

LCD for Outpatient Physical and Occupational Therapy Services (L26884)

Contractor Information

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National Government Services, Inc.

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CMS National Coverage Policy

Language quoted from Centers for Medicare and Medicaid Services (CMS). National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See Section 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act (SSA):

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Sections 1861(g), 1861(p), 1861(s)(2) and 1862(a)(14) of Title XVIII of the Social Security Act define the services of non-physician practitioners.

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1862(a)(20) excludes payment for PT or OT services furnished incident to the physician by personnel that do not meet the qualifications that apply to therapists, except licensing.

Code of Federal Regulations

42 CFR, Sections 410.59 and 410.61 describe outpatient occupational therapy services and the plan of treatment for outpatient rehabilitation services, respectively.

42 CFR, Sections 410.60 and 410.61 describe outpatient physical therapy services and the plan of treatment for outpatient rehabilitation services, respectively.

42 CFR, Sections 410.74, 410.75, 410.76, and 419.22 define the services of non-physician practitioners.

42 CFR, Sections 424.24 and 424.27 describe therapy certification and plan requirements.

42 CFR, Sections 424.4, 482.56, 484 and 485.705 define therapy personnel qualification requirements.

42 CFR, Section 486 describes coverage for services rendered by physical therapists in independent practice.

Federal Register

Federal Register, Vol. 72, No. 227, November 27, 2007, pages 66328-66333 and 66397-66408, revises personnel qualification standards for therapy services and certification requirements.

Federal Register, July 22, 2002, Decision Memo for Neuromuscular Electrical Stimulation (NMES) for Spinal Cord Injury (CAG 00153R), at:

<http://www.cms.gov/mcd/viewdecisionmemo.asp?from2=viewdecisionmemo.asp&id=55&>

CMS Publications:

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15:

220 through 230 Coverage and documentation requirements for physical and occupational therapy services.

CMS Publication 100-03, *Medicare National Coverage Decisions Manual*, (multiple sections):

provides coverage information on several specific types of therapy services. See body of LCD for individual references.

CMS Publication 100-04, *Claims Processing Manual*, Chapter 5:

10.2 Financial limitation for therapy services (therapy cap).

CMS Publication 100-04, *Claims Processing Manual*, Chapter 5:

20-100 HCPCS coding and therapy billing requirements.

CMS Publication 100-04, *Claims Processing Manual*, Chapter 20:

1-10 Orthotics billing.

CMS, “11 Part B Billing Scenarios for PTs and OTs”,
http://www.cms.hhs.gov/TherapyServices/02_billing_scenarios.asp#TopOfPage

Primary Geographic Jurisdiction

Wisconsin

Oversight Region

Region V

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Indications and Limitations of Coverage and/or Medical Necessity

Abstract

This Local Coverage Determination (LCD) describes the coverage limits of outpatient physical and occupational therapy services under Medicare Part B, billed to either the Medicare Fiscal Intermediary (FI) or Part A MAC, or Medicare Carrier or Part B MAC when services are provided under a therapy plan of care. These limits include specific conditions under which certain physical and occupational therapy services may be considered covered by Medicare. This LCD shall not be construed to either expand or contract the limits of coverage imposed by the therapy cap as established by Medicare. This LCD shall not be construed to expand coverage to services defined as non-covered by National Coverage Determinations (NCDs).

Definitions

CLINICIAN refers to a physician, nonphysician practitioner (physician assistant, clinical nurse specialist and nurse practitioner) or a therapist (but not to an assistant, aide or any other personnel) providing a service within their scope of practice and consistent with state and local law. *Clinicians make clinical judgments and are responsible for all services they are permitted to supervise. Services that require the skills of a therapist may be appropriately furnished by clinicians, that is, by or under the supervision of qualified physicians/NPPs when their scope of practice, state and local laws allow it and their personal professional training is sufficient to provide to the beneficiary skills equivalent to a therapist for that service.*

QUALIFIED PROFESSIONAL means a physical therapist, occupational therapist, physician, or nonphysician practitioner (NPP) who is licensed or certified by the state to perform therapy services. *Qualified professionals may also include physical therapist assistants (PTA) and occupational therapy assistants (OTA) when working under the supervision of a qualified therapist, within the scope of practice allowed by state law.*

QUALIFIED AXILIARY PERSONNEL means staff (auxiliary personnel) who have been educated and trained as therapists and qualify to furnish therapy services only under direct supervision incident to a physician or NPP. *Qualified personnel may or may not be licensed as therapists but meet all of the requirements for therapists with the exception of licensure.*

THERAPIST refers to physical therapists and occupational therapists qualified according to Medicare policy.

SKILLS OF A THERAPIST are defined by the scope of practice for therapists in the state. For clinicians who are not therapists (e.g., physicians and NPPs), personal professional training should be sufficient to provide to the beneficiary skills equivalent to a therapist (OT or PT) for that service. Skills of a therapist also include therapists supervising assistants.

PROVIDER refers to a facility or agency such as a rehabilitation agency, hospital, critical access hospitals (CAH), skilled nursing facilities (SNF), comprehensive outpatient rehabilitation facilities (CORF), home health agencies, or outpatient rehabilitation facilities (ORF).

SUPPLIERS of therapy services include individual practitioners such as physicians, NPPs, physical therapists and occupational therapists who have Medicare provider numbers.

Medical Necessity

Section 1862(a)(1)(A) of the SSA states: "No Medicare payment shall be made for expenses incurred for items or services which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Services which do not meet the requirements for covered therapy services in Medicare manuals are not payable as therapy services. Services related to activities for the general good and welfare of patients, such as general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation, do not constitute (covered) therapy services for Medicare purposes. Services related to recreational activities such as golf, tennis, running, etc., are also not covered as therapy services.

To be considered reasonable and necessary, the services must meet Medicare guidelines. The guidelines for coverage of outpatient therapies have basic requirements in common.

- *There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time.*
- *If an individual's expected rehabilitation potential would be insignificant in relation to the extent and duration of therapy services required to achieve such potential, therapy would not be covered because is not considered rehabilitative or reasonable and necessary.*
- When there is limited potential for restoration of function, establishment of a safe and effective maintenance program must require the unique skills of a therapist.
- A therapy plan of care is developed either by the physician/NPP, or by the physical therapist who will provide the physical therapy services, or the occupational therapist who will provide the occupational therapy services, (only a physician may develop the plan of care in a CORF). The plan must be certified by a physician/NPP.
- All services provided are to be specific and effective treatments for the patient's condition according to accepted standards of medical practice; and the amount, frequency, and duration of the services must be reasonable.
- The services that are provided must meet the description of skilled therapy below.

Skilled Therapy

Services that do not require the professional skills of a therapist to perform or supervise are not medically necessary. The skills of a therapist may also be furnished by an appropriately trained and experienced physician or NPP, or by an assistant (PTA, OTA) appropriately supervised by a therapist. Therefore, if a patient's therapy can proceed safely and effectively through a home exercise program, self management program, restorative nursing program or caregiver assisted program, payment cannot be made for therapy services. Consider the following points when determining if a service is skilled.

- *Rehabilitative therapy occurs when the skills of a therapist (as defined by the scope of practice for therapists in each state) are necessary to safely and effectively furnish a recognized therapy service, whose goal is improvement of an impairment or functional limitation.*
- The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can only be safely and effectively performed by a qualified clinician, or therapists supervising assistants. Services that do not require the skills of a therapist are not considered reasonable or necessary therapy services, even if they are performed or supervised by a therapist, physician or NPP.
- *While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a qualified therapist are needed to treat the illness or injury, or whether the service(s) can be carried out by non-skilled personnel.*
- *Therapy is not required to effect improvement or restoration of function where a patient suffers a transient and easily reversible loss or reduction in function which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities (CMS Publication 100-02, Medicare Benefit Policy Manual, chapter 15, section 220.2(C)).* Patients must require the unique skills of a therapist to realize improved function in order for therapy to be covered. For example, therapy may not be covered for a fully functional patient who developed temporary weakness from a brief period of bed rest following abdominal surgery. It is reasonably expected that as discomfort reduces and the patient gradually resumes daily activities, function will return without skilled therapy intervention.
- If at any point in the treatment of an illness or injury it is determined that the treatment is not rehabilitative, or becomes repetitive and does not require the unique skills of a therapist, the services are non-covered.
- There may be circumstances where the patient, with or without the assistance of an aide or other caregiver, does activities planned by a clinician. Although these activities may be supportive to the patient's treatment, if they can be done by the patient, aides or other caregivers without the active participation of qualified professional/auxiliary personnel, they are considered unskilled.
- If a patient's limited ability to comprehend instructions, follow directions, or remember skills that are necessary to achieve an increase in function, is so severe as to make functional improvement very unlikely, rehabilitative therapy is not required, and therefore, is not covered. However, limited services in these circumstances may be covered with supportive documentation, if the skills of a therapist are required to establish and teach a caregiver a safety or maintenance program.
 - This does not apply to the limited situations where rehabilitative therapy is reasonable and achieving meaningful goals is appropriate, even when a patient does not have the ability to comprehend instructions, follow directions or remember skills. Examples include sitting and standing balance activities that help a patient recover the ability to sit upright in a seat or wheelchair, or safely transfer from the wheelchair to a toilet.
 - This also does not apply to those patients who have the potential to recover abilities to remember or follow directions, and treatment may be aimed at rehabilitating these abilities, such as following a traumatic brain injury.
- The use of therapy equipment such as therapeutic pools or gym machines alone does not necessarily make the treatment skilled.

- Medicare does not cover packaged or predetermined therapy services or programs, such as Back Schools or pre-operative joint classes with preset educational activities and exercises for all participants involved. Services must be individualized, medically necessary and require the unique skills of a therapist. (Packaged or predetermined therapy services do not apply to post-surgical protocols that provide ranges and guidance.)
- Services which do not meet the requirements for covered therapy services under Medicare are not payable using codes and descriptions for therapy services. Also, services not provided under a therapy plan of care, or provided by staff that are not qualified or appropriately supervised are not covered, payable therapy services

Maintenance Therapy

The specialized skill, knowledge and judgment of a therapist may be required, and services are covered, to design or establish the maintenance program, assure patient safety, train the patient, family members, caregiver, and/or unskilled personnel and make infrequent but periodic reevaluations of the program. The services of a qualified professional are not necessary to carry out a maintenance program, and are not covered under ordinary circumstances. The patient may perform such a program independently or with the assistance of unskilled personnel, caregivers or family members. For circumstances in which the patient's safety is at risk, services shall be covered when the skilled maintenance program is carried out by the qualified professional/auxiliary personnel (e.g., where there is an unhealed, unstable fracture) with documented justification.

Maintenance programs can take several forms.

Individual Activities Concurrent with Rehabilitative Treatment

An individualized plan of exercise and activity for patients and their caregiver(s) may be developed by clinicians to maintain and enhance a patient's progress during the course of skilled therapy, as well as after discharge from therapy services. Such programs are an integral part of therapy from the start of care and should be updated and modified as the patient progresses. Therapist skills are required to develop and revise the program, and train the patient and/or caregiver to follow it. As the patient or caregiver masters an activity or exercise, transition to a maintenance program for completion of the activity or exercise is expected. Prior to discharge, the maintenance program may be revised based on the patient's attained functional status so that the patient does not regress or lose important functional skills, or to gain further improvement. Maintenance programs are not covered if established after the rehabilitative therapy has been completed (i.e., after the long term goals for the rehabilitative therapy have been achieved).

Evaluation and Maintenance Program without Rehabilitation Therapy

When there is no expectation of significant functional improvement, therapy may be covered for the establishment of a safe and effective maintenance program to maintain or prevent decline in function. Maintenance program development and periodic monitoring are covered if the specialized knowledge and judgment of a therapist is required to design or establish the plan, assure patient safety, train the patient, family members and/or unskilled personnel, and make infrequent but periodic reevaluations of the plan. For example, the skills of a physical therapist (PT) may be covered to develop a maintenance program for a patient with multiple sclerosis for services intended to prevent or minimize deterioration in gait ability caused by the medical condition, when the patient's current condition does not yet justify the need for rehabilitative physical therapy treatment. Evaluation, development of the program and training the family/caregivers would require the skills of a therapist. *The services of a qualified professional are not necessary to carry out the maintenance program under ordinary circumstances. The patient may perform such a program independently or with the assistance of unskilled personnel or family members.*

When patients with chronic progressive conditions experience a deterioration of function, rehabilitative therapy may be appropriate and reasonable to assist the patient in restoring lost function. Other times, the intent of therapy is not necessarily rehabilitative, but to develop a maintenance program to delay or minimize functional deterioration. Instructing patients and/or caregivers in a maintenance program required to delay or minimize functional deterioration in patients suffering from a chronic disease is not expected to require more than 2-4 visits. Supporting documentation is required to justify more than 4 visits. In addition, therapy may be intermittently necessary to determine the need for assistive equipment and/or establish/revise a program to maximize function.

Non-covered indications for maintenance programs include the following services.

- Non-individualized services
- Services considered to be routine or non-skilled (e.g., supportive nursing services)
- Maintenance programs for patients without a complex condition that requires development of such a program by a skilled therapist
- Exercises or activities that could have been transitioned to an independent or caregiver assisted program (e.g., consistently repetitive exercises/activities)
- Non-cooperation by patient or caregiver(s)
- Continuation of treatment solely for the purpose of staff training and education, or development of a formal maintenance program after rehabilitative therapy has been completed.

Personnel Authorized to Provide Outpatient Therapy Services

Medicare billable therapy services may be provided by any of the following within their scope of practice and consistent with state and local law:

- physician;
- non-physician practitioner (NPP) (physician assistants, nurse practitioners, clinical nurse specialists);
- qualified physical and occupational therapists, and assistants working under the supervision of a qualified therapist;
- qualified personnel, with or without a license to practice therapy, who have been educated and trained as therapists and qualify to furnish therapy services only under direct supervision incident to a physician or NPP.

The new personnel qualifications for physical therapists, physical therapist assistants, occupational therapists and occupational therapy assistants were discussed in the 2008 Physician Fee Schedule. See the Federal Register of November 27, 2007 for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008.

Personnel NOT Authorized to Provide Outpatient Therapy Services

Students*, aides, athletic trainers, exercise physiologists, massage therapists, recreation therapists, kinesiotherapists, low vision specialists, lymphedema specialists, pilates instructors, rehabilitation technicians and life skills trainers are not considered qualified therapy professionals and may not bill their services under the Medicare therapy benefit, even if performed under the supervision of a qualified therapist.

* See Therapy Students section for further clarification regarding student participation in treatment.

CMS established the qualifications to assure that all personnel who provide therapy services are suitably trained in the discipline they practice. Personnel who do not meet the applicable professional standards to be considered qualified professional/personnel cannot furnish or be paid for physical or occupational therapy services.

Therapy Students

Qualified professionals may serve as clinical instructors for therapy students within their scope of practice. Physical therapist assistants and occupational therapy assistants may only serve as clinical instructors for physical therapist assistant students and occupational therapy assistant students, respectively, when performed under the direction and supervision of the licensed physical or occupational therapist (in states where licensure applies).

Services performed by a student (therapy student or therapy assistant student) are not reimbursed, even if provided under “line of sight” supervision of the therapist. However, the services of a qualified professional are covered, even when a student is participating in the care.

To be covered when the student is participating, the qualified professional must be present in the room and must:

- direct the service, making the skilled judgment and assessment, and assume responsibility for the treatment;
- not be engaged in treating another patient or doing other tasks at the same time (such as documentation); AND must
- sign all documentation appropriately. A student may also sign the documentation, but it is not necessary since the Part B payment is for the qualified professional’s service, not for the student’s services.

Supervision Levels

Supervision levels for outpatient therapy services depend on the setting where they are provided. Direct supervision (in the office suite) by a physician/NPP is required for therapists and qualified auxiliary personnel when therapy services are provided incident to the services of a physician/NPP. Also, direct supervision by a physical therapist (for PTAs) or occupational therapist (for OTAs) is required when assistants provide therapy services in the private practice setting or in the office of a physician/NPP. General supervision (the supervising therapist is available but not necessarily on the premises) is required by a physical therapist (for PTAs) or occupational therapist (for OTAs) when therapy services are provided in any other setting.

Private Practice Therapy Services

All therapy medical necessity, certification, documentation and coding guidelines of this LCD apply to all outpatient settings, including therapy services provided by private practitioners. In addition, in the private practice setting, all services not performed by the therapist must be performed by an assistant who is an employee of the practice and must be under direct supervision of the therapist.

To qualify as a private practice, each individual must be enrolled as a private practitioner and employed in one of the following practice types:

- unincorporated solo practice, partnership, or group practice;
- physician/NPP group or groups that are not professional corporations, if allowed by state and local law;
- physical or occupational therapist employed by physician/NPP group practices (PTPP, OTPP), if state and local law permits this employee relationship.

Private practice also includes therapists who are practicing therapy as employees of another supplier, of a professional corporation or other incorporated therapy practice. Private practice does not include individuals when they are working as employees of an institutional provider.

Services should be furnished in the therapist’s or group’s office or in the patient’s home. The office is defined as the location(s) where the practice is operated during the hours that the therapist engages in the practice at that location. If the services are furnished in a private practice office space, that space shall be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice.

Therapy Provided by Physicians and Physician Employees

Physical and occupational therapy services may be provided by physicians, non-physician practitioners (NPPs), or incident-to the services of physicians/NPPs when provided by physical or occupational therapists, in the office or home. All therapy medical necessity, certification, documentation, and coding guidelines of this LCD apply with one exception. When therapy services are performed incident-to a physician's/NPP's service, the *therapist* does not need a license to practice therapy, unless it is required by state law. All other physical or occupational therapist qualifications (education and training) must be met. Therapy services must be directly supervised. *The services of PTAs and OTAs also may not be billed incident to a physician's/NPP's service. However, if a PT and PTA (or an OT and OTA) are both employed in a physician's office, the services of the PTA, when directly supervised by the PT or the services of the OTA, when directly supervised by the OT may be billed by the physician group as PT or OT services using the PIN/NPI of the enrolled PT (or OT). (See Section 230.4 for private practice rules on billing services performed in a physician's office.) If the PT or OT is not enrolled, Medicare shall not pay for the services of a PTA or OTA billed incident to the physician's service, because they do not meet the qualification standards in 42CFR484.4.,*

Indications and Limitations of Coverage and/or Medical Necessity:

The following services are typically considered rehabilitative. This is not intended to be an exhaustive list of therapy services and does not assure coverage.

Therapy services should be provided in a manner that meets the patient's needs. The treatment plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources. Because medical review decisions are made based on documentation in the medical record, this LCD provides recommendations intended to assist qualified professionals/auxiliary personnel in documenting to support both the medical necessity and the skilled nature of the therapy services provided. In addition, any numerical guidelines related to individual codes in this section of the LCD, are based on contractor medical review experience. These are provided to remind qualified professionals/auxiliary personnel of the importance of justifying therapy services in the documentation as the patient progresses through an episode of care. The guidelines presented under the sections "Supportive Documentation Recommendations" are not mandated, and it is not necessary to document these recommended points for each treatment session (unless otherwise specified in the LCD).

Please refer to CMS publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, section 220.3 for the Medicare minimal documentation requirements for therapy services.

CPT 97001 – Physical therapy evaluation

CPT 97003 – Occupational therapy evaluation

The initial evaluation should document the necessity of a course of therapy through objective findings and subjective patient/caregiver self-reporting. Initial evaluations must be completed by the therapist or physician/NPP that will be providing the therapy services. Initial evaluations are completed to determine the medical necessity of initiating rehabilitative therapy or skilled instruction in maintenance activities that the patient and/or caregiver can perform at home.

Initial evaluation may be warranted when there is a change in functional ability. The evaluation should clearly describe the presenting complaint or problem for which the patient is seeking services of the physical or occupational therapist.

The evaluation process assesses, for example, the severity and impact of the current problem, the possibility of multi-site or multi-system involvement, the presence of pre-existing systemic conditions (e.g., diseases), and the stability of the condition. If the patient presents with multi-system involvement and/or multiple site involvement, all pertinent areas/conditions should be assessed at the initial evaluation (i.e., cervical pain and knee pain; low back pain and rotator cuff irritation; cervical pain and low back pain). Only one initial evaluation code should be used, and all presenting complaints and problems evaluated. If over the course of an episode of treatment, a new, unrelated diagnosis occurs, another initial evaluation may be covered.

Initial evaluations may be covered when the documentation justifies the need for a skilled therapy evaluation, even if it is determined that the patient does not require a skilled level of treatment.

- *When an evaluation is the only service provided by a provider/supplier in an episode of treatment, the evaluation serves as the plan of care if it contains a diagnosis, or in states where a therapist may not diagnose, a description of the condition from which a diagnosis may be determined by the referring physician/NPP. The goal, frequency, and duration of treatment are implied in the diagnosis and one-time service. The referral/order of a physician/NPP is the certification that the evaluation is needed and the patient is under the care of a physician. Therefore, when evaluation is the only service, a referral/order and evaluation are the only required documentation. If the patient presented for evaluation without a referral or order and does not require treatment, a physician referral/order or certification of the evaluation is required for payment of the evaluation. A referral/order dated after the evaluation shall be interpreted as certification of the plan to evaluate the patient.*

Screening may be more appropriate than evaluation in some circumstances. For example, a patient develops an acute lateral epicondylitis from painting. The patient seeks physician attention who subsequently recommends that the patient see an occupational therapist. By the time the patient sees the OT, she presents without any pain and has resumed all normal functional activities. Completing a screening interview of this patient should lead the therapist to determine that an OT evaluation and treatment would not be medically necessary.

- A screening is the gathering of information to determine the need for further evaluation by the clinician. The screening process may include a review of the patient's medical record, a patient interview and observation of the patient.
- Routine screening is not a billable service. Although some regulations and state practice acts require screening evaluations at specific intervals (such as at admission to a nursing home, or quarterly during the patient's stay), for Medicare payment, evaluations must meet Medicare coverage guidelines.

Initial evaluations from other therapy disciplines performed on the same beneficiary may also be covered, provided the evaluation and plan of care are not duplicative.

For initial evaluations, PTs shall use code 97001 and OTs shall use code 97003. Physicians and other qualified non-physician providers should use the evaluation and management codes 99201-99350 for evaluations.

Consider the following points when billing for an evaluation.

- These evaluation codes are untimed, billable as one unit.
- Do not bill for a therapy initial evaluation for each therapy discipline on more than one date of service. If an evaluation spans more than one day, the evaluation should only be billed as one unit for the entire evaluation service (typically billed on the day that the evaluation is completed). Do not count as therapy "treatment" the additional minutes needed to complete the evaluation during the subsequent session(s).
- Do not bill test and measurement, range of motion (ROM) or manual muscle testing (MMT) codes (CPT 95831-95834, 95851-95852, 97750, 97755) on the same day as the initial evaluation. The procedures performed are included in the initial evaluation codes and are not allowed by the Correct Coding Initiative(CCI) edits.
- Do not bill therapy screenings utilizing the evaluation codes. Screenings are not billable services.
- Evaluations for deconditioning after hospitalization where it is anticipated that prior functional abilities would spontaneously return through patient, caregiver and/or nursing activities are not considered medically necessary and are not covered.
- Pre-operative evaluations performed routinely to ascertain the patient's post-surgical needs and/or to explain the services that will be provided post-operatively are non-covered. The patient's post-op experience and functional limitations are unknown prior to the surgery and will at that time require a new evaluation of the situation when medically necessary.
- If treatment is given on the same day as the initial evaluation, the treatment is billed using the appropriate CPT codes. The documentation must clearly describe the treatment that was provided in addition to the evaluation.

Supportive Documentation Recommendations for 97001 and 97003

Refer to the *Documentation Requirements* Section of this LCD for further information.

CPT 97002 – Physical therapy reevaluation

CPT 97004 – Occupational therapy reevaluation

The reevaluation is focused on evaluation of progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment, or terminating services. Reevaluation provides additional objective information not included in other documentation, such as treatment or progress notes.

