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Coding and
Payment Guide

For the Physical Therapist

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SAMPLE

— 2017 ICD-10

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Introduction

Coding systems and claim forms are part of the reality of modern health care. This *Coding and Payment Guide* provides a comprehensive explanation of the coding and payment systems used by physical therapists. Organized by topics and by numerical procedure code listings pertinent to physical therapy, it can be used as a coding as well as a payment resource.

Coding systems grew out of the need for data collection. By having a standard notation for the procedures performed and for the diseases, injuries, and illnesses diagnosed, statisticians could identify effective treatments as well as broad practice patterns. Before long, these early coding systems emerged as the basis to pay claims. Coding systems and claim forms have evolved to become the basis of payment for health care services. The correct application of codes and knowledge of payer policies correlates directly to payment.

The administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 required the standardization of the several hundred health care claim formats previously in existence, as well as the establishment of standardized code sets for medical data including diagnoses, drugs, procedures, equipment, and supplies. The goal of the national standards is to reduce the administrative encumbrances of the existing system, simplify the way medical claims are paid, reduce costs, and promote the growth of electronic business in the health care industry.

Other mechanisms involved in getting paid may also include documentation of functional deficits, but any translation to a claim form would be payer specific.

Coding Systems

Coding systems seek to answer two questions: what was wrong with the patient (i.e., the diagnosis or diagnoses) and what was done to treat the patient (i.e., the procedures or services rendered).

Under the aegis of the federal government, a three-tiered coding system emerged for health care providers and outpatient facilities. The Physicians' Current Procedural Terminology (CPT®) codes report medical procedures and services and comprises Level I of the system. A second level, known as HCPCS Level II codes, are mainly used to identify products, supplies, and services that are not included in the CPT codes. Dovetailing with each of these is the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) classification system that reports the diagnosis of illnesses, diseases, and injuries.

Further explanations of each of these coding systems follows.

HCPCS Level I or CPT Codes

CMS, in conjunction with the American Medical Association (AMA), the American Dental Association (ADA), and several other professional groups developed, adopted, and implemented a coding system describing services rendered to patients. Known as HCPCS Level I, the CPT coding system is the most commonly used system to report procedures and services. Copyright of CPT codes and descriptions is held by the AMA. This system reports outpatient and provider services.

CPT codes predominantly describe medical services and procedures, and are adapted to provide a common billing language that providers

and payers can use for payment purposes. The codes are required for billing by both private and public insurance carriers, managed care companies, and workers' compensation programs.

The AMA's CPT Editorial Panel reviews the coding system and adds, revises, and deletes codes and descriptions. The panel accepts information and feedback from providers about new codes and revisions to existing codes that could better reflect the provided service or procedure. The American Physical Therapy Association (APTA) is represented on the Health Care Professional Advisory Committee (HCPAC) for both the AMA CPT Editorial Panel and the AMA Relative Value Update Committee (RUC). The CPT HCPAC representative provides input for the development and revision of CPT codes, while the RUC HCPAC representative provides input into the establishment of relative values for the codes.

The majority of codes are found in category I of the CPT coding system. These five-digit codes describe procedures and services that are customarily performed including those performed by the physical therapist.

CPT category II codes are supplemental tracking codes that are primarily used when participating in the Physician Quality Reporting System (PQRS) established by Medicare and are intended to aid in the collection of data about quality of care. Category II codes are alphanumeric, consisting of four digits followed by an F and should never be used in lieu of a category I CPT code. A complete list of the category II codes can be found at the AMA website at <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-ii-codes.page>. More information regarding the PQRS can be found on the CMS website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>, and at <http://www.apta.org/pqrs>.

Category III of the CPT coding system contains temporary tracking codes for new and emerging technologies that are meant to aid in the collection of data on these new services and procedures as well as facilitate the payment process. However, it should be noted that few payers reimburse for emerging technology procedures and services. CPT category III codes consist of four numeric digits followed by a T. Like category II codes, category III codes are released twice a year (January 1 and July 1) and can be found on the AMA CPT website at <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-iii-codes.page>. RVUs are not assigned for category III codes and payment is made at the discretion of the payer. A service described by a CPT code may eventually become a category I code, as the efficacy and safety of the service is documented and as the category II codes are sunsetted after five years and then must be reviewed for continued use as category III descriptors.

