

Local Coverage Article:

Billing and Coding: OUTPATIENT PHYSICAL AND OCCUPATIONAL THERAPY SERVICES (A56566)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
National Government Services, Inc.	MAC - Part A	06101 - MAC A	J - 06	Illinois
National Government Services, Inc.	MAC - Part B	06102 - MAC B	J - 06	Illinois
National Government Services, Inc.	MAC - Part A	06201 - MAC A	J - 06	Minnesota
National Government Services, Inc.	MAC - Part B	06202 - MAC B	J - 06	Minnesota
National Government Services, Inc.	MAC - Part A	06301 - MAC A	J - 06	Wisconsin
National Government Services, Inc.	MAC - Part B	06302 - MAC B	J - 06	Wisconsin
National Government Services, Inc.	A and B and HHH MAC	13101 - MAC A	J - K	Connecticut
National Government Services, Inc.	A and B and HHH MAC	13102 - MAC B	J - K	Connecticut
National Government Services, Inc.	A and B and HHH MAC	13201 - MAC A	J - K	New York - Entire State
National Government Services, Inc.	A and B and HHH MAC	13202 - MAC B	J - K	New York - Downstate
National Government Services, Inc.	A and B and HHH MAC	13282 - MAC B	J - K	New York - Upstate
National Government Services, Inc.	A and B and HHH MAC	13292 - MAC B	J - K	New York - Queens
National Government Services, Inc.	A and B and HHH MAC	14111 - MAC A	J - K	Maine
National Government Services, Inc.	A and B and HHH MAC	14112 - MAC B	J - K	Maine
National Government Services, Inc.	A and B and HHH MAC	14211 - MAC A	J - K	Massachusetts
National Government Services, Inc.	A and B and HHH MAC	14212 - MAC B	J - K	Massachusetts

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Inc.	MAC			
National Government Services, Inc.	A and B and HHH MAC	14311 - MAC A	J - K	New Hampshire
National Government Services, Inc.	A and B and HHH MAC	14312 - MAC B	J - K	New Hampshire
National Government Services, Inc.	A and B and HHH MAC	14411 - MAC A	J - K	Rhode Island
National Government Services, Inc.	A and B and HHH MAC	14412 - MAC B	J - K	Rhode Island
National Government Services, Inc.	A and B and HHH MAC	14511 - MAC A	J - K	Vermont
National Government Services, Inc.	A and B and HHH MAC	14512 - MAC B	J - K	Vermont

Article Information

General Information

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Billing and Coding

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N/A

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N/A

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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, and the correction notice for this rule, published in the Federal Register on January 15, 2008, pages 2431-2433, addresses 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 (NCD) 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

Communication from CMS that the Contractor LCD is not required to include the V57.1-V57.89 ICD-9-CM codes.

CMS Transmittal No. 4149, Publication 100-04, *Medicare Claims Processing Manual*, October 23, 2018, removes Functional Reporting requirements and edits for outpatient therapy services.

CMS Transmittal No. 179, Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius, Change request #8458, January 14, 2014, provides clarification that coverage of skilled nursing and skilled therapy services "...does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care."

Article Guidance

Article Text:

This article contains coding guidelines that complement the Local Coverage Determination (LCD) for OUTPATIENT PHYSICAL AND OCCUPATIONAL THERAPY SERVICES (L33631).

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.

The diagnosis code(s) must best describe the patient's condition for which the service was performed.

A claim submitted without a valid ICD-10-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act.

Unless otherwise specified, italicized text within this article represents quotation from CMS sources.

CMS National Coverage provisions:

Services that do not meet the requirements for covered therapy services in Medicare manuals are not payable using codes and descriptions as therapy services. For example, services related to activities for the general good and welfare of patients, e.g., 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.

MAINTENANCE PROGRAM (MP) means a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness.

In the case of rehabilitative therapy, improvement is evidenced by successive objective measurements whenever possible. If an individual's expected rehabilitation potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, rehabilitative therapy is not reasonable and necessary.

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)).

In the case of maintenance therapy, treatment by the therapist is necessary to maintain, prevent or slow further deterioration of the patient's functional status and the services cannot be safely carried out by the beneficiary him or herself, a family member, another caregiver or unskilled personnel.

Skilled Therapy *A service is not considered a skilled therapy service merely because it is furnished by a therapist or by a therapist/therapy assistant under the direct or general supervision, as applicable, of a therapist. If a service can be self-administered or safely and effectively furnished by an unskilled person, without the direct or general supervision, as applicable, of a therapist, the service cannot be regarded as a skilled therapy service even though a therapist actually furnishes the service. Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a therapist furnishes the service.*

Skilled therapy services may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

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.

Once a maintenance program is established, coverage of therapy services to carry out a maintenance program turns on the beneficiary's need for skilled care. A maintenance program can generally be performed by the beneficiary alone or with the assistance of a family member, caregiver or unskilled personnel. In such situations, coverage is not provided. However, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of safe and effective services in a maintenance program.

While a beneficiary's particular medical condition is a valid factor in deciding if skilled (rehabilitative or maintenance) 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 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

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

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.

Coding Information and Documentation Requirements for Specific Services:

CPT 97161-97163 – Physical therapy evaluation CPT 97165-97167 – Occupational therapy evaluation

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.

For initial evaluations, PTs shall use codes 97161-97163 and OTs shall use codes 97165-97167. 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.

- 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 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.
- CPT codes 95831-95834 are deleted for 2020. To report manual muscle testing, please refer to evaluation codes 97161-97168.
- Do not bill therapy screenings utilizing the evaluation codes. Screenings are not billable services.
- 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.

CPT 97164 – Physical therapy reevaluation CPT 97168 – 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.

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.
- 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 Requirements for 97161-97163, 97164, and 97165-97167, 97168

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

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

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 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.

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 Requirements for 97010

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

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

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.

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 Requirements 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)

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 Requirements 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)

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.

Supportive Documentation Requirements for 97018

- Documentation needs to support more than 2 visits to educate patient and/or caregiver in home use once effectiveness has been determined.
- 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)

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.

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

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 Requirements for 97022

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

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

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

Only 1 unit of CPT code 97024 is covered per date of service.

(CMS Publication 100-03, Medicare National Coverage Determinations (NCD) Manual, Section 150.5) 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 Requirements (required at least every 10 visits) 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)

Only 1 unit of CPT code 97028 should be billed per date of service.

Supportive Documentation Requirements (required at least every 10 visits) for 97028

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

Only 1 unit of CPT code 97028 should be billed per date of service.

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

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

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, as well as the medical necessity of the constant contact to justify billing 97032 versus G0283. Devices delivering high voltage stimulation may require one-on-one patient contact (e.g., MicroVas, when applied in a high voltage mode).

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.
 - 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)

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.

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.

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*

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.

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.

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

Supportive Documentation Requirements (required at least every 10 visits) 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.

Iontophoresis will be allowed for treatment of intractable, disabling primary focal hyperhidrosis (ICD-10-CM codes L74.510-L74.513 or L74.519) 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.

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.

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 Requirements (required at least every 10 visits) 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

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 97035 – Ultrasound (to one or more areas)

See list of "ICD-10 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.

Supportive Documentation Requirements (required at least every 10 visits) 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

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.

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.

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

Supportive Documentation Requirements 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. Effective 7/1/2019, this service is reported with CPT code 0552T.

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

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).

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.

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 Requirements (required at least every 10 visits) 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, 97129, 97130, 97139, 97140, 97150, 97530, 97533, 97535, 97537, 97542, 97602, 97605, 97606, 97607, 97608, 97750, 97755, 97760, 97761, 97763 and 97799)

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, 97129, 97130, 97140, 97530, 97533, 97535, 97537, 97542, 97760, 97761, and 97763 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)

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).

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.

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

Supportive Documentation Requirements (required at least every 10 visits) 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).

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.

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

Supportive Documentation Requirements (required at least every 10 visits) for 97112

Objective loss of activities of daily living (ADLs), mobility, balance, coordination deficits, hypo- and hypertonicity, posture and effect on function. ADL means basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

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.

See CPT 97150 Group Therapy for guidelines when treating more than one patient at the same time in the aquatic environment.

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

Documentation must clearly support the need for aquatic therapy greater than 8 visits.

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.

Supportive Documentation Requirements (required at least every 10 visits) 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)

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.*

(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-10-CM diagnosis code G82.20 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 Requirements (required at least every 10 visits) 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)

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).

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

Do not bill 97124 for percussion for postural drainage.

Supportive Documentation Requirements (required at least every 10 visits) 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 Requirements for 97139 Please see section Documentation Requirements for Unlisted Procedure Codes.

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

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.

The therapeutic exercise component for MLD / CDT is covered under CPT code 97110.

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 Requirements (required at least every 10 visits) 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)

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

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.

Report 97150 for each member of the group.

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).

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 Requirements 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 (use of dynamic activities to improve functional performance), each 15 minutes

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

Supportive Documentation Requirements (required at least every 10 visits) 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 97129 (code effective 01/01/2020) – Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (on-on-one) patient contact; initial 15 minutes

CPT 97130 (code effective 01/01/2020) ;each additional 15 minutes (list separately in addition to code for primary procedure)

This activity is designed to improve attention, memory, and problem-solving, including the use of compensatory techniques.

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. These services are also reimbursable when billed by clinical psychologists.

Claims for cognitive skills development should include diagnoses that reflect the underlying condition requiring therapy, as well as the symptoms or manifestations of the condition.

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

Supportive Documentation Requirements (required at least every 10 visits) for 97129, 97130

- 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

This service is payable to speech-language pathologists under certain conditions. More information on this coverage can be found in the Speech-Language Pathology LCD (L33580).

CPT 97533 – Sensory integration

Utilization of this service should be infrequent for Medicare patients.

This service is payable to speech-language pathologists under certain conditions. More information on this coverage can be found in the Speech-Language Pathology LCD (L33580).

Supportive Documentation Requirements (required at least every 10 visits) 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, each 15 minutes

IADL means activities related to living independently in the community, including but not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

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.

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.

Supportive Documentation Requirements (required at least every 10 visits) 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, each 15 minutes

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.

For wheelchair management/propulsion training use 97542.

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 Requirements (required at least every 10 visits) 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. Consider the following points when providing wheelchair management services.

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.

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 (97161-97163 or 97165-97167), with the minutes spent for the evaluation/assessment assigned to either 97161-97163 or 97165-97167. 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 97162. 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.

Supportive Documentation Requirements (at least every 4 visits) 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 codes 97597 and 97598: coverage criteria have been moved to the LCD for Debridement Services (L33614), effective 04/01/2016.

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

Do not report 97602 in conjunction with 11042-11047

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 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

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 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.

Additional guidance for debridement codes:

- Do not bill for more than one unit per session for CPT code 97602, regardless of the number or complexity of the wounds treated.
- 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 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 code 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 code 97602 to describe the service.
- For wound assessment it is not appropriate to bill therapy re-evaluation codes (97164, 97168) along with code 97602. The assessment, including measurements of the wound and a written report, is considered a part of code 97602.
- Patient and caregiver instructions are included in code 97602. Do not bill separately under any other code for instructing the patient/caregiver in care of the wound.
- This code represents "sometimes therapy" services and will be paid under the OPPS 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 code 97602 may bill this code 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 Requirements (required at least every 10 visits) for 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.

CPT 97605, 97606, 97607, 97608 – Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (dme), 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 – surface area greater than 50 square centimeters

CPT 97607- Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters.

CPT 97608- Total wound(s) surface area 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. CPT Codes 97607 and 97608 are reported when a mechanically-powered device is used.

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 and 97607 and 97608. 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 (97164, 97168) along with 97605/97606 or 97607 and 97608. The assessment, including measurements of the wound and a written report, is considered a part of 97605/97606 or 97607 and 97608.

Supportive Documentation Requirements (required at least every 10 visits) for 97605, 97606, 97607 and 97608

- 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

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.

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 97161-97168 (due to CCI edits).

Supportive Documentation Requirements (required at least every 10 visits) 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, with written report, each 15 minutes

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 97161-97168 (due to CCI edits). Utilization of this service should be infrequent.

Supportive Documentation Requirements 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(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes

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 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.

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 97763. 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.

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

Payment for prosthetics and orthotics is made on the basis of a fee schedule whether it is billed to the DME MAC or the 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 to report the initial encounter 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 (97161-97163 or 97165-97167), with the minutes spent for the evaluation assigned to either 97161-97163 or 97165-97167. 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 97165. 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, 2017, Code 97760 includes orthotic management and training provided at the initial encounter. Subsequent encounters, reported with code 97763 (effective 2018) include 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.

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 Requirements 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), initial prosthetic(s) encounter, 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 Requirements 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 97763 - Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

Per CPT Changes 2018, these assessments are intended for established patients who have already received their orthotic or prosthetic device, to check for skin integrity, wound changes, abnormalities of fit or a loss of function directly related to the device (e.g., pain, skin breakdown, and falls of devices or other problems related to the orthotic or prosthetic).

If the checkout assessment resulted in the need for further training in the use of the orthotic/prosthetic, code 97763 would be appropriate for the training.

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

Supportive Documentation Requirements for 97763

- 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 Requirements for 97799 Please see Documentation Requirements for Unlisted Procedure codes. This is an untimed code, billable as "1" unit.

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

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.

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.

Supportive Documentation Requirements (required at least every 10 visits) 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 95851, and 95852 - Muscle and Range of Motion Testing

For the typical patient, the evaluation (97161-97163, 97165-97167) and reevaluation codes (97164, 97168) 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.

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:

CPT codes 95831-95834 are deleted for 2020. To report manual muscle testing, please refer to evaluation codes 97161-97168.

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.

These codes are not covered on the same visit date as CPT codes 97161-97168 (due to CCI edits).

Supportive Documentation Requirements 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 (29065, 29075, 29085, 29086, 29345, 29355, 29365, 29405, 29425, and 29445, 29200-29280, 28520-29590, 29799)

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.)

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.

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

Bilateral unna boots should be billed with a modifier -50 (bilateral procedure).

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 Requirements for 29799

This is an untimed code, billable as "1" unit. Please see section Documentation Requirements for Unlisted Procedure Codes.

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.

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 90912 – Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient

90913; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (list separately in addition to code for primary procedure)

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.

When providing biofeedback procedures for urinary incontinence, use CPT 90901 when EMG and/or manometry are not performed. CPT 90912 and 90913 describe 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.

Additional documentation is necessary to justify biofeedback services beyond 5-6 visits. The descriptor for codes 90901 does not include a time element; therefore, this code should be billed as one (1) unit.