Reevaluations are distinct from therapy assessments. Assessments are considered a routine aspect of intervention and are not billed separately from the intervention. For example, a patient is being seen in physical or occupational therapy for shoulder pain and limited shoulder functional range of motion due to capsular tightness. Prior to performing shoulder joint mobilizations, the therapist assesses the patient's ROM and pain level/pattern to determine the effect of prior treatment and, if further mobilization is warranted, to determine the appropriate mobilizations. After the mobilizations are completed, the ROM is assessed again to determine the effects of the treatment just performed. The time required to assess the patient before and after the intervention is added to the minutes of the treatment intervention (code 97140 in this example). *Continuous assessment of the patient's progress is a component of the ongoing therapy services, and is not payable as a reevaluation.*

Consider the following points when billing for a reevaluation.

- *Indications for a reevaluation include new clinical findings, a significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care.*
- When reevaluations are done for a significant change in condition, documentation must show a significant improvement, decline or change in the patient's diagnosis, condition or functional status that was not anticipated in the current plan of care. When a patient exhibits a demonstrable change in functional ability, a reevaluation may be necessary to revise long term goals and interventions. The plan of care may need to be revised and recertified if significant changes are made, such as a change in the long-term goals.
- If a patient is hospitalized during the therapy interval, a reevaluation may be medically necessary if there has been a significant change in the patient's condition which has caused a change in function, long term goals, and/or treatment plan.
- Reevaluations may be appropriate at a planned discharge when documentations supports the medical necessity for the reevaluation service.
- Therapy reevaluations should contain all the applicable components of an initial evaluation and must be completed by a clinician. (See the Reevaluation section of Documentation Requirements for information regarding therapy assistant participation in the reevaluation process.)
- A reevaluation is not a routine, recurring service. Do not bill for routine reevaluations, including those done for the purpose of completing an updated plan of care, a recertification report, a progress report, or a physician progress report. *Although some state regulations and practice acts require reevaluations at specific intervals, for Medicare payment, reevaluations must meet Medicare coverage guidelines.*
- These reevaluation codes are untimed, billable as one unit.
- Do not bill for reevaluations as unlisted codes (97039, 97139, 97799) or test and measurement, ROM, MMT codes (95831-95834, 95851-95852, 97750, 97755).

Supportive Documentation Recommendations for 97002 and 97004

Refer to the Documentation Requirements Section of this LCD for further information.

MODALITIES

General Modality Guidelines

(CPT codes 97010, 97012, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, G0281, G0283, and G0329)

CPT codes 97012, 97016, 97018, 97022, 97024, 97026, and 97028 require supervision by the qualified professional/auxiliary personnel of the patient during the intervention.

CPT codes 97032, 97033, 97034, 97035, 97036, and 97039 require direct (one-on-one) contact with the patient by the provider (constant attendance). Coverage for these codes indicates the provider is performing the modality and cannot be performing another procedure at the same time. Only the actual time of the provider's direct contact with the patient, providing services requiring the skills of a therapist, is covered for these codes.

Modalities chosen to treat the patient's symptoms/conditions should be selected based on the most effective and efficient means of achieving the patient's functional goals. Seldom should a patient require more than one (1) or two (2) modalities to the same body part during the therapy session. Use of more than two (2) modalities on each visit date is unusual and should be carefully justified in the documentation.

The use of modalities as stand-alone treatments is rarely therapeutic, and usually not required or indicated as the sole treatment approach to a patient's condition. The use of exercise and activities has proven to be an essential part of a therapeutic program. Therefore, a treatment plan should not consist solely of modalities, but should also include therapeutic procedures. (There are exceptions, including wound care or when patient care is focused on modalities because the acute patient is unable to endure therapeutic procedures.) Use of only passive modalities that exceeds 4 visits should be very well supported in the documentation.

Multiple heating modalities should not be used on the same day. Exceptions are rare and usually involve musculoskeletal pathology/injuries in which both superficial and deep structures are impaired. Documentation must support the use of multiple modalities as contributing to the patient's progress and restoration of function. For example, it would not be medically necessary to perform both thermal ultrasound and thermal diathermy on the same area, in the same visit, as both are considered deep heat modalities.

When the symptoms that required the use of certain modalities begin to subside and function improves, the medical record should reflect the discontinuation of those modalities, so as to determine the patient's ability to self-manage any residual symptoms. As the patient improves, the medical record should reflect a progression of the other procedures of the treatment program (therapeutic exercise, therapeutic activities, etc). In all cases, the patient and/or caregiver should be taught aspects of self-management of his/her condition from the start of therapy.

Based on the CPT descriptors, these modalities apply to one or more areas treated (e.g., paraffin bath used for the left and right hand is billed as one unit).

CPT 97010 - hot or cold packs (to one or more areas)

Hot or cold packs (including ice massage) applied in the absence of associated procedures or modalities, or used alone to reduce discomfort are considered not to require the unique skills of a therapist.

Code 97010 is bundled. It may be bundled with any therapy code. Regardless of whether code 97010 is billed alone or in conjunction with another therapy code, this code is never paid separately. If billed alone, this code will be denied.

Supportive Documentation Recommendations for 97010

- The area(s) treated
- The type of hot or cold application

CPT 97012 - Traction, Mechanical (to one or more areas)

Traction is generally limited to the cervical or lumbar spine with the expectation of relieving pain in or originating from those areas.

Specific indications for the use of mechanical traction include cervical and/or lumbar radiculopathy and back disorders such as disc herniation, lumbago, and sciatica.

This modality is typically used in conjunction with therapeutic procedures, not as an isolated treatment.

Documentation should support the medical necessity of continued traction treatment in the clinic for greater than 12 visits. For cervical conditions, treatment beyond one month can usually be accomplished by self-administered mechanical traction in the home. The time devoted to patient education related to the use of home traction should be billed under 97012.

Only 1 unit of CPT code 97012 is generally covered per date of service.

Equipment and tables utilizing roller systems are not considered true mechanical traction. Services using this type of equipment are non-covered.

Non-Surgical Spinal Decompression Non-surgical spinal decompression *is performed for symptomatic relief of pain associated with lumbar disk problems. The treatment combines pelvic and/or cervical traction connected to a special table that permits the traction application. There is insufficient scientific data to support the benefits of this technique. Therefore, non-surgical spinal decompression is not covered by Medicare (CMS Publication 100-03, Medicare National Coverage Determinations (NCD) Manual: Section 160.16).* Examples of this type of non-covered procedure include, but are not limited to, VAX-D™, DRX-3000, DRX9000, Decompression Reduction Stabilization (DRS) System, IDD, MedX., Spina System, Accua-Spina System, SpineMED Decompression Table, Lordex Traction Unit, Triton DTS, and Z-Grav. If billed for purpose of receiving a denial, these services should be billed using CPT code 97039 and not with CPT 97012.

Supportive Documentation Recommendations for 97012

- Type of traction and part of the body to which it is applied, etiology of symptoms requiring treatment.

CPT 97014 – Electrical stimulation (unattended) (to one or more areas)

CPT 97014 is not a Medicare recognized code. See HCPCS code G0283 for electrical stimulation (unattended).

CPT 97016 - Vasopneumatic Devices (to one or more areas)

The use of vasopneumatic devices may be considered reasonable and necessary for the application of pressure to an extremity for the purpose of reducing edema or lymphedema.

Specific indications for the use of vasopneumatic devices include reduction of edema after acute injury or lymphedema of an extremity. Education on the use of a lymphedema pump for home use is covered when medically necessary and can typically be completed in three (3) or fewer visits once the patient has demonstrated measurable benefit in the clinic environment.

Note: Further treatment of lymphedema by a vasopneumatic device rendered by a clinician after the educational visits is generally not reasonable and necessary unless the patient presents with a condition or status requiring the skills and knowledge of a physical or occupational therapist.

The use of vasopneumatic devices is generally not covered as a temporary treatment while awaiting receipt of ordered compression stockings.

See NCD 280.6 in CMS Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual* for further coverage and use information on Pneumatic Compression Devices.

Supportive Documentation Recommendations for 97016

- Area of the body being treated, location of edema
- Objective edema measurements (1+, 2+ pitting, girth, etc), comparison with uninvolved side
- Effects of edema on function
- Type of device used

CPT 97018 – Paraffin Bath (to one or more areas)

Paraffin bath treatments typically do not require the unique skills of a therapist. However, the skills, knowledge and judgment of a therapist might be required in the provision of such treatment or baths in a complicated case. Only in cases with complicated conditions will paraffin be covered, and then coverage is generally limited to educating the patient/caregiver in home use. Paraffin is contraindicated for open wounds or areas with documented desensitization.

Once a trial of monitored paraffin treatment has been done in the clinic over 1-2 visits and the patient has had a favorable response, the patient can usually be taught to use a paraffin unit in 1-2 visits. Consequently, it is inappropriate for a patient to continue paraffin treatment in the clinic setting.

- Only 1 unit of CPT code 97018 is generally covered per date of service.
- Documentation needs to support more than 2 visits to educate patient and/or caregiver in home use once effectiveness has been determined.

Supportive Documentation Recommendations for 97018

- Rationale for requiring the unique skills of a therapist to apply and train the patient/caregiver, including the complicating factors
- Area of body treated

CPT 97022 – Whirlpool (to one or more areas)

Whirlpool bath treatments typically do not require the unique skills of a therapist. However, therapist supervision of the whirlpool modality may be medically necessary for the following indications:

- a condition complicated by a circulatory deficiency or areas of desensitization;
- an open wound which is draining, has a foul odor, or necrotic tissue;
- exfoliative skin impairments.

If greater than 8 visits are needed for whirlpools that require the skills of a therapist, the documentation should support the medical necessity of the continued treatment.

Only 1 unit of CPT code 97022 should be billed per date of service.

Dry hydrotherapy massage (also known as aquamassage, hydromassage, or water massage) is considered investigational and is non-covered.

Whirlpool should not be separately billed when provided on the same date of service as debridement (97597-97598) for the same body part.

Fluidotherapy (Billable as CPT code 97022)

Fluidotherapy is a superficial dry heat modality consisting of a whirlpool of finely divided solid particles suspended in a heated air stream, the mixture having the properties of a liquid. *Use of fluidized therapy dry heat is covered as an acceptable alternative to other heat therapy modalities in the treatment of acute or sub-acute traumatic or non-traumatic musculoskeletal disorders of the extremities.* (CMS Publication 100-03, Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Section 150.8)

Supportive Documentation Recommendations for 97022

- Rationale for requiring the unique skills of a therapist to apply, including the complicating factors
- Area(s) being treated

CPT 97024 – Diathermy (i.e., microwave)

The objective of these treatments is to cause vasodilation and relieve pain from muscle spasm. Because heating is accomplished without physical contact between the modality and the skin, it can be used even if skin is abraded, as long as there is no significant edema.

Diathermy achieves a greater rise in deep tissue temperature than microwave. As diathermy is considered a deep heat treatment, careful consideration should be given to the size, location and depth of the tissue the diathermy is intended to heat. For example, it may not be appropriate to perform diathermy treatment to the wrist or hand as most intended tissues would be considered superficial and the area is relatively small.

Diathermy may be indicated when a large area of deep tissues requires heat. It would not be reasonable and necessary to perform both thermal ultrasound and diathermy to the same region of the body in the same visit as both are considered deep heat modalities.

Pulsed wave diathermy is covered for the same conditions and to the same extent as standard diathermy. (CMS Publication 100-03, *Medicare National Coverage Determinations* (NCD) Manual, Section 150.5)

Diathermy is not considered reasonable and necessary for the treatment of asthma, bronchitis, or any other pulmonary condition. (CMS Publication 100-03, *Medicare National Coverage Determinations* (NCD) Manual, Section 240.3) Microwave is not a covered service.

Only 1 unit of CPT code 97024 is covered per date of service. If no objective and/or subjective improvement is noted after 6 treatments, a change in treatment plan (alternative strategies) should be implemented, or documentation should include the therapist's rationale for continued diathermy. Documentation must clearly support the need for diathermy more than 12 visits.

Supportive Documentation Recommendations for 97024

- Area(s) being treated
- Objective clinical findings/measurements to support the need for a deep heat treatment
- Subjective findings to include pain ratings, pain location, activities which increase or decrease pain, effect on function, etc.

CPT 97026 – Infrared (to one or more areas)

-including Anodyne

Not covered: *The Centers for Medicare & Medicaid Services has determined that there is sufficient evidence to conclude the use of infrared therapy devices and any related accessories is not reasonable and necessary. The use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy, is non-covered for the treatment, including the symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues. See CMS Publication 100-03 Medicare National Coverage Determinations (NCD) Manual, section 270.6 and Publication 100-04, Medicare Claims Processing Manual, Chapter 5, section 20.4.*

CPT 97028 - Ultraviolet (to one or more areas)

Treatment of this type is generally used for patients requiring the application of a drying heat. For example, this treatment would be considered reasonable and necessary for the treatment of severe psoriasis where there is limited range of motion.

Only 1 unit of CPT code 97028 is covered per date of service.

Supportive Documentation Recommendations for 97028

- Area(s) being treated
- Objective clinical findings/measurements to support the need for ultraviolet
- Minimal erythema dosage

CPT 97032 – electrical stimulation (manual) (to one or more areas), each 15 minutes

- See codes **G0281-G0283** for instructions regarding supervised electrical stimulation

Most non-wound care electrical stimulation treatment provided in therapy should be billed as G0283 as it is often provided in a supervised manner (after skilled application by the qualified professional/auxiliary personnel) without constant, direct contact required throughout the treatment.

97032 is a constant attendance electrical stimulation modality that requires direct (one-on-one) manual patient contact by the qualified professional/auxiliary personnel. Because the use of a constant, direct contact electrical stimulation modality is less frequent, documentation should clearly describe the type of electrical stimulation provided to justify billing 97032 versus G0283.

Types of electrical stimulation that may require constant attendance and should be billed as 97032 when continuous presence by the qualified professional/auxiliary personnel is required include the following examples.

- Direct motor point stimulation delivered via a probe
- Instructing a patient in the use of a home TENS unit
 - Once a trial of TENS has been done in the clinic over 1-2 visits and the patient has had a favorable response, the patient can usually be taught to use a TENS unit for pain control in 1-2 visits. Consequently, it is inappropriate for a patient to continue treatment for pain with a TENS unit in the clinic setting.
 - Note that CPT code 64550 is for application of surface (transcutaneous) neurostimulator and is an operative/postoperative code. Use of this code would seldom fall under a therapy plan of treatment.
- Functional Electrical Stimulation (FES) or Neuromuscular Electrical Stimulation (NMES) while performing a therapeutic exercise or functional activity may be billed as 97032. Do not bill for CPT codes 97110, 97112, 97116 or 97530 for the same time period.
 - Use for Walking in Patients with Spinal Cord Injury (SCI)
The type of NMES that is used to enhance the ability to walk of SCI patients is commonly referred to as functional electrical stimulation (FES). See the section on CPT code 97116 for information on coverage for this use of NMES. (CMS Publication 100-03, *Medicare National Coverage Determinations* (NCD) Manual, section 160.12)
- Ultrasound with electrical stimulation provided concurrently (e.g., Medcosound, Rich-Mar devices), should be billed as ultrasound (97035). Do not bill for both ultrasound and electrical stimulation for the same time period.
- If providing an electrical stimulation modality that is typically considered supervised (G0283) to a patient requiring constant attendance for safety reasons due to cognitive deficits, do not bill as 97032. This type of monitoring may be done by non-skilled personnel.

• Non-Implantable Pelvic Floor Electrical Stimulation (CMS Publication 100-03, *Medicare National Coverage Determinations* (NCD) Manual, section 230.8.)

Non-implantable pelvic floor electrical stimulators provide neuromuscular electrical stimulation through the pelvic floor with the intent of strengthening and exercising pelvic floor musculature. Stimulation delivered by vaginal or anal probes connected to an external pulse generator may be billed as 97032. Stimulation delivered via electrodes should be billed as G0283.

- *The methods of pelvic floor electrical stimulation vary in location, stimulus frequency (Hz), stimulus intensity or amplitude (mA), pulse duration (duty cycle), treatments per day, number of treatment days per week, length of time for each treatment session, overall time period for device use, and between clinic and home settings. In general, the stimulus frequency and other parameters are chosen based on the patient's clinical diagnosis.*
- *Pelvic floor electrical stimulation with a non-implantable stimulator is covered for the treatment of stress and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training.*
- *A failed trial of PME training is defined as no clinically significant improvement in urinary continence after completing 4 weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle strength.*
- *The patient's medical record must indicate that the patient receiving a non-implantable pelvic floor electrical stimulator was cognitively intact, motivated, and had failed a documented trial of pelvic muscle exercise (PME) training.*

Utilization of electrical stimulation may be necessary during the initial phase of treatment, but there must be an improvement in function. These modalities should be utilized with appropriate therapeutic procedures to effect continued improvement. Note: Coverage for this indication is limited to those patients where the nerve supply to the muscle is intact, including brain, spinal cord, and peripheral nerves, and other non-neurological reasons for disuse are causing the atrophy (e.g., post-casting or splinting of a limb, and contracture due to soft tissue scarring).

Documentation must clearly support the medical necessity of electrical stimulation more than 12 visits as adjunctive therapy or for muscle retraining.

Some patients can be trained in the use of a home muscle stimulator for retraining weak muscles. Only 1-2 visits should be necessary to complete the training. Once training is completed, this procedure should not be billed as a treatment modality in the clinic.

Non-covered Indications

- Electrical Stimulation (CPT code 97032) used in the treatment of facial nerve paralysis, commonly known as Bell's palsy (CMS Manual 100-03, *Medicare National Coverage Determinations* (NCD) Manual, section 160.15)
- Electrical Stimulation (CPT code 97032) used to treat motor function disorders such as multiple sclerosis (CMS Manual 100-03, *Medicare National Coverage Determinations* (NCD) Manual, section 160.2)
- Electrical Stimulation (CPT code 97032) for the treatment of strokes when it is determined there is no potential for restoration of function
- Electrical Stimulation when it is the only intervention utilized purely for strengthening of a muscle with at least Fair graded strength. Most muscle strengthening is more efficiently accomplished through a treatment program that includes active procedures such as therapeutic exercises and therapeutic activities.

Supportive Documentation Recommendations for 97032

- Type of electrical stimulation used (do not limit the description to "manual" or "attended")
- Area(s) being treated
- If used for muscle weakness, objective rating of strength and functional deficits
- If used for pain include pain rating, location of pain, effect of pain on function

CPT 97033 – Iontophoresis (to one or more areas)

Iontophoresis is the introduction into the tissues, by means of an electric current, of the ions of a chosen medication. This modality is used to reduce pain and edema caused by a local inflammatory process in soft tissue, e.g., tendonitis, bursitis.

The evidence from published, peer-reviewed literature is insufficient to conclude that the iontophoretic delivery of non-steroidal anti-inflammatory drugs (NSAIDs) or corticosteroids is superior to placebo when used for the treatment of musculoskeletal disorders. Therefore, iontophoresis will not be covered for these indications.

Iontophoresis will be allowed for treatment of intractable, disabling primary focal hyperhidrosis (ICD-9-CM code 705.21) that has not been responsive to recognized standard therapy. Good hygiene measures, extra-strength antiperspirants (for axillary hyperhidrosis), and topical aluminum chloride should initially be tried.

CPT 97034 - Contrast Baths (to one or more areas)

Contrast baths are a form of therapeutic heat and cold applied to distal extremities in an alternating pattern. The effectiveness of contrast baths is thought to be due to reflex hyperemia produced by the alternating exposure to heat and cold.

Hot and cold baths ordinarily do not require the skills of a therapist. However, the skills, knowledge and judgment of a therapist might be required in the provision of such treatments in a particular case, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fracture or other complication.

Documentation must indicate the presence of these complicating factors for reimbursement of this code. If there are no complicating factors requiring the skills of a therapist, this modality is non-covered.

CPT Code 97034 is not covered when the services provided are hot and cold packs.

This modality should be used in conjunction with therapeutic procedures, not as an isolated treatment.

No more than 2 visits will generally be covered to educate the patient and/or caregiver in home use, and to evaluate effectiveness. Documentation must support the medical necessity of continued use of this modality for greater than 2 visits.

This is a constant attendance code requiring direct, one-on-one patient contact by the provider. Only the actual time of the provider's direct contact with the patient is to be billed.

Supportive Documentation Recommendations for 97034

- Rationale requiring the unique skills of a therapist to apply, including the complicating factors
- Area(s) being treated
- Subjective findings to include pain ratings, pain location, effect on function

CPT 97035 – Ultrasound (to one or more areas)

Therapeutic ultrasound is a deep heating modality that produces a sound wave of 0.8 to 3.0 MHz. In the human body ultrasound has several pronounced effects on biologic tissues. It is attenuated by certain tissues and reflected by bone. Thus, tissues lying immediately next to bone may receive as much as 30% greater dosage of ultrasound than tissue not adjacent to bone. Because of the increased extensibility ultrasound produces in tissues of high collagen content, combined with the close proximity of joint capsules, tendons, and ligaments to cortical bone where tissue may receive a more intense irradiation, ultrasound is an ideal modality for increasing mobility in those tissues.

Covered ultrasound may be pulsed or continuous width, and should be used in conjunction with therapeutic procedures, not as an isolated treatment.

Specific indications for the use of ultrasound application include but are not limited to:

- limited joint motion that requires an increase in extensibility;
- symptomatic soft tissue calcification;
- neuromas.

Ultrasound application is not considered reasonable and necessary for the treatment of:

- asthma, bronchitis, or any other pulmonary condition;
- conditions for which the ultrasound can be applied by the patient without the need for a therapist or other professional to administer, and/or for extended period of time (e.g., devices such as PainShield MD);
- wounds. (see list “**ICD-9 Codes that DO NOT Support Medical Necessity**”)

Phonophoresis (the use of ultrasound to enhance the delivery of topically applied drugs) will be reimbursed as ultrasound, billable using CPT 97035. Separate payment will not be made for the contact medium or drugs.

Ultrasound with electrical stimulation provided concurrently (e.g., Medcosound, Rich-Mar devices), should be billed as ultrasound (97035). Do not bill for both ultrasound and electrical stimulation for the same time period.

If no objective and/or subjective improvement is noted after 6 treatments, a change in treatment plan (alternative strategies) should be implemented or documentation should support the need for continued use of ultrasound. Documentation must clearly support the need for ultrasound more than 12 visits.

Supportive Documentation Recommendations for 97035

- Area(s) being treated
- Frequency and intensity of ultrasound
- Objective clinical findings such as measurements of range of motion and functional limitations to support the need for ultrasound
- Subjective findings to include pain ratings, pain location, effect on function

CPT 97036 – Hubbard Tank (to one or more areas) This modality involves the patient’s immersion in a tank of agitated water in order to relieve muscle spasm, improve circulation, or cleanse wounds, ulcers, or exfoliative skin conditions.

Qualified professional/auxiliary personnel one-on-one supervision of the patient is required. If the level of care does not require the skills of a therapist, then the service is not covered.

Hubbard tank treatments more than 12 visits require clear documentation supporting the medical necessity of continued use of this modality.

It is not medically necessary to have more than one form of hydrotherapy during a visit (CPT codes 97022, 97036).

Supportive Documentation Recommendations for 97036

- Rationale requiring the unique skills of a therapist to apply, including the complicating factors
- Area(s) being treated

CPT 97039 - Unlisted Modality (Specify type and time if constant attendance)

If an existing CPT code does not describe the service performed, an unlisted CPT code may be used. The use of unlisted codes should be rare. If unlisted codes are billed, the claim and medical record must clearly state what modality or procedure is billed as an unlisted code. If not, the unlisted code billed will be subject to denial for insufficient information.

Note: Low level/cold laser light therapy (LLLT) is considered not reasonable and necessary under SSA 1862(a)(1)(A) and is not payable by Medicare. This procedure is considered non-covered billed under any HCPCS/CPT codes, including S8948 and 97039.

Supportive Documentation Recommendations for 97039 Please see section Documentation Recommendations for Unlisted Procedure Codes.

