OPTUM360®

APTA American Physical Therapy Association

CODING & PAYMENT GUIDE

For the Physical Therapist

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

2021

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Contents

Getting Started with Coding and Payment Guide

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

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

CPT/HCPCS Codes

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

Resequencing of CPT Codes

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

ICD-10-CM

Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

Detailed Code Information

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

Appendix Codes and Descriptions

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

CCI Edit Updates

The *Coding and Payment Guide* series includes the a 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 version XX.X, the most current version available at press time. The CCI edits are located in a section at the back of the book. Optum360 maintains a website to accompany the *Coding and Payment Guide* series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is https:// www.optum360coding.com/ ProductUpdates/. The 2022 edition password is: **XXXXXXXX22**. Log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

Index

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

For example:

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

Ankle
Strapping, 29540

Strapping
Ankle, 29540

General Guidelines

Providers

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

Sample Page and Key

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

performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component.

Typically, 60 minutes are spent face-to-face with the patient and/or family.

97168 Re-evaluation of occupational therapy established plan of care, requiring these components:

- An assessment of changes in patient functional or medical status with revised plan of care;
- An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and
- A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required.

Typically, 30 minutes are spent face-to-face with the patient and/or family.

97169 Athletic training evaluation, low complexity, requiring these components:

- A history and physical activity profile with no comorbidities that affect physical activity;
- An examination of affected body area and other symptomatic or related systems addressing 1-2 elements from any of the following: body structures, physical activity, and/or participation deficiencies; and
- Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.

Typically, 15 minutes are spent face-to-face with the patient and/or family.

97170 Athletic training evaluation, moderate complexity, requiring these components:

- A medical history and physical activity profile with 1-2 comorbidities that affect physical activity;
- An examination of affected body area and other symptomatic or related systems addressing a total of 3 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; and
- Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.

Typically, 30 minutes are spent face-to-face with the patient and/or family.

97171 Athletic training evaluation, high complexity, requiring these components:

- A medical history and physical activity profile, with 3 or more comorbidities that affect physical activity;
- A comprehensive examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies;
- Clinical presentation with unstable and unpredictable characteristics; and
- Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.

Typically, 45 minutes are spent face-to-face with the patient and/or family.

97172 Re-evaluation of athletic training established plan of care requiring these components:

- An assessment of patient's current functional status when there is a documented change; and
- A revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome with an update in management options, goals, and interventions.

Typically, 20 minutes are spent face-to-face with the patient and/or family.

These codes must be reported with modifiers GN, GO, GP, indicating the type of therapist who performed the evaluation.

When reporting these codes, append with modifier KX. This modifier alerts the contractor to override a denial for that service due to the threshold amount.

An exception may be made when the patient's condition is justified by documentation indicating that the beneficiary requires continued skilled therapy (i.e., beyond the therapy threshold).

CMS does not require an order or prescription referral from a physician or other appropriate health care professional for physical therapy services; however, it should be noted that state laws may apply and take precedence over the CMS requirement.

