contact.

Coding Tips

These codes are used to report medical team conferences, with direct patient and/or family contact (99366) or without direct patient and/or family contact (99367–99368). For medical team participation by a nonphysician health care professional with direct patient and/or family contact, see 99366; without direct patient or family contact, see 99368. For medical team participation by the physician without direct patient and/or family contact, see 99367. Time required for record keeping and generating reports is not counted. The time for the team conference starts when review of an individual patient begins and ends when the review is completed. The health care professional who reports the service should be present for all time reported. Do not count time used for other services such as prolonged services (99358–99359), E/M services, psychotherapy, or care plan oversight (99374–99380). Medical team meetings of less than 30 minutes should not be reported separately. For physician participation with face-to-face patient contact, report the appropriate E/M code. Do not report codes 99367–99368 in the same month as 99437, 99439, 99487, or 99489–99491.

Documentation Tips

Providers should be certain that sufficient documentation is provided in the medical record to accurately verify the description of the services rendered and to support medical necessity of the service. Additionally, records should be legible and signed with the appropriate name and title of the provider of the service.

Reimbursement Tips

Some payers may not provide coverage if the patient or patient's family is not present. Check with third-party payers for coverage guidelines.

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: **99366** 2023,Nov; 2022,Nov; 2022,Jul; 2022,Jan; 2021,Jan; 2019,Jul; 2018,Apr **99367** 2023,Nov; 2022,Nov; 2022,Jul; 2022,Jan; 2021,Jan; 2019,Dec; 2019,Jul; 2018,Apr **99368** 2023,Nov; 2022,Nov; 2022,Jul; 2022,Jan; 2021,Jan; 2019,Jul; 2018,Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99366	0.82	0.35	0.05	1.22
99367	1.1	0.43	0.07	1.6
99368	0.72	0.28	0.04	1.04
Facility RVU	**Work**	**PE**	**MP**	**Total**
99366	0.82	0.32	0.05	1.19
99367	1.1	0.43	0.07	1.6
99368	0.72	0.28	0.04	1.04

	FUD	Status	MUE	Modifiers				IOM Reference
99366	N/A	B	0(3)	N/A	N/A	N/A	N/A	None
99367	N/A	B	0(3)	N/A	N/A	N/A	N/A	
99368	N/A	B	0(3)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

qualified health care professional. Educated, licensed or certified, and regulated professional operating under a specified scope of practice to provide patient services that are separate and distinct from other clinical staff.

64408

64408 Injection(s), anesthetic agent(s) and/or steroid; vagus nerve

Explanation

The practitioner injects one or more anesthetic agents and/or steroids near the vagus nerve. The vagus nerve supplies sensory fibers to the pharynx and glottis, and carries parasympathetic fibers to the digestive system and heart. The practitioner draws a local anesthetic and/or steroid into a syringe and injects it into the targeted area near the nerve.

Coding Tips

Report imaging guidance and localization separately if utilized.

For injection of anesthetic agent and/or steroid to the cervical plexus or phrenic nerve, see 64999.

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 64408 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

G52.2 Disorders of vagus nerve
G89.28 Other chronic postprocedural pain
G89.29 Other chronic pain
G89.3 Neoplasm related pain (acute) (chronic)
G89.4 Chronic pain syndrome

AMA: **64408** 2023,Jan; 2022,Dec; 2022,Jul; 2021,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
64408	0.75	1.59	0.11	2.45
Facility RVU	**Work**	**PE**	**MP**	**Total**
64408	0.75	0.48	0.11	1.34