Please see the Unlisted Procedure Codes section of article A46198, Outpatient Physical and Occupational Therapy Services – Supplemental Instructions Article, for specific billing instructions.

CPT G0283 - Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

See 97032 for instructions in manual electrical stimulation.

Most non-wound care electrical stimulation treatment provided in therapy should be billed as G0283 as it is often provided in a supervised manner (after skilled application by the qualified professional/auxiliary personnel) without constant, direct contact required throughout the treatment.

Code G0283 is classified as a “supervised” modality, even though it is labeled as “unattended.” A supervised modality does not require direct (one-on-one) patient contact by the provider. Most electrical stimulation conducted via the application of electrodes is considered unattended electrical stimulation. Examples of unattended electrical stimulation modalities include Interferential Current (IFC), Transcutaneous Electrical Nerve Stimulation (TENS), cyclical muscle stimulation (Russian stimulation).

These modalities should be utilized with appropriate therapeutic procedures to effect continued improvement. Note: Coverage for this indication is limited to those patients where the nerve supply to the muscle is intact, including brain, spinal cord, and peripheral nerves, and other non-neurological reasons for disuse are causing the atrophy (e.g., post-casting or splinting of a limb, and contracture due to soft tissue scarring).

If unattended electrical stimulation is used for control of pain and swelling, there should be documented objective and/or subjective improvement in swelling and/or pain within 6 visits. If no improvement is noted, a change in treatment plan (alternative strategies) should be implemented or documentation should support the need for continued use of this modality.

Documentation must clearly support the need for electrical stimulation more than 12 visits. Some patients can be trained in the use of a home TENS unit for pain control. Only 1-2 visits should be necessary to complete the training (which may be billed as 97032). Once training is completed, code G0283 should not be billed as a treatment modality in the clinic.

Non-Implantable Pelvic Floor Electrical Stimulation

(CMS Publication 100-03, Medicare *National Coverage Determinations (NCD) Manual*, section 230.8.) *Non-implantable pelvic floor electrical stimulators provide neuromuscular electrical stimulation through the pelvic floor with the intent of strengthening and exercising pelvic floor musculature. Stimulation delivered by vaginal or anal probes connected to an external pulse generator may be billed as 97032. Stimulation delivered via electrodes should be billed as G0283.*

- *The methods of pelvic floor electrical stimulation vary in location, stimulus frequency (Hz), stimulus intensity or amplitude (mA), pulse duration (duty cycle), treatments per day, number of treatments days per week, length of time for each treatment session, overall time period for device use, and between clinic and home settings. In general, the stimulus frequency and other parameters are chosen based on the patient's clinical diagnosis.*
- *Pelvic floor electrical stimulation with a non-implantable stimulator is covered for the treatment of stress and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training.*
- *A failed trial of PME training is defined as no clinically significant improvement in urinary continence after completing 4 weeks of pelvic muscle exercises designed to increase periurethral muscle strength.*
- **The patient's medical record must indicate that the patient receiving a non-implantable pelvic floor electrical stimulator was cognitively intact, motivated, and had failed a documented trial of pelvic muscle exercise (PME) training. Documentation should also include the method of delivery (e.g., probe or electrode).**

The charges for the electrodes are included in the practice expense portion of code G0283. Do not bill the Medicare contractor or the patient for electrodes used to provide electrical stimulation as a clinic modality.

Do not bill Medicare for unattended electrical stimulation using code 97014.

Supportive Documentation Recommendations for G0283

- **Type of electrical stimulation used (e.g., TENS, IFC)**
- **Area(s) being treated**
- **If used for pain include pain rating, location of pain, effect of pain on function**

THERAPEUTIC PROCEDURES

General Guidelines for Therapeutic Procedures

(CPT codes 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97530, 97532, 97533, 97535, 97537, 97542, 97597, 97598, 97602, 97605, 97606, 97750, 97755, 97760, 97761, 97762 and 97799)

Therapeutic procedures attempt to reduce impairments and restore function through the application of clinical skills and/or services. Use of these procedures is expected to result in improvement of the limitations/deficits in a reasonable and generally predictable period of time.

Use of these procedures requires the qualified professional/auxiliary personnel to have direct (one-on-one) patient contact. Only the actual time of direct contact with the patient providing a service which requires the skills of a therapist is considered for coverage. Supervision of a previously taught exercise or exercise program, patients performing an exercise independently without direct contact by the qualified professional/auxiliary personnel, or use of different exercise equipment without requiring the intervention/skills of the qualified professional/ auxiliary personnel are not covered. The patient may be in the facility for a longer period of time, but only the time the qualified professional/auxiliary personnel is actually providing direct, one-on-one, patient contact which requires the skills of a therapist is considered covered time for these procedures, and only those minutes of treatment should be recorded.

Under Medicare, time spent in documentation of services (medical record production) is part of the coverage of the respective CPT code; there is no separate coverage for time spent on documentation (except for CPT Code 96125).

CPT codes 97110, 97112, 97113, 97116, 97124, 97140, 97530, 97532, 97533, 97535, 97537, 97542, 97760, 97761, and 97762 describe different types of therapeutic interventions. The expected goals documented in the treatment plan, effected by the use of each of these procedures, will help define whether these procedures are reasonable and necessary. Therefore, since any one or a combination of these procedures may be used in a treatment plan, documentation must support the use of each procedure as it relates to a specific therapeutic goal.

CPT 97110 - Therapeutic Exercises to develop strength and endurance, range of motion and flexibility (one or more areas, each 15 minutes)

Therapeutic exercises are used for the purpose of restoring strength, endurance, range of motion and flexibility where loss or restriction is a result of a specific disease or injury and has resulted in a functional limitation. Therapeutic exercises may require active, active-assisted, or passive participation by the patient (e.g., isokinetic exercise, lumbar stabilization, stretching and strengthening).

Many therapeutic exercises may require the unique skills of a therapist to evaluate the patient's abilities, design the program, and instruct the patient or caregiver in safe completion of the special technique. However, after the teaching has been successfully completed, repetition of the exercise, and monitoring for the completion of the task, in the absence of additional skilled care, is non-covered.

For example, as part of the initial therapy program following total knee arthroplasty (TKA), a patient may start a session on the exercise bike to begin gentle range of motion activity. Initially the patient requires skilled progression in the program from pedal-rocks, building to full revolutions, perhaps assessing and varying the seat height and resistance along the way. Once the patient is able to safely exercise on the bike, no longer requiring frequent assessment and progression, even if set up is required, the bike now becomes an "independent" program and is no longer covered by Medicare. While the qualified professional/auxiliary personnel may still require the patient to "warm up" on the bike prior to other therapeutic interventions, it is considered a non-skilled, unbillable service and should not be included in the total timed code treatment minutes. *Non-skilled interventions need not be recorded in the Treatment Notes as they are not billable.* However, notation of non-skilled exercises may be reported if the documentation indicates that the service was not billed (e.g., not included in the treatment minutes documented).

Exercises to promote overall fitness, flexibility, endurance (in absence of a complicated patient condition), aerobic conditioning, weight reduction, and maintenance exercises to maintain range of motion and/or strength are non-covered. In addition, exercises that do not require, or no longer require, the skilled assessment and intervention of a qualified professional/auxiliary personnel are non-covered. Repetitive type exercises often can be taught to the patient or a caregiver as part of a self-management, caregiver or nursing program.

Documentation should include not only measurable indicators such as functional loss of joint motion or muscle strength, but also information on the impact of these limitations on the patient's life and how improvement in one or more of these measures leads to improved function.

Documentation of progress should show the condition is responsive to the therapy chosen and that the response is (or is expected to be) clinically meaningful. Metrics of progress that are functionally meaningful (or obviously related to clinical functional improvement) should be documented wherever possible. For example, long courses of therapy resulting in small changes in range of motion might not represent meaningful clinical progress benefiting the patient's function.

Documentation should describe new exercises added, or changes made to the exercise program to help justify that the services are skilled. Documentation must also show that exercises are being transitioned as clinically indicated to an independent or caregiver-assisted exercise program (“home exercise program” (HEP)). An HEP is an integral part of the therapy plan of care and should be modified as the patient progresses during the course of treatment. It is appropriate to transition portions of the treatment to an HEP as the patient or caregiver master the techniques involved in the performance of the exercise.

If an exercise is taught to a patient and performed for the purpose of restoring functional strength, range of motion, endurance training, and flexibility, CPT code (97110) is the appropriate code. For example, a gym ball exercise used for the purpose of increasing the patient’s strength should be considered as therapeutic exercise when coding for billing. Also, the minutes spent taping, such as McConnell taping, to facilitate a strengthening intervention would be counted under 97110.

Lack of exercise equipment at home does not make continued treatment in the clinic skilled or reasonable and necessary. The home program may need to be carried out through community resources.

Documentation must clearly support the need for continued therapeutic exercise greater than 12-18 visits.

For many patients a passive-only exercise program should not be used more than 2-4 visits to develop and train the patient or caregiver in performing PROM. Documentation would be necessary to support services beyond this level (such as PROM where there is an unhealed, unstable fracture, or new rotator cuff repair, requiring the skills of a therapist to ensure that the extremity is maintained in proper position and alignment during the PROM).

Supportive Documentation Recommendations for 97110

- **Objective measurements of loss of strength and range of motion (with comparison to the uninvolved side) and effect on function**
- **If used for pain include pain rating, location of pain, effect of pain on function**
Specific exercises performed, purpose of exercises as related to function, instructions given, and/or assistance needed to perform exercises to demonstrate that the skills of a therapist were required
When skilled cardiopulmonary monitoring is required, include documentation of pulse oximetry, heart rate, blood pressure, perceived exertion, etc.

CPT 97112 - Neuromuscular Re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities (one or more areas, each 15 minutes)
This therapeutic procedure is provided for the purpose of restoring balance, coordination, kinesthetic sense, posture, and proprioception (e.g., proprioceptive neuromuscular facilitation (PNF), BAP’s boards, vestibular rehabilitation, desensitization techniques, balance and posture training).

This procedure may be reasonable and necessary for restoring prior function which has been affected by:

- loss of deep tendon reflexes and vibration sense accompanied by paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers;
- nerve palsy, such as peroneal nerve injury causing foot drop;
- muscular weakness or flaccidity as result of a cerebral dysfunction, a nerve injury or disease or having had a spinal cord disease or trauma;
- poor static or dynamic sitting/standing balance;
- postural abnormalities;
- loss of gross and fine motor coordination;
- hypo/hypertonicity.

If an exercise/activity is taught to the patient and performed for the purpose of restoring functional balance, motor coordination, kinesthetic sense, posture, or proprioception for sitting or standing activities, CPT (97112) is the appropriate code. For example, a gym ball exercise used for the purpose of improving balance should be considered as neuromuscular reeducation when coding for billing. The minutes spent taping, such as McConnell taping or kinesiotaping techniques, to enhance proprioception would be counted under CPT code 97112.

When therapy is instituted because there is a history of falls or a falls screening has identified a significant fall risk, documentation should indicate:

- specific fall dates and/or hospitalization(s) and reason for the fall(s), if known;
- most recent prior functional level of mobility, including assistive device, level of assist, frequency of falls or “near-falls”;
- cognitive status;
- prior therapy intervention;
- functional loss due to the recent change in condition;
- balance assessments (preferably standardized), lower extremity ROM and muscle strength testing;
- patient and caregiver training;
- carry-over of therapy techniques to objectively document progress.

It may not be reasonable and necessary to extend visits for a patient with falls, or any patient receiving therapy services, if the purpose of the extended visits is to:

- remind the patient to ask for assistance;
- offer close supervision of activities due to poor safety awareness;
- remind a patient to slow down;
- offer routine verbal cues for compensatory or adaptive techniques already taught;
- remind a patient to use an assistive device;
- train multiple caregivers; or
- begin a maintenance program.

In these instances, once the appropriate cues have been determined by the qualified professional/auxiliary personnel, training of caregivers can be provided and the care should be turned over to supportive personnel or caregivers since repetitive cues and reminders do not require the skills of a therapist.

Documentation must clearly support the need for continued neuromuscular reeducation greater than 12-18 visits.

Supportive Documentation Recommendations for 97112

- Objective loss of ADLs, mobility, balance, coordination deficits, hypo- and hypertonicity, posture and effect on function
- Specific exercises/activities performed (including progression of the activity), purpose of the exercises as related to function, instruction given, and/or assistance needed, to support that the skills of a therapist were required

CPT 97113 - Aquatic Therapy with Therapeutic Exercises (one or more areas, each 15 minutes)

Aquatic therapy refers to any therapeutic exercise, therapeutic activity, neuromuscular re-education, or gait activity that is performed in a water environment including whirlpools, hubbard tanks, underwater treadmills and pools.

This procedure may be reasonable and necessary for the loss or restriction of joint motion, strength, mobility, balance or function due to pain, injury, or illness by using the buoyancy and resistance properties of water.

Aquatic therapy may be considered reasonable and necessary for a patient without the ability to tolerate land-based exercises for rehabilitation. Aquatic therapy exercises should be used to facilitate progression to land based therapy and to increased function. The qualified professional/personnel auxiliary personnel does not need to be in the water with the patient unless there is an identified safety issue.

Exercises in the water environment to promote overall fitness, flexibility, improved endurance, aerobic conditioning, weight reduction, or for maintenance purposes are non-covered.

This code should not be used in situations where no exercise is being performed in the water environment (e.g., debridement of ulcers).

If continued aquatic exercise is needed, the patient should be instructed in a home program during these visits. Lack of pool facilities at home does not make continued treatment skilled or reasonable and necessary. The home program may need to be carried out through community resources. Documentation must clearly support the need for aquatic therapy greater than 8 visits.

Consider the following points when providing aquatic therapy services.

- **Does your patient require the skills as a therapist, or could the patient achieve functional improvement through a community-based aquatic exercise program?**
- **There are a limited number of therapeutic exercises generally performed in the water. These exercises become repetitive quickly. Once a patient can demonstrate an exercise safely, you may no longer bill Medicare for the time it takes the patient to perform this now independent exercise. If the same exercise is performed over a number of sessions, the documentation must describe the skilled nature of the qualified professional's/auxiliary personnel's intervention during the therapeutic exercise to support the ongoing medical necessity.**
- **Patients who will not be continuing their water-based program as a maintenance program should be transitioned to land-based exercises as soon as reasonably possible for the patient's condition.**
- **The aquatic therapy treatment minutes counted toward the total timed code treatment minutes should only include actual skilled exercise time that required direct one-on-one patient contact by the qualified professional/auxiliary personnel. Do not include minutes for the patient to dress/undress, get into and out of the pool, etc.**
- **Do not bill for the water modality used to provide the aquatic environment, such as whirlpool (97022), in addition to 97113.**
- **See CPT 97150 Group Therapy for guidelines when treating more than one patient at the same time in the aquatic environment.**

Supportive Documentation Recommendations for 97113

- **Justification for use of a water environment**
- **Objective loss of ADLs, mobility, ROM, strength, balance, coordination, posture and effect on function**
- **If used for pain include pain rating, location of pain, effect of pain on function**
- **Specific exercises/activities performed (including progression of the activity), purpose of exercises as related to function, instructions given, and/or assistance needed to perform exercises to demonstrate that the skills and of a therapist were required.**

CPT 97116 - Gait Training (includes stair climbing) (one or more areas, each 15 minutes) This procedure may be reasonable and necessary for training patients and instructing caregivers in ambulating patients whose walking abilities have been impaired by neurological, muscular, or skeletal abnormalities or trauma.

Indications for gait training include, but are not limited to:

- a cerebral vascular accident resulting in impairment in the ability to ambulate, now stabilized and ready to begin rehabilitation;
- musculoskeletal trauma, requiring ambulation reeducation;
- a chronic, progressively debilitating condition for which safe ambulation has recently become a concern;
- an injury or condition that requires instruction in the use of a walker, crutches, or cane;
- a patient fitted with a brace or lower limb orthosis or prosthesis and requires instruction in ambulation;
- a condition that requires retraining in stairs/steps or other uneven surfaces appropriate to home and community function (ramps, inclines, curbs, grass, etc);
- instructing a caregiver in appropriate guarding and assistive techniques.

Gait training is not considered reasonable and necessary when the patient's walking ability is not expected to improve.

Repetitive walk-strengthening exercise (such as for feeble patients or to increase endurance or gait distance) does not require the skills of the therapist and is considered not reasonable and necessary and is non-covered.

Antalgic gait alone does not support the need for ongoing skilled gait training. Antalgic gait refers to a gait pattern assumed in order to avoid or lessen pain. Limited gait training may be appropriate, when supported as medically necessary in the documentation, to teach the patient improved gait patterns to reduce the stress on the painful area. In most circumstances, as the pain decreases (with or without skilled therapy intervention) the gait will improve spontaneously without the need for skilled gait training intervention.

Documentation must clearly support the need for continued gait training beyond 12-18 visits within a 4-6 week period.

Neuromuscular Electrostimulation - Use for Walking in Patients with Spinal Cord Injury (SCI) (CPT code 97116) - *The type of NMES that is used to enhance the ability to walk of SCI patients is commonly referred to as functional electrical stimulation (FES). These devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence. Coverage for the use of NMES/FES is limited to SCI patients, for walking, who have completed a training program, which consists of at least 32 physical therapy sessions with the device over a period of 3 months. The trial period of physical therapy will enable the physician treating the patient for his or her spinal cord injury to properly evaluate the person's ability to use these devices frequently and for the long term. Physical therapy necessary to perform this training must be directly performed by the physical therapist as part of a one-on-one training program.*

The goal of physical therapy must be to train SCI patients on the use of NMES/FES devices to achieve walking, not to reverse or retard muscle atrophy.

Coverage for NMES/FES for walking will be covered in SCI patients with all of the following characteristics:

1. *Persons with intact lower motor units (L1 and below) (both muscle and peripheral nerve);*

2. *Persons with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently;*
3. *Persons that demonstrate brisk muscle contraction to NMES and have sensory perception [of] electrical stimulation sufficient for muscle contraction;*
4. *Persons that possess high motivation, commitment and cognitive ability to use such devices for walking;*
5. *Persons that can transfer independently and can demonstrate independent standing tolerance for at least 3 minutes;*
6. *Persons that can demonstrate hand and finger function to manipulate controls;*
7. *Persons with at least 6-month post recovery spinal cord injury and restorative surgery;*
8. *Persons with[out] hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and*
9. *Persons who have demonstrated a willingness to use the device long-term.*

(Italicized information about NMES for walking in SCI patients is from CMS Publication 100-03, Medicare National Coverage Determinations (NCD) Manual, section 160.12)

ICD-9-CM diagnosis code 344.1 must be present for payment to be made. However, while paraplegia of lower limbs is a necessary condition for coverage, the nine criteria above are also required.

97116 is the only code to be billed. It must be used for one-on-one face-to-face service provided by the physician or therapist.

Supportive Documentation Recommendations for 97116

- *Objective measurements of balance and gait distance, assistive device used, amount of assistance required, gait deviations and limitations being addressed, use of orthotic or prosthesis, need for and description of verbal cueing*
- *Presence of complicating factors (pain, balance deficits, gait deficits, stairs, architectural or safety concerns)*
- *Specific gait training techniques used, instructions given, and/or assistance needed, and the patient's response to the intervention, to demonstrate that the skills of a therapist were required*

CPT 97124 – Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion) (one or more areas, each 15 minutes) Massage may be medically necessary as adjunctive treatment to another therapeutic procedure on the same day, which is designed to reduce edema, improve joint motion, or relieve muscle spasm.

Massage chairs, aquamassage tables and roller beds are not considered massage. These services are non-covered.

Massage is not covered as an isolated treatment.

Documentation must clearly support the need for continued massage beyond 6-8 visits, including instruction, as appropriate, to the patient and caregiver for continued treatment.

This code is not covered on the same visit date as CPT code 97140 (manual therapy techniques).

Do not bill 97124 for percussion for postural drainage.

Supportive Documentation Recommendations for 97124

- *Area(s) being treated*

- *Objective clinical findings such as measurements of range of motion, description of muscle spasms and effect on function*
- *Subjective findings including pain ratings, pain location, effect on function*

CPT 97139 - Unlisted Therapeutic Procedure (specify)

If an existing CPT code does not describe the service performed, an unlisted CPT code may be used. The use of unlisted codes should be rare. If unlisted codes are billed, the claim and medical record must clearly state what modality or procedure is billed as an unlisted code. If not, the unlisted code billed will be subject to denial for insufficient information.

Supportive Documentation Recommendations for 97139

Please see section Documentation Recommendations for Unlisted Procedure Codes.

Please see the Unlisted Procedure Codes section of article A49932, Outpatient Physical and Occupational Therapy Services – Supplemental Instructions Article, for specific billing instructions.

CPT 97140 - Manual Therapy Techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes

- *Manual traction may be considered reasonable and necessary for cervical dysfunctions such as cervical pain and cervical radiculopathy.*
- *Joint Mobilization (peripheral and/or spinal) may be considered reasonable and necessary if restricted or painful joint motion is present and documented. It may be reasonable and necessary as an adjunct to therapeutic exercises when loss of articular motion and flexibility impedes the therapeutic procedure.*
- *Myofascial release/soft tissue mobilization, one or more regions, may be reasonable and necessary for treatment of restricted motion of soft tissues in involved extremities, neck, and trunk. Skilled manual techniques (active or passive) are applied to soft tissue to effect changes in the soft tissues, articular structures, neural or vascular systems.*
- *Manipulation, which is a high-velocity, low-amplitude thrust technique or Grade V thrust technique, may be reasonable and necessary for treatment of painful spasm or restricted motion in the periphery, extremities or spinal regions.*
- *Manual lymphatic drainage/complex decongestive therapy (MLD/CDT)
MLD / CDT is indicated for both primary and secondary lymphedema. Lymphedema in the Medicare population is usually secondary lymphedema, caused by known precipitating factors. Common causes include surgical removal of lymph nodes, fibrosis secondary to radiation, and traumatic injury to the lymphatic system.*

Both primary and secondary lymphedemas are chronic and progressive conditions which can be brought under long-term control with effective management. By maintaining control of the lymphedema, patients can:

- *restore a normal, or near-normal, shape;*
- *reduce the potential for complications (e.g., cellulitis, lymphangitis, deformity, injury, fibrosis, lymphangiosarcoma (rare), etc.);*
- *reduce functional deficits to resume activities of daily living.*

MLD/CDT consists of skin care, manual lymph drainage, compression wrapping, and therapeutic exercises. Coverage of MLD / CDT would only be allowed if all of the following conditions have been met:

- *there is a physician-documented diagnosis of lymphedema (primary or secondary);*
- *the patient has documented signs or symptoms of lymphedema;*
- *the patient or patient caregiver has the ability to understand and comply with the continuation of the treatment regimen at home.*

The goal of treatment is to reduce lymphedema of an extremity by routing the fluid to functional pathways, preventing backflow as the new routes become established, and to use the most appropriate methods to maintain such reduction of the extremity after therapy is complete. This therapy involves intensive treatment to reduce the volume by a combination of manual decongestive therapy and serial compression bandaging, followed by an exercise program. Ultimately the plan must be to transfer the responsibility of care from the therapist to management by the patient, patient's family, or patient's caregiver.

- *In moderate-severe lymphedema, daily visits may be required for the first week.*
- *Education should be provided to the patient and/or caregiver on the correct application of the compression bandage.*
- *The therapeutic exercise component for MLD / CDT is covered under CPT code 97110.*

MLD/CDT is not covered for:

- *conditions reversible by exercise or elevation of the affected area;*
- *dependent edema related to congestive heart failure or other cardiomyopathies;*
- *patients who do not have the physical and cognitive abilities, or support systems, to accomplish self-management in a reasonable time;*
- *continuing treatment for a patient non-compliant with a program for self-management.*

Documentation must clearly support the need for continued manual therapy treatment beyond 12-18 visits. When the patient and/or caregiver has been instructed in the performance of specific techniques, the performance of these same techniques should not be continued in the clinic setting and counted as minutes of skilled therapy.

CPT code 97124 (massage) is not covered on the same visit as this code.