Telehealth Services

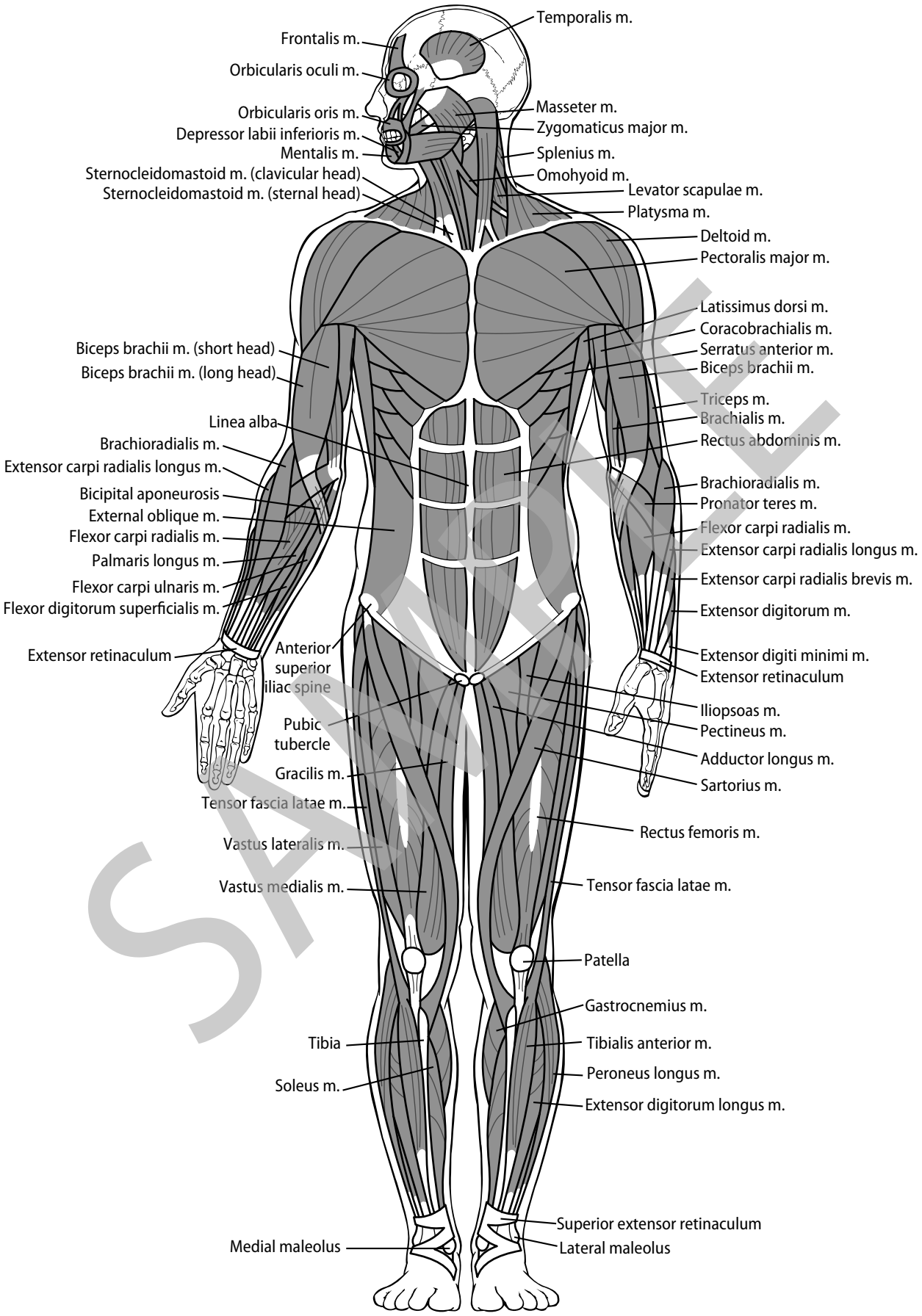
Telehealth services have been defined as two-way, real-time interactive communication using audio and video technology. At the time of publication, under temporary rules in response to the COVID-19 public health emergency (PHE), the Centers for Medicare and Medicaid Services (CMS) and some commercial payers cover telehealth services rendered by physical therapists and physical therapist assistants. Some commercial payers are permanently lifting restrictions on physical therapy via telehealth, and each payer's status is subject to change. As of late 2020, the PHE is in effect, but providers should check with payers and their Medicare Administrative Contractor, as well as with their state practice act, before providing and billing services via telehealth.

Patients may be new or established, and the services usually are the same as would be provided during an in-person evaluation. Currently, codes 97161–97164, 97110, 97112, 97116, 97150, 97530, 97535, 97542, 97750, 97755, 97760, 97761, and 98960–98962* are typically considered appropriate for telehealth.

(*Indicates codes recognized by CPT as appropriate telehealth services. Other codes are considered by Medicare to be appropriate telehealth services.)