Supportive Documentation Requirements (required at least every 10 visits) for 90901 and 90912/90913

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 95992 – Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day

Coverage for 95992 is limited to the following condition:

H81.11-H81.13 BENIGN PAROXYSMAL VERTIGO

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

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 (report CPT 0552T, effective 7/1/2019)
- 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)
- Work-hardening programs
- Pelvic Floor Dysfunction (not including incontinence)
- pelvic floor congestion
- pelvic floor pain not of spinal origin
- hypersensitive clitoris
- prostatitis
- cystourethrocele
- enterocele
- rectocele
- vulvodynia
- vulvar vestibulitis syndrome (VVS)

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.

- Frequency Specific Microcurrent: non-covered due to lack of medical literature supporting the effectiveness of this therapy
- Whole body periodic acceleration: does not meet the benefit requirement that it requires the services of a skilled professional
- Light beam Generator therapy: non-covered due to lack of medical literature supporting the effectiveness of this therapy
- 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.

General Documentation Requirements

The patient's medical record must contain documentation that fully supports the medical necessity for services included within the 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 (CPT codes 97161-97163, 97165-97167) 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

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 patient live alone, with a caregiver, in a group home, in a residential care facility, in a skilled nursing facility (SNF), etc.?

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

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.

Objectively measure and/or describe the patient's current level of functioning. Examples, based on the patient's need, may include:

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	Additional Points
Diagnosis	<p>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.</p> <p><u>Bill the most relevant diagnosis.</u> <i>As always, when billing for therapy services, the ICD-10 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.</i></p> <p><i>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.</i></p>
Long Term Goals (LTGs)	<p>LTGs should:</p> <ul style="list-style-type: none"> 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 <u>function-based</u> and written in objective, measurable terms with a predicted date for achieving the goals.
Type of Treatment	<p>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</p>

	be provided.
Amount of Treatment	<p>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.</p> <p>Treatment provided more than one session per day per discipline will require additional documentation to support this amount of therapy.</p>
Frequency of Treatment	<p>Refers to the number of times in a week that the type of treatment is provided.</p> <p>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.</p>
Duration of Treatment	<p><i>Refers to the number of weeks, or the number of treatment sessions, for this plan of care.</i></p> <p>Clinicians could also estimate the duration of the entire episode of care in this setting.</p>

Re-evaluations (CPT codes 97164, 97168) See CPT 97164 and 97168 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. 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). 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.

In the case of maintenance therapy, treatment by the therapist is necessary to maintain, prevent or slow further deterioration of the patient's functional status and the services cannot be safely carried out by the beneficiary him or herself, a family member, another caregiver or unskilled personnel.

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 (97165), followed by 20 minutes fluidotherapy (97022). Time documentation in the treatment note

Timed Code Treatment Minutes: 0 minutes

Total Treatment Time: 50 minutes

Canalith Repositioning: Documentation should include:

- Results of physiologic testing (if performed)
- A plan for the continuing care,
- The progress demonstrated,
- The number of anticipated additional services,
- Explanation of why the patient would be unable to performing the exercises at home without the immediate supervision of a trained professional.

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/auxiliary personnel, the time spent by the qualified professional/auxiliary 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.

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 97161-97163 and 97165-97167" 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 > 8 minutes through 22 minutes

2 units > 23 minutes through 37 minutes

3 units > 38 minutes through 52 minutes

4 units > 53 minutes through 67 minutes

5 units > 68 minutes through 82 minutes

6 units > 83 minutes through 97 minutes

7 units > 98 minutes through 112 minutes

8 units > 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 97165)

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 97165 + 2 units 97110

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

40 minutes PT evaluation (CPT 97163)

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 97163 + 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.

Any two CPT codes for "therapeutic procedures" requiring direct one-on-one patient contact (CPT codes 97110-97763)

Any two CPT codes for modalities requiring "constant attendance" and direct one-on-one patient contact (CPT codes 97032-97039)

Any two CPT codes requiring either constant attendance or direct one-on-one patient contact - as described in (a) or (b) above - (CPT codes 97032-97763), for example, any CPT code for a therapeutic procedure (e.g., 97116 - gait training) with any attended modality CPT code (e.g., 97035 - ultrasound)

Any CPT code for therapeutic procedures requiring direct one-on-one patient contact (CPT codes 97110-97763) with the group therapy CPT code (97150) requiring constant attendance, for example, group therapy (97150) with neuromuscular reeducation (97112)

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)

Any evaluation or reevaluation code (CPT codes 97161-97168) with any other timed or untimed CPT codes, including constant attendance modalities (CPT codes 97032-97039), therapeutic procedures (CPT 97110-97763) 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: 97012, 97016, 97018, 97022, 97024, 97028, 97129, 97150, 97161-97168, 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, 97130, 97530, 97533, 97535, 97537, 97542, 97760, 97761, 97763.

Canalith repositioning (95992) should generally be limited to five or fewer encounters. Sessions in excess of this parameter must be documented as to their need and why these exercises cannot be performed by the beneficiary without the supervision of trained professionals. Denials due to the limits described in this section of the article may be appealed.

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

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

HCPCS code G0295 is status N (non-covered) under Medicare.

Group 1 Codes:

CODE	DESCRIPTION
29065	APPLICATION, CAST; SHOULDER TO HAND (LONG ARM)
29075	APPLICATION, CAST; ELBOW TO FINGER (SHORT ARM)
29085	APPLICATION, CAST; HAND AND LOWER FOREARM (GAUNTLET)
29086	APPLICATION, CAST; FINGER (EG, CONTRACTURE)

CODE	DESCRIPTION
29105	APPLICATION OF LONG ARM SPLINT (SHOULDER TO HAND)
29125	APPLICATION OF SHORT ARM SPLINT (FOREARM TO HAND); STATIC
29126	APPLICATION OF SHORT ARM SPLINT (FOREARM TO HAND); DYNAMIC
29130	APPLICATION OF FINGER SPLINT; STATIC
29131	APPLICATION OF FINGER SPLINT; DYNAMIC
29200	STRAPPING; THORAX
29240	STRAPPING; SHOULDER (EG, VELPEAU)
29260	STRAPPING; ELBOW OR WRIST
29280	STRAPPING; HAND OR FINGER
29345	APPLICATION OF LONG LEG CAST (THIGH TO TOES);
29355	APPLICATION OF LONG LEG CAST (THIGH TO TOES); WALKER OR AMBULATORY TYPE
29365	APPLICATION OF CYLINDER CAST (THIGH TO ANKLE)
29405	APPLICATION OF SHORT LEG CAST (BELOW KNEE TO TOES);
29425	APPLICATION OF SHORT LEG CAST (BELOW KNEE TO TOES); WALKING OR AMBULATORY TYPE
29445	APPLICATION OF RIGID TOTAL CONTACT LEG CAST
29505	APPLICATION OF LONG LEG SPLINT (THIGH TO ANKLE OR TOES)
29515	APPLICATION OF SHORT LEG SPLINT (CALF TO FOOT)
29520	STRAPPING; HIP
29530	STRAPPING; KNEE
29540	STRAPPING; ANKLE AND/OR FOOT
29550	STRAPPING; TOES
29580	STRAPPING; UNNA BOOT
29799	UNLISTED PROCEDURE, CASTING OR STRAPPING
90901	BIOFEEDBACK TRAINING BY ANY MODALITY
90912	BIOFEEDBACK TRAINING, PERINEAL MUSCLES, ANORECTAL OR URETHRAL SPHINCTER, INCLUDING EMG AND/OR MANOMETRY, WHEN PERFORMED; INITIAL 15 MINUTES OF ONE-ON-ONE PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL CONTACT WITH THE PATIENT
90913	BIOFEEDBACK TRAINING, PERINEAL MUSCLES, ANORECTAL OR URETHRAL SPHINCTER, INCLUDING EMG AND/OR MANOMETRY, WHEN PERFORMED; EACH ADDITIONAL 15 MINUTES OF ONE-ON-ONE PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL CONTACT WITH THE PATIENT (LIST SEPARATELY IN

CODE	DESCRIPTION
	ADDITION TO CODE FOR PRIMARY PROCEDURE)
95851	RANGE OF MOTION MEASUREMENTS AND REPORT (SEPARATE PROCEDURE); EACH EXTREMITY (EXCLUDING HAND) OR EACH TRUNK SECTION (SPINE)
95852	RANGE OF MOTION MEASUREMENTS AND REPORT (SEPARATE PROCEDURE); HAND, WITH OR WITHOUT COMPARISON WITH NORMAL SIDE
95992	CANALITH REPOSITIONING PROCEDURE(S) (EG, EPLEY MANEUVER, SEMONT MANEUVER), PER DAY
96125	STANDARDIZED COGNITIVE PERFORMANCE TESTING (EG, 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
97010	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; HOT OR COLD PACKS
97012	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; TRACTION, MECHANICAL
97016	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; VASOPNEUMATIC DEVICES
97018	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; PARAFFIN BATH
97022	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; WHIRLPOOL
97024	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; DIATHERMY (EG, MICROWAVE)
97026	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; INFRARED
97028	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ULTRAVIOLET
97032	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ELECTRICAL STIMULATION (MANUAL), EACH 15 MINUTES
97033	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; IONTOPHORESIS, EACH 15 MINUTES
97034	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; CONTRAST BATHS, EACH 15 MINUTES
97035	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ULTRASOUND, EACH 15 MINUTES
97036	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; HUBBARD TANK, EACH 15 MINUTES
97039	UNLISTED MODALITY (SPECIFY TYPE AND TIME IF CONSTANT ATTENDANCE)
97110	THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; THERAPEUTIC EXERCISES TO DEVELOP STRENGTH AND ENDURANCE, RANGE OF MOTION AND FLEXIBILITY
97112	THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES;

CODE	DESCRIPTION
	NEUROMUSCULAR REEDUCATION OF MOVEMENT, BALANCE, COORDINATION, KINESTHETIC SENSE, POSTURE, AND/OR PROPRIOCEPTION FOR SITTING AND/OR STANDING ACTIVITIES
97113	THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; AQUATIC THERAPY WITH THERAPEUTIC EXERCISES
97116	THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; GAIT TRAINING (INCLUDES STAIR CLIMBING)
97124	THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; MASSAGE, INCLUDING EFFLEURAGE, PETRISSAGE AND/OR TAPOTEMENT (STROKING, COMPRESSION, PERCUSSION)
97129	THERAPEUTIC INTERVENTIONS THAT FOCUS ON COGNITIVE FUNCTION (EG, ATTENTION, MEMORY, REASONING, EXECUTIVE FUNCTION, PROBLEM SOLVING, AND/OR PRAGMATIC FUNCTIONING) AND COMPENSATORY STRATEGIES TO MANAGE THE PERFORMANCE OF AN ACTIVITY (EG, MANAGING TIME OR SCHEDULES, INITIATING, ORGANIZING, AND SEQUENCING TASKS), DIRECT (ONE-ON-ONE) PATIENT CONTACT; INITIAL 15 MINUTES
97130	THERAPEUTIC INTERVENTIONS THAT FOCUS ON COGNITIVE FUNCTION (EG, ATTENTION, MEMORY, REASONING, EXECUTIVE FUNCTION, PROBLEM SOLVING, AND/OR PRAGMATIC FUNCTIONING) AND COMPENSATORY STRATEGIES TO MANAGE THE PERFORMANCE OF AN ACTIVITY (EG, MANAGING TIME OR SCHEDULES, INITIATING, ORGANIZING, AND SEQUENCING TASKS), DIRECT (ONE-ON-ONE) PATIENT CONTACT; EACH ADDITIONAL 15 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
97139	UNLISTED THERAPEUTIC PROCEDURE (SPECIFY)
97140	MANUAL THERAPY TECHNIQUES (EG, MOBILIZATION/ MANIPULATION, MANUAL LYMPHATIC DRAINAGE, MANUAL TRACTION), 1 OR MORE REGIONS, EACH 15 MINUTES
97150	THERAPEUTIC PROCEDURE(S), GROUP (2 OR MORE INDIVIDUALS)
97161	PHYSICAL THERAPY EVALUATION: LOW COMPLEXITY, REQUIRING THESE COMPONENTS: A HISTORY WITH NO PERSONAL FACTORS AND/OR COMORBIDITIES THAT IMPACT THE PLAN OF CARE; AN EXAMINATION OF BODY SYSTEM(S) USING STANDARDIZED TESTS AND MEASURES ADDRESSING 1-2 ELEMENTS FROM ANY OF THE FOLLOWING: BODY STRUCTURES AND FUNCTIONS, ACTIVITY LIMITATIONS, AND/OR PARTICIPATION RESTRICTIONS; A CLINICAL PRESENTATION WITH STABLE AND/OR UNCOMPLICATED CHARACTERISTICS; AND CLINICAL DECISION MAKING OF LOW COMPLEXITY USING STANDARDIZED PATIENT ASSESSMENT INSTRUMENT AND/OR MEASURABLE ASSESSMENT OF FUNCTIONAL OUTCOME. TYPICALLY, 20 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
97162	PHYSICAL THERAPY EVALUATION: MODERATE COMPLEXITY, REQUIRING THESE COMPONENTS: A HISTORY OF PRESENT PROBLEM WITH 1-2 PERSONAL FACTORS