ICD-10-CM Codes

In response to ICD-9-CM's shortcomings, new coding systems were developed and soon will be implemented in the United States. The World Health Organization (WHO) created and adopted ICD-10 in 1994 and it has been used in much of the world since then. This system is the basis for the new U.S. diagnosis coding system, International

29505-29515

29505 Application of long leg splint (thigh to ankle or toes)

29515 Application of short leg splint (calf to foot)

Explanation

In 29505, the qualified health care provider applies a long leg splint from thigh to the ankle or toes. A long leg posterior splint is used to immobilize a number of injuries around the knee or ankle. The qualified health care provider wraps cotton bandaging around the involved leg from the upper thigh to the ankle or toes. Plaster strips or fiberglass splint material are applied along the posterior aspect of the leg from the upper thigh to the ankle or toes. After the splint material dries, it is secured into place by an Ace wrap. In 29515, the qualified health care provider applies a short leg splint from calf to foot. A short leg splint is used to immobilize the ankle. The qualified health care provider wraps cotton bandaging from just below the knee to the toes. Plaster strips or fiberglass splinting material are applied to the posterior of the calf, around the heel, and along the bottom of the foot to the toes. After the splint material dries, it is secured into place by an Ace wrap.

Coding Tips

The code for the initial treatment of a fracture or dislocation includes the application, maintenance, and removal of the first cast or traction. See Application of Casts and Strapping in the CPT book in the Surgery section, under Musculoskeletal System. Splint supplies are reported separately, see HCPCS Level II codes.

According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure. See Application of Casts and Strapping in the CPT book in the Surgery section, under Musculoskeletal System.

Documentation Tips

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

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

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

Reimbursement Tips

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

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

Terms To Know

splint. Brace or support. 1) dynamic splint: brace that permits movement of an anatomical structure such as a hand, wrist, foot, or other part of the body after surgery or injury. 2) static splint: brace that prevents movement and maintains support and position for an anatomical structure after surgery or injury.

ICD-10-CM Diagnostic Codes

M22.01	Recurrent dislocation of patella, right knee
M22.02	Recurrent dislocation of patella, left knee
M22.11	Recurrent subluxation of patella, right knee
M22.12	Recurrent subluxation of patella, left knee
M22.41	Chondromalacia patellae, right knee
M22.42	Chondromalacia patellae, left knee
M23.51	Chronic instability of knee, right knee
M23.52	Chronic instability of knee, left knee
M24.461	Recurrent dislocation, right knee
M24.462	Recurrent dislocation, left knee
M25.461	Effusion, right knee
M25.462	Effusion, left knee
M66.361	Spontaneous rupture of flexor tendons, right lower leg
M66.362	Spontaneous rupture of flexor tendons, left lower leg
M66.861	Spontaneous rupture of other tendons, right lower leg
M66.862	Spontaneous rupture of other tendons, left lower leg
S97.01XA	Crushing injury of right ankle, initial encounter
S97.02XA	Crushing injury of left ankle, initial encounter

Please note that this list of associated ICD-10-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Status	MUE
29505	1.43	2.38	0	A	1(2)
29515	1.43	2.05	0	A	1(2)

	Modifiers				Medicare References
29505	51	50	N/A	N/A	None
29515	51	50	N/A	N/A	

* with documentation

95831-95834

95831 Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk

95832 hand, with or without comparison with normal side

95833 total evaluation of body, excluding hands

95834 total evaluation of body, including hands

Explanation

Muscles or muscle groups are tested for strength. Code 95831 applies to manually testing the arm, leg, or trunk; 95832 applies to manually testing the hands; 95833 applies to manually testing the body exclusive of the hands; 95834 applies to manually testing the body inclusive of the hands.

Coding Tips

These codes are not to be reported for every muscle test. Rather, each of these codes is to be reported only one time for each extremity or area of the body designated by the code descriptor. Some aspects of manual muscle testing usually are included in the physical therapy evaluation/reevaluation (97001–97002). If reporting 95831–95834, the evaluator is required to prepare a signed and documented separate report that identifies the specific muscles tested, the grade of strength and scale used to measure, and comparative muscle grades if applicable. If such a report is not prepared and included in the medical record as a separate billable procedure, then the appropriate evaluation or reevaluation code (97001–97002) should be used, or 97750 also can be used to report manual muscle testing as a separate procedure from an evaluation or re-evaluation.