Supportive Documentation Recommendations for 97140

- *Area(s) being treated*
- *Soft tissue or joint mobilization technique used*
- *Objective and subjective measurements of areas treated (may include ROM, capsular end-feel, pain descriptions and ratings,) and effect on function*
- *For MLD/CDP, supportive documentation should include:*
 - *medical history related to onset, exacerbation and etiology of the lymphedema*
 - *comorbidities*
 - *prior treatment*
 - *cognitive and physical ability of patient and/or caregiver to follow self-management techniques;*
 - *pain/discomfort descriptions and ratings;*
 - *limitation of function related to self-care, mobility, ADLs and/or safety;*
 - *prior level of function;*
 - *limb measurements of affected and unaffected limbs at start of care and periodically throughout treatment;*
 - *description of skin condition, wounds, infected sites, scars.*

CPT 97150 - Therapeutic Procedure(s), Group (2 or more individuals)

Report 97150 for each member of the group.

Group therapy procedures involve constant attendance of the physician, NPP, therapist, or assistant, but by definition do not require one-on-one patient contact.

Group therapy consists of therapy treatment provided simultaneously to two or more patients who may or may not be doing the same activities. If the therapist is dividing attention among the patients, providing only brief, intermittent personal contact, or giving the same instructions to two or more patients at the same time, one unit of CPT code 97150 is appropriate per patient.

Examples:

- In a 25-minute period, a therapist works with two patients, A and B, and divides his/her time between the two patients. The therapist moves back and forth between the two patients, spending a minute or two at a time, and provides occasional assistance and modifications to patient A's exercise program and offers verbal cues for patient B's gait training and balance activities on the parallel bars. The therapist does not track continuous identifiable episodes of direct one-on-one contact with either patient. The appropriate coverage is one (1) unit of CPT code 97150 for each patient.***
- In a 45-minute period, a therapist works with 3 patients - A, B, and C - providing therapeutic exercises to each patient with direct one-on-one contact in the following sequence: Patient A receives 8 minutes, patient B receives 8 minutes and patient C received 8 minutes. After this initial 24-minute period, the therapist returns to work with patient A for 10 more minutes (18 minutes total), then patient B for 5 more minutes (13 minutes total), and finally patient C for 6 additional minutes (14 minutes total). During the times the patients are not receiving direct one-on-one contact with the therapist, they are each exercising independently. The therapist appropriately bills each patient one 15 minute unit of therapeutic exercise (CPT code 97110).***

Supervision of a previously taught exercise program or supervising patients who are exercising independently is not a skilled service and is not covered as group therapy or as any other therapeutic procedure. Supervision of patients exercising on machines or exercise equipment, in the absence of the delivery of skilled care, is not a skilled service and is not covered as group therapy or as any other therapeutic procedure.

Non-covered as group therapy

- Groups directed by a student, therapy aide, rehabilitation technician, nursing aide, recreational therapist, exercise physiologist, or athletic trainer***
- Routine (i.e., supportive) groups that are part of a maintenance program, nursing rehabilitation program, or recreational therapy program***
- Groups using biofeedback for relaxation***
- Viewing videotapes; listening to audiotapes***
- Group treatment that does not require the unique skills of a therapist***

If group therapy is billed on a given day, it must be listed in the Treatment Note. The minutes of this untimed code must be added to the Total Treatment Time for that day. Further documentation describing the skilled nature of the group session documented in the progress report or the treatment note may assist in supporting the medical necessity of the service.

Supportive Documentation Recommendations for 97150

- The purpose of the group and the number of participants in the group***
- Description of the skilled activity provided in the group setting, such as instruction in proper form, or upgrading the difficulty of the activity for an individual.***

CPT 97530 - Therapeutic Activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Therapeutic activities are considered reasonable and necessary for patients needing a broad range of rehabilitative techniques that involve movement. Movement activities can be for a specific body part or could involve the entire body. This procedure involves the use of functional activities (e.g., bending, lifting, carrying, reaching, catching, pushing, pinching, grasping, transfers, bed mobility and overhead activities) to restore functional performance in a progressive manner. The activities are usually directed at a loss or restriction of mobility, strength, balance, or coordination. They require the skills of the therapist to design the activities to address a specific functional need of the patient and to instruct the patient in their performance. These dynamic activities must be part of an active treatment plan and must be directed at a specific outcome.

In order for therapeutic activities to be covered, the following requirements must be met:

- *the patient has a documented condition for which therapeutic activities can reasonably be expected to restore or improve functioning;*
- *there is a clear correlation between the type of therapeutic activity performed and the patient's underlying medical condition;*
- *the patient's condition is such that he/she is unable to perform the therapeutic activities without the skilled intervention of the qualified professional/auxiliary personnel.*

Documentation must clearly support the need for continued therapeutic activity treatment beyond 10-12 visits.

Supportive Documentation Recommendations for 97530

- *Objective measurements of loss of ADLs, balance, strength, coordination, range of motion, mobility and effect on function*
- *Specific activities performed, and amount and type of assistance to demonstrate that the skills and expertise of the therapist were required*

CPT 97532 – Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training) direct (one-on-one) patient contact by the provider, each 15 minutes

This activity is designed to improve attention, memory, and problem-solving, including the use of compensatory techniques. Cognitive skill training may be medically necessary for patients with acquired cognitive deficits resulting from head trauma, or acute neurologic events including cerebrovascular accidents. Impaired functions may include but are not limited to ability to follow simple commands, attention to tasks, problem solving skills, memory, ability to follow numerous steps in a process, perform in a logical sequence and ability to compute. Conditions without potential for improvement or restoration, such as chronic progressive brain conditions, would not be appropriate. Evidence-based reviews indicate that cognitive rehabilitation (and specifically memory rehabilitation) is not recommended for patients with severe cognitive dysfunction. Cognitive skill training should be aimed towards improving or restoring specific functions which were impaired by an identified illness or injury, and expected outcomes should be reasonably attainable by the patient as specified by the plan of care.

Cognitive skills are an important component of many tasks, and the techniques used to improve cognitive functioning are integral to the broader impairment being addressed. Cognitive therapy techniques are most often covered as components of other therapeutic procedures, and, typically are better reported using other codes (such as 97535).

Activities billed as cognitive skills development include only those that require the skills of a therapist and must be provided with direct (one-on-one) contact between the patient and the qualified professional/auxiliary personnel. Those services that a patient may engage in without a skilled therapist qualified professional/auxiliary personnel are not covered under the Medicare benefit.

Coverage for 97532 is limited to the following conditions.

- **310.1 PERSONALITY CHANGE DUE TO CONDITIONS CLASSIFIED ELSEWHERE**
- **310.8 OTHER SPECIFIED NONPSYCHOTIC MENTAL DISORDERS FOLLOWING ORGANIC BRAIN DAMAGE**
- **310.9 UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER FOLLOWING ORGANIC BRAIN DAMAGE**

Please also add the ICD-9-CM code for the underlying disorder (cause).

Note: the restrictions placed upon this code do not apply to vision impairment rehabilitation services as defined in PM AB-02-078.

Supportive Documentation Recommendations for 97532

- *Objective assessment of the patient's cognitive impairment and functional abilities*
- *Prognosis for recovery of the specific impaired cognitive abilities (remediation)*
- *A determination of a range of compensatory strategies that the individual can realistically utilize to improve daily functioning in a meaningful way*
- *Specific cognitive activities performed, amount of assistance, and the patient's response to the intervention, to demonstrate that the skills and expertise of the therapist were required*

CPT 97533 – Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes

Sensory integrative techniques are performed to enhance sensory processing and promote adaptive responses to environmental demands. These treatments are performed when a deficit in processing input from one of the sensory systems (e.g., vestibular, proprioceptive, tactile, visual or auditory) decreases an individual's ability to make adaptive sensory, motor and behavioral responses to environmental demands. Individuals in need of sensory integrative treatments demonstrate a variety of problems, including sensory defensiveness, over-reactivity to environmental stimuli, attention difficulties, and behavioral problems.

Sensory integration treatments are often associated with pediatric populations. For non-pediatric patients, these services may be medically necessary for acquired sensory problems resulting from head trauma, illness, or acute neurologic events including cerebrovascular accidents. They are not appropriate for patients with progressive neurological conditions without potential for functional adaptation. Therapy is not considered a cure for sensory integrative impairments, but is used to facilitate the development of the nervous system's ability to process sensory input differently.

Utilization of this service should be infrequent for Medicare patients.

Supportive Documentation Recommendations for 97533

- *Objective assessments of the patient's sensory integration impairments and functional limitations*
- *Describe the treatment techniques used that will improve sensory processing and promote adaptive responses to environmental demands, and the patient's response to the intervention, to support that the skills of a therapist were required*

CPT 97535 Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes

This procedure is reasonable and necessary only when it requires the skills of a therapist, is designed to address specific needs of the patient, and is part of an active treatment plan directed at a specific outcome.

The patient must have a condition for which self-care/home management training is reasonable and necessary. The training should be focused on a functional limitation(s) in which there is potential for improvement in a functional task that will be meaningful to the patient and the caregiver. The patient and/or caregiver must have the capacity and willingness to learn from instructions. Documentation must relate the training to expected functional goals that are attainable by the patient.

This code should be used for activities of daily living (ADL) and compensatory training for ADL, safety procedures, and instructions in the use of adaptive equipment and assistive technology for use in the home environment. See more specific codes for exercise training, orthotics, gait devices, etc.

This code should not be used globally for all home instructions. When instructing the patient in a self management program, use the code that best describes the focus of the self management activity. For example, if the instruction given is for exercises to be done at home to improve ROM or strength use 97110; if instructing the patient in balance or coordination activities at home, use 97112; if instructing the patient on using a sock aide for dressing, use 97535; if teaching the patient aquatic exercises to use as a independent program in the community pool, use 97113.

Services provided to the same patient by physical therapy and occupational therapy may be covered if separate and distinct goals are documented in the treatment plans and there is no duplication of services.

Many ADL/IADL impairments may require the unique skills of a therapist to evaluate the patient's abilities, design the program and instruct the patient or caregiver in safe completion of the special technique. However, repetitious completion of the activity, once taught and monitored, is non-covered care.

For example, as part of the initial occupational therapy program following a total hip arthroplasty (THA), a patient may need to learn adaptive lower extremity dressing techniques due to pain, limited ROM and hip precautions. The occupational therapist will need to evaluate the patient to determine the appropriate technique to be taught based on the patient's unique assessment and will instruct the patient and/or caregiver in the special technique. Once the special dressing technique has been taught and monitored for safe completion, repetitious carrying out or practicing of the dressing technique would be considered non-skilled and would not be covered. Non-skilled interventions need not be recorded in the Treatment Notes as they are not billable. However, notation of non-skilled activities may be reported if the documentation indicates that the service was not billed (e.g., not included in the treatment minutes documented).

As the patient progresses through an episode of care involving self care/home management training, documentation needs to clearly support that the skills of a therapist continue to be necessary. Documentation that demonstrates progression in the technique to more complex or less patient dependence will assist in demonstrating that the technique remains skilled. It is important that documentation demonstrates that the skills of a therapist are needed and that the patient is not merely practicing techniques that have already been taught.

Supportive Documentation Recommendations for 97535

- Objective measurements of the patient's activity of daily living (ADL)/instrumental activity of daily living (IADL) impairment to be addressed*
- The specific ADL and/or compensatory training provided, specific safety procedures addressed, specific adaptive equipment/assistive technology utilized, instruction given and assist required (verbal or physical), and the patient's response to the intervention, to support that the services provided required the skills and expertise of a therapist*

CPT 97537 - Community/Work Reintegration Training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis) direct one-on-one contact by provider, each 15 minutes

For wheelchair management/propulsion training use 97542

This training may be medically necessary when performed in conjunction with a patient's individual treatment plan aimed at improving or restoring specific community functions which were impaired by an identified illness or injury and when realistically expected outcomes are specified in the plan. This code should be utilized when a patient is trained in the use of assistive technology to assist with mobility, seating systems and environmental control systems for use in the community.

General activity programs, and all activities which are primarily social or diversional in nature, will be denied because the professional skills of a therapist are not required. Services must be necessary for medical treatment of an illness or injury rather than related solely to specific leisure or employment opportunities, work skills or work settings.

Coverage greater than 4-6 visits for community training should be justified by documentation to show the medical necessity of the length of treatment.

Supportive Documentation Recommendations for 97537

- *Objective measurements of the patient's community IADL impairment to be addressed*
- *Specific training provided, amount of assist required (verbal or physical), and the patient's response to the intervention, to support that the services rendered required the skills of a therapist*

CPT 97542 - Wheelchair Management (e.g., assessment, fitting, training), each 15 minutes

This code is used to reflect the skilled wheelchair management intervention clinicians provide related to the assessment, fitting and/or training for patients who must utilize a wheelchair for mobility. This service trains the patient, family and/or caregiver in functional activities that promote safe wheelchair mobility and transfers. Patients who are wheelchair bound may occasionally need skilled input on positioning to avoid pressure points, contractures, and other medical complications.

CPT Changes 2006 – An Insider's View provides further clarification regarding the assessment portion of this code. A wheelchair assessment may include but is not limited to the patient's strength, endurance, living situation, ability to transfer in and out of the chair, level of independence, weight, skin integrity, muscle tone, and sitting balance. Following verification of the patient's need, patient measurements are taken of the patient prior to ordering the equipment to ensure accuracy of sizing wheelchair components. This measurement may also involve testing the patient's abilities with various chair functions including propulsion, transferring from the chair to other surfaces (bed, toilet, car), and use of the chair's locking mechanism on various types of equipment for optimal determination of the appropriate equipment by the patient and caregiver.

For example, 97542 would be used when assessing and fitting the patient with a wheelchair and custom seating system to provide stabilization, support, balance, and pressure management. To achieve functional goals related to independent wheelchair management, 97542 would also be used when training the patient in the safe operation and management of the wheelchair in the home and community environment. (This example is based upon the Clinical Example for 97542 in the CPT Changes 2006 – an Insider's View.)

There may be circumstances where a patient may be seen one time for a wheelchair assessment. If it is not necessary to complete a full patient evaluation, but only an assessment related to specific wheelchair needs, this one-time only session may be billed under 97542 with the appropriate units reflecting the time spent in the assessment.

For many patient situations however, a full patient evaluation is needed to develop the appropriate treatment plan in addition to wheelchair fitting and training. In these situations, it may be appropriate to bill the initial evaluation code (97001 or 97003), with the minutes spent for the evaluation/assessment assigned to either 97001 or 97003. On the day that the evaluation code is billed, the minutes assigned to 97542 should only be related to any wheelchair fitting and training provided, as 97542 is a timed code. For example, if a physical therapist spends 35 minutes gathering the patient history, prior functional status, current functional status, social considerations, range of motion, strength, sensation, balance, and transfers, this time would be assigned to the PT initial evaluation code 97001. As the session continues, the PT spends 45 minutes assessing the patient in a variety of wheelchair set ups, trying a variety of adaptations to best meet the patient's comfort and functional needs, and initiates training with the patient and family, this 45 minutes would be assigned to code 97542.

Consider the following points when providing wheelchair management services.

- *Assessment for non-specialized wheelchairs, cushions, lapboards, wheelchair trays, or lap buddies for a patient without a complicating condition typically does not require the unique skills of a therapist.*
- *A seating assessment is not medically necessary for every patient.*
- *Skilled intervention would not be necessary for wheelchair issues that the patient can self-correct.*
- *The patient/caregiver must have the capacity and willingness to learn from instructions.*
- *When wheelchair and seating assessments are reasonable, care should be turned over to supportive personnel or a caregiver once the necessary modifications are completed.*
- *Ongoing visits for increasing sitting times are generally not reasonable and necessary when no patient problems are documented.*
- *Visits made for restraint reduction are generally non-covered.*
- *It is expected that multiple wheelchair and seating deficits discovered during the initial evaluation would be treated concurrently. If not, documentation must indicate that a new problem/deficit occurred, or include rationale why a problem being treated in the later stages of therapy was not addressed previously.*

Typically up to 3-4 dates of service should be sufficient to train the patient/caregiver in wheelchair management. Coverage beyond this utilization should have supportive documentation.

Supportive Documentation Recommendations for 97542

- *Documentation for a skilled wheelchair assessment should include the following:*
 - *the recent event that prompted the need for a skilled wheelchair assessment;*
 - *any previous wheelchair assessments have been completed, such as during a Part A SNF stay;*
 - *most recent prior functional level;*
 - *if applicable, any previous interventions that have been tried by nursing staff, caregivers or the patient that may have failed, prompting the initiation of skilled therapy intervention;*
 - *functional deficits due to poor seating or positioning;*
 - *objective assessments of applicable impairments such as range of motion (ROM), strength, sitting balance, skin integrity, sensation and tone;*
 - *the response of the patient or caregiver to the fitting and training.*
- *When billing CPT code 97542 for wheelchair management/training, documentation must relate the training to expected functional goals that are attainable by the patient and /or caregiver.*
- *Describe the interventions to show that the skills of a therapist were required. For example, describe the various wheelchair adaptations trialed and the patient's response to the intervention. If training is provided, describe the type of training, the amount of assistance required and the patient response to the training.*

CPT 97545 - Work hardening/conditioning; initial 2 hours; and CPT 97546 - each additional hour

These services are related solely to specific work skills and will be denied as not medically necessary for the diagnosis or treatment of an illness or injury.

CPT 97597 - Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters

CPT 97598 - total wound(s) surface area greater than 20 square centimeters

CPT 97602 - Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session

Do not report 97597-97602 in conjunction with 11040-11044

Active wound care procedures are performed to remove devitalized tissue and promote healing, and involve selective and non-selective debridement techniques. Debridement is indicated whenever necrotic tissue is present in an open wound. Debridement may also be indicated in cases of abnormal wound healing or repair. Debridement will not be considered a reasonable and necessary procedure for a wound that is clean and free of necrotic tissue.

The wound care performed must be in accordance with accepted standards of medical practice. If debridement is performed, the type of debridement should be appropriate to the type of wound and the devitalized tissue, and the patient's condition. Not all wounds require debridement at each session or the same level of debridement at each session. It is unusual to debride more than one time per week for more than three months. A greater frequency or duration of selective debridement should be justified in the documentation. Most very small wounds do not require selective debridement. Ulcers that may require selective debridement are typically larger than 2 x 2 cm. Wounds with tunneling, regardless of size, may require selective debridement. Selective debridement is usually not reasonable and necessary for blisters, ulcers smaller than those described above and uninfected ulcers with clear borders.

Documentation for each treatment must include a detailed description of the procedure and the method (e.g., scalpel, scissors, 4x4 gauze, wet-to-dry, enzyme) used when billing 97597, 97598 and 97602. Because the correct debridement code is dependent on type of debridement and wound size, documentation should include frequent wound measurements. The documentation should also include a description of the appearance of the wound (especially size, but also depth, stage, bed characteristics), as well as the type of tissue or material removed. The documentation must meet the criteria of the code billed.

Medicare coverage for wound care on a continuing basis for a particular wound requires documentation in the patient's record that the wound is improving in response to the wound care being provided. It is not medically reasonable or necessary to continue a given type of wound care if evidence of wound improvement cannot be shown.

Evidence of improvement includes measurable changes (decreases) in at least some of the following:

- *drainage;*
- *inflammation;*
- *swelling;*
- *pain;*
- *wound dimensions (diameter, depth);*
- *necrotic tissue/slough.*

Such evidence must be documented periodically (e.g. weekly.) A wound that shows no improvement after 30 days requires a new approach, which may include a physician/NPP reassessment of underlying infection, metabolic, nutritional, or vascular problems inhibiting wound healing, or a new treatment approach.

In rare instances, the goal of wound care provided in outpatient settings may be only to prevent progression of the wound, which, due to severe underlying debility or other factors such as inoperability, is not expected to improve. If this is the case, documentation should clearly indicate this rationale for continued skilled wound care.

Examples of Selective Debridement (without anesthesia) (CPT codes 97597, 97598)

- *Conservative Sharp Debridement: Conservative sharp debridement is a minor procedure that requires no anesthesia. Scalpel, scissors, forceps, or tweezers may be used and only clearly identified devitalized tissue is removed. Generally, there is no bleeding associated with this procedure.*
- *High Pressure Water Jet Lavage: (non-immersion hydrotherapy) is an irrigation device, with or without pulsation used to provide a water jet to administer a shearing effect to loosen debris, within a wound. Some electric pulsatile irrigation devices include suction to remove debris from the wound after it is irrigated.*

Examples of Non-Selective Debridement (without anesthesia) (CPT 97602) include the following items.

- *Blunt debridement*
 - *Blunt debridement involves the removal of necrotic tissue by cleansing or scraping (abrasion). It may also involve the cleaning and dressing of small or superficial lesions.*
- *Enzymatic debridement*
 - *Debridement with topical proteolytic enzymes is used as an adjunctive therapy in treating chronic wounds. The manufacturers' product insert contains indications, contraindications, precautions, dosage and administration guidelines; it is the clinician's responsibility to comply with those guidelines.*
- *Wet-to-moist dressings*
 - *Wet-to-moist dressings may be used with wounds that have a high percentage of necrotic tissue. Wet-to-moist dressings should be used cautiously as maceration of surrounding tissue may hinder healing.*
- *Autolytic and chemical debridement*

Additional guidance for debridement codes

- *These codes are not timed.*
- *Do not bill for more than one unit per session, regardless of the number or complexity of the wounds treated.*
- *Do not bill for both 97597/97598 and 97602 for the same wound.*
- *Use the -59 modifier to indicate nonselective and selective debridement provided in a single encounter at different anatomical sites.*
- *Application and removal of dressings to the wound is included in the work and practice expenses of 97597, 97598 and 97602 and should not be billed separately under a therapy plan of care. Charges for dressings, gauze, tape, sterile water for irrigation, tweezers, scissors, q-tips, and medications used in the wound care treatment will be denied even if the wound care service is found to be medically reasonable and necessary. Payment for dressings applied to the wound is included in HCPCS codes 97597, 97598 and 97602 and they are not to be billed separately.*
- *If a simple dressing change is performed without any active wound procedure as described by these codes, do not bill these codes to describe the service.*

- *For wound assessment it is not appropriate to bill therapy re-evaluation codes (97002, 97004) along with codes the 97597, 97598 and 97602 codes. The assessment, including measurements of the wound and a written report, is considered a part of the 97597, 97598 and 97602 codes.*
- *97022 (whirlpool) and codes 97597/97598 (selective wound debridement) should not be billed together as the whirlpool treatment is a component of the selective wound debridement code (unless there is a separately identifiable condition being treated and documentation supports this treatment).*
- *Patient and caregiver instructions are included in codes 97597, 97598 and 97602. Do not bill separately under any other code for instructing the patient/caregiver in care of the wound.*
- *These codes represent “sometimes therapy” services and will be paid under the OPSS when (a) the service is not performed by a therapist, and (b) it is inappropriate to bill the service under a therapy plan of care. Nurses performing debridement (where allowed by state scope of practice acts) described by codes 97597, 97598 and 97602 may bill these codes using revenue codes other than the therapy revenue codes 42x (PT) and 43x (OT).*
- *Payment for 97602, when performed by a qualified professional/auxiliary personnel under a therapy plan of care, is recognized as a bundled service under the Medicare Physician Fee Schedule (MPFS). Regardless of whether billed alone or in conjunction with another therapy code, separate payment is never made for 97602.*
- *Evaluation and management services should not be billed along with the debridement service unless a significant, separately identifiable evaluation and management service, correctly identified with modifier -25 on the claim, was also provided to the patient during the same encounter. (Therapists should not use the evaluation and management codes at any time.)*

Supportive Documentation Recommendations for 97597, 97598 and 97602

- *Etiology and duration of wound*
- *Prior treatment by a physician, non-physician practitioner, nurse and/or therapist*
- *Stage of wound*
- *Description of wound: length, width, depth, grid drawing and/or photographs*
- *Amount, frequency, color, odor, type of exudate*
- *Evidence of infection, undermining, or tunneling*
- *Nutritional status*
- *Comorbidities (e.g., diabetes mellitus, peripheral vascular disease)*
- *Pressure support surfaces in use*
- *Patient’s functional level*
- *Skilled plan of treatment, including specific frequency, modalities and procedures*
- *Type of debridement performed, including instrument used, to support the debridement code billed*
- *Changing plan of treatment based on clinical judgment of the patient’s response or lack of response to treatment*
- *Frequent skilled observation and assessment of wound healing are recommended daily or weekly to justify the skilled service. At a minimum, the Progress Report must document the continuing skilled assessment of wound healing as it has progressed since the evaluation or last Progress Report.*

Note: While debridement is considered a covered service for appropriately selected wounds, the following services are considered non-covered for the treatment of wounds.