CODE	DESCRIPTION
	AND/OR COMORBIDITIES THAT IMPACT THE PLAN OF CARE; AN EXAMINATION OF BODY SYSTEMS USING STANDARDIZED TESTS AND MEASURES IN ADDRESSING A TOTAL OF 3 OR MORE ELEMENTS FROM ANY OF THE FOLLOWING: BODY STRUCTURES AND FUNCTIONS, ACTIVITY LIMITATIONS, AND/OR PARTICIPATION RESTRICTIONS; AN EVOLVING CLINICAL PRESENTATION WITH CHANGING CHARACTERISTICS; AND CLINICAL DECISION MAKING OF MODERATE COMPLEXITY USING STANDARDIZED PATIENT ASSESSMENT INSTRUMENT AND/OR MEASURABLE ASSESSMENT OF FUNCTIONAL OUTCOME. TYPICALLY, 30 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
97163	PHYSICAL THERAPY EVALUATION: HIGH COMPLEXITY, REQUIRING THESE COMPONENTS: A HISTORY OF PRESENT PROBLEM WITH 3 OR MORE PERSONAL FACTORS AND/OR COMORBIDITIES THAT IMPACT THE PLAN OF CARE; AN EXAMINATION OF BODY SYSTEMS USING STANDARDIZED TESTS AND MEASURES ADDRESSING A TOTAL OF 4 OR MORE ELEMENTS FROM ANY OF THE FOLLOWING: BODY STRUCTURES AND FUNCTIONS, ACTIVITY LIMITATIONS, AND/OR PARTICIPATION RESTRICTIONS; A CLINICAL PRESENTATION WITH UNSTABLE AND UNPREDICTABLE CHARACTERISTICS; AND CLINICAL DECISION MAKING OF HIGH COMPLEXITY USING STANDARDIZED PATIENT ASSESSMENT INSTRUMENT AND/OR MEASURABLE ASSESSMENT OF FUNCTIONAL OUTCOME. TYPICALLY, 45 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
97164	RE-EVALUATION OF PHYSICAL THERAPY ESTABLISHED PLAN OF CARE, REQUIRING THESE COMPONENTS: AN EXAMINATION INCLUDING A REVIEW OF HISTORY AND USE OF STANDARDIZED TESTS AND MEASURES IS REQUIRED; AND REVISED PLAN OF CARE USING A STANDARDIZED PATIENT ASSESSMENT INSTRUMENT AND/OR MEASURABLE ASSESSMENT OF FUNCTIONAL OUTCOME TYPICALLY, 20 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
97165	OCCUPATIONAL THERAPY EVALUATION, LOW COMPLEXITY, REQUIRING THESE COMPONENTS: AN OCCUPATIONAL PROFILE AND MEDICAL AND THERAPY HISTORY, WHICH INCLUDES A BRIEF HISTORY INCLUDING REVIEW OF MEDICAL AND/OR THERAPY RECORDS RELATING TO THE PRESENTING PROBLEM; AN ASSESSMENT(S) THAT IDENTIFIES 1-3 PERFORMANCE DEFICITS (IE, RELATING TO PHYSICAL, COGNITIVE, OR PSYCHOSOCIAL SKILLS) THAT RESULT IN ACTIVITY LIMITATIONS AND/OR PARTICIPATION RESTRICTIONS; AND CLINICAL DECISION MAKING OF LOW COMPLEXITY, WHICH INCLUDES AN ANALYSIS OF THE OCCUPATIONAL PROFILE, ANALYSIS OF DATA FROM PROBLEM-FOCUSED ASSESSMENT(S), AND CONSIDERATION OF A LIMITED NUMBER OF TREATMENT OPTIONS. PATIENT PRESENTS WITH NO COMORBIDITIES THAT AFFECT OCCUPATIONAL PERFORMANCE. MODIFICATION OF TASKS OR ASSISTANCE (EG, PHYSICAL OR VERBAL) WITH ASSESSMENT(S) IS NOT NECESSARY TO ENABLE COMPLETION OF EVALUATION COMPONENT. TYPICALLY, 30 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
97166	OCCUPATIONAL THERAPY EVALUATION, MODERATE COMPLEXITY, REQUIRING THESE COMPONENTS: AN OCCUPATIONAL PROFILE AND MEDICAL AND THERAPY

CODE	DESCRIPTION
	<p>HISTORY, WHICH INCLUDES AN EXPANDED REVIEW OF MEDICAL AND/OR THERAPY RECORDS AND ADDITIONAL REVIEW OF PHYSICAL, COGNITIVE, OR PSYCHOSOCIAL HISTORY RELATED TO CURRENT FUNCTIONAL PERFORMANCE; AN ASSESSMENT(S) THAT IDENTIFIES 3-5 PERFORMANCE DEFICITS (IE, RELATING TO PHYSICAL, COGNITIVE, OR PSYCHOSOCIAL SKILLS) THAT RESULT IN ACTIVITY LIMITATIONS AND/OR PARTICIPATION RESTRICTIONS; AND CLINICAL DECISION MAKING OF MODERATE ANALYTIC COMPLEXITY, WHICH INCLUDES AN ANALYSIS OF THE OCCUPATIONAL PROFILE, ANALYSIS OF DATA FROM DETAILED ASSESSMENT(S), AND CONSIDERATION OF SEVERAL TREATMENT OPTIONS. PATIENT MAY PRESENT WITH COMORBIDITIES THAT AFFECT OCCUPATIONAL PERFORMANCE. MINIMAL TO MODERATE MODIFICATION OF TASKS OR ASSISTANCE (EG, PHYSICAL OR VERBAL) WITH ASSESSMENT(S) IS NECESSARY TO ENABLE PATIENT TO COMPLETE EVALUATION COMPONENT. TYPICALLY, 45 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.</p>
97167	<p>OCCUPATIONAL THERAPY EVALUATION, HIGH COMPLEXITY, REQUIRING THESE COMPONENTS: AN OCCUPATIONAL PROFILE AND MEDICAL AND THERAPY HISTORY, WHICH INCLUDES REVIEW OF MEDICAL AND/OR THERAPY RECORDS AND EXTENSIVE ADDITIONAL REVIEW OF PHYSICAL, COGNITIVE, OR PSYCHOSOCIAL HISTORY RELATED TO CURRENT FUNCTIONAL PERFORMANCE; AN ASSESSMENT(S) THAT IDENTIFIES 5 OR MORE PERFORMANCE DEFICITS (IE, RELATING TO PHYSICAL, COGNITIVE, OR PSYCHOSOCIAL SKILLS) THAT RESULT IN ACTIVITY LIMITATIONS AND/OR PARTICIPATION RESTRICTIONS; AND CLINICAL DECISION MAKING OF HIGH ANALYTIC COMPLEXITY, WHICH INCLUDES AN ANALYSIS OF THE PATIENT PROFILE, ANALYSIS OF DATA FROM COMPREHENSIVE ASSESSMENT(S), AND CONSIDERATION OF MULTIPLE TREATMENT OPTIONS. PATIENT PRESENTS WITH COMORBIDITIES THAT AFFECT OCCUPATIONAL PERFORMANCE. SIGNIFICANT MODIFICATION OF TASKS OR ASSISTANCE (EG, PHYSICAL OR VERBAL) WITH ASSESSMENT(S) IS NECESSARY TO ENABLE PATIENT TO COMPLETE EVALUATION COMPONENT. TYPICALLY, 60 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.</p>
97168	<p>RE-EVALUATION OF OCCUPATIONAL THERAPY ESTABLISHED PLAN OF CARE, REQUIRING THESE COMPONENTS: AN ASSESSMENT OF CHANGES IN PATIENT FUNCTIONAL OR MEDICAL STATUS WITH REVISED PLAN OF CARE; AN UPDATE TO THE INITIAL OCCUPATIONAL PROFILE TO REFLECT CHANGES IN CONDITION OR ENVIRONMENT THAT AFFECT FUTURE INTERVENTIONS AND/OR GOALS; AND A REVISED PLAN OF CARE. A FORMAL REEVALUATION IS PERFORMED WHEN THERE IS A DOCUMENTED CHANGE IN FUNCTIONAL STATUS OR A SIGNIFICANT CHANGE TO THE PLAN OF CARE IS REQUIRED. TYPICALLY, 30 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.</p>
97530	<p>THERAPEUTIC ACTIVITIES, DIRECT (ONE-ON-ONE) PATIENT CONTACT (USE OF DYNAMIC ACTIVITIES TO IMPROVE FUNCTIONAL PERFORMANCE), EACH 15 MINUTES</p>
97533	<p>SENSORY INTEGRATIVE TECHNIQUES TO ENHANCE SENSORY PROCESSING AND</p>

CODE	DESCRIPTION
	PROMOTE ADAPTIVE RESPONSES TO ENVIRONMENTAL DEMANDS, DIRECT (ONE-ON-ONE) PATIENT CONTACT, EACH 15 MINUTES
97535	SELF-CARE/HOME MANAGEMENT TRAINING (EG, 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, EACH 15 MINUTES
97537	COMMUNITY/WORK REINTEGRATION TRAINING (EG, SHOPPING, TRANSPORTATION, MONEY MANAGEMENT, AVOCATIONAL ACTIVITIES AND/OR WORK ENVIRONMENT/MODIFICATION ANALYSIS, WORK TASK ANALYSIS, USE OF ASSISTIVE TECHNOLOGY DEVICE/ADAPTIVE EQUIPMENT), DIRECT ONE-ON-ONE CONTACT, EACH 15 MINUTES
97542	WHEELCHAIR MANAGEMENT (EG, ASSESSMENT, FITTING, TRAINING), EACH 15 MINUTES
97545	WORK HARDENING/CONDITIONING; INITIAL 2 HOURS
97546	WORK HARDENING/CONDITIONING; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
97602	REMOVAL OF DEVITALIZED TISSUE FROM WOUND(S), NON-SELECTIVE DEBRIDEMENT, WITHOUT ANESTHESIA (EG, WET-TO-MOIST DRESSINGS, ENZYMATIC, ABRASION, LARVAL THERAPY), INCLUDING TOPICAL APPLICATION(S), WOUND ASSESSMENT, AND INSTRUCTION(S) FOR ONGOING CARE, PER SESSION
97605	NEGATIVE PRESSURE WOUND THERAPY (EG, VACUUM ASSISTED DRAINAGE COLLECTION), UTILIZING DURABLE MEDICAL EQUIPMENT (DME), 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
97606	NEGATIVE PRESSURE WOUND THERAPY (EG, VACUUM ASSISTED DRAINAGE COLLECTION), UTILIZING DURABLE MEDICAL EQUIPMENT (DME), INCLUDING TOPICAL APPLICATION(S), WOUND ASSESSMENT, AND INSTRUCTION(S) FOR ONGOING CARE, PER SESSION; TOTAL WOUND(S) SURFACE AREA GREATER THAN 50 SQUARE CENTIMETERS
97607	NEGATIVE PRESSURE WOUND THERAPY, (EG, VACUUM ASSISTED DRAINAGE COLLECTION), UTILIZING DISPOSABLE, NON-DURABLE MEDICAL EQUIPMENT INCLUDING PROVISION OF EXUDATE MANAGEMENT COLLECTION SYSTEM, TOPICAL APPLICATION(S), WOUND ASSESSMENT, AND INSTRUCTIONS FOR ONGOING CARE, PER SESSION; TOTAL WOUND(S) SURFACE AREA LESS THAN OR EQUAL TO 50 SQUARE CENTIMETERS
97608	NEGATIVE PRESSURE WOUND THERAPY, (EG, VACUUM ASSISTED DRAINAGE COLLECTION), UTILIZING DISPOSABLE, NON-DURABLE MEDICAL EQUIPMENT INCLUDING PROVISION OF EXUDATE MANAGEMENT COLLECTION SYSTEM,

CODE	DESCRIPTION
	TOPICAL APPLICATION(S), WOUND ASSESSMENT, AND INSTRUCTIONS FOR ONGOING CARE, PER SESSION; TOTAL WOUND(S) SURFACE AREA GREATER THAN 50 SQUARE CENTIMETERS
97750	PHYSICAL PERFORMANCE TEST OR MEASUREMENT (EG, MUSCULOSKELETAL, FUNCTIONAL CAPACITY), WITH WRITTEN REPORT, EACH 15 MINUTES
97755	ASSISTIVE TECHNOLOGY ASSESSMENT (EG, TO RESTORE, AUGMENT OR COMPENSATE FOR EXISTING FUNCTION, OPTIMIZE FUNCTIONAL TASKS AND/OR MAXIMIZE ENVIRONMENTAL ACCESSIBILITY), DIRECT ONE-ON-ONE CONTACT, WITH WRITTEN REPORT, EACH 15 MINUTES
97760	ORTHOTIC(S) MANAGEMENT AND TRAINING (INCLUDING ASSESSMENT AND FITTING WHEN NOT OTHERWISE REPORTED), UPPER EXTREMITY(IES), LOWER EXTREMITY(IES) AND/OR TRUNK, INITIAL ORTHOTIC(S) ENCOUNTER, EACH 15 MINUTES
97761	PROSTHETIC(S) TRAINING, UPPER AND/OR LOWER EXTREMITY(IES), INITIAL PROSTHETIC(S) ENCOUNTER, EACH 15 MINUTES
97763	ORTHOTIC(S)/PROSTHETIC(S) MANAGEMENT AND/OR TRAINING, UPPER EXTREMITY(IES), LOWER EXTREMITY(IES), AND/OR TRUNK, SUBSEQUENT ORTHOTIC(S)/PROSTHETIC(S) ENCOUNTER, EACH 15 MINUTES
97799	UNLISTED PHYSICAL MEDICINE/REHABILITATION SERVICE OR PROCEDURE
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
G0283	ELECTRICAL STIMULATION (UNATTENDED), TO ONE OR MORE AREAS FOR INDICATION(S) OTHER THAN WOUND CARE, AS PART OF A THERAPY PLAN OF CARE
G0295	ELECTROMAGNETIC THERAPY, TO ONE OR MORE AREAS, FOR WOUND CARE OTHER THAN DESCRIBED IN G0329 OR FOR OTHER USES
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
0552T	LOW-LEVEL LASER THERAPY, DYNAMIC PHOTONIC AND DYNAMIC THERMOKINETIC ENERGIES, PROVIDED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL

CPT/HCPCS Modifiers

N/A

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph:

It is the responsibility of the provider to code to the highest level specified in the ICD-10-CM. The correct use of an ICD-10-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 the related local coverage determination.

See the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. The specific condition for which therapy services are provided must be specified as the diagnosis supporting the medical necessity of each service.

Coverage for CPT code **95992** is limited to the following diagnoses:

Group 1 Codes:

ICD-10 CODE	DESCRIPTION
H81.11	Benign paroxysmal vertigo, right ear
H81.12	Benign paroxysmal vertigo, left ear
H81.13	Benign paroxysmal vertigo, bilateral

ICD-10 Codes that DO NOT Support Medical Necessity

Group 1 Paragraph:

The following ICD-10-CM Codes do not support the medical necessity for the CPT/HCPCS code 97035.