	FUD	Status	MUE	Modifiers				IOM Reference
64408	0	A	1(3)	51	50	N/A	80*	None

* with documentation

64415-64416

64415 Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed

64416 brachial plexus, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed

Explanation

The practitioner injects one or more anesthetic agents and/or steroids near the brachial plexus to relieve pain and inflammation in 64415. The practitioner draws a local anesthetic and/or steroid into a syringe and injects it into a targeted area near the brachial plexus, approached in one of several locations: interscalene, superior trunk, supraclavicular, infraclavicular, or axillary. In 64416, a local anesthetic and/or steroid is continuously infused through a catheter to provide a nerve block lasting longer than the block effect achieved through a single injection. An indwelling catheter is placed and positioned to provide anesthesia to the brachial plexus. An infusion pump is connected to the catheter to supply a continuous flow of infused agent at a set rate. The infusion system may be used for regional surgical anesthesia when general anesthesia is not required and for postoperative pain management. Catheter placement is included in 64416 and is not reported separately. Imaging guidance and any contrast injection, when performed, is included in both codes.

Coding Tips

Imaging guidance is included in these procedures and not reported separately. Do not report 64415 or 64416 with 76942, 77002, or 77003. Do not report 64416 with 01996.

These codes 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. Documentation should also indicate if the procedure was a single injection or a continuous infusion by catheter.

Reimbursement Tips

Codes 64415 and 64416 describe unilateral procedures. If a 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

G54.0 Brachial plexus disorders
G56.41 Causalgia of right upper limb ☑
G56.42 Causalgia of left upper limb ☑
G56.43 Causalgia of bilateral upper limbs ☑
G90.511 Complex regional pain syndrome I of right upper limb ☑
G90.512 Complex regional pain syndrome I of left upper limb ☑
G90.513 Complex regional pain syndrome I of upper limb, bilateral ☑
M12.511 Traumatic arthropathy, right shoulder ☑
M12.512 Traumatic arthropathy, left shoulder ☑
M25.511 Pain in right shoulder ☑
M25.512 Pain in left shoulder ☑
M25.521 Pain in right elbow ☑

64490-64492

64490 Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level

\+ **64491** second level (List separately in addition to code for primary procedure)

\+ **64492** third and any additional level(s) (List separately in addition to code for primary procedure)

Explanation

The practitioner injects a diagnostic or therapeutic agent into a cervical or thoracic paravertebral facet joint or into the nerves that innervate the joint using fluoroscopic or CT guidance. The paravertebral facet joints, also called zygapophyseal, or "Z," joints, consist of the bony surfaces between the vertebrae that articulate with each other. The injection may be performed on a single level or on multiple levels. Report 64490 for a single level, 64491 for a second level, and 64492 for the third and any additional levels.

Coding Tips

Report 64491 in addition to 64490. Report 64492 in addition to 64490 and 64491. A "level" constitutes the number of facet joints injected and not the number of nerves. Image guidance (fluoroscopic or CT) is required for these procedures. If the service is not performed with image guidance, see 20552 or 20553. When ultrasound guidance is used, see 0213T–0218T. For unilateral injection of the T12-L1 and L1-L2 levels or the nerves at that junction, see 64490 and 64494. For bilateral injection of the T12-L1 and L1-L2 levels or the nerves at that junction, see 64490 with modifier 50 and 64494 with two units.

Only one unit per level may be reported for these codes, even if multiple injections are performed at the same level or site.

Documentation Tips

Medical record documentation should clearly indicate the facet joints injected and the substance administered. The type of imaging guidance used should be documented.

Reimbursement Tips

64490 is a unilateral procedure. If 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). 64491 and 64492 should be reported twice when performed bilaterally. Do not report with modifier 50 per CPT guidelines. Medicare may still require the use of modifier 50.