Those services may be paid at the same rate as in-person services; providers should review payment policies and fee schedules of commercial and federal payers before billing for telehealth services. The most recent list of approved telehealth codes from CMS indicates that only 97535 meets the qualifications of an audio-only service, and all others should be provided using audio/video technology. Note that not all commercially available audio/video communication systems are approved for use with telehealth services.

Muscles



Procedure Codes

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

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

Appropriate Codes for Physical Therapists

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

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

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

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

CPT Symbols

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

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

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

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

Modifiers

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

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

For example, modifier 59 Distinct procedural service, could be used when billing for both 97022 Whirlpool, and 97597–97606 Wound debridement, to indicate that the two services were distinct from one another, or performed on different areas of the body.

29105

29105 Application of long arm splint (shoulder to hand)

Explanation

The qualified health care provider applies a splint from the shoulder to the hand. A long arm posterior splint is used to immobilize a number of injuries around the elbow and forearm. A cotton bandage is wrapped around the forearm from the midpalm region to midarm. Plaster strips or fiberglass splints are applied along the back of the arm and forearm to maintain the elbows and wrist in the desired position.

Coding Tips

According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure. The code for the initial treatment of a fracture or dislocation includes the application, maintenance, and removal of the first cast or traction. See Application of Casts and Strapping in the CPT book in the Surgery section, under Musculoskeletal System. In general, casting supplies should be reported separately.

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

Documentation Tips

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

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

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

Reimbursement Tips

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

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

ICD-10-CM Diagnostic Codes

M24.421 Recurrent dislocation, right elbow ☑

M66.221 Spontaneous rupture of extensor tendons, right upper arm ☑

M66.231 Spontaneous rupture of extensor tendons, right forearm ☑

M66.321 Spontaneous rupture of flexor tendons, right upper arm ☑

M66.331 Spontaneous rupture of flexor tendons, right forearm ☑

M66.821 Spontaneous rupture of other tendons, right upper arm ☑

M66.831 Spontaneous rupture of other tendons, right forearm ☑

M80.021A Age-related osteoporosis with current pathological fracture, right humerus, initial encounter for fracture A ☑

M80.031A Age-related osteoporosis with current pathological fracture, right forearm, initial encounter for fracture A ☑

M80.821A Other osteoporosis with current pathological fracture, right humerus, initial encounter for fracture ☑

M84.321A Stress fracture, right humerus, initial encounter for fracture ☑

M84.331A Stress fracture, right ulna, initial encounter for fracture ☑

M84.333A Stress fracture, right radius, initial encounter for fracture ☑

M84.421A Pathological fracture, right humerus, initial encounter for fracture ☑

M84.431A Pathological fracture, right ulna, initial encounter for fracture ☑

M84.433A Pathological fracture, right radius, initial encounter for fracture ☑

M84.521A Pathological fracture in neoplastic disease, right humerus, initial encounter for fracture ☑

M84.531A Pathological fracture in neoplastic disease, right ulna, initial encounter for fracture ☑

M84.533A Pathological fracture in neoplastic disease, right radius, initial encounter for fracture ☑

S42.311A Greenstick fracture of shaft of humerus, right arm, initial encounter for closed fracture ☑

S42.321A Displaced transverse fracture of shaft of humerus, right arm, initial encounter for closed fracture ☑

S42.324A Nondisplaced transverse fracture of shaft of humerus, right arm, initial encounter for closed fracture ☑

S42.331A Displaced oblique fracture of shaft of humerus, right arm, initial encounter for closed fracture ☑

S42.334A Nondisplaced oblique fracture of shaft of humerus, right arm, initial encounter for closed fracture ☑

S42.341A Displaced spiral fracture of shaft of humerus, right arm, initial encounter for closed fracture ☑

S42.344A Nondisplaced spiral fracture of shaft of humerus, right arm, initial encounter for closed fracture ☑

S42.351A Displaced comminuted fracture of shaft of humerus, right arm, initial encounter for closed fracture ☑

S42.354A Nondisplaced comminuted fracture of shaft of humerus, right arm, initial encounter for closed fracture ☑