Group 1 Codes:

ICD-10 CODE	DESCRIPTION
E84.0	Cystic fibrosis with pulmonary manifestations
E84.9	Cystic fibrosis, unspecified
I70.232	Atherosclerosis of native arteries of right leg with ulceration of calf
I70.233	Atherosclerosis of native arteries of right leg with ulceration of ankle
I70.234	Atherosclerosis of native arteries of right leg with ulceration of heel and midfoot
I70.235	Atherosclerosis of native arteries of right leg with ulceration of other part of foot
I70.238	Atherosclerosis of native arteries of right leg with ulceration of other part of lower leg
I70.239	Atherosclerosis of native arteries of right leg with ulceration of unspecified site
I70.242	Atherosclerosis of native arteries of left leg with ulceration of calf
I70.243	Atherosclerosis of native arteries of left leg with ulceration of ankle
I70.244	Atherosclerosis of native arteries of left leg with ulceration of heel and midfoot

ICD-10 CODE	DESCRIPTION
I70.245	Atherosclerosis of native arteries of left leg with ulceration of other part of foot
I70.248	Atherosclerosis of native arteries of left leg with ulceration of other part of lower leg
I70.249	Atherosclerosis of native arteries of left leg with ulceration of unspecified site
I70.332	Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of calf
I70.333	Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of ankle
I70.334	Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of heel and midfoot
I70.335	Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of other part of foot
I70.338	Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of other part of lower leg
I70.339	Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of unspecified site
I70.342	Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of calf
I70.343	Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of ankle
I70.344	Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of heel and midfoot
I70.345	Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of other part of foot
I70.348	Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of other part of lower leg
I70.349	Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of unspecified site
I70.432	Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of calf
I70.433	Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of ankle
I70.434	Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of heel and midfoot
I70.435	Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of other part of foot
I70.438	Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of other part of lower leg

ICD-10 CODE	DESCRIPTION
I70.439	Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of unspecified site
I70.442	Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of calf
I70.443	Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of ankle
I70.444	Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of heel and midfoot
I70.445	Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of other part of foot
I70.448	Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of other part of lower leg
I70.449	Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of unspecified site
I70.532	Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of calf
I70.533	Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of ankle
I70.534	Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of heel and midfoot
I70.535	Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of other part of foot
I70.538	Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of other part of lower leg
I70.539	Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of unspecified site
I70.542	Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of calf
I70.543	Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of ankle
I70.544	Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of heel and midfoot
I70.545	Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of other part of foot
I70.548	Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of other part of lower leg
I70.549	Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with

ICD-10 CODE	DESCRIPTION
	ulceration of unspecified site
I70.632	Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of calf
I70.633	Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of ankle
I70.634	Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of heel and midfoot
I70.635	Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of other part of foot
I70.638	Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of other part of lower leg
I70.639	Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of unspecified site
I70.642	Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of calf
I70.643	Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of ankle
I70.644	Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of heel and midfoot
I70.645	Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of other part of foot
I70.648	Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of other part of lower leg
I70.649	Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of unspecified site
I70.732	Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of calf
I70.733	Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of ankle
I70.734	Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of heel and midfoot
I70.735	Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of other part of foot
I70.738	Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of other part of lower leg
I70.739	Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of unspecified site
I70.742	Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of calf

ICD-10 CODE	DESCRIPTION
I70.743	Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of ankle
I70.744	Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of heel and midfoot
I70.745	Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of other part of foot
I70.748	Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of other part of lower leg
I70.749	Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of unspecified site
I83.001	Varicose veins of unspecified lower extremity with ulcer of thigh
I83.002	Varicose veins of unspecified lower extremity with ulcer of calf
I83.003	Varicose veins of unspecified lower extremity with ulcer of ankle
I83.004	Varicose veins of unspecified lower extremity with ulcer of heel and midfoot
I83.005	Varicose veins of unspecified lower extremity with ulcer other part of foot
I83.008	Varicose veins of unspecified lower extremity with ulcer other part of lower leg
I83.009	Varicose veins of unspecified lower extremity with ulcer of unspecified site
I83.011	Varicose veins of right lower extremity with ulcer of thigh
I83.012	Varicose veins of right lower extremity with ulcer of calf
I83.013	Varicose veins of right lower extremity with ulcer of ankle
I83.014	Varicose veins of right lower extremity with ulcer of heel and midfoot
I83.015	Varicose veins of right lower extremity with ulcer other part of foot
I83.018	Varicose veins of right lower extremity with ulcer other part of lower leg
I83.019	Varicose veins of right lower extremity with ulcer of unspecified site
I83.021	Varicose veins of left lower extremity with ulcer of thigh
I83.022	Varicose veins of left lower extremity with ulcer of calf
I83.023	Varicose veins of left lower extremity with ulcer of ankle
I83.024	Varicose veins of left lower extremity with ulcer of heel and midfoot
I83.025	Varicose veins of left lower extremity with ulcer other part of foot
I83.028	Varicose veins of left lower extremity with ulcer other part of lower leg
I83.029	Varicose veins of left lower extremity with ulcer of unspecified site
I83.201	Varicose veins of unspecified lower extremity with both ulcer of thigh and inflammation

ICD-10 CODE	DESCRIPTION
I83.202	Varicose veins of unspecified lower extremity with both ulcer of calf and inflammation
I83.203	Varicose veins of unspecified lower extremity with both ulcer of ankle and inflammation
I83.204	Varicose veins of unspecified lower extremity with both ulcer of heel and midfoot and inflammation
I83.205	Varicose veins of unspecified lower extremity with both ulcer other part of foot and inflammation
I83.208	Varicose veins of unspecified lower extremity with both ulcer of other part of lower extremity and inflammation
ICD-10 CODE	DESCRIPTION
I83.209	Varicose veins of unspecified lower extremity with both ulcer of unspecified site and inflammation
I83.211	Varicose veins of right lower extremity with both ulcer of thigh and inflammation
I83.212	Varicose veins of right lower extremity with both ulcer of calf and inflammation
I83.213	Varicose veins of right lower extremity with both ulcer of ankle and inflammation
I83.214	Varicose veins of right lower extremity with both ulcer of heel and midfoot and inflammation
I83.215	Varicose veins of right lower extremity with both ulcer other part of foot and inflammation
I83.218	Varicose veins of right lower extremity with both ulcer of other part of lower extremity and inflammation
I83.219	Varicose veins of right lower extremity with both ulcer of unspecified site and inflammation
I83.221	Varicose veins of left lower extremity with both ulcer of thigh and inflammation
I83.222	Varicose veins of left lower extremity with both ulcer of calf and inflammation
I83.223	Varicose veins of left lower extremity with both ulcer of ankle and inflammation
I83.224	Varicose veins of left lower extremity with both ulcer of heel and midfoot and inflammation
I83.225	Varicose veins of left lower extremity with both ulcer other part of foot and inflammation
I83.228	Varicose veins of left lower extremity with both ulcer of other part of lower extremity and inflammation
I83.229	Varicose veins of left lower extremity with both ulcer of unspecified site and inflammation
I87.011	Postthrombotic syndrome with ulcer of right lower extremity

ICD-10 CODE	DESCRIPTION
I87.012	Postthrombotic syndrome with ulcer of left lower extremity
I87.013	Postthrombotic syndrome with ulcer of bilateral lower extremity
I87.019	Postthrombotic syndrome with ulcer of unspecified lower extremity
I87.031	Postthrombotic syndrome with ulcer and inflammation of right lower extremity
I87.032	Postthrombotic syndrome with ulcer and inflammation of left lower extremity
I87.033	Postthrombotic syndrome with ulcer and inflammation of bilateral lower extremity
I87.039	Postthrombotic syndrome with ulcer and inflammation of unspecified lower extremity
I87.311	Chronic venous hypertension (idiopathic) with ulcer of right lower extremity
I87.312	Chronic venous hypertension (idiopathic) with ulcer of left lower extremity
I87.313	Chronic venous hypertension (idiopathic) with ulcer of bilateral lower extremity
I87.319	Chronic venous hypertension (idiopathic) with ulcer of unspecified lower extremity
I87.331	Chronic venous hypertension (idiopathic) with ulcer and inflammation of right lower extremity
I87.332	Chronic venous hypertension (idiopathic) with ulcer and inflammation of left lower extremity
I87.333	Chronic venous hypertension (idiopathic) with ulcer and inflammation of bilateral lower extremity
I87.339	Chronic venous hypertension (idiopathic) with ulcer and inflammation of unspecified lower extremity
J40	Bronchitis, not specified as acute or chronic
J41.0	Simple chronic bronchitis
J41.1	Mucopurulent chronic bronchitis
J41.8	Mixed simple and mucopurulent chronic bronchitis
J42	Unspecified chronic bronchitis
J43.0	Unilateral pulmonary emphysema [MacLeod's syndrome]
J43.1	Panlobular emphysema
J43.2	Centrilobular emphysema
J43.8	Other emphysema
J43.9	Emphysema, unspecified
J44.0	Chronic obstructive pulmonary disease with (acute) lower respiratory infection
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J44.9	Chronic obstructive pulmonary disease, unspecified

ICD-10 CODE	DESCRIPTION
J45.20	Mild intermittent asthma, uncomplicated
J45.21	Mild intermittent asthma with (acute) exacerbation
J45.22	Mild intermittent asthma with status asthmaticus
J45.30	Mild persistent asthma, uncomplicated
J45.31	Mild persistent asthma with (acute) exacerbation
J45.32	Mild persistent asthma with status asthmaticus
J45.40	Moderate persistent asthma, uncomplicated
J45.41	Moderate persistent asthma with (acute) exacerbation
J45.42	Moderate persistent asthma with status asthmaticus
J45.50	Severe persistent asthma, uncomplicated
J45.51	Severe persistent asthma with (acute) exacerbation
J45.52	Severe persistent asthma with status asthmaticus
J45.901	Unspecified asthma with (acute) exacerbation
J45.902	Unspecified asthma with status asthmaticus
J45.909	Unspecified asthma, uncomplicated
J45.990	Exercise induced bronchospasm
J45.991	Cough variant asthma
J45.998	Other asthma
J47.0	Bronchiectasis with acute lower respiratory infection
J47.1	Bronchiectasis with (acute) exacerbation
J47.9	Bronchiectasis, uncomplicated
J60	Coalworker's pneumoconiosis
J61	Pneumoconiosis due to asbestos and other mineral fibers
J62.0	Pneumoconiosis due to talc dust
J62.8	Pneumoconiosis due to other dust containing silica
J63.0	Aluminosis (of lung)
J63.1	Bauxite fibrosis (of lung)
J63.2	Berylliosis
J63.3	Graphite fibrosis (of lung)
J63.4	Siderosis
J63.5	Stannosis
J63.6	Pneumoconiosis due to other specified inorganic dusts

ICD-10 CODE	DESCRIPTION
J64	Unspecified pneumoconiosis
J65	Pneumoconiosis associated with tuberculosis
J66.0	Byssinosis
J66.1	Flax-dressers' disease
J66.2	Cannabinosis
J66.8	Airway disease due to other specific organic dusts
J67.0	Farmer's lung
J67.1	Bagassosis
J67.2	Bird fancier's lung
J67.3	Suberosis
J67.4	Maltworker's lung
J67.5	Mushroom-worker's lung
J67.6	Maple-bark-stripper's lung
J67.7	Air conditioner and humidifier lung
J67.8	Hypersensitivity pneumonitis due to other organic dusts
J67.9	Hypersensitivity pneumonitis due to unspecified organic dust
J81.0	Acute pulmonary edema
J82.81	Chronic eosinophilic pneumonia
J82.82	Acute eosinophilic pneumonia
J82.83	Eosinophilic asthma
J82.89	Other pulmonary eosinophilia, not elsewhere classified
J98.3	Compensatory emphysema
L89.000	Pressure ulcer of unspecified elbow, unstageable
L89.001	Pressure ulcer of unspecified elbow, stage 1
ICD-10 CODE	DESCRIPTION
L89.002	Pressure ulcer of unspecified elbow, stage 2
L89.003	Pressure ulcer of unspecified elbow, stage 3
L89.004	Pressure ulcer of unspecified elbow, stage 4
L89.006	Pressure-induced deep tissue damage of unspecified elbow
L89.009	Pressure ulcer of unspecified elbow, unspecified stage
L89.010	Pressure ulcer of right elbow, unstageable
L89.011	Pressure ulcer of right elbow, stage 1

ICD-10 CODE	DESCRIPTION
L89.012	Pressure ulcer of right elbow, stage 2
L89.013	Pressure ulcer of right elbow, stage 3
L89.014	Pressure ulcer of right elbow, stage 4
L89.016	Pressure-induced deep tissue damage of right elbow
L89.019	Pressure ulcer of right elbow, unspecified stage
L89.020	Pressure ulcer of left elbow, unstageable
L89.021	Pressure ulcer of left elbow, stage 1
L89.022	Pressure ulcer of left elbow, stage 2
L89.023	Pressure ulcer of left elbow, stage 3
L89.024	Pressure ulcer of left elbow, stage 4
L89.026	Pressure-induced deep tissue damage of left elbow
L89.029	Pressure ulcer of left elbow, unspecified stage
L89.100	Pressure ulcer of unspecified part of back, unstageable
L89.101	Pressure ulcer of unspecified part of back, stage 1
L89.102	Pressure ulcer of unspecified part of back, stage 2
L89.103	Pressure ulcer of unspecified part of back, stage 3
L89.104	Pressure ulcer of unspecified part of back, stage 4
L89.106	Pressure-induced deep tissue damage of unspecified part of back
L89.109	Pressure ulcer of unspecified part of back, unspecified stage
L89.110	Pressure ulcer of right upper back, unstageable
L89.111	Pressure ulcer of right upper back, stage 1
L89.112	Pressure ulcer of right upper back, stage 2
L89.113	Pressure ulcer of right upper back, stage 3
L89.114	Pressure ulcer of right upper back, stage 4
L89.116	Pressure-induced deep tissue damage of right upper back
L89.119	Pressure ulcer of right upper back, unspecified stage
L89.120	Pressure ulcer of left upper back, unstageable
L89.121	Pressure ulcer of left upper back, stage 1
L89.122	Pressure ulcer of left upper back, stage 2
L89.123	Pressure ulcer of left upper back, stage 3
L89.124	Pressure ulcer of left upper back, stage 4
L89.126	Pressure-induced deep tissue damage of left upper back

ICD-10 CODE	DESCRIPTION
L89.129	Pressure ulcer of left upper back, unspecified stage
L89.130	Pressure ulcer of right lower back, unstageable
L89.131	Pressure ulcer of right lower back, stage 1
L89.132	Pressure ulcer of right lower back, stage 2
L89.133	Pressure ulcer of right lower back, stage 3
L89.134	Pressure ulcer of right lower back, stage 4
L89.136	Pressure-induced deep tissue damage of right lower back
L89.139	Pressure ulcer of right lower back, unspecified stage
L89.140	Pressure ulcer of left lower back, unstageable
L89.141	Pressure ulcer of left lower back, stage 1
L89.142	Pressure ulcer of left lower back, stage 2
L89.143	Pressure ulcer of left lower back, stage 3
L89.144	Pressure ulcer of left lower back, stage 4
L89.146	Pressure-induced deep tissue damage of left lower back
L89.149	Pressure ulcer of left lower back, unspecified stage
L89.150	Pressure ulcer of sacral region, unstageable
L89.151	Pressure ulcer of sacral region, stage 1
L89.152	Pressure ulcer of sacral region, stage 2
L89.153	Pressure ulcer of sacral region, stage 3
L89.154	Pressure ulcer of sacral region, stage 4
L89.156	Pressure-induced deep tissue damage of sacral region
L89.159	Pressure ulcer of sacral region, unspecified stage
L89.200	Pressure ulcer of unspecified hip, unstageable
L89.201	Pressure ulcer of unspecified hip, stage 1
L89.202	Pressure ulcer of unspecified hip, stage 2
L89.203	Pressure ulcer of unspecified hip, stage 3
L89.204	Pressure ulcer of unspecified hip, stage 4
L89.206	Pressure-induced deep tissue damage of unspecified hip
L89.209	Pressure ulcer of unspecified hip, unspecified stage
L89.210	Pressure ulcer of right hip, unstageable
L89.211	Pressure ulcer of right hip, stage 1
L89.212	Pressure ulcer of right hip, stage 2