Code 97750 Physical performance test or measurement is an alternate code. When reporting 97750, documentation must include a report of all elements of the test or measure.

Documentation Tips

Documentation to support 95831–95834 includes a description of the protocol for the procedure, the specific area(s) of the body being tested/measured, the purpose of the procedure, and the outcome, as well as impact on the individual's plan of care. According to the AMA, a grading system that uses either a numeric scale ranging from 0 to 5, or language equivalent to this scale such as zero, fair, good, or normal could be used.

Examples of examination findings include:

- Electrophysiologic integrity
- Muscle strength, power, and endurance
- Muscle tension

When modifier KX is reported, the medical record documentation should include:

- The patient's complaints
- The condition that indicates why the evaluation was necessary
- The description of any complex situations that directly and substantially impact the patient's treatment

Reimbursement Tips

This service is considered a "sometimes-therapy" service and is subject to the Medicare outpatient physical therapy cap when performed by the physical therapist. The following modifiers are used to identify therapy services, whether or not the financial limitations are in effect, although the common working file (CWF) does track the financial limitation using the therapy modifiers. The

following three modifiers refer only to services provided under plans of care for physical therapy, occupational therapy, and speech-language pathology services, and should only be reported with codes on the list of applicable therapy codes:

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

GO Services delivered under an outpatient occupational therapy plan of care

GP Services delivered under an outpatient physical therapy plan of care

There is a two-tiered exceptions process to the outpatient therapy caps: an automatic exceptions process and a medical review exceptions process. Under the automatic exceptions process, therapists must append reported codes with modifier KX when services will exceed the therapy cap, which is \$1,940 for 2016. Services above the threshold initially are approved without medical review, but still are subject to review by the Medicare administrative contractor. Modifier KX is added to other required modifiers (GN for speech-language pathology services, GO for occupational therapy services, and GP for physical therapy services). The medical review exceptions process is required at the \$3,700 threshold. Under this process, CMS determine which therapy services to review by considering factors that include: (1) providers with patterns of aberrant billing practices compared with their peers; (2) providers with a high claims denial percentage or who are less compliant with applicable Medicare program requirements; and (3) newly enrolled providers.

These services are considered separate procedures, are usually a component of a more complex service, and are not identified separately. When performed alone or with other unrelated procedures/services, they may be reported. If performed alone, list the code; if performed with other unrelated procedures/services, list the code and append modifier 59 Distinct procedural service.

These services may be billed in addition to the standard evaluation. Note that because these codes are outside the physical medicine series of codes it is advisable for the physical therapist to obtain payment information or prior authorization from the payer before rendering the service.

Terms To Know

myelopathy. Pathological or functional changes in the spinal cord, often resulting from nonspecific and noninflammatory lesions.

neuropathy. Abnormality, disease, or malfunction of the nerves.

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

ICD-10-CM Diagnostic Codes

G56.01	Carpal tunnel syndrome, right upper limb
G56.02	Carpal tunnel syndrome, left upper limb
G58.0	Intercostal neuropathy
G58.7	Mononeuritis multiplex
G60.0	Hereditary motor and sensory neuropathy
G60.1	Refsum's disease
G60.2	Neuropathy in association with hereditary ataxia
G60.3	Idiopathic progressive neuropathy
G60.9	Hereditary and idiopathic neuropathy, unspecified
G61.0	Guillain-Barre syndrome
G61.1	Serum neuropathy
G61.81	Chronic inflammatory demyelinating polyneuropathy