ICD-10-CM Diagnostic Codes

M43.02 Spondylolysis, cervical region
M43.03 Spondylolysis, cervicothoracic region
M43.04 Spondylolysis, thoracic region
M43.05 Spondylolysis, thoracolumbar region
M43.12 Spondylolisthesis, cervical region
M43.13 Spondylolisthesis, cervicothoracic region
M43.14 Spondylolisthesis, thoracic region
M45.2 Ankylosing spondylitis of cervical region
M45.3 Ankylosing spondylitis of cervicothoracic region
M45.4 Ankylosing spondylitis of thoracic region
M45.5 Ankylosing spondylitis of thoracolumbar region
M46.22 Osteomyelitis of vertebra, cervical region
M46.23 Osteomyelitis of vertebra, cervicothoracic region
M46.24 Osteomyelitis of vertebra, thoracic region
M46.25 Osteomyelitis of vertebra, thoracolumbar 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
M48.02 Spinal stenosis, cervical region
M48.03 Spinal stenosis, cervicothoracic region
M48.04 Spinal stenosis, thoracic region
M48.05 Spinal stenosis, thoracolumbar 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
M51.04 Intervertebral disc disorders with myelopathy, thoracic region
M51.05 Intervertebral disc disorders with myelopathy, thoracolumbar region
M51.14 Intervertebral disc disorders with radiculopathy, thoracic region
M51.15 Intervertebral disc disorders with radiculopathy, thoracolumbar region
M54.12 Radiculopathy, cervical region
M54.13 Radiculopathy, cervicothoracic region
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M99.12 Subluxation complex (vertebral) of thoracic region
M99.21 Subluxation stenosis of neural canal of cervical region
M99.22 Subluxation stenosis of neural canal of thoracic region
M99.31 Osseous stenosis of neural canal of cervical region
M99.32 Osseous stenosis of neural canal of thoracic region
M99.41 Connective tissue stenosis of neural canal of cervical region
M99.42 Connective tissue stenosis of neural canal of thoracic region
M99.51 Intervertebral disc stenosis of neural canal of cervical region
M99.52 Intervertebral disc stenosis of neural canal of thoracic region
M99.61 Osseous and subluxation stenosis of intervertebral foramina of cervical region
M99.62 Osseous and subluxation stenosis of intervertebral foramina of thoracic region
M99.71 Connective tissue and disc stenosis of intervertebral foramina of cervical region
M99.72 Connective tissue and disc stenosis of intervertebral foramina of thoracic region

92610

92610 Evaluation of oral and pharyngeal swallowing function

Explanation

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

Coding Tips

Only one unit per day may be reported for this code, regardless of the amount of time taken to render the service.

Medicare has provisionally identified this code as telehealth/telemedicine services. Current Medicare coverage guidelines, including place of service, should be reviewed. Commercial payers should be contacted regarding their coverage guidelines.

Documentation Tips

Speech pathology is considered medically appropriate treatment for mental disability when disorders such as aphasia or dysarthria are exhibited. The diagnosis and treatment of swallowing disorders (dysphagia) are also medically necessary, regardless of the presence of a communication disability and, therefore, should be documented in the medical record.

The ICD-10-CM seventh character A Initial encounter, is appropriate when documentation indicates that the therapist is the first clinician to provide active treatment for the condition. Assign the seventh character D Subsequent encounter, when the documentation indicates that the therapist is providing skilled therapy during the healing or recovery phase but is still under the active care of the provider.

Examples of documentation include:

- Oral motor function, phonation, and speech product
- Sensorimotor integration

Reimbursement Tips

This service is considered a "sometimes-therapy" service and is subject to the Medicare outpatient therapy threshold when performed by a therapist. The following modifiers are used to identify therapy services, whether the financial threshold is in effect, although the common working file (CWF) does track the financial threshold using the therapy modifiers. 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 threshold dollar amount 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.