ICD-10 CODE	DESCRIPTION
L89.213	Pressure ulcer of right hip, stage 3
L89.214	Pressure ulcer of right hip, stage 4
L89.216	Pressure-induced deep tissue damage of right hip
L89.219	Pressure ulcer of right hip, unspecified stage
L89.220	Pressure ulcer of left hip, unstageable
L89.221	Pressure ulcer of left hip, stage 1
L89.222	Pressure ulcer of left hip, stage 2
L89.223	Pressure ulcer of left hip, stage 3
L89.224	Pressure ulcer of left hip, stage 4
L89.226	Pressure-induced deep tissue damage of left hip
L89.229	Pressure ulcer of left hip, unspecified stage
L89.300	Pressure ulcer of unspecified buttock, unstageable
L89.301	Pressure ulcer of unspecified buttock, stage 1
L89.302	Pressure ulcer of unspecified buttock, stage 2
L89.303	Pressure ulcer of unspecified buttock, stage 3
L89.304	Pressure ulcer of unspecified buttock, stage 4
L89.306	Pressure-induced deep tissue damage of unspecified buttock
L89.309	Pressure ulcer of unspecified buttock, unspecified stage
L89.310	Pressure ulcer of right buttock, unstageable
L89.311	Pressure ulcer of right buttock, stage 1
L89.312	Pressure ulcer of right buttock, stage 2
L89.313	Pressure ulcer of right buttock, stage 3
L89.314	Pressure ulcer of right buttock, stage 4
L89.316	Pressure-induced deep tissue damage of right buttock
L89.319	Pressure ulcer of right buttock, unspecified stage
L89.320	Pressure ulcer of left buttock, unstageable
L89.321	Pressure ulcer of left buttock, stage 1
L89.322	Pressure ulcer of left buttock, stage 2
L89.323	Pressure ulcer of left buttock, stage 3
ICD-10 CODE	DESCRIPTION
L89.324	Pressure ulcer of left buttock, stage 4
L89.326	Pressure-induced deep tissue damage of left buttock

ICD-10 CODE	DESCRIPTION
L89.329	Pressure ulcer of left buttock, unspecified stage
L89.40	Pressure ulcer of contiguous site of back, buttock and hip, unspecified stage
L89.41	Pressure ulcer of contiguous site of back, buttock and hip, stage 1
L89.42	Pressure ulcer of contiguous site of back, buttock and hip, stage 2
L89.43	Pressure ulcer of contiguous site of back, buttock and hip, stage 3
L89.44	Pressure ulcer of contiguous site of back, buttock and hip, stage 4
L89.45	Pressure ulcer of contiguous site of back, buttock and hip, unstageable
L89.46	Pressure-induced deep tissue damage of contiguous site of back, buttock and hip
L89.500	Pressure ulcer of unspecified ankle, unstageable
L89.501	Pressure ulcer of unspecified ankle, stage 1
L89.502	Pressure ulcer of unspecified ankle, stage 2
L89.503	Pressure ulcer of unspecified ankle, stage 3
L89.504	Pressure ulcer of unspecified ankle, stage 4
L89.506	Pressure-induced deep tissue damage of unspecified ankle
L89.509	Pressure ulcer of unspecified ankle, unspecified stage
L89.510	Pressure ulcer of right ankle, unstageable
L89.511	Pressure ulcer of right ankle, stage 1
L89.512	Pressure ulcer of right ankle, stage 2
L89.513	Pressure ulcer of right ankle, stage 3
L89.514	Pressure ulcer of right ankle, stage 4
L89.516	Pressure-induced deep tissue damage of right ankle
L89.519	Pressure ulcer of right ankle, unspecified stage
L89.520	Pressure ulcer of left ankle, unstageable
L89.521	Pressure ulcer of left ankle, stage 1
L89.522	Pressure ulcer of left ankle, stage 2
L89.523	Pressure ulcer of left ankle, stage 3
L89.524	Pressure ulcer of left ankle, stage 4
L89.526	Pressure-induced deep tissue damage of left ankle
L89.529	Pressure ulcer of left ankle, unspecified stage
L89.600	Pressure ulcer of unspecified heel, unstageable
L89.601	Pressure ulcer of unspecified heel, stage 1
L89.602	Pressure ulcer of unspecified heel, stage 2

ICD-10 CODE	DESCRIPTION
L89.603	Pressure ulcer of unspecified heel, stage 3
L89.604	Pressure ulcer of unspecified heel, stage 4
L89.606	Pressure-induced deep tissue damage of unspecified heel
L89.609	Pressure ulcer of unspecified heel, unspecified stage
L89.610	Pressure ulcer of right heel, unstageable
L89.611	Pressure ulcer of right heel, stage 1
L89.612	Pressure ulcer of right heel, stage 2
L89.613	Pressure ulcer of right heel, stage 3
L89.614	Pressure ulcer of right heel, stage 4
L89.616	Pressure-induced deep tissue damage of right heel
L89.619	Pressure ulcer of right heel, unspecified stage
L89.620	Pressure ulcer of left heel, unstageable
L89.621	Pressure ulcer of left heel, stage 1
L89.622	Pressure ulcer of left heel, stage 2
L89.623	Pressure ulcer of left heel, stage 3
L89.624	Pressure ulcer of left heel, stage 4
L89.626	Pressure-induced deep tissue damage of left heel
L89.629	Pressure ulcer of left heel, unspecified stage
L89.810	Pressure ulcer of head, unstageable
L89.811	Pressure ulcer of head, stage 1
L89.812	Pressure ulcer of head, stage 2
L89.813	Pressure ulcer of head, stage 3
L89.814	Pressure ulcer of head, stage 4
L89.816	Pressure-induced deep tissue damage of head
L89.819	Pressure ulcer of head, unspecified stage
L89.890	Pressure ulcer of other site, unstageable
L89.891	Pressure ulcer of other site, stage 1
L89.892	Pressure ulcer of other site, stage 2
L89.893	Pressure ulcer of other site, stage 3
L89.894	Pressure ulcer of other site, stage 4
L89.896	Pressure-induced deep tissue damage of other site
L89.899	Pressure ulcer of other site, unspecified stage

ICD-10 CODE	DESCRIPTION
L89.90	Pressure ulcer of unspecified site, unspecified stage
L89.91	Pressure ulcer of unspecified site, stage 1
L89.92	Pressure ulcer of unspecified site, stage 2
L89.93	Pressure ulcer of unspecified site, stage 3
L89.94	Pressure ulcer of unspecified site, stage 4
L89.95	Pressure ulcer of unspecified site, unstageable
L89.96	Pressure-induced deep tissue damage of unspecified site
L97.105	Non-pressure chronic ulcer of unspecified thigh with muscle involvement without evidence of necrosis
L97.106	Non-pressure chronic ulcer of unspecified thigh with bone involvement without evidence of necrosis
L97.108	Non-pressure chronic ulcer of unspecified thigh with other specified severity
L97.115	Non-pressure chronic ulcer of right thigh with muscle involvement without evidence of necrosis
L97.116	Non-pressure chronic ulcer of right thigh with bone involvement without evidence of necrosis
L97.118	Non-pressure chronic ulcer of right thigh with other specified severity
L97.125	Non-pressure chronic ulcer of left thigh with muscle involvement without evidence of necrosis
L97.126	Non-pressure chronic ulcer of left thigh with bone involvement without evidence of necrosis
L97.128	Non-pressure chronic ulcer of left thigh with other specified severity
L97.201	Non-pressure chronic ulcer of unspecified calf limited to breakdown of skin
L97.202	Non-pressure chronic ulcer of unspecified calf with fat layer exposed
L97.203	Non-pressure chronic ulcer of unspecified calf with necrosis of muscle
L97.204	Non-pressure chronic ulcer of unspecified calf with necrosis of bone
L97.205	Non-pressure chronic ulcer of unspecified calf with muscle involvement without evidence of necrosis
L97.206	Non-pressure chronic ulcer of unspecified calf with bone involvement without evidence of necrosis
L97.208	Non-pressure chronic ulcer of unspecified calf with other specified severity
L97.209	Non-pressure chronic ulcer of unspecified calf with unspecified severity
L97.211	Non-pressure chronic ulcer of right calf limited to breakdown of skin
L97.212	Non-pressure chronic ulcer of right calf with fat layer exposed

ICD-10 CODE	DESCRIPTION
L97.213	Non-pressure chronic ulcer of right calf with necrosis of muscle
L97.214	Non-pressure chronic ulcer of right calf with necrosis of bone
L97.215	Non-pressure chronic ulcer of right calf with muscle involvement without evidence of necrosis
L97.216	Non-pressure chronic ulcer of right calf with bone involvement without evidence of necrosis
L97.218	Non-pressure chronic ulcer of right calf with other specified severity
L97.219	Non-pressure chronic ulcer of right calf with unspecified severity
L97.221	Non-pressure chronic ulcer of left calf limited to breakdown of skin
L97.222	Non-pressure chronic ulcer of left calf with fat layer exposed
ICD-10 CODE	DESCRIPTION
L97.223	Non-pressure chronic ulcer of left calf with necrosis of muscle
L97.224	Non-pressure chronic ulcer of left calf with necrosis of bone
L97.225	Non-pressure chronic ulcer of left calf with muscle involvement without evidence of necrosis
L97.226	Non-pressure chronic ulcer of left calf with bone involvement without evidence of necrosis
L97.228	Non-pressure chronic ulcer of left calf with other specified severity
L97.229	Non-pressure chronic ulcer of left calf with unspecified severity
L97.301	Non-pressure chronic ulcer of unspecified ankle limited to breakdown of skin
L97.302	Non-pressure chronic ulcer of unspecified ankle with fat layer exposed
L97.303	Non-pressure chronic ulcer of unspecified ankle with necrosis of muscle
L97.304	Non-pressure chronic ulcer of unspecified ankle with necrosis of bone
L97.305	Non-pressure chronic ulcer of unspecified ankle with muscle involvement without evidence of necrosis
L97.306	Non-pressure chronic ulcer of unspecified ankle with bone involvement without evidence of necrosis
L97.308	Non-pressure chronic ulcer of unspecified ankle with other specified severity
L97.309	Non-pressure chronic ulcer of unspecified ankle with unspecified severity
L97.311	Non-pressure chronic ulcer of right ankle limited to breakdown of skin
L97.312	Non-pressure chronic ulcer of right ankle with fat layer exposed
L97.313	Non-pressure chronic ulcer of right ankle with necrosis of muscle
L97.314	Non-pressure chronic ulcer of right ankle with necrosis of bone

ICD-10 CODE	DESCRIPTION
L97.315	Non-pressure chronic ulcer of right ankle with muscle involvement without evidence of necrosis
L97.316	Non-pressure chronic ulcer of right ankle with bone involvement without evidence of necrosis
L97.318	Non-pressure chronic ulcer of right ankle with other specified severity
L97.319	Non-pressure chronic ulcer of right ankle with unspecified severity
L97.321	Non-pressure chronic ulcer of left ankle limited to breakdown of skin
L97.322	Non-pressure chronic ulcer of left ankle with fat layer exposed
L97.323	Non-pressure chronic ulcer of left ankle with necrosis of muscle
L97.324	Non-pressure chronic ulcer of left ankle with necrosis of bone
L97.325	Non-pressure chronic ulcer of left ankle with muscle involvement without evidence of necrosis
L97.326	Non-pressure chronic ulcer of left ankle with bone involvement without evidence of necrosis
L97.328	Non-pressure chronic ulcer of left ankle with other specified severity
L97.329	Non-pressure chronic ulcer of left ankle with unspecified severity
L97.401	Non-pressure chronic ulcer of unspecified heel and midfoot limited to breakdown of skin
L97.402	Non-pressure chronic ulcer of unspecified heel and midfoot with fat layer exposed
L97.403	Non-pressure chronic ulcer of unspecified heel and midfoot with necrosis of muscle
L97.404	Non-pressure chronic ulcer of unspecified heel and midfoot with necrosis of bone
L97.405	Non-pressure chronic ulcer of unspecified heel and midfoot with muscle involvement without evidence of necrosis
L97.406	Non-pressure chronic ulcer of unspecified heel and midfoot with bone involvement without evidence of necrosis
L97.408	Non-pressure chronic ulcer of unspecified heel and midfoot with other specified severity
L97.409	Non-pressure chronic ulcer of unspecified heel and midfoot with unspecified severity
L97.411	Non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin
L97.412	Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed
L97.413	Non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle
L97.414	Non-pressure chronic ulcer of right heel and midfoot with necrosis of bone
L97.415	Non-pressure chronic ulcer of right heel and midfoot with muscle involvement without evidence of necrosis

ICD-10 CODE	DESCRIPTION
L97.416	Non-pressure chronic ulcer of right heel and midfoot with bone involvement without evidence of necrosis
L97.418	Non-pressure chronic ulcer of right heel and midfoot with other specified severity
L97.419	Non-pressure chronic ulcer of right heel and midfoot with unspecified severity
L97.421	Non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin
L97.422	Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed
L97.423	Non-pressure chronic ulcer of left heel and midfoot with necrosis of muscle
L97.424	Non-pressure chronic ulcer of left heel and midfoot with necrosis of bone
L97.425	Non-pressure chronic ulcer of left heel and midfoot with muscle involvement without evidence of necrosis
L97.426	Non-pressure chronic ulcer of left heel and midfoot with bone involvement without evidence of necrosis
L97.428	Non-pressure chronic ulcer of left heel and midfoot with other specified severity
L97.429	Non-pressure chronic ulcer of left heel and midfoot with unspecified severity
L97.501	Non-pressure chronic ulcer of other part of unspecified foot limited to breakdown of skin
L97.502	Non-pressure chronic ulcer of other part of unspecified foot with fat layer exposed
L97.503	Non-pressure chronic ulcer of other part of unspecified foot with necrosis of muscle
L97.504	Non-pressure chronic ulcer of other part of unspecified foot with necrosis of bone
L97.505	Non-pressure chronic ulcer of other part of unspecified foot with muscle involvement without evidence of necrosis
L97.506	Non-pressure chronic ulcer of other part of unspecified foot with bone involvement without evidence of necrosis
L97.508	Non-pressure chronic ulcer of other part of unspecified foot with other specified severity
L97.509	Non-pressure chronic ulcer of other part of unspecified foot with unspecified severity
L97.511	Non-pressure chronic ulcer of other part of right foot limited to breakdown of skin
L97.512	Non-pressure chronic ulcer of other part of right foot with fat layer exposed
L97.513	Non-pressure chronic ulcer of other part of right foot with necrosis of muscle
L97.514	Non-pressure chronic ulcer of other part of right foot with necrosis of bone
L97.515	Non-pressure chronic ulcer of other part of right foot with muscle involvement without evidence of necrosis
L97.516	Non-pressure chronic ulcer of other part of right foot with bone involvement without evidence of necrosis