S42.361A Displaced segmental fracture of shaft of humerus, right arm, initial encounter for closed fracture ☑

S42.364A Nondisplaced segmental fracture of shaft of humerus, right arm, initial encounter for closed fracture ☑

S42.411A Displaced simple supracondylar fracture without intercondylar fracture of right humerus, initial encounter for closed fracture ☑

S42.414A Nondisplaced simple supracondylar fracture without intercondylar fracture of right humerus, initial encounter for closed fracture ☑

S42.421A Displaced comminuted supracondylar fracture without intercondylar fracture of right humerus, initial encounter for closed fracture ☑

97035

97035 Application of a modality to 1 or more areas; ultrasound, each 15 minutes

Explanation

The qualified health care provider applies ultrasound to increase circulation to one or more areas. A water bath or some form of ultrasound lotion must be used as a coupling agent to facilitate the procedure. The delivery of corticosteroid medication via ultrasound is called phonophoresis and is reported using this code. The medication as a supply may or may not be paid by the payer. Ultrasound or phonophoresis requires constant attendance and is billed in multiple in 15-minute units.

Coding Tips

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

Documentation Tips

When providing maintenance therapy services, develop and document maintenance goals as opposed to restorative goals. Also, indicate in the documentation that the skills of the physical therapist were necessary to maintain, prevent, or slow further deterioration of the patient's functional status, and that the services could not be conducted for or by the patient without the assistance of the physical therapist. Consistent use of modalities over an episode of care may be highlighted for payer review, as the expectation is for modality use to decrease as the patient progresses.

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

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

Reimbursement Tips

If this is a covered service and two separate treatment sessions are provided on the same date of service (e.g., a.m. and p.m.), then both may be reported, but would require modifier 76 to indicate that the service-based code (not the time descriptors) is being reported for two separate sessions on the same date. Check with third-party payers as their guidelines may differ. According to the CPT guidelines, this code is not reported with modifier 51 but has not been designated as modifier 51 exempt or as an add-on code in the CPT book.

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

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

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

GO Services delivered under an outpatient occupational therapy plan of care

GP Services delivered under an outpatient physical therapy plan of care

Claims for services above the $2,110 threshold require the use of modifier KX. When appending modifier KX, the physical therapist indicates that the service thresholds are reasonable and medically necessary, and that there is documentation of medical necessity for the services in the patient's medical record. Services exceeding modifier KX thresholds for outpatient therapy and do not have modifier KX appended are denied by Medicare contractors.

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

ICD-10-CM Diagnostic Codes

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

AMA: **97035** 2018,May,5; 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
97035	0.21	0.2	0.01	0.42
Facility RVU	**Work**	**PE**	**MP**	**Total**
97035	0.21	0.2	0.01	0.42

	FUD	Status	MUE	Modifiers				IOM Reference
97035	N/A	A	2(3)	N/A	N/A	N/A	80*	100-03,240.3

* with documentation

Terms To Know

phonophoresis. Use of ultrasound to increase the diffusion of a drug into the skin.

ultrasound. Imaging using ultra-high sound frequency bounced off body structures.

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

97597-97598

97597 Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less

\+ **97598** each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Explanation

The qualified health care provider performs wound care management by using selective debridement techniques to remove devitalized or necrotic tissue from an open wound. Selective techniques are those in which the provider has complete control over which tissue is removed and which is left behind, and include high-pressure waterjet with or without suction and sharp debridement using scissors, a scalpel, or forceps. Wound assessment, topical applications, instructions regarding ongoing care of the wound, and the possible use of agitated water, such as provided through a whirlpool or Hubbard tank for treatment are included in these codes. Report 97597 for a total wound surface area less than or equal to 20 sq cm and 97598 for each additional 20 sq cm or part thereof.

Coding Tips

CPT code 97022 (whirlpool) should not be billed in addition to 97597 or 97598 if the whirlpool is for the purpose of treating the wound.

Do not report these codes with debridement codes 11010–11047.

The physical therapist must provide direct, one-to-one patient contact when billing these procedures.