- *Topical application of oxygen (CMS Publication 11-03, Medicare National Coverage Determinations (NCD) Manual, section 270.4.)*
- *Ultrasound*
- *Infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE) (CMS Publication 11-03, Medicare National Coverage Determinations (NCD) Manual, section 270.6.)*
- *Low Level Laser Treatment (LLLT)*
- *Magnet therapy*

- *Autologous blood-derived products for chronic, non-healing wounds (CMS Publication 11-03, Medicare National Coverage Determinations (NCD) Manual, section 270.3.)*
- *Routine dressing changes*
- *Non-Contact Normothermic Wound Therapy (NNWT) (CMS Publication 11-03, Medicare National Coverage Determinations (NCD) Manual, section 270.2.)*

CPT 97605 – Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session: total wound(s) surface area less than or equal to 50 square centimeters

CPT 97606 – total wound(s) surface greater than 50 square centimeters

Negative pressure wound therapy (NPWT) involves negative pressure to the wound bed to manage wound exudates and promote wound healing. NPWT consists of a sterile sponge held in place with transparent film, a drainage tube inserted into the sponge, and a connection to a vacuum source.

NPWT is indicated for use as an adjunct to standard treatment in carefully selected patients who have failed all other forms of treatment. NPWT may be indicated for wounds such as:

- *Stage III or IV pressure ulcers;*
- *Neuropathic (for example, diabetic) ulcers;*
- *Chronic arterial or venous insufficiency ulcers;*
- *Complications of surgically created or traumatic wounds.*

NPWT is not covered for:

- *Stage I or II pressure ulcers;*
- *Wounds with eschar if debridement is not attempted;*
- *Untreated osteomyelitis within the vicinity of the wound;*
- *Cancer present in the wound;*
- *Active bleeding;*
- *The presence of a fistula to an organ or body cavity within the vicinity of the wound.*

Additional guidance for NPWT codes

- *These codes are not timed.*
- *Do not bill for more than one unit per session, regardless of the number or complexity of the wounds treated.*
- *Patient and caregiver instructions are included in codes 97605/97606. Do not bill separately under any other code for instructing the patient/caregiver in care of the wound.*
- *It is not appropriate to bill therapy re-evaluation codes (97002, 97004) along with 97605/97606. The assessment, including measurements of the wound and a written report, is considered a part of 97605/97606.*

Supportive Documentation Recommendations for 97605 and 97606

- *Etiology and duration of wound*
- *Prior treatment by a physician, non-physician practitioner, nurse and/or therapist*
- *Stage of wound*
- *Description of wound: length, width, depth, grid drawing and/or photographs*
- *Amount, frequency, color, odor, type of exudate*
- *Evidence of infection, undermining, or tunneling*
- *Nutritional status*

- *Comorbidities (e.g., diabetes mellitus, peripheral vascular disease)*
- *Pressure support surfaces in use*
- *Patient's functional level*
- *Skilled plan of treatment, including specific frequency, modalities and procedures*
- *Changing plan of treatment based on clinical judgment of the patient's response or lack of response to treatment*
- *Frequent skilled observation and assessment of wound healing are recommended daily or weekly to justify the skilled service. At a minimum, the Progress Report must document the continuing skilled assessment of wound healing as it has progressed since the evaluation or last Progress Report.*

CPT 97750 - Physical Performance Test or Measurement (e.g., musculoskeletal, functional capacity) with written report, each 15 minutes

Physical performance testing may be reasonable and necessary for patients with neurological, musculoskeletal, or pulmonary conditions. These tests and measurements are beyond the usual evaluation services performed. Examples of physical performance tests or measurements include isokinetic testing, Functional Capacity Evaluation (FCE) and Tinetti. This code may be used for the 6-minute walk test, with a computerized report of the patient's oxygen saturation levels with increasing stress levels, performed under a PT or OT plan of care on pulmonary rehabilitation patients.

The therapy evaluation and re-evaluation codes are for a comprehensive review of the patient including, but not limited to, history, systems review, current clinical findings, establishment of a therapy diagnosis, and estimation of the prognosis and determination and/or revision of further treatment. CPT 97750 is intended to focus on patient performance of a specific activity or group of activities (CPT Assistant, December 2003).

There must be written evidence documenting the problem requiring the test, the specific test performed, and a separate measurement report. This report may include torque curves and other graphic reports with interpretation.

It is not reasonable and necessary for the test to be performed and billed on a routine basis (i.e., monthly or instead of billing a reevaluation) or to be routinely performed on all patients treated. 97750 should not be used to bill for patient assessments/re-assessments such as ROM testing or manual muscle testing completed at the start of care (as this is typically part of the examination included in the initial evaluation) and/or as the patient progresses through the episode of treatment.

CPT code 97750 is not covered on the same day as CPT codes 97001-97004 (due to CCI edits).

Supportive Documentation Recommendations for 97750

- *Problem requiring the test and the specific test performed*
- *Separate measurement report, including any graphic reports*
- *Application to functional activity*
- *How the test impacts the plan of care*

CPT 97755 - Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes

The provider performs an assessment of the suitability and benefits of acquiring any assistive technology device or equipment that will help restore, augment, or compensate for existing functional ability in the patient (e.g., provision of large amounts of rehabilitative engineering).

Coverage is specifically for assessment of mobility, seating and environmental control systems that require high level adaptations, not for routine seating and mobility systems (e.g., manual/power wheelchair evaluations).

This is an assessment code, per each 15 minutes, and must be accompanied by a written report explaining the nature and complexity of the assistive technology needed by the patient. This can include testing multiple components/systems to determine optimal interface between client and technology applications, and determining the appropriateness of commercial (off the shelf) or customized components/systems. This assessment may require more than one patient visit due to the complexity of the patient's condition and his/her decreased tolerance for activity at one session.

Training for use in assistive technology in the home environment is coded as 97535 and for use in the community as 97537.

CPT code 97755 is not covered on the same day as CPT codes 97001-97004 (due to CCI edits). Utilization of this service should be infrequent.

Supportive Documentation Recommendations for 97755

- *The goal of the assessment*
- *The technology/component/system involved*
- *A description of the process involved in assessing the patient's response*
- *The outcome of the assessment*
- *Documentation of how this information affects the treatment plan*

CPT 97760 - Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes

Code 97760 should not be reported with 97116 for the same extremity

An orthotic is a brace that includes rigid and semi-rigid components that are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. (Elastic stockings, garter belts, neoprene braces and similar devices do not come within the scope of the definition of a brace.) HCFA Ruling 96-1 clarifies that the "orthotics" benefit is limited to leg, arm, back, and neck braces that are used independently rather than in conjunction with, or as components of, other medical or non-medical equipment.

When consideration is made for a patient to require an orthotic, the therapist targets the problems in performance of movements or tasks, or identifies a part that requires immobilization, and selects the most appropriate orthotic device, then fits the device, and trains the patient and/or caregivers in its use and application. The goal is either to promote indicated immobilization or to assist the patient to function at a higher level by decreasing functional limitations or the risk of further functional limitations.

The complexity of the patient's condition is to be documented to show the medical necessity of skilled therapy to assess, fit, and instruct in the use of the orthotic.

An orthotic may be prefabricated or custom-fabricated.

A prefabricated orthotic is one that is manufactured in quantity and then modified with a specific patient in mind. A prefabricated orthotic may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific patient (i.e., custom fitted). An orthotic that is assembled from prefabricated components is considered prefabricated.

A custom fabricated orthotic is one that is individually made for a specific patient starting with basic materials including, but not limited to, plastic, metal, leather, or cloth, from the patient's individualized measurements.

A molded-to-patient model orthotic is a particular type of custom fabricated orthotic in which an impression of the specific body part is made and the impression is then used to make a positive model. The orthotic is molded from the patient-specific model.

Outpatient hospital therapy departments, comprehensive outpatient rehabilitation facilities (CORFs), outpatient rehabilitation facilities, nursing homes (limited to patients covered under a Medicare Part B stay), and home health agencies (limited to patients not under a HH plan of care) bill the Fiscal Intermediary/Part A MAC for the orthotic utilizing the relevant HCPCS Level II L code and revenue code 274 on the claim form. These settings do not require a DME supplier billing enrollment to bill and be reimbursed for the L codes.

A physical or occupational therapist in private practice or a physician/NPP is considered by Medicare to be a "supplier" and must bill the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for orthotics. Any supplier that issues orthotics must be enrolled as a supplier of Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS) prior to billing the DME MAC. Follow the directions from the DME MAC when billing for orthotics (utilizing an L code). Note: Therapists in private practice and physicians/NPPs should follow the guidance below for billing CPT 97760 to the Medicare carrier/Part B MAC.

Payment for prosthetics and orthotics is made on the basis of a fee schedule whether it is billed to the DME MAC or the FI/Part A MAC.

The L codes for orthotics provide a brief description of the device and describe whether the device needs to be molded to a patient model, custom fabricated, custom fitted, or have no fitting specifications. Select the appropriate L code based on the description of the brace provided.

The Medicare payment for the L codes includes the following items.

- *Assessment of the patient regarding the orthotic*
- *Measurement and/or fitting*
- *Supplies to fabricate or modify the orthotic*
- *Time associated with making the orthotic*

CPT 97760 should be used for orthotic "training" completed by qualified professionals/auxiliary personnel. CPT 97760 may be used in conjunction with the L code only for the time spent training the patient in the use of the orthotic. Orthotic training may include teaching the patient regarding a wearing schedule, placing and removing the orthosis, skin care and performing tasks while wearing the device. To avoid duplicate billing, the time spent assessing, measuring and/or fitting, fabricating or modifying, or making the orthotic may not be included in calculating the number of units to bill for CPT 97760 when also billing the appropriate L code. CPT 97760 is a "timed" code and only minutes actually spent in the training of the patient should be counted when determining units to bill when an L code is also billed.

There may be circumstances where a patient is only going to be seen for a brief therapy episode for issuance of an orthotic. If it is not necessary to complete a full, comprehensive patient evaluation, but only an assessment related to determining the specific orthotic, do not bill an initial therapy evaluation code in addition to the L code.

For other patient situations however, a full patient initial evaluation is needed to develop the appropriate treatment plan in addition to an assessment related to determining the specific orthotic. In these situations, it may be appropriate to bill the initial evaluation code (97001 or 97003), with the minutes spent for the evaluation assigned to either 97001 or 97003. For example, a patient is referred to occupational therapy for a wrist-hand orthotic with possible continued therapy. The OT spends 35 minutes evaluating the patient which includes the history, subjective complaints, prior and current functional levels, ROM, strength, sensation, skin integrity, and ADL assessment. This time would be assigned to the OT evaluation code 97003. The OT then begins the assessment of the patient for the orthotic which includes determining the need for the orthotic and the type of orthotic, subsequently fabricating the appropriate device and fitting it to the patient. This time, which takes 45 minutes, would be reimbursed under the L code. The OT spends an additional 20 minutes training the patient in the wearing schedule of the orthotic, skin care and exercises to be performed while the orthotic is in place. These 20 minutes would be assigned to code 97760, billable as 1 unit for the training component.

Per CPT Assistant, February 2007, “Code 97760 includes additional orthotic management and training during follow-up visits including exercises performed in the orthotic, instruction in skin care and orthotic wearing time, and time associated with modification of the orthotic due to healing of tissues, change in edema, or interruption in skin integrity.”

For an orthotic to be billed, it must be medically necessary for the patient's condition. To bill for training the patient to use the orthotic (CPT 97760) the documentation must justify the need for a skilled qualified professional/auxiliary personnel to train the patient in the use and care of the orthotic. When the management of the orthotic can be turned over to the patient, the caregiver or nursing staff, the services of the therapist will no longer be covered.

An orthotic provided for positioning and/or increasing range of motion in a non-functional extremity must include documentation that the unique skills of a therapist are required to fit and manage the orthotic and that the orthotic is medically necessary for the patient's condition.

*For **uncomplicated** conditions, the following services would not be considered reasonable and necessary as they would not require the unique skills of a therapist.*

- *Issuing off-the-shelf splints for foot drop or wrist drop*
- *Issuing off-the-shelf foot or elbow cradles for routine pressure relief (these are not considered orthotics)*
- *Issuing “carrots” (i.e., cylindrical, cone-shaped forms) or towel rolls for hand contractures for hygiene purposes*
- *Bed positioning (e.g., pillows, wedges, rolls, foot cradles to relieve potential pressure areas)*

Repetitive range of motion prior to placing an orthotic/positioner to maintain the range of motion is not reasonable and necessary when the therapeutic intent is primarily to maintain range of motion within a chronic condition.

Ongoing therapy visits for increasing wearing time are generally not reasonable and necessary when patient problems related to the orthotic have not been observed.

Ongoing visits by the qualified professional/auxiliary personnel to apply the device would be considered monitoring. Once the initial fit is established, any further visits should be used for specific documented problems and modifications that require skilled therapy; these are billed with CPT 97762. It is reasonable and necessary to require 1-3 visits to fit and educate the patient or caregiver. The medical necessity of any further visits must be supported by documentation in the medical record.

Coverage under CPT code 97760 is not for prefabricated/commercial (i.e., off the shelf) components such as, but not limited to a lumbar roll, non-customized foam supports/wedges (e.g., heel cushions), or multi-podus boots. Such components do not require the skills of a therapist and are non-covered. Minor modifications to prefabricated orthotics do not constitute a customized orthotic.

It is not appropriate to bill CPT 97760 for measurements taken to obtain custom fitted burn or pressure garments. These garments do not fit the definition of an orthotic.

Supportive Documentation Recommendations for 97760

- A description of the patient's condition (including applicable impairments and functional limitations) that necessitates an orthotic
- Any complicating factors
- The specific orthotic provided and the date issued
- A description of the skilled training provided
- Response of the patient to the orthotic

CPT 97761 - Prosthetic training, upper and/or lower extremity(s), each 15 minutes

Prosthetic training is the professional instruction necessary for a patient to properly use an artificial device that has been developed to replace a missing body part.

Prosthetic training includes preparation of the stump, skin care, modification of prosthetic fit (revisions to socket liner or stump socks), and initial mobility and functional activity training. Once a patient begins gait training with the prosthesis, use code 97116.

Supportive Documentation Recommendations for 97761

- Type of prosthesis, extremity involved
- Specific training provided and amount of assistance needed
- Any complicating factors and specific description of these (with objective measurements), such as pain, joint restrictions/contractures, strength deficits, etc.

CPT 97762 - Checkout for orthotic/prosthetic use, established patient, each 15 minutes

These assessments are intended for established patients who have already received their orthotic or prosthetic device.

These assessments of the response to wearing the device may be reasonable and necessary when patients experience a loss of function directly related to the device (e.g., pain, skin breakdown, and falls). According to CPT Assistant – February 2007, code 97762 includes patient's response to wearing the device, whether the patient is donning/doffing the device correctly, patient's need for padding, underwrap, or socks, and of the patient's tolerance to any dynamic forces being applied.

If the checkout assessment resulted in the need for further training in the use of the orthotic/prosthetic, codes 97760/97761 would be appropriate for the training.

These assessments may not be considered reasonable and necessary when a device is newly issued or when a device is reissued or replaced after normal wear and no modifications are needed.

Documentation must clearly support the need for more than 2 visits for the checkout assessment.

CPT code 97762 is not covered on the same date as CPT codes 97001-97004.

Supportive Documentation Recommendations for 97762

- *Reason for assessment*
- *Findings from the assessment*
- *Specific device, modifications made, instruction given*

CPT 97799 - Unlisted physical medicine/rehabilitation service or procedure, not timed

If an existing CPT code does not describe the service performed, an unlisted CPT code may be used. The use of unlisted codes should be rare. If unlisted codes are billed, the claim and medical record must clearly state what modality or procedure is billed as an unlisted code. If not, the unlisted code billed will be subject to denial for insufficient information.

Supportive Documentation Recommendations for 97799

Please see Documentation Requirements for Unlisted Procedure codes.

This is an untimed code, billable as "1" unit.

Please see the Unlisted Procedure Codes section of article A46198, Outpatient Physical and Occupational Therapy Services – Supplemental Instructions Article, for specific billing instructions.

CPT G0281 – Electrical stimulation, (unattended), to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care

CPT G0329 - Electromagnetic therapy, to one or more areas for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care

G0281 code replaces code 97014, only where it applies to treatment of wounds, as defined in the code narrative.

Nationally Covered Indications (CMS Publication 100-03, Medicare National Coverage Determinations (NCD) Manual, section 270.1): *Electrical stimulation (ES) and electromagnetic therapy for the treatment of wounds are considered adjunctive therapies, and will only be covered for chronic Stage III or Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers. Chronic ulcers are defined as ulcers that have not healed within 30 days of occurrence. ES or electromagnetic therapy will be covered only after appropriate standard wound therapy has been provided for at least 30 days and there are no measurable signs of healing. This 30-day period may begin while the wound is acute.*

Standard wound care includes optimization of nutritional status, debridement by any means to remove devitalized tissue, maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings, and necessary treatment to resolve any infection that may be present. Standard wound care based on the specific type of wound includes frequent repositioning of a patient with pressure ulcers (usually every 2 hours), off-loading of pressure and good glucose control for diabetic ulcers, establishment of adequate circulation for arterial ulcers, and the use of a compression system for patients with venous ulcers.

Measurable signs of healing include a decrease in wound size (either surface area or volume), decrease in amount of exudates, and decrease in amount of necrotic tissue. ES or electromagnetic therapy must be discontinued when the wound demonstrates a 100% epithelialized wound bed. ES and electromagnetic therapy services can only be covered when performed by a therapist, a physician or incident to a physician's service.

Evaluation of the wound is an integral part of wound therapy. When providing ES or electromagnetic therapy, the therapist must evaluate and frequently reassess the wound, contacting the treating physician if the wound worsens (do not bill a re-evaluation code for the wound assessment). If ES or electromagnetic therapy is being used, wounds must be evaluated at least monthly by the treating physician.

Per NCD 270.1, electrical stimulation (G0281) and electromagnetic therapy (G0329) are NOT COVERED for the treatment of:

- *stage I or stage II wounds;*
- *electrical stimulation or electromagnetic therapy when used as an initial treatment modality;*
- *continued treatment with ES or electromagnetic therapy if measurable signs of healing have not been demonstrated within any 30-day period of treatment;*
- *wounds that demonstrate a 100% epithelialized wound bed;*
- *a patient in the home setting, as unsupervised use by patients in the home has not been found to be medically reasonable and necessary.*

Supportive Documentation Recommendations for G0281 and G0329

- *Etiology and duration of wound*
- *Type of prior treatments by a physician, non-physician practitioner, nurse and/or therapist that failed, including the duration of the failed treatment*
- *Stage of wound*
- *Description of wound: length, width, depth, grid drawing and/or photographs*
- *Amount, frequency, color, odor, type of exudate*
- *Evidence of infection, undermining, or tunneling*
- *Nutritional status*
- *Comorbidities (e.g., diabetes mellitus, peripheral vascular disease)*
- *Pressure support surfaces in use*
- *Patient's functional level*
- *Skilled plan of treatment, including specific frequency of the modality*
- *Changing plan of treatment based on clinical judgment of the patient's response or lack of response to treatment*
- *Frequent skilled observation and assessment of wound healing (at least weekly, but preferably with each treatment session)*

CPT G0282 - Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281

This code is not covered by Medicare.

Other Available Therapy Codes

CPT Codes 95831, 95832, 95833, 95834, 95851, and 95852 - Muscle and Range of Motion Testing

For the typical patient, the evaluation (97001, 97002) and reevaluation codes (97003, 97004) include all the necessary evaluation tools, including range of motion and manual muscle testing. Baseline measurements may be done with an initial evaluation, but are not separately billable in addition to the evaluation. In addition, assessments, which are separate from evaluations and reevaluations, are included in the therapy treatment services and procedures and should be coded consistent with the intervention for which the assessment is necessary.

Assessments must be provided by therapists or physician/NPP (not therapy assistants) and include objective testing and measurement (such as ROM and manual muscle testing) to make clinical judgments regarding the patient's condition to determine the next step in the treatment plan.

On rare occasions, it may be appropriate to perform a thorough range of motion or manual muscle test during the course of treatment that is separate from the evaluation/reevaluation. Patients with complicated conditions may warrant specialized tests and measures with standardized reports. For example, a patient with an incomplete C5 quadriplegia at six months post-injury may need specialized testing for ROM or strength measurements to address specific deficits and goals.

Testing must be pertinent to the plan of care and the diagnosis.

Every muscle or joint in the affected extremity or trunk section, as described in the code descriptor, must be tested when coding these procedures. For example:

- *Code 95831 is “Muscle testing, manual with report: extremity (excluding hand) or trunk”. To use this code for extremity manual muscle testing, every muscle of at least one extremity would need to be tested, with documentation of why such a thorough assessment was warranted. It would not be appropriate to bill code 95831 if only hip strength needed to be tested.*
- *Code 95851 is “Range of motion measurements and report; each extremity (excluding hand) or trunk section (spine)”. To use this code for extremity ROM testing, every joint of an extremity would need to be tested, with documentation of why such a thorough assessment was warranted. It would not be appropriate to bill code 95851 if only shoulder ROM needed to be tested.*

It is not reasonable or necessary for these codes to be performed on a routine basis or to be routinely used for all patients (e.g., monthly or in the place of billing for a reevaluation).

These codes are not covered on the same visit date as CPT codes 97001-97004 (due to CCI edits).

Supportive Documentation Recommendations

These codes are typically consultative. It is expected that the administration of these tests will generate material that will be formulated into a report. That report should clearly indicate the purpose and rationale for the test, the test performed with results and how the information affects the treatment plan.

Application of Casts and Strapping Codes

The casting and strapping procedures apply when the cast application or strapping is a replacement procedure used during or after the period of follow-up care, or when the cast application or strapping is an initial service performed without a restorative treatment or procedure(s) to stabilize or protect a fracture, injury, or dislocation and/or to afford comfort to a patient.

A physician who applies the initial cast, strap or splint and also assumes all of the subsequent fracture, dislocation, or injury care cannot use the application of casts and strapping codes as an initial service, since the first cast/splint or strap application is included in the treatment of fracture and/or dislocation codes. A temporary cast/splint/strap is not considered to be part of the preoperative care.

General Guidelines for Casting (CPT codes 29065, 29075, 29085, 29086, 29345, 29355, 29365, 29405, 29425, and 29445)

Therapists typically do not utilize casting interventions for the treatment of fractures. However, casting techniques used by therapists for positioning and stretching are a covered service when an improvement can be noted in an individual’s movement patterns and skills. For example, a spastic hand can be casted to facilitate relaxation of the fingers. Serial casting can be essential for individuals with traumatic brain injury-induced spasticity, CVA, and other conditions. Casting should not be utilized for basic contracture management issues. Casting goals should objectively indicate expectation of progress, whereas, the main function of contracture management is to decrease the risk of further contracture.

More than 8-10 visits for evaluation, treatment, modification and caregiver education would not be considered reasonable and necessary without significant documentation.

These are untimed codes.

General Guidelines for Strapping

(CPT codes 29200-29280, 28520-29590, 29799. For dates of service prior to 2010, CPT code 29220 is used to report low back strapping, and for dates of service between 01/01/2010 and 09/30/2010, CPT code 29799 is used to report the service.)

Strapping refers to the application of overlapping strips of adhesive plaster or tape to a body part to exert pressure and hold a structure in place. Strapping may be used to treat strains, sprains, dislocations, and some fractures. The strapping codes are intended to be used when the desired effect is to provide total immobilization or restriction of movement. These services are typically performed outside a therapy plan of care.