ICD-10 CODE	DESCRIPTION
L97.518	Non-pressure chronic ulcer of other part of right foot with other specified severity
L97.519	Non-pressure chronic ulcer of other part of right foot with unspecified severity
L97.521	Non-pressure chronic ulcer of other part of left foot limited to breakdown of skin
L97.522	Non-pressure chronic ulcer of other part of left foot with fat layer exposed
L97.523	Non-pressure chronic ulcer of other part of left foot with necrosis of muscle
L97.524	Non-pressure chronic ulcer of other part of left foot with necrosis of bone
L97.525	Non-pressure chronic ulcer of other part of left foot with muscle involvement without evidence of necrosis
L97.526	Non-pressure chronic ulcer of other part of left foot with bone involvement without evidence of necrosis
L97.528	Non-pressure chronic ulcer of other part of left foot with other specified severity
L97.529	Non-pressure chronic ulcer of other part of left foot with unspecified severity
L97.801	Non-pressure chronic ulcer of other part of unspecified lower leg limited to breakdown of skin
L97.802	Non-pressure chronic ulcer of other part of unspecified lower leg with fat layer exposed
L97.803	Non-pressure chronic ulcer of other part of unspecified lower leg with necrosis of muscle
L97.804	Non-pressure chronic ulcer of other part of unspecified lower leg with necrosis of bone
L97.805	Non-pressure chronic ulcer of other part of unspecified lower leg with muscle involvement without evidence of necrosis
L97.806	Non-pressure chronic ulcer of other part of unspecified lower leg with bone involvement without evidence of necrosis
L97.808	Non-pressure chronic ulcer of other part of unspecified lower leg with other specified severity
L97.809	Non-pressure chronic ulcer of other part of unspecified lower leg with unspecified severity
L97.811	Non-pressure chronic ulcer of other part of right lower leg limited to breakdown of skin
L97.812	Non-pressure chronic ulcer of other part of right lower leg with fat layer exposed
L97.813	Non-pressure chronic ulcer of other part of right lower leg with necrosis of muscle
L97.814	Non-pressure chronic ulcer of other part of right lower leg with necrosis of bone
L97.815	Non-pressure chronic ulcer of other part of right lower leg with muscle involvement without evidence of necrosis

ICD-10 CODE	DESCRIPTION
L97.816	Non-pressure chronic ulcer of other part of right lower leg with bone involvement without evidence of necrosis
L97.818	Non-pressure chronic ulcer of other part of right lower leg with other specified severity
L97.819	Non-pressure chronic ulcer of other part of right lower leg with unspecified severity
L97.821	Non-pressure chronic ulcer of other part of left lower leg limited to breakdown of skin
L97.822	Non-pressure chronic ulcer of other part of left lower leg with fat layer exposed
L97.823	Non-pressure chronic ulcer of other part of left lower leg with necrosis of muscle
L97.824	Non-pressure chronic ulcer of other part of left lower leg with necrosis of bone
L97.825	Non-pressure chronic ulcer of other part of left lower leg with muscle involvement without evidence of necrosis
L97.826	Non-pressure chronic ulcer of other part of left lower leg with bone involvement without evidence of necrosis
ICD-10 CODE	DESCRIPTION
L97.828	Non-pressure chronic ulcer of other part of left lower leg with other specified severity
L97.829	Non-pressure chronic ulcer of other part of left lower leg with unspecified severity
L97.905	Non-pressure chronic ulcer of unspecified part of unspecified lower leg with muscle involvement without evidence of necrosis
L97.906	Non-pressure chronic ulcer of unspecified part of unspecified lower leg with bone involvement without evidence of necrosis
L97.908	Non-pressure chronic ulcer of unspecified part of unspecified lower leg with other specified severity
L97.915	Non-pressure chronic ulcer of unspecified part of right lower leg with muscle involvement without evidence of necrosis
L97.916	Non-pressure chronic ulcer of unspecified part of right lower leg with bone involvement without evidence of necrosis
L97.918	Non-pressure chronic ulcer of unspecified part of right lower leg with other specified severity
L97.925	Non-pressure chronic ulcer of unspecified part of left lower leg with muscle involvement without evidence of necrosis
L97.926	Non-pressure chronic ulcer of unspecified part of left lower leg with bone involvement without evidence of necrosis
L97.928	Non-pressure chronic ulcer of unspecified part of left lower leg with other specified severity

ICD-10 CODE	DESCRIPTION
L98.415	Non-pressure chronic ulcer of buttock with muscle involvement without evidence of necrosis
L98.416	Non-pressure chronic ulcer of buttock with bone involvement without evidence of necrosis
L98.418	Non-pressure chronic ulcer of buttock with other specified severity
L98.425	Non-pressure chronic ulcer of back with muscle involvement without evidence of necrosis
L98.426	Non-pressure chronic ulcer of back with bone involvement without evidence of necrosis
L98.428	Non-pressure chronic ulcer of back with other specified severity
L98.495	Non-pressure chronic ulcer of skin of other sites with muscle involvement without evidence of necrosis
L98.496	Non-pressure chronic ulcer of skin of other sites with bone involvement without evidence of necrosis
L98.498	Non-pressure chronic ulcer of skin of other sites with other specified severity
S31.020A	Laceration with foreign body of lower back and pelvis without penetration into retroperitoneum, initial encounter
S31.020D	Laceration with foreign body of lower back and pelvis without penetration into retroperitoneum, subsequent encounter
S31.020S	Laceration with foreign body of lower back and pelvis without penetration into retroperitoneum, sequela
S31.040A	Puncture wound with foreign body of lower back and pelvis without penetration into retroperitoneum, initial encounter
S31.040D	Puncture wound with foreign body of lower back and pelvis without penetration into retroperitoneum, subsequent encounter
S31.040S	Puncture wound with foreign body of lower back and pelvis without penetration into retroperitoneum, sequela
S31.832A	Laceration with foreign body of anus, initial encounter
S31.832D	Laceration with foreign body of anus, subsequent encounter
S31.832S	Laceration with foreign body of anus, sequela
S31.834A	Puncture wound with foreign body of anus, initial encounter
S31.834D	Puncture wound with foreign body of anus, subsequent encounter
S31.834S	Puncture wound with foreign body of anus, sequela
S71.001A	Unspecified open wound, right hip, initial encounter
S71.001D	Unspecified open wound, right hip, subsequent encounter

ICD-10 CODE	DESCRIPTION
S71.001S	Unspecified open wound, right hip, sequela
S71.002A	Unspecified open wound, left hip, initial encounter
S71.002D	Unspecified open wound, left hip, subsequent encounter
S71.002S	Unspecified open wound, left hip, sequela
S71.009A	Unspecified open wound, unspecified hip, initial encounter
S71.009D	Unspecified open wound, unspecified hip, subsequent encounter
S71.009S	Unspecified open wound, unspecified hip, sequela
S71.011A	Laceration without foreign body, right hip, initial encounter
S71.011D	Laceration without foreign body, right hip, subsequent encounter
S71.011S	Laceration without foreign body, right hip, sequela
S71.012A	Laceration without foreign body, left hip, initial encounter
S71.012D	Laceration without foreign body, left hip, subsequent encounter
S71.012S	Laceration without foreign body, left hip, sequela
S71.019A	Laceration without foreign body, unspecified hip, initial encounter
S71.019D	Laceration without foreign body, unspecified hip, subsequent encounter
S71.019S	Laceration without foreign body, unspecified hip, sequela
S71.031A	Puncture wound without foreign body, right hip, initial encounter
S71.031D	Puncture wound without foreign body, right hip, subsequent encounter
S71.031S	Puncture wound without foreign body, right hip, sequela
S71.032A	Puncture wound without foreign body, left hip, initial encounter
S71.032D	Puncture wound without foreign body, left hip, subsequent encounter
S71.032S	Puncture wound without foreign body, left hip, sequela
S71.039A	Puncture wound without foreign body, unspecified hip, initial encounter
S71.039D	Puncture wound without foreign body, unspecified hip, subsequent encounter
S71.039S	Puncture wound without foreign body, unspecified hip, sequela
S71.051A	Open bite, right hip, initial encounter
S71.051D	Open bite, right hip, subsequent encounter
S71.051S	Open bite, right hip, sequela
S71.052A	Open bite, left hip, initial encounter
S71.052D	Open bite, left hip, subsequent encounter
S71.052S	Open bite, left hip, sequela
S71.059A	Open bite, unspecified hip, initial encounter

ICD-10 CODE	DESCRIPTION
S71.059D	Open bite, unspecified hip, subsequent encounter
S71.059S	Open bite, unspecified hip, sequela
S71.101A	Unspecified open wound, right thigh, initial encounter
S71.101D	Unspecified open wound, right thigh, subsequent encounter
S71.101S	Unspecified open wound, right thigh, sequela
S71.102A	Unspecified open wound, left thigh, initial encounter
S71.102D	Unspecified open wound, left thigh, subsequent encounter
S71.102S	Unspecified open wound, left thigh, sequela
S71.109A	Unspecified open wound, unspecified thigh, initial encounter
S71.109D	Unspecified open wound, unspecified thigh, subsequent encounter
S71.109S	Unspecified open wound, unspecified thigh, sequela
S71.111A	Laceration without foreign body, right thigh, initial encounter
S71.111D	Laceration without foreign body, right thigh, subsequent encounter
S71.111S	Laceration without foreign body, right thigh, sequela
S71.112A	Laceration without foreign body, left thigh, initial encounter
S71.112D	Laceration without foreign body, left thigh, subsequent encounter
S71.112S	Laceration without foreign body, left thigh, sequela
S71.119A	Laceration without foreign body, unspecified thigh, initial encounter
S71.119D	Laceration without foreign body, unspecified thigh, subsequent encounter
S71.119S	Laceration without foreign body, unspecified thigh, sequela
S71.131A	Puncture wound without foreign body, right thigh, initial encounter
S71.131D	Puncture wound without foreign body, right thigh, subsequent encounter
S71.131S	Puncture wound without foreign body, right thigh, sequela
S71.132A	Puncture wound without foreign body, left thigh, initial encounter
S71.132D	Puncture wound without foreign body, left thigh, subsequent encounter
S71.132S	Puncture wound without foreign body, left thigh, sequela
S71.139A	Puncture wound without foreign body, unspecified thigh, initial encounter
S71.139D	Puncture wound without foreign body, unspecified thigh, subsequent encounter
S71.139S	Puncture wound without foreign body, unspecified thigh, sequela
S71.151A	Open bite, right thigh, initial encounter
S71.151D	Open bite, right thigh, subsequent encounter
S71.151S	Open bite, right thigh, sequela

ICD-10 CODE	DESCRIPTION
S71.152A	Open bite, left thigh, initial encounter
S71.152D	Open bite, left thigh, subsequent encounter
ICD-10 CODE	DESCRIPTION
S71.152S	Open bite, left thigh, sequela
S71.159A	Open bite, unspecified thigh, initial encounter
S71.159D	Open bite, unspecified thigh, subsequent encounter
S71.159S	Open bite, unspecified thigh, sequela
T20.20XA	Burn of second degree of head, face, and neck, unspecified site, initial encounter
T20.20XD	Burn of second degree of head, face, and neck, unspecified site, subsequent encounter
T20.20XS	Burn of second degree of head, face, and neck, unspecified site, sequela
T20.211A	Burn of second degree of right ear [any part, except ear drum], initial encounter
T20.211D	Burn of second degree of right ear [any part, except ear drum], subsequent encounter
T20.211S	Burn of second degree of right ear [any part, except ear drum], sequela
T20.212A	Burn of second degree of left ear [any part, except ear drum], initial encounter
T20.212D	Burn of second degree of left ear [any part, except ear drum], subsequent encounter
T20.212S	Burn of second degree of left ear [any part, except ear drum], sequela
T20.219A	Burn of second degree of unspecified ear [any part, except ear drum], initial encounter
T20.219D	Burn of second degree of unspecified ear [any part, except ear drum], subsequent encounter
T20.219S	Burn of second degree of unspecified ear [any part, except ear drum], sequela
T20.23XA	Burn of second degree of chin, initial encounter
T20.23XD	Burn of second degree of chin, subsequent encounter
T20.23XS	Burn of second degree of chin, sequela
T20.24XA	Burn of second degree of nose (septum), initial encounter
T20.24XD	Burn of second degree of nose (septum), subsequent encounter
T20.24XS	Burn of second degree of nose (septum), sequela
T20.25XA	Burn of second degree of scalp [any part], initial encounter
T20.25XD	Burn of second degree of scalp [any part], subsequent encounter
T20.25XS	Burn of second degree of scalp [any part], sequela

ICD-10 CODE	DESCRIPTION
T20.26XA	Burn of second degree of forehead and cheek, initial encounter
T20.26XD	Burn of second degree of forehead and cheek, subsequent encounter
T20.26XS	Burn of second degree of forehead and cheek, sequela
T20.27XA	Burn of second degree of neck, initial encounter
T20.27XD	Burn of second degree of neck, subsequent encounter
T20.27XS	Burn of second degree of neck, sequela
T20.29XA	Burn of second degree of multiple sites of head, face, and neck, initial encounter
T20.29XD	Burn of second degree of multiple sites of head, face, and neck, subsequent encounter
T20.29XS	Burn of second degree of multiple sites of head, face, and neck, sequela
T20.60XA	Corrosion of second degree of head, face, and neck, unspecified site, initial encounter
T20.60XD	Corrosion of second degree of head, face, and neck, unspecified site, subsequent encounter
T20.60XS	Corrosion of second degree of head, face, and neck, unspecified site, sequela
T20.611A	Corrosion of second degree of right ear [any part, except ear drum], initial encounter
T20.611D	Corrosion of second degree of right ear [any part, except ear drum], subsequent encounter
T20.611S	Corrosion of second degree of right ear [any part, except ear drum], sequela
T20.612A	Corrosion of second degree of left ear [any part, except ear drum], initial encounter
T20.612D	Corrosion of second degree of left ear [any part, except ear drum], subsequent encounter
T20.612S	Corrosion of second degree of left ear [any part, except ear drum], sequela
T20.619A	Corrosion of second degree of unspecified ear [any part, except ear drum], initial encounter
T20.619D	Corrosion of second degree of unspecified ear [any part, except ear drum], subsequent encounter
T20.619S	Corrosion of second degree of unspecified ear [any part, except ear drum], sequela
T20.63XA	Corrosion of second degree of chin, initial encounter
T20.63XD	Corrosion of second degree of chin, subsequent encounter
T20.63XS	Corrosion of second degree of chin, sequela
T20.64XA	Corrosion of second degree of nose (septum), initial encounter
T20.64XD	Corrosion of second degree of nose (septum), subsequent encounter