Documentation Tips

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

Reimbursement Tips

This service is considered a "sometimes-therapy" service and is subject to the Medicare outpatient physical therapy threshold when performed by the physical therapist. The following modifiers are used to identify therapy services, whether the financial threshold are 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 only be reported with codes on the list of applicable therapy codes:

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

GO Services delivered under an outpatient occupational therapy plan of care

GP Services delivered under an outpatient physical therapy plan of care

Claims for services above the $2,110 threshold require the use of modifier KX. When appending modifier KX, the physical therapist indicates that the service thresholds are reasonable and medically necessary, and that there is documentation of medical necessity for the services in the patient's medical record. Services exceeding modifier KX thresholds for outpatient therapy and do not have modifier KX appended are denied by Medicare contractors.

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

ICD-10-CM Diagnostic Codes

E10.621 Type 1 diabetes mellitus with foot ulcer

E11.621 Type 2 diabetes mellitus with foot ulcer

I70.231 Atherosclerosis of native arteries of right leg with ulceration of thigh A ☑

I70.232 Atherosclerosis of native arteries of right leg with ulceration of calf A ☑

I70.233 Atherosclerosis of native arteries of right leg with ulceration of ankle A ☑

I70.234 Atherosclerosis of native arteries of right leg with ulceration of heel and midfoot A ☑

I70.431 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of thigh A ☑

I70.432 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of calf A ☑

I70.433 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of ankle A ☑

I70.434 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of heel and midfoot A ☑

I70.531 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of thigh A ☑

I70.532 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of calf A ☑

I70.533 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of ankle A ☑

I70.534 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of heel and midfoot A ☑

I70.631 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of thigh A ☑

I70.632 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of calf A ☑

I70.633 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of ankle A ☑

I70.634 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of heel and midfoot A ☑

I83.011 Varicose veins of right lower extremity with ulcer of thigh A ☑

I83.012 Varicose veins of right lower extremity with ulcer of calf A ☑

I83.013 Varicose veins of right lower extremity with ulcer of ankle A ☑

I83.014 Varicose veins of right lower extremity with ulcer of heel and midfoot A ☑

I83.211 Varicose veins of right lower extremity with both ulcer of thigh and inflammation A ☑

I83.212 Varicose veins of right lower extremity with both ulcer of calf and inflammation A ☑

I83.213 Varicose veins of right lower extremity with both ulcer of ankle and inflammation A ☑

I83.214 Varicose veins of right lower extremity with both ulcer of heel and midfoot and inflammation A ☑

I87.011 Postthrombotic syndrome with ulcer of right lower extremity ☑

I87.013 Postthrombotic syndrome with ulcer of bilateral lower extremity ☑

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

CPT Index

[Resequenced]

HCPCS Level II Definitions and Guidelines

Introduction

One of the keys to gaining accurate reimbursement lies in understanding the multiple coding systems that are used to identify services and supplies. To be well versed in reimbursement practices, coders should be familiar not only with the American Medical Association's (AMA) Physicians' Current Procedural Terminology (CPT®) coding system (HCPCS Level I) but also with HCPCS Level II codes, which are becoming increasingly important to reimbursement as they are extended to a wider array of medical services.

HCPCS Level II—National Codes

HCPCS Level II codes commonly are referred to as national codes or by the acronym HCPCS (pronounced "hik-piks"), which stands for the Healthcare Common Procedure Coding System. HCPCS codes are used for billing Medicare and Medicaid patients and have been adopted by some third-party payers.

These codes, updated and published annually by the Centers for Medicare and Medicaid Services (CMS), are intended to supplement the CPT coding system by including codes for nonphysician services, administration of injectable drugs, durable medical equipment (DME), and office supplies.