G61.89	Other inflammatory polyneuropathies
G61.9	Inflammatory polyneuropathy, unspecified
G62.0	Drug-induced polyneuropathy
G62.1	Alcoholic polyneuropathy
G65.0	Sequelae of Guillain-Barre syndrome
G65.1	Sequelae of other inflammatory polyneuropathy
G65.2	Sequelae of toxic polyneuropathy
G70.00	Myasthenia gravis without (acute) exacerbation
G70.01	Myasthenia gravis with (acute) exacerbation
G70.1	Toxic myoneural disorders
G71.0	Muscular dystrophy
G71.11	Myotonic muscular dystrophy
G71.12	Myotonia congenita
G71.13	Myotonic chondrodystrophy
G71.14	Drug induced myotonia
G71.2	Congenital myopathies
G71.3	Mitochondrial myopathy, not elsewhere classified
G72.1	Alcoholic myopathy
G72.3	Periodic paralysis
M24.241	Disorder of ligament, right hand
M24.242	Disorder of ligament, left hand
M33.02	Juvenile dermatomyositis with myopathy
M33.12	Other dermatomyositis with myopathy
M33.22	Polymyositis with myopathy
M34.82	Systemic sclerosis with myopathy
M60.141	Interstitial myositis, right hand
M60.142	Interstitial myositis, left hand
M60.19	Interstitial myositis, multiple sites
M60.841	Other myositis, right hand
M60.842	Other myositis, left hand
M60.89	Other myositis, multiple sites
M62.041	Separation of muscle (nontraumatic), right hand
M62.042	Separation of muscle (nontraumatic), left hand
M62.3	Immobility syndrome (paraplegic)
M62.441	Contracture of muscle, right hand
M62.442	Contracture of muscle, left hand
M62.541	Muscle wasting and atrophy, not elsewhere classified, right hand
M62.542	Muscle wasting and atrophy, not elsewhere classified, left hand
M62.59	Muscle wasting and atrophy, not elsewhere classified, multiple sites
M62.81	Muscle weakness (generalized)
M62.82	Rhabdomyolysis
M62.838	Other muscle spasm
M79.1	Myalgia
M79.641	Pain in right hand
M79.642	Pain in left hand
M79.644	Pain in right finger(s)
M79.645	Pain in left finger(s)
M79.7	Fibromyalgia
R25.2	Cramp and spasm
R29.5	Transient paralysis
R41.4	Neurologic neglect syndrome

S64.21XA	Injury of radial nerve at wrist and hand level of right arm, initial encounter
S64.21XD	Injury of radial nerve at wrist and hand level of right arm, subsequent encounter
S64.22XA	Injury of radial nerve at wrist and hand level of left arm, initial encounter
S64.22XD	Injury of radial nerve at wrist and hand level of left arm, subsequent encounter
S64.31XA	Injury of digital nerve of right thumb, initial encounter
S64.31XD	Injury of digital nerve of right thumb, subsequent encounter
S64.32XA	Injury of digital nerve of left thumb, initial encounter
S64.32XD	Injury of digital nerve of left thumb, subsequent encounter
S64.490A	Injury of digital nerve of right index finger, initial encounter
S64.490D	Injury of digital nerve of right index finger, subsequent encounter
S64.491A	Injury of digital nerve of left index finger, initial encounter
S64.491D	Injury of digital nerve of left index finger, subsequent encounter
S64.492A	Injury of digital nerve of right middle finger, initial encounter
S64.492D	Injury of digital nerve of right middle finger, subsequent encounter
S64.493A	Injury of digital nerve of left middle finger, initial encounter
S64.493D	Injury of digital nerve of left middle finger, subsequent encounter
S64.494A	Injury of digital nerve of right ring finger, initial encounter
S64.494D	Injury of digital nerve of right ring finger, subsequent encounter
S64.495A	Injury of digital nerve of left ring finger, initial encounter
S64.495D	Injury of digital nerve of left ring finger, subsequent encounter
S64.496A	Injury of digital nerve of right little finger, initial encounter
S64.496D	Injury of digital nerve of right little finger, subsequent encounter
S64.497A	Injury of digital nerve of left little finger, initial encounter
S64.497D	Injury of digital nerve of left little finger, subsequent encounter
S64.498A	Injury of digital nerve of other finger, initial encounter
S64.498D	Injury of digital nerve of other finger, subsequent encounter
S64.8X1D	Injury of other nerves at wrist and hand level of right arm, subsequent encounter

Please note that this list of associated ICD-10-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Status	MUE
95831	0.43	0.86	N/A	A	5(2)
95832	0.45	0.84	N/A	A	1(3)
95833	0.61	1.05	N/A	A	-
95834	0.89	1.44	N/A	A	-

	Modifiers				Medicare References
95831	N/A	N/A	N/A	80*	100-2,15,230.4
95832	N/A	N/A	N/A	80*	
95833	N/A	N/A	N/A	80*	
95834	N/A	N/A	N/A	80*	

* with documentation