ICD-10 CODE	DESCRIPTION
T20.64XS	Corrosion of second degree of nose (septum), sequela
T20.65XA	Corrosion of second degree of scalp [any part], initial encounter
T20.65XD	Corrosion of second degree of scalp [any part], subsequent encounter
T20.65XS	Corrosion of second degree of scalp [any part], sequela
T20.66XA	Corrosion of second degree of forehead and cheek, initial encounter
T20.66XD	Corrosion of second degree of forehead and cheek, subsequent encounter
T20.66XS	Corrosion of second degree of forehead and cheek, sequela
T20.67XA	Corrosion of second degree of neck, initial encounter
T20.67XD	Corrosion of second degree of neck, subsequent encounter
T20.67XS	Corrosion of second degree of neck, sequela
T20.69XA	Corrosion of second degree of multiple sites of head, face, and neck, initial encounter
T20.69XD	Corrosion of second degree of multiple sites of head, face, and neck, subsequent encounter
T20.69XS	Corrosion of second degree of multiple sites of head, face, and neck, sequela
T21.20XA	Burn of second degree of trunk, unspecified site, initial encounter
T21.20XD	Burn of second degree of trunk, unspecified site, subsequent encounter
T21.20XS	Burn of second degree of trunk, unspecified site, sequela
T21.21XA	Burn of second degree of chest wall, initial encounter
T21.21XD	Burn of second degree of chest wall, subsequent encounter
T21.21XS	Burn of second degree of chest wall, sequela
T21.22XA	Burn of second degree of abdominal wall, initial encounter
T21.22XD	Burn of second degree of abdominal wall, subsequent encounter
T21.22XS	Burn of second degree of abdominal wall, sequela
T21.23XA	Burn of second degree of upper back, initial encounter
T21.23XD	Burn of second degree of upper back, subsequent encounter
T21.23XS	Burn of second degree of upper back, sequela
T21.24XA	Burn of second degree of lower back, initial encounter
T21.24XD	Burn of second degree of lower back, subsequent encounter
T21.24XS	Burn of second degree of lower back, sequela
T21.25XA	Burn of second degree of buttock, initial encounter
T21.25XD	Burn of second degree of buttock, subsequent encounter

ICD-10 CODE	DESCRIPTION
T21.25XS	Burn of second degree of buttock, sequela
T21.26XA	Burn of second degree of male genital region, initial encounter
T21.26XD	Burn of second degree of male genital region, subsequent encounter
T21.26XS	Burn of second degree of male genital region, sequela
T21.27XA	Burn of second degree of female genital region, initial encounter
T21.27XD	Burn of second degree of female genital region, subsequent encounter
T21.27XS	Burn of second degree of female genital region, sequela
T21.29XA	Burn of second degree of other site of trunk, initial encounter
T21.29XD	Burn of second degree of other site of trunk, subsequent encounter
T21.29XS	Burn of second degree of other site of trunk, sequela
T21.60XA	Corrosion of second degree of trunk, unspecified site, initial encounter
T21.60XD	Corrosion of second degree of trunk, unspecified site, subsequent encounter
T21.60XS	Corrosion of second degree of trunk, unspecified site, sequela
T21.61XA	Corrosion of second degree of chest wall, initial encounter
T21.61XD	Corrosion of second degree of chest wall, subsequent encounter
T21.61XS	Corrosion of second degree of chest wall, sequela
T21.62XA	Corrosion of second degree of abdominal wall, initial encounter
T21.62XD	Corrosion of second degree of abdominal wall, subsequent encounter
T21.62XS	Corrosion of second degree of abdominal wall, sequela
ICD-10 CODE	DESCRIPTION
T21.63XA	Corrosion of second degree of upper back, initial encounter
T21.63XD	Corrosion of second degree of upper back, subsequent encounter
T21.63XS	Corrosion of second degree of upper back, sequela
T21.64XA	Corrosion of second degree of lower back, initial encounter
T21.64XD	Corrosion of second degree of lower back, subsequent encounter
T21.64XS	Corrosion of second degree of lower back, sequela
T21.65XA	Corrosion of second degree of buttock, initial encounter
T21.65XD	Corrosion of second degree of buttock, subsequent encounter
T21.65XS	Corrosion of second degree of buttock, sequela
T21.66XA	Corrosion of second degree of male genital region, initial encounter
T21.66XD	Corrosion of second degree of male genital region, subsequent encounter
T21.66XS	Corrosion of second degree of male genital region, sequela

ICD-10 CODE	DESCRIPTION
T21.67XA	Corrosion of second degree of female genital region, initial encounter
T21.67XD	Corrosion of second degree of female genital region, subsequent encounter
T21.67XS	Corrosion of second degree of female genital region, sequela
T21.69XA	Corrosion of second degree of other site of trunk, initial encounter
T21.69XD	Corrosion of second degree of other site of trunk, subsequent encounter
T21.69XS	Corrosion of second degree of other site of trunk, sequela
T22.20XA	Burn of second degree of shoulder and upper limb, except wrist and hand, unspecified site, initial encounter
T22.20XD	Burn of second degree of shoulder and upper limb, except wrist and hand, unspecified site, subsequent encounter
T22.20XS	Burn of second degree of shoulder and upper limb, except wrist and hand, unspecified site, sequela
T22.211A	Burn of second degree of right forearm, initial encounter
T22.211D	Burn of second degree of right forearm, subsequent encounter
T22.211S	Burn of second degree of right forearm, sequela
T22.212A	Burn of second degree of left forearm, initial encounter
T22.212D	Burn of second degree of left forearm, subsequent encounter
T22.212S	Burn of second degree of left forearm, sequela
T22.219A	Burn of second degree of unspecified forearm, initial encounter
T22.219D	Burn of second degree of unspecified forearm, subsequent encounter
T22.219S	Burn of second degree of unspecified forearm, sequela
T22.221A	Burn of second degree of right elbow, initial encounter
T22.221D	Burn of second degree of right elbow, subsequent encounter
T22.221S	Burn of second degree of right elbow, sequela
T22.222A	Burn of second degree of left elbow, initial encounter
T22.222D	Burn of second degree of left elbow, subsequent encounter
T22.222S	Burn of second degree of left elbow, sequela
T22.229A	Burn of second degree of unspecified elbow, initial encounter
T22.229D	Burn of second degree of unspecified elbow, subsequent encounter
T22.229S	Burn of second degree of unspecified elbow, sequela
T22.231A	Burn of second degree of right upper arm, initial encounter
T22.231D	Burn of second degree of right upper arm, subsequent encounter
T22.231S	Burn of second degree of right upper arm, sequela

ICD-10 CODE	DESCRIPTION
T22.232A	Burn of second degree of left upper arm, initial encounter
T22.232D	Burn of second degree of left upper arm, subsequent encounter
T22.232S	Burn of second degree of left upper arm, sequela
T22.239A	Burn of second degree of unspecified upper arm, initial encounter
T22.239D	Burn of second degree of unspecified upper arm, subsequent encounter
T22.239S	Burn of second degree of unspecified upper arm, sequela
T22.241A	Burn of second degree of right axilla, initial encounter
T22.241D	Burn of second degree of right axilla, subsequent encounter
T22.241S	Burn of second degree of right axilla, sequela
T22.242A	Burn of second degree of left axilla, initial encounter
T22.242D	Burn of second degree of left axilla, subsequent encounter
T22.242S	Burn of second degree of left axilla, sequela
T22.249A	Burn of second degree of unspecified axilla, initial encounter
T22.249D	Burn of second degree of unspecified axilla, subsequent encounter
T22.249S	Burn of second degree of unspecified axilla, sequela
T22.251A	Burn of second degree of right shoulder, initial encounter
T22.251D	Burn of second degree of right shoulder, subsequent encounter
T22.251S	Burn of second degree of right shoulder, sequela
T22.252A	Burn of second degree of left shoulder, initial encounter
T22.252D	Burn of second degree of left shoulder, subsequent encounter
T22.252S	Burn of second degree of left shoulder, sequela
T22.259A	Burn of second degree of unspecified shoulder, initial encounter
T22.259D	Burn of second degree of unspecified shoulder, subsequent encounter
T22.259S	Burn of second degree of unspecified shoulder, sequela
T22.261A	Burn of second degree of right scapular region, initial encounter
T22.261D	Burn of second degree of right scapular region, subsequent encounter
T22.261S	Burn of second degree of right scapular region, sequela
T22.262A	Burn of second degree of left scapular region, initial encounter
T22.262D	Burn of second degree of left scapular region, subsequent encounter
T22.262S	Burn of second degree of left scapular region, sequela
T22.269A	Burn of second degree of unspecified scapular region, initial encounter
T22.269D	Burn of second degree of unspecified scapular region, subsequent encounter

ICD-10 CODE	DESCRIPTION
T22.269S	Burn of second degree of unspecified scapular region, sequela
T22.291A	Burn of second degree of multiple sites of right shoulder and upper limb, except wrist and hand, initial encounter
T22.291D	Burn of second degree of multiple sites of right shoulder and upper limb, except wrist and hand, subsequent encounter
T22.291S	Burn of second degree of multiple sites of right shoulder and upper limb, except wrist and hand, sequela
T22.292A	Burn of second degree of multiple sites of left shoulder and upper limb, except wrist and hand, initial encounter
T22.292D	Burn of second degree of multiple sites of left shoulder and upper limb, except wrist and hand, subsequent encounter
T22.292S	Burn of second degree of multiple sites of left shoulder and upper limb, except wrist and hand, sequela
T22.299A	Burn of second degree of multiple sites of unspecified shoulder and upper limb, except wrist and hand, initial encounter
T22.299D	Burn of second degree of multiple sites of unspecified shoulder and upper limb, except wrist and hand, subsequent encounter
T22.299S	Burn of second degree of multiple sites of unspecified shoulder and upper limb, except wrist and hand, sequela
T22.60XA	Corrosion of second degree of shoulder and upper limb, except wrist and hand, unspecified site, initial encounter
T22.60XD	Corrosion of second degree of shoulder and upper limb, except wrist and hand, unspecified site, subsequent encounter
T22.60XS	Corrosion of second degree of shoulder and upper limb, except wrist and hand, unspecified site, sequela
T22.611A	Corrosion of second degree of right forearm, initial encounter
T22.611D	Corrosion of second degree of right forearm, subsequent encounter
T22.611S	Corrosion of second degree of right forearm, sequela
T22.612A	Corrosion of second degree of left forearm, initial encounter
T22.612D	Corrosion of second degree of left forearm, subsequent encounter
T22.612S	Corrosion of second degree of left forearm, sequela
T22.619A	Corrosion of second degree of unspecified forearm, initial encounter
T22.619D	Corrosion of second degree of unspecified forearm, subsequent encounter
T22.619S	Corrosion of second degree of unspecified forearm, sequela
T22.621A	Corrosion of second degree of right elbow, initial encounter

ICD-10 CODE	DESCRIPTION
T22.621D	Corrosion of second degree of right elbow, subsequent encounter
T22.621S	Corrosion of second degree of right elbow, sequela
T22.622A	Corrosion of second degree of left elbow, initial encounter
ICD-10 CODE	DESCRIPTION
T22.622D	Corrosion of second degree of left elbow, subsequent encounter
T22.622S	Corrosion of second degree of left elbow, sequela
T22.629A	Corrosion of second degree of unspecified elbow, initial encounter
T22.629D	Corrosion of second degree of unspecified elbow, subsequent encounter
T22.629S	Corrosion of second degree of unspecified elbow, sequela
T22.631A	Corrosion of second degree of right upper arm, initial encounter
T22.631D	Corrosion of second degree of right upper arm, subsequent encounter
T22.631S	Corrosion of second degree of right upper arm, sequela
T22.632A	Corrosion of second degree of left upper arm, initial encounter
T22.632D	Corrosion of second degree of left upper arm, subsequent encounter
T22.632S	Corrosion of second degree of left upper arm, sequela
T22.639A	Corrosion of second degree of unspecified upper arm, initial encounter
T22.639D	Corrosion of second degree of unspecified upper arm, subsequent encounter
T22.639S	Corrosion of second degree of unspecified upper arm, sequela
T22.641A	Corrosion of second degree of right axilla, initial encounter
T22.641D	Corrosion of second degree of right axilla, subsequent encounter
T22.641S	Corrosion of second degree of right axilla, sequela
T22.642A	Corrosion of second degree of left axilla, initial encounter
T22.642D	Corrosion of second degree of left axilla, subsequent encounter
T22.642S	Corrosion of second degree of left axilla, sequela
T22.649A	Corrosion of second degree of unspecified axilla, initial encounter
T22.649D	Corrosion of second degree of unspecified axilla, subsequent encounter
T22.649S	Corrosion of second degree of unspecified axilla, sequela
T22.651A	Corrosion of second degree of right shoulder, initial encounter
T22.651D	Corrosion of second degree of right shoulder, subsequent encounter
T22.651S	Corrosion of second degree of right shoulder, sequela
T22.652A	Corrosion of second degree of left shoulder, initial encounter
T22.652D	Corrosion of second degree of left shoulder, subsequent encounter