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

ICD-10-CM Diagnostic Codes

I69.020	Aphasia following nontraumatic subarachnoid hemorrhage
I69.021	Dysphasia following nontraumatic subarachnoid hemorrhage
I69.091	Dysphagia following nontraumatic subarachnoid hemorrhage
I69.120	Aphasia following nontraumatic intracerebral hemorrhage
I69.121	Dysphasia following nontraumatic intracerebral hemorrhage
I69.191	Dysphagia following nontraumatic intracerebral hemorrhage
I69.220	Aphasia following other nontraumatic intracranial hemorrhage
I69.221	Dysphasia following other nontraumatic intracranial hemorrhage
I69.291	Dysphagia following other nontraumatic intracranial hemorrhage
I69.320	Aphasia following cerebral infarction
I69.321	Dysphasia following cerebral infarction
I69.391	Dysphagia following cerebral infarction
I69.820	Aphasia following other cerebrovascular disease
I69.821	Dysphasia following other cerebrovascular disease
I69.891	Dysphagia following other cerebrovascular disease
R13.0	Aphagia
R13.11	Dysphagia, oral phase
R13.12	Dysphagia, oropharyngeal phase
R13.13	Dysphagia, pharyngeal phase
R13.14	Dysphagia, pharyngoesophageal phase
R13.19	Other dysphagia
R63.31	Pediatric feeding disorder, acute P
R63.32	Pediatric feeding disorder, chronic P
R63.39	Other feeding difficulties
T17.318A	Gastric contents in larynx causing other injury, initial encounter
T17.328A	Food in larynx causing other injury, initial encounter
T17.398A	Other foreign object in larynx causing other injury, initial encounter

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
92610	1.3	1.22	0.04	2.56
Facility RVU	**Work**	**PE**	**MP**	**Total**
92610	1.3	0.76	0.04	2.1

	FUD	Status	MUE	Modifiers				IOM Reference
92610	N/A	A	1(2)	N/A	N/A	N/A	80*	None

* with documentation

95872

95872 Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied

Explanation

Needle electromyography (EMG) records the electrical properties of muscle using an oscilloscope. Recordings, which may be amplified and heard through a loudspeaker, are made during needle insertion, with the muscle at rest, and during contraction. This procedure uses a single fiber electrode to obtain additional information on specific muscles, including quantitative measurement of jitter, blocking, and/or fiber density.

Coding Tips

Single-fiber EMG testing is the innervation of one or more nerve cells and some of the muscles stimulated. Code 95872 describes testing of each muscle studied. Normally, 20 pairs of nerves must be studied to significantly study each muscle. Each muscle is coded only once. However, if another muscle is studied, the code is reported again.

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

Reimbursement Tips

Therapists in private practice may bill for the technical and professional component of certain diagnostic tests in the 95860–95937 code range, such as electromyograms and nerve conduction studies.

Some third-party payers reimburse only for the technical portion of many procedures whose codes are in this subsection of the CPT book. It is important for each clinician to determine how insurers require therapists to bill services. Therapists should keep track of experiences with each insurance company and policy, providing data for future claims.This code 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.

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

- The physical therapist is certified by the American Board of Physical Therapist Specialties (ABPTS) as a clinical electrophysiologic-certified specialist and is permitted to provide the service under state law.
- The physical therapist is personally supervised by an ABPTS-certified physical therapist; only the certified physical therapist may bill for the service.

Medicare will permit a physical therapist without ABPTS certification to provide certain electromyography services if that physical therapist was not ABPTS-certified as of July 1, 2001, and had been furnishing such diagnostic tests prior to May 1, 2001. The requirements vary depending on the CPT code reported. Further CMS clarification can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Diagnostic-Services-by-Physical-Therapists.