Strapping is not always synonymous with taping (such as McConnell taping or kinesiotaping). See additional information on taping under codes 97110 and 97112. See code 97140 for wrapping techniques for manual lymphatic drainage.

For dates of service on and after 10/1/2010, low back strapping (regardless of CPT code billed) will be considered a non-reimbursable service under Medicare, as the service has been removed from CPT as an obsolete procedure [CPT Changes 2010 – An Insider’s View, page 91].

Special instructions for code 29580 – Strapping; Unna boot

The application of Unna boot paste (zinc, gelatin, or other product) as a bandage or “colloid” dressing, is applied to an extremity for the treatment of dermatological, vascular, and on occasion, other conditions. These dressings are often covered by an elastic bandage to give added support, hold the dressing in place and provide a protective cover. Unna boot application is appropriate in the treatment of ulcerations with and without inflammation due to stasis dermatitis produced by vascular insufficiency. The Unna boot is also appropriate for treating ligamentous injuries (sprains and strains) of the ankle. Unna boots need to be changed on a regular basis, depending on the exact type used and the indication. Bilateral unna boots should be billed with a modifier -50 (bilateral procedure).

These are untimed codes.

CPT 29799 - Unlisted procedure, casting or strapping

If an existing CPT code does not describe the service performed, an unlisted CPT code may be used. The use of unlisted codes should be rare. If unlisted codes are billed, the medical record and claim must clearly state what modality or procedure is billed as an unlisted code. If not, the unlisted code billed will be subject to denial for insufficient information. As of 10/01/2010, low back strapping (formerly CPT code 29220) should not be billed with CPT code 29799.

Supportive Documentation Recommendations for 29799

This is an untimed code, billable as "1" unit.

Please see section Documentation Recommendations for Unlisted Procedure Codes.

Please see the Unlisted Procedure Codes section of article A49932, Outpatient Physical and Occupational Therapy Services - Supplemental Instructions Article, for specific billing instructions.

General Guidelines for Splinting (Codes 29105-29131, 29505-29515)

See codes 97760 and 97762 for further information on orthotics.

According to CPT Assistant-February 2007, orthosis application differs from the purpose of an application of a cast or strapping device. Casting and strapping codes should not be reported for orthotics fitting and training.

Splinting codes, though rarely used by therapists, may be appropriate for clinical situations (e.g., fracture, sprain, dislocation) where temporary immobilization/fixation is required until there is further treatment disposition.

This example is based upon a clinical vignette in CPT Assistant-April 2002. Patient C is a 70-year-old female who presents to the outpatient orthopaedic clinic following a left ankle injury when her foot became twisted in her dog's run chain. After the orthopaedist evaluates the patient, radiologic views were obtained that substantiated the diagnosis of a sprained ankle ligament. A short-leg plaster posterior molded splint is applied by the physical therapist due to the degree of swelling (billable as CPT 29515). Upon return to the orthopaedic clinic, the splint is removed, x-rays repeated, and based on those findings, a short-leg fiberglass nonwalking cast is applied.

These are untimed codes.

CPT 90901 – Biofeedback training by any modality

CPT 90911 – Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry

Biofeedback therapy provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone into a tone or light, the loudness or brightness of which shows the extent of activity in the function being measured.

Biofeedback therapy differs from electromyography which is a diagnostic procedure used to record and study the electrical properties of skeletal muscle. An electromyography device may be used to provide feedback with certain types of biofeedback.

Biofeedback therapy is covered under Medicare only when it is reasonable and necessary for the individual patient for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and more conventional treatments (heat, cold, massage, exercise, support) have not been successful. This therapy is not covered for treatment of ordinary muscle tension states or for psychosomatic conditions. (CMS Publication 100-03, Medicare National Coverage Determinations (NCD) Manual, Section 30.1)

Biofeedback for incontinence

Biofeedback is covered for the treatment of stress and/or urge incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training. Biofeedback is not a treatment, per se, but a tool to help patients learn how to perform PME. Biofeedback-assisted PME incorporates the use of an electronic or mechanical device to relay visual and/or auditory evidence of pelvic floor muscle tone, in order to improve awareness of pelvic floor musculature and to assist patients in the performance of PME.

A failed trial of PME training is defined as no clinically significant improvement in urinary incontinence after completing four weeks of an ordered plan of pelvic muscle exercises to increase periurethral muscle strength.

Medicare will allow biofeedback as an initial incontinence treatment modality only when, in the opinion of the physician, that approach is most appropriate and there is documentation of medical justification and rationale for why a PME trial was not attempted first.

Patient selection is a major part of the process and the patient should be motivated, cognitively intact, and compliant. In addition, there must be assurance that the pelvic floor musculature is intact. Biofeedback therapy has proven successful for urinary incontinence when all three of the following conditions exist:

- *the patient is capable of participation in the plan of care;*
- *the patient is motivated to actively participate in the plan of care, including being responsive to the care requirements (e.g., practice and follow-through by self or caregiver); and*
- *the patient's condition is appropriately treated with biofeedback (e.g., pathology does not exist preventing success of treatment).*

When providing biofeedback procedures for urinary incontinence, use CPT 90901 when EMG and/or manometry are not performed.

CPT 90911 describes biofeedback that is more involved than conventional biofeedback measures (code 90901) and includes evaluations of the EMG activity of the pelvic muscles, urinary sphincter and/or anal sphincter by using sensors. This procedure can use manometry (measure of pressure of gases or liquids by use of a manometer) or EMG (electromyography - the recording of electrical activity initiated in the muscle tissue for testing purposes) to measure activity. The EMG activity is evaluated and provides objective information regarding the muscle activity and provides a basis for pelvic muscle rehabilitation utilizing biofeedback.

Biofeedback is non-covered for:

- *home use of biofeedback therapy;*
- *pelvic floor electrical stimulation lacking documentation of the failure of a trial of pelvic muscle exercise (PME) training, unless there is physician documentation justifying the need to initiate treatment with biofeedback before PME is attempted;*
- *patients who do not have sufficient cognitive ability to adhere to and follow the PME protocol and/or cooperate in keeping a personal voiding diary.*

Patients not showing improvement after 5-6 visits of retraining with biofeedback are not likely to improve with additional sessions. Additional documentation is necessary to justify biofeedback services beyond 5-6 visits.

The descriptor for codes 90901 and 90911 does not include a time element; therefore, these codes should be billed as one (1) unit.

Supportive Documentation Recommendations for 90901 and 90911

As noted in the NCD descriptions above, biofeedback is covered only when more conventional treatments such as heat, cold, massage, exercise (such as PME), and/or support have not been successful. Therefore, documentation must provide a clear history of the conventional treatments unsuccessfully tried before initiating biofeedback. Since biofeedback is only covered when there is a lack of response to other therapies, the lack of response to or contraindication to, other therapies must be noted in the patient's record.

Additionally for the treatment of incontinence, include:

- *identification of the type and degree of incontinence, expectations from the treatment and the time frame in which an improvement is anticipated;*
- *clear documentation of the formal instruction, monitoring and follow-up of a prescribed course of PME;*
- *evidence of behavioral modification training including, but not limited to, bladder retraining and fluid intake modification;*

- *the use of a patient record-keeping system, such as a personal voiding diary, in evaluating and monitoring progress.*

CPT 96125 – Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional’s time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.

For psychological and neuropsychological testing by physician or psychologist, see 96101-96103, 96118-96120

According to CPT 2008 Changes, An Insider’s View, patients who have compromised functioning abilities due to acute neurological events such as TBI or CVA must undergo assessment to determine if abilities such as orientation, memory and high-level language function have been comprised and to what extent. Health care professionals such as speech-language pathologists (SLPs) and OTs perform a battery of test procedures called standardized cognitive performance testing in order to make these important determinations. These tests evaluate different aspects of neurocognitive function including memory (short-term, long-term, and organizational), reasoning, sensory processing, visual perceptual status, orientation, right hemisphere processing for temporal and spatial organization, social pragmatics, and elements of decision-making and executive function.

Code 96125 has been established to report these test procedures when performed by qualified health care professionals, such as SLPs and OTs. Code 96125 is a time-based code intended to be reported per hour, including the time administering the tests to the patient, interpreting the results, and preparing the report. Note that this code includes both face-to-face time and non-face-to-face time.

Clinical example:

A 36 year old male with TBI from a MVA is referred to the health care professional for standardized cognitive performance testing following a recent discharge. The qualified health care professional selects and completes face-to-face administration of the appropriate standardized test(s) to examine the patient’s current level of functional cognitive performance. Raw and standardized scores are derived and analyzed. A written report is prepared by the qualified health care professional and sent to the referring physician.

Miscellaneous Services (Non-covered)

The following are non-covered as skilled therapy services. This is not an all inclusive list.

- *Iontophoresis, except as indicated for primary focal hyperhidrosis*
- *Anodyne*
- *Low level laser treatment (LLLT)/cold laser therapy*
- *Dry hydrotherapy massage (e.g., aquamassage, hydromassage, or water massage)*
- *Massage chairs or roller beds*
- *Interactive metronome therapy*
- *Loop reflex training*
- *Vestibular ocular reflex training*
- *Continuous passive motion (CPM) device setup and adjustments*
- *Craniosacral therapy*
- *Electro-magnetic therapy, except as indicated for chronic wounds*
- *Constraint Induced Movement Therapy (CIMT)*
- *Driving assessments*
- *Work-hardening programs*
- *Pelvic Floor Dysfunction (not including incontinence)*

- *Due to the lack of peer reviewed evidence concerning the effect on patient health outcomes, skilled therapy interventions (e.g., ultrasound, electrical stimulation, soft tissue mobilization, and therapeutic exercise) for the treatment of the following conditions is considered investigational and thus non-covered.*
 - *pelvic floor congestion*
 - *pelvic floor pain not of spinal origin*
 - *hypersensitive clitoris*
 - *prostatitis*
 - *cystourethrocele*
 - *enterocele*
 - *rectocele*
 - *vulvodynia*
 - *vulvar vestibulitis syndrome (VVS)*

- *Functional Electrical Stimulating (FES) devices other than those that assist in walking are not covered under Medicare [NCD 160.12]. Consequently, any services related to the evaluation for or training of patients to use such a device is not covered. Such devices may include, but are not limited, to the Ergys® system.*

Other Comments:

For claims submitted to the fiscal intermediary or Part A MAC: This coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated National Government Services to process their claims.

In addition to a detailed service description, information in the medical record submitted to the contractor must specify the type of modality utilized and, if the modality requires the constant attendance of the qualified professional/auxiliary personnel, the time spent by the qualified professional/auxiliary personnel, one-on-one with the beneficiary.

Bill type codes only apply to providers who bill these services to the fiscal intermediary or Part A MAC. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.

Limitation of liability and refund requirements apply when denials are likely, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.

For outpatient settings other than CORFs, references to "physicians" throughout this policy include non-physicians, such as nurse practitioners, clinical nurse specialists and physician assistants. Such non-physician practitioners, with certain exceptions, may certify, order and establish the plan of care as authorized by State law. (See Sections 1861[s][2] and 1862[a][14] of Title XVIII of the Social Security Act; 42 CFR, Sections 410.74, 410.75, 410.76 and 419.22; 58 FR 18543, April 7, 2000.)

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

011x	Hospital Inpatient (Including Medicare Part A)
012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient
022x	Skilled Nursing - Inpatient (Medicare Part B only)
023x	Skilled Nursing - Outpatient
034x	Home Health - Other (for medical and surgical services not under a plan of treatment)
074x	Clinic - Outpatient Rehabilitation Facility (ORF)
075x	Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)
085x	Critical Access Hospital

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the fiscal intermediary or Part A MAC. Revenue codes do not apply to physicians, other professionals (such as physical therapists and occupational therapists in private practice) and suppliers who bill these services to the carrier or Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.

0420	Physical Therapy - General Classification
0421	Physical Therapy - Visit
0424	Physical Therapy - Evaluation or Re-evaluation
0429	Physical Therapy - Other Physical Therapy
0430	Occupational Therapy - General Classification
0431	Occupational Therapy - Visit
0434	Occupational Therapy - Evaluation or Reevaluation
0439	Occupational Therapy - Other Occupational Therapy

CPT/HCPCS Codes

For most revenue codes, Outpatient Prospective Payment System (OPPS) requirements mandate CPT/HCPCS coding on the claim. When the revenue code you are reporting requires CPT/HCPCS coding, the appropriate code(s) may be chosen from the list below when submitting your claim to Medicare.

This list represents common physical and occupational therapy services and is not all-inclusive.

29065	Application of long arm cast
29075	Application of forearm cast
29085	Apply hand/wrist cast
29086	Apply finger cast
29105	Apply long arm splint
29125	Apply forearm splint
29126	Apply forearm splint
29130	Application of finger splint
29131	Application of finger splint
29200	Strapping of chest
29240	Strapping of shoulder
29260	Strapping of elbow or wrist
29280	Strapping of hand or finger
29345	Application of long leg cast
29355	Application of long leg cast
29365	Application of long leg cast
29405	Apply short leg cast
29425	Apply short leg cast
29445	Apply rigid leg cast
29505	Application long leg splint
29515	Application lower leg splint
29520	Strapping of hip
29530	Strapping of knee
29540	Strapping of ankle and/or ft
29550	Strapping of toes
29580	Application of paste boot
29590	Application of foot splint
29799	Casting/strapping procedure
90901	Biofeedback train any meth
90911	Biofeedback peri/uro/rectal

95831	Limb muscle testing manual
95832	Hand muscle testing manual
95833	Body muscle testing manual
95834	Body muscle testing manual
95851	Range of motion measurements
95852	Range of motion measurements
96125	Cognitive test by hc pro
97001	Pt evaluation
97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
97010	Hot or cold packs therapy
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy eg microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97039	Physical therapy treatment
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97139	Physical medicine procedure
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97532	Cognitive skills development
97533	Sensory integration

97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97597	Rmvl devital tis 20 cm/<
97598	Rmvl devital tis addl 20 cm<
97602	Wound(s) care non-selective
97605	Neg press wound tx < 50 cm
97606	Neg press wound tx > 50 cm
97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic mgmt and training
97761	Prosthetic training
97762	C/o for orthotic/prosth use
97799	Physical medicine procedure
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers

ICD-9 Codes that Support Medical Necessity

It is the responsibility of the provider to code to the highest level specified in the ICD-9-CM (e.g., to the fourth or fifth digit). The correct use of an ICD-9-CM code does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

See the “Indications and Limitations of Coverage and/or Medical Necessity” section.

When coding for therapy services, the primary diagnosis codes should indicate the reason for the encounter, and the specific condition for which therapy services are provided MUST also be included as secondary and subsequent diagnoses. Claims without secondary diagnoses may be denied.

Primary Diagnoses:

V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY
V57.21	CARE INVOLVING OCCUPATIONAL THERAPY
V57.3	CARE INVOLVING SPEECH-LANGUAGE THERAPY
V57.81	CARE INVOLVING ORTHOTIC TRAINING
V57.89	CARE INVOLVING OTHER SPECIFIED REHABILITATION PROCEDURE

Diagnoses that Support Medical Necessity

Not applicable

ICD-9 Codes that DO NOT Support Medical Necessity

The following ICD-9-CM Codes do not support the medical necessity for the CPT/HCPCS code 97035.

277.00	CYSTIC FIBROSIS WITHOUT MECONIUM ILEUS
277.02	CYSTIC FIBROSIS WITH PULMONARY MANIFESTATIONS
454.0	VARICOSE VEINS OF LOWER EXTREMITIES WITH ULCER
454.2	VARICOSE VEINS OF LOWER EXTREMITIES WITH ULCER AND INFLAMMATION
459.11	POSTPHLEBETIC SYNDROME WITH ULCER
459.13	POSTPHLEBETIC SYNDROME WITH ULCER AND INFLAMMATION
459.31	CHRONIC VENOUS HYPERTENSION WITH ULCER
459.33	CHRONIC VENOUS HYPERTENSION WITH ULCER AND INFLAMMATION
490	BRONCHITIS NOT SPECIFIED AS ACUTE OR CHRONIC
491.0	SIMPLE CHRONIC BRONCHITIS
491.1	MUCOPURULENT CHRONIC BRONCHITIS
491.20	OBSTRUCTIVE CHRONIC BRONCHITIS WITHOUT EXACERBATION
491.21	OBSTRUCTIVE CHRONIC BRONCHITIS WITH (ACUTE) EXACERBATION
491.22	OBSTRUCTIVE CHRONIC BRONCHITIS WITH ACUTE BRONCHITIS
491.8	OTHER CHRONIC BRONCHITIS
491.9	UNSPECIFIED CHRONIC BRONCHITIS
492.0	EMPHYSEMATOUS BLEB
492.8	OTHER EMPHYSEMA
493.00	EXTRINSIC ASTHMA UNSPECIFIED
493.01	EXTRINSIC ASTHMA WITH STATUS ASTHMATICUS
493.02	EXTRINSIC ASTHMA WITH (ACUTE) EXACERBATION
493.10	INTRINSIC ASTHMA UNSPECIFIED
493.11	INTRINSIC ASTHMA WITH STATUS ASTHMATICUS

493.12	INTRINSIC ASTHMA WITH (ACUTE) EXACERBATION
493.20	CHRONIC OBSTRUCTIVE ASTHMA UNSPECIFIED
493.21	CHRONIC OBSTRUCTIVE ASTHMA WITH STATUS ASTHMATICUS
493.22	CHRONIC OBSTRUCTIVE ASTHMA WITH (ACUTE) EXACERBATION
493.81	EXERCISE-INDUCED BRONCHOSPASM
493.82	COUGH VARIANT ASTHMA
493.90	ASTHMA UNSPECIFIED
493.91	ASTHMA UNSPECIFIED TYPE WITH STATUS ASTHMATICUS
493.92	ASTHMA UNSPECIFIED WITH (ACUTE) EXACERBATION
494.0	BRONCHIECTASIS WITHOUT ACUTE EXACERBATION
494.1	BRONCHIECTASIS WITH ACUTE EXACERBATION
495.0	FARMERS' LUNG
495.1	BAGASSOSIS
495.2	BIRD-FANCIERS' LUNG
495.3	SUBEROSIS
495.4	MALT WORKERS' LUNG
495.5	MUSHROOM WORKERS' LUNG
495.6	MAPLE BARK-STRIPPERS' LUNG
495.7	'VENTILATION' PNEUMONITIS
495.8	OTHER SPECIFIED ALLERGIC ALVEOLITIS AND PNEUMONITIS
495.9	UNSPECIFIED ALLERGIC ALVEOLITIS AND PNEUMONITIS
496	CHRONIC AIRWAY OBSTRUCTION NOT ELSEWHERE CLASSIFIED
500	COAL WORKERS' PNEUMOCONIOSIS
501	ASBESTOSIS
502	PNEUMOCONIOSIS DUE TO OTHER SILICA OR SILICATES
503	PNEUMOCONIOSIS DUE TO OTHER INORGANIC DUST
504	PNEUMONOPATHY DUE TO INHALATION OF OTHER DUST

505	PNEUMOCONIOSIS UNSPECIFIED
518.2	COMPENSATORY EMPHYSEMA
518.3	PULMONARY EOSINOPHILIA
518.4	ACUTE EDEMA OF LUNG UNSPECIFIED
707.00	PRESSURE ULCER, UNSPECIFIED SITE
707.01	PRESSURE ULCER, ELBOW
707.02	PRESSURE ULCER, UPPER BACK
707.03	PRESSURE ULCER, LOWER BACK
707.04	PRESSURE ULCER, HIP
707.05	PRESSURE ULCER, BUTTOCK
707.06	PRESSURE ULCER, ANKLE
707.07	PRESSURE ULCER, HEEL
707.09	PRESSURE ULCER, OTHER SITE
707.12	ULCER OF CALF
707.13	ULCER OF ANKLE
707.14	ULCER OF HEEL AND MIDFOOT
707.15	ULCER OF OTHER PART OF FOOT
707.19	ULCER OF OTHER PART OF LOWER LIMB
707.20	PRESSURE ULCER, UNSPECIFIED STAGE
707.21	PRESSURE ULCER, STAGE I
707.22	PRESSURE ULCER, STAGE II
707.23	PRESSURE ULCER, STAGE III
707.24	PRESSURE ULCER, STAGE IV
707.25	PRESSURE ULCER, UNSTAGEABLE
879.7	OPEN WOUND OF OTHER AND UNSPECIFIED PARTS OF TRUNK COMPLICATED
890.0	OPEN WOUND OF HIP AND THIGH WITHOUT COMPLICATION
941.20	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF FACE AND HEAD UNSPECIFIED SITE
941.21	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF EAR (ANY PART)
941.24	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF CHIN
941.25	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF NOSE (SEPTUM)
941.26	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF SCALP (ANY PART)

941.27 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF FOREHEAD AND CHEEK

941.28 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF NECK

941.29 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF MULTIPLE SITES (EXCEPT WITH EYE) OF FACE HEAD AND NECK

942.20 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF UNSPECIFIED SITE OF TRUNK

942.21 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF BREAST

942.22 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF CHEST WALL EXCLUDING BREAST AND NIPPLE

942.23 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF ABDOMINAL WALL

942.24 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF BACK (ANY PART)

942.25 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF GENITALIA

942.29 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF OTHER AND MULTIPLE SITES OF TRUNK

943.20 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF UNSPECIFIED SITE OF UPPER LIMB

943.21 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF FOREARM

943.22 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF ELBOW

943.23 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF UPPER ARM

943.24 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF AXILLA

943.25 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF SHOULDER

943.26 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF SCAPULAR REGION

943.29 BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF MULTIPLE SITES OF UPPER LIMB EXCEPT WRIST AND HAND

944.20

	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF UNSPECIFIED SITE OF HAND
944.21	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF SINGLE DIGIT (FINGER (NAIL)) OTHER THAN THUMB
944.22	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN OF (SECOND DEGREE) OF THUMB (NAIL)
944.23	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF TWO OR MORE DIGITS OF HAND NOT INCLUDING THUMB
944.24	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF TWO OR MORE DIGITS OF HAND INCLUDING THUMB
944.25	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF PALM OF HAND
944.26	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF BACK OF HAND
944.27	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF WRIST
944.28	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF MULTIPLE SITES OF WRIST(S) AND HAND(S)
945.20	BLISTERS EPIDERMAL LOSS (SECOND DEGREE) OF UNSPECIFIED SITE OF LOWER LIMB (LEG)
945.21	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF TOE(S) (NAIL)
945.22	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF FOOT
945.23	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF ANKLE
945.24	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF LOWER LEG
945.25	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF KNEE
945.26	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF THIGH (ANY PART)
945.29	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF MULTIPLE SITES OF LOWER LIMB(S)
946.2	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF MULTIPLE SPECIFIED SITES
948.00	

	BURN (ANY DEGREE) INVOLVING LESS THAN 10 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF LESS THAN 10 PERCENT OR UNSPECIFIED AMOUNT
948.10	BURN (ANY DEGREE) INVOLVING 10-19 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF LESS THAN 10 PERCENT OR UNSPECIFIED AMOUNT
948.11	BURN (ANY DEGREE) INVOLVING 10-19 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 10-19%
948.20	BURN (ANY DEGREE) INVOLVING 20-29 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF LESS THAN 10 PERCENT OR UNSPECIFIED AMOUNT
948.21	BURN (ANY DEGREE) INVOLVING 20-29 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 10-19%
948.22	BURN (ANY DEGREE) INVOLVING 20-29 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 20-29%
948.30	BURN (ANY DEGREE) INVOLVING 30-39 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF LESS THAN 10 PERCENT OR UNSPECIFIED AMOUNT
948.31	BURN (ANY DEGREE) INVOLVING 30-39 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 10-19%
948.32	BURN (ANY DEGREE) INVOLVING 30-39 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 20-29%
948.33	BURN (ANY DEGREE) INVOLVING 30-39 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 30-39%
948.40	BURN (ANY DEGREE) INVOLVING 40-49 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF LESS THAN 10 PERCENT OR UNSPECIFIED AMOUNT
948.41	BURN (ANY DEGREE) INVOLVING 40-49 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 10-19%
948.42	BURN (ANY DEGREE) INVOLVING 40-49 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 20-29%
948.43	BURN (ANY DEGREE) INVOLVING 40-49 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 30-39%
948.44	