When using HCPCS Level II codes, keep the following in mind:

- CMS does not use consistent terminology for unlisted services or procedures. The code descriptions may include any one of the following terms: unlisted, not otherwise classified (NOC), unspecified, unclassified, other, and miscellaneous.
- If billing for specific supplies and materials, avoid CPT code 99070 General supplies, and be as specific as possible unless the Medicare administrative contractor or local payer directs otherwise.
- Coding and billing should be based on the service provided. Documentation should describe the patient's problems and the service provided to enable the payer to determine reasonableness and necessity of care.
- Refer to the Online CMS Manual System (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html or third-party payment policy to determine whether the care provided is a covered service.
- When both a CPT and HCPCS Level II code share nearly identical narratives, apply the CPT code. If the narratives are not identical, select the code with the narrative that better describes the service. Generally, for Medicare claims, the HCPCS Level II code is more specific and takes precedence over the CPT code.

Structure and Use of HCPCS Level II Codes

The main terms are in boldface type in the index. Main term entries include tests, services, supplies, orthotics, prostheses, medical equipment, drugs, therapies, and some medical and surgical procedures. Where possible, entries are listed under a common main term. In some instances, the common term is a noun; in others, the main term is a descriptor.

HCPCS Level II Codes: Sections A–V

Level II codes consist of one alphabetic character (letters A through V) and four numbers. Similar to CPT codes, they also can have modifiers, which can be alphanumeric or two letters. National modifiers can be used with all levels of HCPCS codes.

The HCPCS coding system is arranged in 16 sections:

A codes	A0021–A9999	Transportation Services Including Ambulance, Medical/Surgical Supplies, and Administrative, Miscellaneous, and Investigational
B codes	B4034–B9999	Enteral and Parenteral Therapy
C codes	C1300–C9899	Outpatient PSS
E codes	E0100–E8002	Durable Medical Equipment
G codes	G0008–G9987	Procedures/Professional Services (Temporary Codes)
H codes	H0001–H2037	Alcohol and Drug Abuse Treatment Services
J codes	J0120–J9999	Drugs Administered Other Than Oral Method, Chemotherapy Drugs (Exception: Oral Immunosuppressive Drugs)
K codes	K0001–K0903	Durable Medical Equipment for Medicare Administrative Contractors (DME MACs) (Temporary Codes)
L codes	L0112–L9900	Orthotic and Prosthetic Procedures, Devices
M codes	M0064–M1071	Medical Services
P codes	P2028–P9615	Pathology and Laboratory Services
Q codes	Q0035–Q9995	Miscellaneous Services (Temporary Codes)
R codes	R0070–R0076	Radiology Services
S codes	S0012–S9999	Commercial Payers (Temporary Codes)
T codes	T1000–T5999	Medicaid Services
U codes	U0001–U0005	COVID-19 Related Services
V codes	V2020–V5364	Vision, Hearing and Speech-Language Pathology Services

Section Guidelines

Examine the instructions found at the beginning of each of the 16 sections. Instructions include the guidelines, notes, unlisted procedures, special reports, and the modifiers that pertain to each section.

Use the alphabetic index to initially locate a code by looking for the type of service or procedure performed. The same rule applies: never code directly from the index. Always check the specific code in the appropriate section.

Glossary

abduction. Pulling away from a central reference line, such as moving away from the midline of the body.

abuse. Medical reimbursement term that describes an incident that is inconsistent with accepted medical, business, or fiscal practices and directly or indirectly results in unnecessary costs to the Medicare program, improper reimbursement, or reimbursement for services that do not meet professionally recognized standards of care or which are medically unnecessary. Examples of abuse include excessive charges, improper billing practices, billing Medicare as primary instead of other third-party payers that are primary, and increasing charges for Medicare beneficiaries but not to other patients.

accountable care organization. Recognized legal entity under state law comprised of providers of services and suppliers with an established mechanism for shared governance who work together to coordinate care for Medicare fee-for-service beneficiaries. Section 3022 of the Affordable Care Act required CMS to develop a shared savings program to promote coordination and cooperation among providers for the purposes of improving the quality of care for Medicare fee-for-service beneficiaries and minimize costs.

acquired. Produced by outside influences and not by genetics or birth defect.

activities of daily living. Self-care activities often used to determine a patient's level of function, such as bathing, dressing, using a toilet, transferring in and out of bed or a chair, continence, eating, and walking.

activity limitations. Difficulties an individual may have in executing a task, action, or activities (e.g., inability to perform tasks due to abnormal vital sign response to increased movement or activity).

add-on code. CPT code representing a procedure performed in addition to the primary procedure and designated with a + symbol in the CPT book. Add-on codes are never reported for stand-alone services but are reported secondarily in addition to the primary procedure.

adduction. Pulling toward a central reference line, such as toward the midline of the body.