ICD-10-CM Diagnostic Codes

A52.15 Late syphilitic neuropathy
G12.25 Progressive spinal muscle atrophy
G37.3 Acute transverse myelitis in demyelinating disease of central nervous system
G58.0 Intercostal neuropathy
G58.7 Mononeuritis multiplex
G58.8 Other specified mononeuropathies
G61.81 Chronic inflammatory demyelinating polyneuritis
G72.89 Other specified myopathies
G81.01 Flaccid hemiplegia affecting right dominant side ☑
G81.02 Flaccid hemiplegia affecting left dominant side ☑
G81.03 Flaccid hemiplegia affecting right nondominant side ☑
G81.04 Flaccid hemiplegia affecting left nondominant side ☑
G81.11 Spastic hemiplegia affecting right dominant side ☑
G81.12 Spastic hemiplegia affecting left dominant side ☑
G81.13 Spastic hemiplegia affecting right nondominant side ☑
G81.14 Spastic hemiplegia affecting left nondominant side ☑
G82.21 Paraplegia, complete
G82.22 Paraplegia, incomplete
G83.4 Cauda equina syndrome
G83.82 Anterior cord syndrome
G83.83 Posterior cord syndrome
G83.89 Other specified paralytic syndromes
G90.09 Other idiopathic peripheral autonomic neuropathy
G90.89 Other disorders of autonomic nervous system
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
M47.893 Other spondylosis, cervicothoracic region
M47.894 Other spondylosis, thoracic region
M47.895 Other spondylosis, thoracolumbar region
M48.03 Spinal stenosis, cervicothoracic region
M50.03 Cervical disc disorder with myelopathy, cervicothoracic region
M50.13 Cervical disc disorder with radiculopathy, cervicothoracic region
M50.23 Other cervical disc displacement, cervicothoracic region
M50.33 Other cervical disc degeneration, cervicothoracic region
M50.83 Other cervical disc disorders, cervicothoracic region
M51.04 Intervertebral disc disorders with myelopathy, thoracic region
M51.05 Intervertebral disc disorders with myelopathy, thoracolumbar region
M51.14 Intervertebral disc disorders with radiculopathy, thoracic region
M51.15 Intervertebral disc disorders with radiculopathy, thoracolumbar region
M54.13 Radiculopathy, cervicothoracic region
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M54.6 Pain in thoracic spine
S24.111A Complete lesion at T1 level of thoracic spinal cord, initial encounter

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 threshold dollar amount 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*	None

* 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.

97124

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

Explanation

The qualified health care provider uses massage to relax muscles, increase localized circulation, soften scar tissue, or mobilize mucous secretions in the lung via tapotement and/or percussion. This code requires direct contact by a qualified health care provider with the patient and is reported in 15-minute units.

Coding Tips

When these techniques are performed for postural drainage, some payer policies may require the submission of other codes, such as 94667 or 94668. Check with third-party payers to determine their specific requirements before submitting the claim.

To report myofascial release, see 97140.

This service 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.

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 on the same session may be added together when determining total time. Check with other third-party payers for their guidelines regarding billing and payment of timed codes.

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

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

Submit claims that document establishment of massage and other therapeutic procedures that are part of an appropriately documented maintenance program to fit the patient's level of ADL function and needed instruction to the patient, supportive personnel, and/or family members to safely and effectively carry out the program.

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

Reimbursement Tips

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 threshold dollar amount 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.

AMA: **97124** 2020,Jul; 2019,Jun; 2018,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
97124	0.35	0.55	0.01	0.91
Facility RVU	**Work**	**PE**	**MP**	**Total**
97124	0.35	0.55	0.01	0.91

	FUD	Status	MUE	Modifiers				IOM Reference
97124	N/A	A	4(3)	N/A	N/A	N/A	80*	None

* with documentation

Correct Coding Initiative Update 32.3

❖Indicates Mutually Exclusive Edit

0733T 0213T, 0216T, 12001-12007, 12011-12057, 13100-13133, 13151-13153, 36000, 36400-36410, 36420-36430, 36440, 36591-36592, 36600, 36640, 43752, 51701-51703, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64450, 64461-64463, 64479-64505, 64510-64530, 69990, 92012-92014, 93000-93010, 93040-93042, 93241-93248, 93318, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96158-96159, 96360-96368, 96372, 96374-96377, 96523, 98975-98977, 99091, 99155, 99156, 99157, 99211-99215, 99221-99223, 99231-99239, 99242-99245, 99252-99255, 99291-99292, 99315-99316, 99347-99350, 99374-99375, 99377-99378, 99424-99427, 99437, 99439, 99457-99458, 99473, 99484, 99492-99494

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