	BURN (ANY DEGREE) INVOLVING 40-49 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 40-49%
948.50	BURN (ANY DEGREE) INVOLVING 50-59 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF LESS THAN 10 PERCENT OR UNSPECIFIED AMOUNT
948.51	BURN (ANY DEGREE) INVOLVING 50-59 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 10-19%
948.52	BURN (ANY DEGREE) INVOLVING 50-59 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 20-29%
948.53	BURN (ANY DEGREE) INVOLVING 50-59 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 30-39%
948.54	BURN (ANY DEGREE) INVOLVING 50-59 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 40-49%
948.55	BURN (ANY DEGREE) INVOLVING 50-59 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 50-59%
948.60	BURN (ANY DEGREE) INVOLVING 60-69 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF LESS THAN 10 PERCENT OR UNSPECIFIED AMOUNT
948.61	BURN (ANY DEGREE) INVOLVING 60-69 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 10-19%
948.62	BURN (ANY DEGREE) INVOLVING 60-69 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 20-29%
948.63	BURN (ANY DEGREE) INVOLVING 60-69 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 30-39%
948.64	BURN (ANY DEGREE) INVOLVING 60-69 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 40-49%
948.65	BURN (ANY DEGREE) INVOLVING 60-69 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 50-59%
948.66	BURN (ANY DEGREE) INVOLVING 60-69 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 60-69%
948.70	BURN (ANY DEGREE) INVOLVING 70-79 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF LESS THAN 10 PERCENT OR UNSPECIFIED AMOUNT

948.71	BURN (ANY DEGREE) INVOLVING 70-79 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 10-19%
948.72	BURN (ANY DEGREE) INVOLVING 70-79 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 20-29%
948.73	BURN (ANY DEGREE) INVOLVING 70-79 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 30-39%
948.74	BURN (ANY DEGREE) INVOLVING 70-79 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 40-49%
948.75	BURN (ANY DEGREE) INVOLVING 70-79 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 50-59%
948.76	BURN (ANY DEGREE) INVOLVING 70-79 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 60-69%
948.77	BURN (ANY DEGREE) INVOLVING 70-79 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 70-79%
948.80	BURN (ANY DEGREE) INVOLVING 80-89 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF LESS THAN 10 PERCENT OR UNSPECIFIED AMOUNT
948.81	BURN (ANY DEGREE) INVOLVING 80-89 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 10-19%
948.82	BURN (ANY DEGREE) INVOLVING 80-89 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 20-29%
948.83	BURN (ANY DEGREE) INVOLVING 80-89 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 30-39%
948.84	BURN (ANY DEGREE) INVOLVING 80-89 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 40-49%
948.85	BURN (ANY DEGREE) INVOLVING 80-89 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 50-59%
948.86	BURN (ANY DEGREE) INVOLVING 80-89 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 60-69%
948.87	BURN (ANY DEGREE) INVOLVING 80-89 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 70-79%
948.88	

	BURN (ANY DEGREE) INVOLVING 80-89 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF 80-89%
948.90	BURN (ANY DEGREE) INVOLVING 90 PERCENT OR MORE OF BODY SURFACE WITH THIRD DEGREE BURN OF LESS THAN 10 PERCENT OR UNSPECIFIED AMOUNT
948.91	BURN (ANY DEGREE) INVOLVING 90 PERCENT OR MORE OF BODY SURFACE WITH THIRD DEGREE BURN OF 10-19%
948.92	BURN (ANY DEGREE) INVOLVING 90 PERCENT OR MORE OF BODY SURFACE WITH THIRD DEGREE BURN OF 20-29%
948.93	BURN (ANY DEGREE) INVOLVING 90 PERCENT OR MORE OF BODY SURFACE WITH THIRD DEGREE BURN OF 30-39%
948.94	BURN (ANY DEGREE) INVOLVING 90 PERCENT OR MORE OF BODY SURFACE WITH THIRD DEGREE BURN OF 40-49%
948.95	BURN (ANY DEGREE) INVOLVING 90 PERCENT OR MORE OF BODY SURFACE WITH THIRD DEGREE BURN OF 50-59%
948.96	BURN (ANY DEGREE) INVOLVING 90 PERCENT OR MORE OF BODY SURFACE WITH THIRD DEGREE BURN OF 60-69%
948.97	BURN (ANY DEGREE) INVOLVING 90 PERCENT OR MORE OF BODY SURFACE WITH THIRD DEGREE BURN OF 70-79%
948.98	BURN (ANY DEGREE) INVOLVING 90 PERCENT OR MORE OF BODY SURFACE WITH THIRD DEGREE BURN OF 80-89%
948.99	BURN (ANY DEGREE) INVOLVING 90 PERCENT OR MORE OF BODY SURFACE WITH THIRD DEGREE BURN OF 90% OR MORE OF BODY SURFACE
949.2	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) UNSPECIFIED SITE
998.30	DISRUPTION OF WOUND, UNSPECIFIED
998.32	DISRUPTION OF EXTERNAL OPERATION (SURGICAL) WOUND
998.33	DISRUPTION OF TRAUMATIC INJURY WOUND REPAIR
998.83	NON-HEALING SURGICAL WOUND

Diagnoses that DO NOT Support Medical Necessity

Not applicable

General Information

Documentation Requirements

The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures, the time of any assessment is included and billed within the appropriate treatment intervention CPT code.

Therapy services shall be payable when the medical record and the information on the claim consistently and accurately report covered therapy services. Documentation must be legible, relevant and sufficient to justify the medical necessity of the services billed.

Medicare requires a legible identifier of the person(s) who provided the service. The method used shall be a hand written or an electronic signature to sign an order or other medical documentation for medical review purposes. Electronic or hand written signatures that have been communicated through facsimile are also acceptable. Effective April 28, 2008, stamp signatures were no longer acceptable.

The document guidelines in CMS Pub 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 220 and 230 identify the minimal expectations of documentation by providers or suppliers or beneficiaries submitting claims for payment of therapy services to the Medicare program. It is encouraged, in order to support the medical necessity and the skilled nature of the treatment, to document more thoroughly and frequently.

Medical review decisions are based on the information submitted in the medical record. Therefore, it is critical that the medical record information submitted is accurate and complete to allow medical review to make a fair payment decision. The medical record information submitted should:

- Paint a picture of the patient's impairments and functional limitations requiring skilled intervention;
- Describe the prior functional level to assist in establishing the patient's potential and prognosis;
- Describe the skilled nature of the therapy treatment provided;
- Justify that the type, frequency and duration of therapy is medically necessary for the individual patient's condition;
- Clearly document both Timed Code Treatment Minutes and Total Treatment Time in order to justify the units billed;
- Identify each specific skilled intervention/modality provided to justify coding.

Documentation may be submitted in any format as long as all the necessary information is captured. Forms 700 & 701 are not required documents. The documentation must establish that the patient needs the unique skills of a therapist to improve functioning. This is accomplished through a description of the patient's condition, and any complexities that impact that condition. Not only should documentation describe the needs of the patient that require the unique skills of a therapist, but should also describe the services provided that required the expertise, knowledge, clinical judgment, decision making and abilities of a clinician that assistants, qualified auxiliary personnel, caretakers or the patient cannot provide independently. *A therapist's skills may be documented, for example, by the descriptions of the skilled treatment, the changes made to the treatment due to an assessment of the patient's needs on a particular treatment day, or due to progress judged sufficient to modify the treatment toward the next more complex or difficult task.*

Documentation should establish the variables that influence the patient's condition, especially those factors that influence the therapist's (or clinician's) decision to provide more services than are typical for the individual's condition. Documentation should establish through objective measurements that the patient is making progress toward goals. When regression or plateaus occur, the reasons for the lack of progress should be noted to justify continued treatment.

Only a clinician may perform an initial examination, evaluation, reevaluation and assessment or establish a diagnosis or a plan of care. The clinician may include as part of the evaluation or reevaluation, objective measurements or observations made by a PTA or OTA within their scope of practice, but the clinician must actively and personally participate in the evaluation or reevaluation. The clinician may not merely summarize the objective findings of others or make judgments drawn from the measurements and/or observations of others.

Initial Evaluation

The initial evaluation, which must be performed by a clinician, should document the medical necessity of a course of therapy through objective findings and subjective patient self-reporting. Documentation of the initial evaluation should list the conditions being treated and any complexities that make treatment more lengthy or difficult. Where it is not obvious, describe the impact of the conditions and complexities so that it is clear to the medical reviewer that the services planned are appropriate for the individual.

The initial evaluation establishes the baseline data necessary for assessing expected rehabilitation potential, setting realistic goals and measuring progress. Initial evaluations need to provide objective, measurable documentation of the patient's impairments and how any noted deficits affect ADLs/IADLs and result in functional limitations. Functional limitations refer to the inability to perform actions, tasks and activities that constitute the "usual activities" for the patient. Functional limitations must be meaningful to the patient and caregiver, and must have potential for improvement. In addition, the remediation of such limitations must be recognized as medically necessary.

To support medical necessity, the evaluation should include the following items.

- Presenting condition or complaint.... "What brings the patient to therapy at this time?"
 - Patients should exhibit a significant change from their "usual" physical or functional ability to warrant an evaluation.
 - Provide an objective description of the changes in function that now necessitate skilled therapy. Simply stating "decline in function" does not adequately justify the initiation of therapy services.
- Diagnosis and description of specific problem(s) to be evaluated
 - Include area of the body, and conditions and complexities that could impact treatment
- Subjective complaints and date of onset
- Relevant medical history
 - Applicable medical history, medications, comorbidities (factors that make therapy more complicated or require extra precautions)
- Prior diagnostic imaging/testing results
- Prior therapy history for the same diagnosis, illness or injury
 - If recent therapy was provided, documentation must clearly establish that additional therapy is reasonable and necessary
- Social support/environment
 - Does the patient live alone, with a caregiver, in a group home, in a residential care facility, in a skilled nursing facility (SNF), etc?
 - What level of support is available, and what level of independence is required for the patient to be safe in the home environment?
 - Does the home situation have obstacles that the patient must overcome (e.g., stairs without handrails)?
 - What are the patient's usual responsibilities in the home environment?

- Prior level of function
 - Key piece of information used for establishing potential, prognosis and realistic functional goals
 - Functional status just prior to the onset of the treating condition requiring therapy
 - Record in objective, measurable and functional terms

- Functional testing
 - Objectively measure and/or describe the patient’s current level of functioning. Examples, based on the patient’s need, may include:
 - mobility status (transfers, bed mobility, gait, etc);
 - self-care dependence (toileting, dressing, grooming, etc);
 - meaningful ADLs/IADLs;
 - pain, and how it limits function; and
 - functional balance.

•Objective impairment testing

- Testing done to determine the source or cause of the functional limitation(s), such as ROM, manual muscle testing, coordination, tone assessment, balance etc.
- Use concise, objective measurements. Avoid minimal/moderate/severe types of descriptions when more specific definitions or measurements are available. For example, when measuring shoulder flexion AROM, document degrees of motion, rather than documenting, “Shoulder flexion: minimal loss of motion.”

•Assessment

- Summary of the therapist’s analysis of the condition being evaluated based on the examination of the patient. Clinical reasoning for treatment should be evident when further therapy is recommended.

•Prognosis for return to prior functional status, or the maximum expected condition

•Plan of care (see paragraph below)

•Signature and credentials of the therapist or physician/NPP completing the initial evaluation and plan of care. Each therapy discipline must have a separate plan of care. The plan of care (POC) must contain ALL of the following information.

Required POC Element

Diagnosis

Additional Points

The diagnosis should be specific and as relevant to the problem being treated as possible. In many cases, both a medical diagnosis (obtained from the physician/NPP) and an impairment-based treatment diagnosis are relevant.

Bill the most relevant diagnosis. As always, when billing for therapy services, the ICD-9 code that best relates to the reason for the treatment shall be on the claim, unless there is a compelling reason. For example, when a patient with diabetes is being treated for gait training due to amputation, the preferred diagnosis is abnormality of gait (which characterizes the treatment). Where it is possible in accordance with State and local laws and the contractors Local Coverage Determinations, avoid using vague or general diagnoses. When a claim includes several types of services, or where the physician/NPP must supply the diagnosis, it may not be possible to use the most relevant therapy code in the primary position. In that case, the relevant code should, if possible, be on the claim in another position.

Codes representing the medical condition that caused the treatment are used when there is no code representing the treatment. Complicating conditions are preferably used in non-primary positions on the claim and are billed in the primary position only in the rare circumstance that there is no more relevant code.

Long Term Goals (LTGs)

LTGs should:

□□□□□□ pertain to the functional impairment findings documented in the evaluation;

reflect the final level the patient is expected to achieve as a result of therapy in the current setting;

□□□□□□ be realistic, and should have a positive effect on the quality of the patient's everyday functions;

□□□□□□ be function-based and written in objective, measurable terms with a predicted date for achieving the goals.

Type of Treatment

The type of treatment includes the type of therapy discipline operating under this POC (PT or OT) and should describe the types of treatment modalities, procedures or interventions to be provided.

Amount of Treatment

Refers to the number of times in a day the type of treatment will be provided. Where not specified, one treatment session a day is assumed.

Frequency of Treatment Treatment provided more than one session per day per discipline will require additional documentation to support this amount of therapy.
Refers to the number of times in a week that the type of treatment is provided.

Duration of Treatment Treatment more than two or three times a week is expected to be a rare occurrence. Treatment frequency of greater than three times per week requires documentation to support this intensity.
Refers to the number of weeks, or the number of treatment sessions, for this plan of care.

Clinicians could also estimate the duration of the entire episode of care in this setting.

Re-evaluations

See CPT 97002 and 97004 for coverage guidelines for therapy re-evaluations.

Re-evaluation documentation must include clear justification for the need for further tests and measurements after the initial evaluation, such as new clinical findings, a significant, unanticipated change in the patient's condition, or failure to respond to the interventions in the plan of care. It is expected that clinicians continually assess the patient's progress as part of the ongoing therapy services. This assessment is not considered a formal re-evaluation; the time of any assessment is included and billed within the appropriate treatment intervention CPT code.

Re-evaluations must be performed by clinicians and contain all applicable components of the initial evaluation. Resolved problems do not need to be re-evaluated; new or ongoing problems may need to be re-evaluated, especially if there is an anticipated change to the long term goals.

Progress Reports

Progress reports provide justification for the medical necessity of treatment. Progress reports shall be written by a clinician at least once every 10 treatment days or at least once every 30 calendar days, whichever is less. Writing progress notes more frequently than the minimum is encouraged to support the medical necessity of treatment. A progress report is not a separately billable service.

In CMS Publication 100-02, *Medicare Benefit Policy Manual*, chapter 15, sections 220-230, Medicare defines the minimum REQUIRED elements of a progress report. It is essential that clinicians include all required elements in their documentation (either in a progress report or treatment note).

Progress note elements include(CMS required elements are italicized):

- *Date of the beginning and end of the reporting period that this report refers to;*
- *Date that the report was written by the clinician, or if dictated, the date on which it was dictated;*
- *Objective reports of the patient's subjective statements, if they are relevant;*
- *Objective measurements (impairment/function testing) to quantify progress and support justification for continued treatment;*
- *Description of changes in status relative to each goal currently being addressed in treatment. Descriptions shall make identifiable reference to the goals in the current plan of care;*
- *Assessment of improvement, extent of progress (or lack thereof) toward each goal;*
- *Plans for continuing treatment, including documentation of treatment plan revisions as appropriate;*
- *Changes to long or short term goals, discharge or an updated plan of care that is sent to the physician/NPP for certification of the next interval of treatment;*

- *Signature* with credentials of the clinician who wrote the report.

No specific format is required to demonstrate patient progress as long as all information noted in the bullets above are included at least once in the medical record for each progress report period (10 treatment days or 30 calendar days, whichever is less). Progress report information may be included in the treatment notes, progress reports and/or formal re-evaluations (when re-evaluation guidelines are met).

During each progress report period, the clinician must personally furnish in its entirety at least one billable service on at least one day of treatment. Verification of the clinician's treatment shall be documented by the clinician's signature on the treatment note and/or progress report.

Treatment Notes

Medical record documentation *is required for every treatment day, and every therapy service* to justify the use of codes and units on the claim.

The treatment note must include the following required information:

- date of treatment;
- identification of each specific treatment, intervention or activity provided in language that can be compared with the CPT codes to verify correct coding;
- record of the total time spent in services represented by timed codes under timed code treatment minutes;
- record of the total treatment time in minutes, which is a sum of the timed and untimed services;
- signature and credentials of each individual(s) that provided skilled interventions.

In addition, the treatment note may include any information that is relevant in supporting the medical necessity and skilled nature of the treatment, such as:

- patient comments regarding pain, function, completion of self management/home exercise program (HEP), etc;
- significant improvement or adverse reaction to treatment;
- significant, unusual or unexpected changes in clinical status;
- parameters of modalities provided and/or specifics regarding exercises such as sets, repetitions, weight;
- description of the skilled components of the specific exercises, training, or activities;
- instructions given for HEP, restorative or self/caregiver managed program, including updates and revisions;
- communication/consultation with other providers (e.g., supervising clinician, attending physician, nurse, another therapist);
- communication with patient, family, caregiver;
- equipment provided
- any additional relevant information to support that the patient continues to require skilled therapy and that the unique skills of a therapist were provided.

If grid or checklist forms are used for daily notes or exercise/activity logs, include the signature and credentials of the qualified professional/auxiliary personnel providing the service each day. Listing of exercise names (e.g., pulleys, UBE, TKE, SLR) does not alone imply that skilled treatment has been provided, especially if the exercises have been performed over multiple sessions. Be sure to occasionally document the skilled components of the exercises so they do not appear repetitive and therefore, unskilled. Documenting functional activities performed (e.g., "ambulated 35 feet with min assist", "upper body dressing with set up and supervision") also does not alone imply that skilled treatment was provided. The skilled components/techniques of the qualified professional/auxiliary personnel used to improve the functional activity should be occasionally documented to support medical necessity.

When documenting treatment time, consistently use the CMS language of total “Timed Code Treatment Minutes” and “Total Treatment Time”. Do not use other language or abbreviations when referring to treatment minutes as it may be difficult for medical review to determine the type of minutes documented. *The amount of time for each specific intervention/modality provided may also be recorded voluntarily.*

Do not record treatment time as “Time in / Time out” for the entire session as this does not accurately reflect the actual treatment time. Do not “round” all treatments to 15-minute increments, but rather record the actual treatment time. Also do not record as “units” of treatment, instead of minutes.

Only “intra-service care” of skilled therapy services should be reflected in the time documentation. Do not include unbillable time, such as time for:

- changing;
- waiting for treatment to begin;
- waiting for equipment;
- resting;
- toileting; or
- performing unskilled or independent exercises or activities.

Examples of treatment time documentation

A treatment session includes 20 minutes therapeutic exercise (97110), 15 minutes therapeutic activities (97530) and 20 minutes unattended electrical stimulation (G0283).

Time documentation in the treatment note

Timed Code Treatment Minutes: 35 minutes
Total Treatment Time: 55 minutes

A 30 minute OT initial evaluation is completed (97003), followed by 20 minutes fluidotherapy (97022).

Time documentation in the treatment note

Timed Code Treatment Minutes: 0 minutes
Total Treatment Time: 50 minutes

Discharge Notes

A discharge note is required for each episode of treatment and must be written by the clinician. The discharge note is a progress report covering the time from the last progress report up to the date of discharge, and includes all required components of a progress report. The discharge note may be considered the last opportunity to justify the medical necessity of the entire treatment episode. Therefore, if a discharge summary has been completed, it may be prudent to submit it with any request of records for medical review, even if the claim under review is for a treatment period prior to the date of discharge.

In the case of an unanticipated discharge, the clinician may base any judgments required to write the report on the treatment notes and verbal reports of the assistant or qualified auxiliary personnel. In the case of a discharge anticipated within 3 treatment days of the progress report, the clinician may provide objective goals which, when met, will authorize the assistant or qualified auxiliary personnel to discharge the patient. In that case, the clinician should verify that the services provided prior to discharge continued to require the skills of a therapist. There must be indication that the clinician has reviewed the treatment notes and agrees to the discharge.

Certifications and Recertifications

Medicare beneficiaries receiving outpatient therapy services must be under the care of a physician/NPP. Orders (sometimes called referrals) and certifications are common means of demonstrating such evidence of physician involvement.

Certification, which is a coverage condition for therapy payment, requires a dated physician/NPP signature on the therapy plan of care or some other document that indicates approval of the plan of care. A certification often differs from an order or referral in that it must contain all required elements of a plan of care. To assist medical review in determining that the certification requirements are met, certifications/recertifications should include the following elements(CMS required elements are italicized):

- The date from which the plan of care being sent for certification becomes effective (for initial certifications, the initial evaluation date will be assumed to be the start date of the certified plan of care);
- *Diagnoses;*
- *Long term treatment goals;*
- *Type, amount, duration and frequency of therapy services;*
- Signature, date and professional identity of the therapist who established the plan; and
- *Dated physician/NPP signature indicating that the therapy service is or was in progress and the physician/NPP makes no record of disagreement with the plan. (Note: The CORF benefit does not recognize an NPP for certification.)*

Effective January 1, 2008, the interval length shall be determined by *the patient's needs, not to exceed 90 days*. Certifications which include all the required plan of care elements will be considered valid for the longest duration in the plan (such as 3x/wk for 6 weeks which will be considered as a total of 18 treatments). If treatment continues past the longest duration specified, a recertification will be required.

Documentation Requirements for Unlisted Procedure Codes (97039, 97139, 97799, 29799)

97039 - In addition to a detailed service description, information in the medical record submitted to the contractor must specify the type of modality utilized and, if the modality requires the constant attendance of the qualified professional/auxilliary personnel, the time spent by the qualified professional/auxilliary personnel, one-on-one with the beneficiary.

97139 - Information in the medical record and on the claim submitted to the contractor must specify the procedure furnished and also meet the other requirements for therapeutic procedures, i.e., the process of effecting change, through the application of clinical skills or services that attempt to improve function.

97799 - Information in the medical record submitted to the contractor must specify the service or procedure furnished, provide an adequate description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service.

29799 - Information in the medical record submitted to the contractor must specify the service. It should also indicate the nature of the injury being treated and the anticipated outcome of the treatment.

Appendices

Not applicable

Utilization Guidelines

The Medicare Physician Fee Schedule (MPFS) is the method of payment for outpatient therapy services, except critical access hospitals (CAH), which are paid on a reasonable cost basis. Although CAHs are not paid via the MPFS, all outpatient coverage, coding and documentation guidelines, as noted in the Medicare manuals and this LCD, apply.

Untimed CPT Codes

When a therapy treatment modality or procedure is not defined in the AMA CPT Manual by a specific time frame (such as “each 15 minutes”), the modality or procedure is considered an “untimed” service. Untimed services are billed *based on the number of times the procedure is performed, often once per day*. Untimed services billed as more than “1” unit will require significant documentation to justify treatment greater than one session per day per therapy discipline. See the section “CPT 97001 & 97003” for additional guidance on billing for evaluations that span more than 1 day. The minutes spent providing untimed services are reflected in the documentation under “Total Treatment Time”(and are not included in the minutes for timed CPT codes when determining the number of timed-based units that may be billed).

Timed CPT Codes

Many CPT codes for therapy modalities and procedures specify that direct (one-on-one) time spent in patient contact is 15 minutes. *The time counted is the time the patient is treated* using skilled therapy modalities and procedures, and is recorded in the documentation as “Timed Code Treatment Minutes.” Pre- and post-delivery services are not to be counted when recording the treatment time. The time counted is the “intra-service” care that begins when the qualified professional/auxiliary personnel is directly working with the patient to deliver the service. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment. The intra-service care includes assessment. The time the patient spends not being treated because of a need for toileting or resting should not be counted. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time. Time spent “supervising” a patient performing an activity that is defined as a timed code, or for the patient to perform an independent activity, even if a therapist is providing the equipment, is considered unbillable time and these minutes should not be counted in the “Timed Code Treatment Minutes.” Therapy timed services require direct, one-on-one patient qualified professional/auxiliary personnel contact, and by definition cannot be billed when performed in a supervised manner.