Advance Beneficiary Notice of Noncoverage. Written communication with a Medicare beneficiary given before Part B services are rendered informing the patient that the provider (including independent laboratories, imaging centers, physicians, practitioners, and/or suppliers) believes Medicare will not pay for some or all of the services to be rendered. Form CMS-R-131 (revised 03/2011) may be used for all situations where Medicare payment is expected to be denied. Synonym: ABN.

anterior. Situated in the front area or toward the belly surface of the body; an anatomical reference point used to show the position and relationship of one body structure to another.

anteroposterior. Front to back.

appeal. Specific request made to a payer for reconsideration of a denial or adverse coverage or payment decision and potential restriction of benefit reimbursement.

assessment. Process of collecting and studying information and data, such as test values, signs, and symptoms.

assigned claim. Claim from a physician or supplier who has agreed to accept the Medicare allowable amount as payment in full for the services rendered. Reimbursement is made directly to the provider of the service.

assignment of benefits. Authorization from the patient allowing the third-party payer to pay the provider directly for medical services. Under Medicare, an assignment is an agreement by the hospital or physician to accept Medicare's payment as the full payment and not to bill the patient for any amounts over the allowance amount, except for deductible and/or coinsurance amounts or noncovered services.

atony. Absence of normal muscle tone and strength.

atrophy. Reduction in size or activity in an anatomic structure, due to wasting away from disease or other factors.

balance billing. Arrangement prohibited in Medicare regulations and some payer contracts whereby a provider bills the patient for charges in excess of the contracted allowable rate or medical necessity denials not reimbursed by the payer. Insurance plan exclusions may still be billable.

beneficiary. Person entitled to receive Medicare or other payer benefits who maintains a health insurance policy claim number.

body functions. The physiological functions of body systems, including psychological functions.

body structures. The structural or anatomical parts of the body, such as organs, limbs, and their components, classified according to body systems.

bundled codes. Inclusive grouping of codes related to a procedure when submitting a claim.

bundled payment. Inclusive grouping of codes related to a procedure resulting in a single payment for services.

carpal tunnel syndrome. Swelling and inflammation in the tendons or bursa surrounding the median nerve caused by repetitive activity. The resulting compression on the nerve causes pain, numbness, and tingling especially to the palm, index, middle finger, and thumb.

Centers for Medicare and Medicaid Services. Federal agency that oversees the administration of the public health programs such as Medicare, Medicaid, and State Children's Insurance Program.

closed dislocation. Simple displacement of a body part without an open wound.

closed fracture. Break in a bone without a concomitant opening in the skin.

closed reduction. Treatment of a fracture by manipulating it into proper alignment without opening the skin.

closed treatment. Realignment of a fracture or dislocation without surgically opening the skin to reach the site. Treatment methods employed include with or without manipulation and with or without traction.

condyle. Rounded end of a bone that forms an articulation.

CORF. Comprehensive outpatient rehabilitation facility. Facility that provides services that include physician's services related to administrative functions; physical, occupational, speech and respiratory therapies; social and psychological services; and prosthetic and orthotic devices. A service is covered as a CORF service if it is also covered as an inpatient hospital service provided to a hospital patient. CORF services require a plan of treatment within a maximum of 60-day intervals for rereviews.

Correct Coding Initiative. Official list of codes from the Centers for Medicare and Medicaid Services' (CMS) *National Correct Coding Policy Manual for Medicare Services* that identifies services considered an integral part of a comprehensive code or mutually exclusive of it.