The first step when billing timed CPT codes is to total the minutes for all timed modalities and procedures provided to the patient on a single date of service for a single discipline. For example, a patient under an OT plan of care receives skilled treatment consisting of 20 minutes therapeutic exercise (CPT 97110) and 20 minutes self-care/home management training (CPT 97535). The total “Timed Code Treatment Minutes” documented will be 40 minutes. In addition, the combined time of 40 minutes will determine the total number of timed code OT units that shall be billed for the day. Whether a single timed code service is provided, or multiple timed code services, the skilled minutes documented in “Timed Code Treatment Minutes” will determine the number of units billed.

Once the minutes have been summed, use the chart below to determine the total allowable units, based on the total Timed Code Treatment minutes.

1 unit \geq 8 minutes through 22 minutes

2 units \geq 23 minutes through 37 minutes

3 units \geq 38 minutes through 52 minutes

4 units \geq 53 minutes through 67 minutes

5 units \geq 68 minutes through 82 minutes

6 units \geq 83 minutes through 97 minutes

7 units \geq 98 minutes through 112 minutes

8 units \geq 113 minutes through 127 minutes

When the total Timed Code Treatment minutes for the day is less than 8 minutes, the service(s) should not be billed.

It is important to allocate the total billable units for timed services to the appropriate CPT codes based upon the number of minutes spent providing each individual service. Any timed service provided for at least 15 minutes, must be billed one unit. Any timed service provided for at least 30 minutes, must be billed two units, and so on. When determining the allocation of units, it is easiest to separate out each service first into “15-minute time blocks”. For example:

20 minutes of Therapeutic Exercise (CPT 97110) = one 15-minute block + 5 remaining minutes

- At least 1 unit must be allocated to this code

38 minutes of Self-care/Home Management Training (97535) = two 15-minute blocks + 8 remaining minutes

- At least 2 units must be allocated to this code
- If 38 minutes of CPT 97535 is the only treatment provided, then 3 units would be billed. However, as demonstrated in the examples below, there may be treatment sessions in which the correct billing would only allow 2 units, based on the “remaining minutes”.

The “remaining minutes” (those minutes remaining after the “15-minute blocks” have been allocated) are considered when the total billable units for the day allow for an additional unit to be billed. See the following examples:

24 minutes of neuromuscular reeducation (CPT 97112)

23 minutes of therapeutic exercise (CPT 97110)

47 total Timed Code Treatment minutes

Utilizing the chart above, 47 minutes falls within the range for 3 units. To allocate those 3 units determine the 15-minute blocks first

24 minutes 97112 = one 15-minute block + 9 remaining minutes

23 minutes 97110 = one 15-minute block + 8 remaining minutes

Each code contains one 15-minute block; therefore, each code shall be billed for at least 1 unit. Since the total minutes allows for 3 units, the third unit shall be applied to the service with the most “remaining minutes” (97112 has 9 remaining minutes, whereas, 97110 has 8 remaining minutes). The correct coding is

2 units 97112 + 1 unit 97110

20 minutes of neuromuscular reeducation (CPT 97112)

20 minutes therapeutic exercise (CPT 97110)

40 total Timed Code Treatment minutes

Utilizing the chart above, 40 minutes falls within the range for 3 units. To allocate those 3 units determine the 15-minute blocks first

20 minutes 97112 = one 15-minute block + 5 remaining minutes

20 minutes 97110 = one 15-minute block + 5 remaining minutes

Each code contains one 15-minute block, therefore, each code shall be billed for at least 1 one unit. As 3 units is allowed, a review of the “remaining minutes” is required to determine which code should be billed the additional unit. Since the “remaining minutes” for each service are the same in this example, either of the codes may be billed for the additional unit. The correct coding is either one of the following

2 units 97112 + 1 unit 97110

OR

1 unit 97112 + 2 units 97110

4 minutes assessing shoulder strength prior to initiating and progressing therapeutic exercise (CPT 97110)

32 minutes therapeutic exercise (CPT 97110)

7 minutes manual therapy (CPT 97140)

43 total Timed Code Treatment minutes

Utilizing the chart above, 43 minutes falls within the range for 3 units. To allocate those 3 units determine the 15-minute blocks first

36 minutes 97110 = two 15-minute blocks + 6 remaining minutes

7 minutes 97140 = zero 15-minute blocks + 7 remaining minutes

Code 97110 must be billed for at least 2 units as it contains two 15-minute blocks. To determine the allocation of the third unit, compare the “remaining minutes”, and apply the additional unit to the service with the most remaining minutes. The correct coding is

2 units 97110 + 1 unit 97140

18 minutes of therapeutic exercise (CPT 97110)

13 minutes of manual therapy (CPT 97140)

10 minutes of gait training (CPT 97116)

8 minutes of ultrasound (CPT 97035)

49 total Timed Code Treatment minutes

Appropriate billing for a total of 49 minutes is 3 units. To allocate those 3 units, determine the 15-minute blocks first

18 minutes 97110 = one 15-minute block + 3 remaining minutes

13 minutes 97140 = zero 15-minute blocks + 13 remaining minutes

10 minutes 97116 = zero 15-minute blocks + 10 remaining minutes

8 minutes 97035 = zero 15-minute blocks + 8 remaining minutes

Code 97110 shall be billed for at least one unit as it contains one 15-minute block. The additional 2 units billable (for a total of 3 units for the day), must be applied to the services with the greatest remaining minutes. The correct coding is

1 unit 97110 + 1 unit 97140 + 1 unit 97116

There are not enough total minutes for the day to allow billing for the ultrasound. However, the ultrasound will still be documented in the treatment notes.

7 minutes of neuromuscular reeducation (CPT 97112)

7 minutes of therapeutic exercise (97110)

7 minutes of manual therapy (97140)

21 total Timed Code Treatment minutes

The clinician shall select which CPT code to bill since each service was performed for the same amount of time and only one unit is allowed. The correct coding is

1 unit 97112

OR

1 unit 97110

OR

1 unit 97140

For treatment sessions with both timed and untimed services, the units and time documented for any untimed CPT codes should not be included in the counting of units and time for the timed CPT codes for a calendar day. The minutes for the timed codes are reflected in the Timed Code Treatment Minutes, with the units allocated as described above. The untimed minutes are reflected in the Total Treatment Time, which is a combination of the timed code minutes and the untimed code minutes. Per CMS, it is important that the total number of timed treatment minutes support the billing of units on the claim, and that the total treatment time reflects services billed as untimed codes. For example:

35 minutes OT evaluation (CPT 97003-untimed code)

25 minutes therapeutic exercise (CPT 97110)

8 minutes therapeutic activities (CPT 97530)

Total Timed Code Treatment minutes = 33 minutes

Total Treatment Time = 68 minutes

The evaluation, being an untimed code, is billable as “1” unit. Do not include the evaluation minutes in the total timed code treatment minutes when determining the appropriate number of units to bill for the timed codes. 33 total minutes of timed codes is billable as 2 units. To allocate the 2 timed code units, break out the 15-minute blocks first

25 minutes 97110 = one 15-minute block + 10 remaining minutes

8 minutes 97530 = zero 15-minute blocks + 8 remaining minutes

Since code 97110 has one 15-minute block, at least 1 unit of 97110 shall be billed. To determine which code shall be billed with the second unit,

compare the remaining minutes. Since code 97110 has more remaining minutes, the second timed code unit shall be applied to this code. Correct coding for this session is

1 unit 97003 + 2 units 97110

The medical record documentation will note that the therapeutic activities were performed.

40 minutes PT evaluation (CPT
97001-untimed)

20 minutes unattended electrical stimulation (CPT G0283-untimed)

10 minute therapeutic exercise for home exercise program (CPT 97110)

Total Timed Code Treatment Minutes = 10 minutes

Total Treatment Time = 70 minutes

The untimed services are billable as 1 unit each. 10 minutes for the timed code is billable as "1" unit. The correct coding for this session is

1 unit 97001 + 1 unit G0283 + 1 unit 97110

Payment for therapy services is based on the qualified professional/auxiliary personnel's time spent in treating the individual patient. For this reason, in the same time period (such as from 1:00 to 1:15) a clinician cannot bill any of the following pairs of CPT codes for therapy services provided to the same, or to different patients.

1. *Any two CPT codes for "therapeutic procedures" requiring direct one-on-one patient contact (CPT codes 97110-97762)*
2. *Any two CPT codes for modalities requiring "constant attendance" and direct one-on-one patient contact (CPT codes 97032-97039)*

3. *Any two CPT codes requiring either constant attendance or direct one-on-one patient contact - as described in (a) or (b) above - (CPT codes 97032-97762), for example, any CPT code for a therapeutic procedure (e.g., 97116 - gait training) with any attended modality CPT code (e.g., 97035 - ultrasound)*
4. *Any CPT code for therapeutic procedures requiring direct one-on-one patient contact (CPT codes 97110-97762) with the group therapy CPT code (97150) requiring constant attendance, for example, group therapy (97150) with neuromuscular reeducation (97112)*
5. *Any CPT code for modalities requiring constant attendance (CPT codes 97032-97039) with the group therapy CPT code (97150) for example, group therapy (97150) with ultrasound (97035)*
6. *Any untimed evaluation or reevaluation code (CPT codes 97001-97004) with any other timed or untimed CPT codes, including constant attendance modalities (CPT codes 97032-97039), therapeutic procedures (CPT 97110-97762) and group therapy (CPT code 97150)*

Miscoded services may lead to improper payment, or if medically reviewed, denials of billed charges. Medical records must always support all HCPCS/CPT codes and units billed.

- Do not bill for documentation time separately (except for CPT code 96125). This is incorporated in the HCPCS/CPT fee reimbursed for each individual service provided.
- Do not code higher than what the procedure requires. Coding in this manner may allow the provider to collect inappropriate revenues without incurring additional costs.
- Do not select the HCPCS/CPT code based on the reimbursement amount associated with a particular HCPCS/CPT. Rather select the HCPCS/CPT based on the code that most accurately describes the service actually provided and/or the intention of the treatment to achieve the desired outcome/goal.
- Do not “unbundle” services/procedures. Unbundling refers to the practice of splitting a single payment code into two or more codes. This may lead to inappropriate multiple payments.
- Do not bill separately for supplies used to provide therapy services, such as electrodes, theraband, theraputty, etc.
- Therapists, or therapy assistants, working together as a “team” to treat a patient cannot each bill separately for the same or different service provided at the same time to the same patient. For example, if an OT and PT are co-treating a patient with sitting balance and ADL deficits for 30 minutes, then only 2 units total can be billed to the patient: either 2 units of OT only; 2 units of PT only; or 1 unit of OT and 1 unit of PT.

Utilization Guidelines and Maximum Billable Units per Date of Service

Rarely, except during an evaluation, should therapy session length be greater than 30-60 minutes. If longer sessions are required, documentation must support as medically necessary the duration of the session and the amount of interventions performed.

The following interventions should be reported no more than one unit per code per day per discipline; additional units will be denied:

97001, 97002, 97003, 97004, 97012, 97016, 97018, 97022, 97024, 97028, 97150, 97597, 97598, 97605, 97606, G0281, G0283, G0329.

The following timed interventions should be reported no more than 2 (two) units per code per day per discipline; additional units will be denied: 97033, 97034, 97035, 97036.

The following interventions should be reported no more than 4 (four) units per code per day per discipline; additional units will be denied:

97032, 97110, 97112, 97113, 97116, 97124, 97530, 97532, 97533, 97535, 97537, 97542, 97760, 97761, 97762.

Denials due to the limits described in this section of the LCD may be appealed.

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Advisory Committee Meeting Notes

Carrier Advisory Committee Meeting Date(s):

05/25/2010 (Connecticut)

05/26/2010 (New York)

05/24/2010 (Indiana)

05/27/2010 (Kentucky)

This coverage determination does not reflect the sole opinion of the contractor or contractor Medical Director. Although the final decision rests with the contractor, this determination is developed in consultation with representatives from Advisory Committee members and/or from various state and local provider organizations.

Start Date of Comment Period

05/10/2010

End Date of Comment Period

06/23/2010

Start Date of Notice Period

11/11/2010

Revision History Number

R6

Revision History Explanation

R6 (effective 11/11/2010): Clarification of “Incident to” coverage for services provided in a physician’s office. This clarification is a direct quote from CMS Publication 100-2, Chapter 15, Section 230.5. No notice is required and none is given.

R5 (effective 11/1/2010): The existing LCD and SIA were resubmitted to all NGS Part A and Part B jurisdictions for public and CAC comment from 5/10/2010 – 6/23/2010. Changes made are:

- Type of Bill 11x added.
- At the request of the PSC, the non-coverage of non-surgical spinal decompression devices was clarified so as to address all such devices, rather than just a single branded product. The devices are now identified as a generic type of device (non-surgical spinal decompression device) and multiple devices were listed as examples.
- Low back strapping (formerly CPT 29220) was identified as an obsolete service and designated a non-covered service regardless of CPT code used to bill it (rescinds prior coding instruction to bill service as 29799).
- Functional Electrical Stimulating (FES) devices other than those that assist in walking are not covered under Medicare [NCD 160.12]. Consequently, any services related to the evaluation for or training of patients to use such a device is not covered. Such devices may include, but are not limited, to the Ergys® system.
- Non-covered conditions for CPT 97035 (Ultrasound) expanded to add any condition for which ultrasound can be applied by the patient without the need for a therapist.
- In response to a reconsideration request, the section on ICD-9 codes supporting medical necessity was revised to indicate that a specific code to identify the type of therapy provided be listed as the primary diagnosis on the claim, with the specific condition necessitating the therapy service(s) listed as secondary.
- HCPCS codes changed to short descriptor type.
- Sources of Information updated to add references reviewed for this revision.
- CMS National Coverage Policy section updated to add CMS Decision Memo for Neuromuscular Electrical Stimulation (NMES) for Spinal Cord Injury.

A version of this LCD with an effective date of 11/01/2010 displayed on the MCD from 09/02/2010 through 09/09/2010. That LCD version was created due to a typographical error and was subsequently removed from the LCD.

R4 (effective 01/01/2010): Deletion of CPT code 29220 (Strapping; Low Back) with directions to use unlisted code 29799 to indicate low back strapping in CPT 2010. Addition of the following section:

CPT 29799 - Unlisted procedure, casting or strapping

If an existing CPT code does not describe the service performed, an unlisted CPT code may be used. The use of unlisted codes should be rare. If unlisted codes are billed, the medical record and claim must clearly state what modality or procedure is billed as an unlisted code. If not, the unlisted code billed will be subject to denial for insufficient information.

Supportive Documentation Recommendations for 29799

Information in the medical record submitted to the contractor must specify the service or procedure furnished, provide an adequate description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service. When strapping is performed, documentation in the medical record should identify the strips or material applied and body area treated. It should also indicate the nature of the injury being treated and the anticipated outcome of the treatment. This is an untimed code, billable as "1" unit.

Please see the Unlisted Procedure Codes section of article A46198, Outpatient Physical and Occupational Therapy Services - Supplemental Instructions Article, for specific billing instructions.

Minor changes made to reflect current template language. No additional comment or notice periods required and none given.

R3 (effective 08/01/2009): Source of revision – Internal – The following ICD-9 CM codes: 277.00, 277.02, 454.0, 454.2, 459.11, 459.13, 459.31, 459.33, 490, 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92, 494.0, 494.1, 495.0, 495.1, 495.2, 495.3, 495.4, 495.5, 495.6, 495.7, 495.8, 495.9, 496, 500, 501, 502, 503, 504, 505, 518.2, 518.3, 518.4, 707.00, 707.01, 707.02, 707.03, 707.04, 707.05, 707.06, 707.07, 707.09, 707.12, 707.13, 707.14, 707.15, 707.19, 707.20, 707.21, 707.22, 707.23, 707.24, 707.25, 879.7, 890.0, 941.20, 941.21, 941.24, 941.25, 941.26, 941.27, 941.28, 941.29, 942.20, 942.21, 942.22, 942.23, 942.24, 942.25, 942.29, 943.20, 943.21, 943.22, 943.23, 943.24, 943.25, 943.26, 943.29, 944.20, 944.21, 944.22, 944.23, 944.24, 944.25, 944.26, 944.27, 944.28, 945.20, 945.21, 945.22, 945.23, 945.24, 945.25, 945.26, 945.29, 946.2, 948.00, 948.10, 948.11, 948.20, 948.21, 948.22, 948.30, 948.31, 948.32, 948.33, 948.40, 948.41, 948.42, 948.43, 948.44, 948.50, 948.51, 948.52, 948.53, 948.54, 948.55, 948.60, 948.61, 948.62, 948.63, 948.64, 948.65, 948.66, 948.70, 948.71, 948.72, 948.73, 948.74, 948.75, 948.76, 948.77, 948.80, 948.81, 948.82, 948.83, 948.84, 948.85, 948.86, 948.87, 948.88, 948.90, 948.91, 948.92, 948.93, 948.94, 948.95, 948.96, 948.97, 948.98, 948.99, 949.2, 998.30, 998.32, 998.33 and 998.83 added to the list of “ICD-9-CM Codes that DO NOT Support Medical Necessity.” The following statement: “The following ICD-9-CM codes do not support the medical necessity for the CPT/HCPCS code 97035. ” added to the section “ICD-9 Codes that DO NOT Support Medical Necessity.” Clarification to the section for “CPT 97033 – Iontophoresis (to one or more areas): Iontophoresis will be allowed for treatment of intractable, disabling primary focal hyperhidrosis (ICD-9-CM 705.21)”. Minor changes made to reflect current template language. No additional comment or notice periods required and none given.

05/15/2009 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary numbers 00180 and 00181 were removed from this LCD as the claims processing for Maine and Massachusetts was transitioned to NHIC, the Part A/Part B MAC contractor in these states.

06/05/2009 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary number 00270 was removed from this LCD as the claims processing for New Hampshire and Vermont was transitioned to NHIC, the Part A/Part B MAC contractor in these states.

R2 (effective 03/01/2009): Source of revision – Internal – Minor changes made to reflect current template language and minor typos corrected. The following bullet was removed from section MLD/CDT

- the services are being performed by a therapist who has received specialized training in this form of treatment.

The following bullet from the section “Miscellaneous Services (Non-covered) has been revised:

- Iontophoresis, except as indicated for primary focal hyperhidrosis

R1: This revised LCD is effective for all National Government Services jurisdictions on July 18, 2008 with these exceptions: for Connecticut – Part B the LCD is effective on August 1, 2008; for Upstate New York – Part B, the LCD is effective on September 1, 2008; and for New York and Connecticut – Part A, the LCD is effective on November 14, 2008. **For New York – Part A (contract 00308), the content of this LCD is currently in effect but the LCD will be transferred to the J-13 contract number 13201 on November 14, 2008.**

This LCD was revised during the Notice period of 05/15/2008-06/30/2008 to add the Jurisdiction 13 (J-13) MAC contractor numbers.

The CMS Statement of Work for the J13 Medicare Administrative Contract (MAC) requires that the contractor retain the most clinically appropriate LCD within the jurisdiction. This NGS policy is being promulgated to the J13 MAC as the most clinically appropriate LCD within that jurisdiction.

The NGS roster of LCDs has been developed under the combined experience of seven Medicare contractor medical directors. The criteria for inclusion in this roster includes areas of identified CERT errors, especially repetitive errors; high volume/high dollar/pervasive problems; patient safety issues; potential for automation; beneficiary access to new technology; implementation of NCD; narrative medical necessity parameters for medical review and provider education; and CMS/law enforcement mandates.

NGS LCDs have undergone an advice and comment process from the providers in 23 states. This advice and comment process, the most comprehensive among all Medicare contractors, has ensured that NGS policies have benefited from the most in-depth and scientifically rigorous scrutiny. The NGS policy development process has resulted in the most clinically appropriate LCDs for providers and Medicare beneficiaries.

11/15/2009 - The description for CPT/HCPCS code 97032 was changed in group 1
11/15/2009 - The description for CPT/HCPCS code 97033 was changed in group 1
11/15/2009 - The description for CPT/HCPCS code 97034 was changed in group 1
11/15/2009 - The description for CPT/HCPCS code 97035 was changed in group 1
11/15/2009 - The description for CPT/HCPCS code 97036 was changed in group 1
11/15/2009 - The description for CPT/HCPCS code 97110 was changed in group 1
11/15/2009 - The description for CPT/HCPCS code 97112 was changed in group 1
11/15/2009 - The description for CPT/HCPCS code 97113 was changed in group 1
11/15/2009 - The description for CPT/HCPCS code 97116 was changed in group 1
11/15/2009 - The description for CPT/HCPCS code 97124 was changed in group 1
11/15/2009 - The description for CPT/HCPCS code 97140 was changed in group 1

11/15/2009 - CPT/HCPCS code 29220 was deleted from group 1

8/1/2010 - The description for Bill Type Code 11 was changed
8/1/2010 - The description for Bill Type Code 12 was changed
8/1/2010 - The description for Bill Type Code 13 was changed
8/1/2010 - The description for Bill Type Code 22 was changed
8/1/2010 - The description for Bill Type Code 23 was changed
8/1/2010 - The description for Bill Type Code 34 was changed
8/1/2010 - The description for Bill Type Code 74 was changed
8/1/2010 - The description for Bill Type Code 75 was changed
8/1/2010 - The description for Bill Type Code 85 was changed

8/1/2010 - The description for Revenue code 0420 was changed
8/1/2010 - The description for Revenue code 0421 was changed
8/1/2010 - The description for Revenue code 0424 was changed
8/1/2010 - The description for Revenue code 0429 was changed

8/1/2010 - The description for Revenue code 0430 was changed
8/1/2010 - The description for Revenue code 0431 was changed
8/1/2010 - The description for Revenue code 0434 was changed
8/1/2010 - The description for Revenue code 0439 was changed

11/21/2010 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:

29505 descriptor was changed in Group 1
90901 descriptor was changed in Group 1
95831 descriptor was changed in Group 1
95832 descriptor was changed in Group 1
95833 descriptor was changed in Group 1
95834 descriptor was changed in Group 1
97024 descriptor was changed in Group 1
97597 descriptor was changed in Group 1
97598 descriptor was changed in Group 1
97605 descriptor was changed in Group 1
97606 descriptor was changed in Group 1

Reason for Change

Last Reviewed On Date

11/11/2010

Related Documents

Article(s)

A49932 - Outpatient Physical and Occupational Therapy Services Supplemental Instructions Article

LCD Attachments

Outpatient Physical and Occupational Therapy Services (a comment and response document) (PDF - 168,928 bytes)

Outpatient Physical and Occupational Therapy Services (November, 2010) (a comment and response document) (HTM - 146,601 bytes)

All Versions

Updated on 11/21/2010 with effective dates 11/11/2010 - N/A

Updated on 11/03/2010 with effective dates 11/11/2010 - N/A

Updated on 09/09/2010 with effective dates 11/01/2010 - 11/10/2010

Updated on 08/01/2010 with effective dates 01/01/2010 - 10/31/2010

Updated on 08/01/2010 with effective dates 01/01/2010 - N/A

Updated on 12/23/2009 with effective dates 01/01/2010 - N/A

Updated on 07/21/2009 with effective dates 08/01/2009 - 12/31/2009

Updated on 05/28/2009 with effective dates 06/05/2009 - 07/31/2009

Updated on 05/28/2009 with effective dates 05/15/2009 - 06/04/2009

Updated on 05/07/2009 with effective dates 05/15/2009 - N/A

Updated on 02/19/2009 with effective dates 03/01/2009 - 05/14/2009

Updated on 11/09/2008 with effective dates 11/14/2008 - 02/28/2009

Updated on 10/24/2008 with effective dates 11/14/2008 - N/A