ICD-10 CODE	DESCRIPTION
T22.652S	Corrosion of second degree of left shoulder, sequela
T22.659A	Corrosion of second degree of unspecified shoulder, initial encounter
T22.659D	Corrosion of second degree of unspecified shoulder, subsequent encounter
T22.659S	Corrosion of second degree of unspecified shoulder, sequela
T22.661A	Corrosion of second degree of right scapular region, initial encounter
T22.661D	Corrosion of second degree of right scapular region, subsequent encounter
T22.661S	Corrosion of second degree of right scapular region, sequela
T22.662A	Corrosion of second degree of left scapular region, initial encounter
T22.662D	Corrosion of second degree of left scapular region, subsequent encounter
T22.662S	Corrosion of second degree of left scapular region, sequela
T22.669A	Corrosion of second degree of unspecified scapular region, initial encounter
T22.669D	Corrosion of second degree of unspecified scapular region, subsequent encounter
T22.669S	Corrosion of second degree of unspecified scapular region, sequela
T22.691A	Corrosion of second degree of multiple sites of right shoulder and upper limb, except wrist and hand, initial encounter
T22.691D	Corrosion of second degree of multiple sites of right shoulder and upper limb, except wrist and hand, subsequent encounter
T22.691S	Corrosion of second degree of multiple sites of right shoulder and upper limb, except wrist and hand, sequela
T22.692A	Corrosion of second degree of multiple sites of left shoulder and upper limb, except wrist and hand, initial encounter
T22.692D	Corrosion of second degree of multiple sites of left shoulder and upper limb, except wrist and hand, subsequent encounter
T22.692S	Corrosion of second degree of multiple sites of left shoulder and upper limb, except wrist and hand, sequela
T22.699A	Corrosion of second degree of multiple sites of unspecified shoulder and upper limb, except wrist and hand, initial encounter
T22.699D	Corrosion of second degree of multiple sites of unspecified shoulder and upper limb, except wrist and hand, subsequent encounter
T22.699S	Corrosion of second degree of multiple sites of unspecified shoulder and upper limb, except wrist and hand, sequela
T23.201A	Burn of second degree of right hand, unspecified site, initial encounter
T23.201D	Burn of second degree of right hand, unspecified site, subsequent encounter
T23.201S	Burn of second degree of right hand, unspecified site, sequela

ICD-10 CODE	DESCRIPTION
T23.202A	Burn of second degree of left hand, unspecified site, initial encounter
T23.202D	Burn of second degree of left hand, unspecified site, subsequent encounter
T23.202S	Burn of second degree of left hand, unspecified site, sequela
T23.209A	Burn of second degree of unspecified hand, unspecified site, initial encounter
T23.209D	Burn of second degree of unspecified hand, unspecified site, subsequent encounter
T23.209S	Burn of second degree of unspecified hand, unspecified site, sequela
T23.211A	Burn of second degree of right thumb (nail), initial encounter
T23.211D	Burn of second degree of right thumb (nail), subsequent encounter
T23.211S	Burn of second degree of right thumb (nail), sequela
T23.212A	Burn of second degree of left thumb (nail), initial encounter
T23.212D	Burn of second degree of left thumb (nail), subsequent encounter
T23.212S	Burn of second degree of left thumb (nail), sequela
T23.219A	Burn of second degree of unspecified thumb (nail), initial encounter
T23.219D	Burn of second degree of unspecified thumb (nail), subsequent encounter
T23.219S	Burn of second degree of unspecified thumb (nail), sequela
T23.221A	Burn of second degree of single right finger (nail) except thumb, initial encounter
T23.221D	Burn of second degree of single right finger (nail) except thumb, subsequent encounter
T23.221S	Burn of second degree of single right finger (nail) except thumb, sequela
T23.222A	Burn of second degree of single left finger (nail) except thumb, initial encounter
T23.222D	Burn of second degree of single left finger (nail) except thumb, subsequent encounter
T23.222S	Burn of second degree of single left finger (nail) except thumb, sequela
T23.229A	Burn of second degree of unspecified single finger (nail) except thumb, initial encounter
T23.229D	Burn of second degree of unspecified single finger (nail) except thumb, subsequent encounter
T23.229S	Burn of second degree of unspecified single finger (nail) except thumb, sequela
T23.231A	Burn of second degree of multiple right fingers (nail), not including thumb, initial encounter
T23.231D	Burn of second degree of multiple right fingers (nail), not including thumb, subsequent encounter
T23.231S	Burn of second degree of multiple right fingers (nail), not including thumb, sequela

ICD-10 CODE	DESCRIPTION
T23.232A	Burn of second degree of multiple left fingers (nail), not including thumb, initial encounter
T23.232D	Burn of second degree of multiple left fingers (nail), not including thumb, subsequent encounter
T23.232S	Burn of second degree of multiple left fingers (nail), not including thumb, sequela
T23.239A	Burn of second degree of unspecified multiple fingers (nail), not including thumb, initial encounter
T23.239D	Burn of second degree of unspecified multiple fingers (nail), not including thumb, subsequent encounter
T23.239S	Burn of second degree of unspecified multiple fingers (nail), not including thumb, sequela
T23.241A	Burn of second degree of multiple right fingers (nail), including thumb, initial encounter
T23.241D	Burn of second degree of multiple right fingers (nail), including thumb, subsequent encounter
T23.241S	Burn of second degree of multiple right fingers (nail), including thumb, sequela
T23.242A	Burn of second degree of multiple left fingers (nail), including thumb, initial encounter
T23.242D	Burn of second degree of multiple left fingers (nail), including thumb, subsequent encounter
T23.242S	Burn of second degree of multiple left fingers (nail), including thumb, sequela
T23.249A	Burn of second degree of unspecified multiple fingers (nail), including thumb, initial encounter
T23.249D	Burn of second degree of unspecified multiple fingers (nail), including thumb, subsequent encounter
T23.249S	Burn of second degree of unspecified multiple fingers (nail), including thumb, sequela
T23.251A	Burn of second degree of right palm, initial encounter
T23.251D	Burn of second degree of right palm, subsequent encounter
T23.251S	Burn of second degree of right palm, sequela
T23.252A	Burn of second degree of left palm, initial encounter
T23.252D	Burn of second degree of left palm, subsequent encounter
ICD-10 CODE	DESCRIPTION
T23.252S	Burn of second degree of left palm, sequela
T23.259A	Burn of second degree of unspecified palm, initial encounter

ICD-10 CODE	DESCRIPTION
T23.259D	Burn of second degree of unspecified palm, subsequent encounter
T23.259S	Burn of second degree of unspecified palm, sequela
T23.261A	Burn of second degree of back of right hand, initial encounter
T23.261D	Burn of second degree of back of right hand, subsequent encounter
T23.261S	Burn of second degree of back of right hand, sequela
T23.262A	Burn of second degree of back of left hand, initial encounter
T23.262D	Burn of second degree of back of left hand, subsequent encounter
T23.262S	Burn of second degree of back of left hand, sequela
T23.269A	Burn of second degree of back of unspecified hand, initial encounter
T23.269D	Burn of second degree of back of unspecified hand, subsequent encounter
T23.269S	Burn of second degree of back of unspecified hand, sequela
T23.271A	Burn of second degree of right wrist, initial encounter
T23.271D	Burn of second degree of right wrist, subsequent encounter
T23.271S	Burn of second degree of right wrist, sequela
T23.272A	Burn of second degree of left wrist, initial encounter
T23.272D	Burn of second degree of left wrist, subsequent encounter
T23.272S	Burn of second degree of left wrist, sequela
T23.279A	Burn of second degree of unspecified wrist, initial encounter
T23.279D	Burn of second degree of unspecified wrist, subsequent encounter
T23.279S	Burn of second degree of unspecified wrist, sequela
T23.291A	Burn of second degree of multiple sites of right wrist and hand, initial encounter
T23.291D	Burn of second degree of multiple sites of right wrist and hand, subsequent encounter
T23.291S	Burn of second degree of multiple sites of right wrist and hand, sequela
T23.292A	Burn of second degree of multiple sites of left wrist and hand, initial encounter
T23.292D	Burn of second degree of multiple sites of left wrist and hand, subsequent encounter
T23.292S	Burn of second degree of multiple sites of left wrist and hand, sequela
T23.299A	Burn of second degree of multiple sites of unspecified wrist and hand, initial encounter
T23.299D	Burn of second degree of multiple sites of unspecified wrist and hand, subsequent encounter
T23.299S	Burn of second degree of multiple sites of unspecified wrist and hand, sequela
T23.601A	Corrosion of second degree of right hand, unspecified site, initial encounter

ICD-10 CODE	DESCRIPTION
T23.601D	Corrosion of second degree of right hand, unspecified site, subsequent encounter
T23.601S	Corrosion of second degree of right hand, unspecified site, sequela
T23.602A	Corrosion of second degree of left hand, unspecified site, initial encounter
T23.602D	Corrosion of second degree of left hand, unspecified site, subsequent encounter
T23.602S	Corrosion of second degree of left hand, unspecified site, sequela
T23.609A	Corrosion of second degree of unspecified hand, unspecified site, initial encounter
T23.609D	Corrosion of second degree of unspecified hand, unspecified site, subsequent encounter
T23.609S	Corrosion of second degree of unspecified hand, unspecified site, sequela
T23.611A	Corrosion of second degree of right thumb (nail), initial encounter
T23.611D	Corrosion of second degree of right thumb (nail), subsequent encounter
T23.611S	Corrosion of second degree of right thumb (nail), sequela
T23.612A	Corrosion of second degree of left thumb (nail), initial encounter
T23.612D	Corrosion of second degree of left thumb (nail), subsequent encounter
T23.612S	Corrosion of second degree of left thumb (nail), sequela
T23.619A	Corrosion of second degree of unspecified thumb (nail), initial encounter
T23.619D	Corrosion of second degree of unspecified thumb (nail), subsequent encounter
T23.619S	Corrosion of second degree of unspecified thumb (nail), sequela
T23.621A	Corrosion of second degree of single right finger (nail) except thumb, initial encounter
T23.621D	Corrosion of second degree of single right finger (nail) except thumb, subsequent encounter
T23.621S	Corrosion of second degree of single right finger (nail) except thumb, sequela
T23.622A	Corrosion of second degree of single left finger (nail) except thumb, initial encounter
T23.622D	Corrosion of second degree of single left finger (nail) except thumb, subsequent encounter
T23.622S	Corrosion of second degree of single left finger (nail) except thumb, sequela
T23.629A	Corrosion of second degree of unspecified single finger (nail) except thumb, initial encounter
T23.629D	Corrosion of second degree of unspecified single finger (nail) except thumb, subsequent encounter
T23.629S	Corrosion of second degree of unspecified single finger (nail) except thumb, sequela
T23.631A	Corrosion of second degree of multiple right fingers (nail), not including thumb, initial encounter

ICD-10 CODE	DESCRIPTION
T23.631D	Corrosion of second degree of multiple right fingers (nail), not including thumb, subsequent encounter
T23.631S	Corrosion of second degree of multiple right fingers (nail), not including thumb, sequela
T23.632A	Corrosion of second degree of multiple left fingers (nail), not including thumb, initial encounter
T23.632D	Corrosion of second degree of multiple left fingers (nail), not including thumb, subsequent encounter
T23.632S	Corrosion of second degree of multiple left fingers (nail), not including thumb, sequela
T23.639A	Corrosion of second degree of unspecified multiple fingers (nail), not including thumb, initial encounter
T23.639D	Corrosion of second degree of unspecified multiple fingers (nail), not including thumb, subsequent encounter
T23.639S	Corrosion of second degree of unspecified multiple fingers (nail), not including thumb, sequela
T23.641A	Corrosion of second degree of multiple right fingers (nail), including thumb, initial encounter
T23.641D	Corrosion of second degree of multiple right fingers (nail), including thumb, subsequent encounter
T23.641S	Corrosion of second degree of multiple right fingers (nail), including thumb, sequela
T23.642A	Corrosion of second degree of multiple left fingers (nail), including thumb, initial encounter
T23.642D	Corrosion of second degree of multiple left fingers (nail), including thumb, subsequent encounter
T23.642S	Corrosion of second degree of multiple left fingers (nail), including thumb, sequela
T23.649A	Corrosion of second degree of unspecified multiple fingers (nail), including thumb, initial encounter
T23.649D	Corrosion of second degree of unspecified multiple fingers (nail), including thumb, subsequent encounter
T23.649S	Corrosion of second degree of unspecified multiple fingers (nail), including thumb, sequela
T23.651A	Corrosion of second degree of right palm, initial encounter
T23.651D	Corrosion of second degree of right palm, subsequent encounter
T23.651S	Corrosion of second degree of right palm, sequela
T23.652A	Corrosion of second degree of left palm, initial encounter

ICD-10 CODE	DESCRIPTION
T23.652D	Corrosion of second degree of left palm, subsequent encounter
T23.652S	Corrosion of second degree of left palm, sequela
T23.659A	Corrosion of second degree of unspecified palm, initial encounter
T23.659D	Corrosion of second degree of unspecified palm, subsequent encounter
T23.659S	Corrosion of second degree of unspecified palm, sequela
T23.661A	Corrosion of second degree back of right hand, initial encounter
T23.661D	Corrosion of second degree back of right hand, subsequent encounter
T23.661S	Corrosion of second degree back of right hand, sequela
T23.662A	Corrosion of second degree back of left hand, initial encounter
T23.662D	Corrosion of second degree back of left hand, subsequent encounter
T23.662S	Corrosion of second degree back of left hand, sequela
T23.669A	Corrosion of second degree back of unspecified hand, initial encounter
T23.669D	Corrosion of second degree back of unspecified hand, subsequent encounter
T23.669S	Corrosion of second degree back of unspecified hand, sequela
T23.671A	Corrosion of second degree of right wrist, initial encounter
T23.671D	Corrosion of second degree of right wrist, subsequent encounter
T23.671S	Corrosion of second degree of right wrist, sequela
T23.672A	Corrosion of second degree of left wrist, initial encounter
T23.672D	Corrosion of second degree of left wrist, subsequent encounter
T23.672S	Corrosion of second degree of left wrist, sequela
ICD-10 CODE	DESCRIPTION
T23.679A	Corrosion of second degree of unspecified wrist, initial encounter
T23.679D	Corrosion of second degree of unspecified wrist, subsequent encounter
T23.679S	Corrosion of second degree of unspecified wrist, sequela
T23.691A	Corrosion of second degree of multiple sites of right wrist and hand, initial encounter
T23.691D	Corrosion of second degree of multiple sites of right wrist and hand, subsequent encounter
T23.691S	Corrosion of second degree of multiple sites of right wrist and hand, sequela
T23.692A	Corrosion of second degree of multiple sites of left wrist and hand, initial encounter
T23.692D	Corrosion of second degree of multiple sites of left wrist and hand, subsequent encounter
T23.692S	Corrosion of second degree of multiple sites of left wrist and hand, sequela

ICD-10 CODE	DESCRIPTION
T23.699A	Corrosion of second degree of multiple sites of unspecified wrist and hand, initial encounter
T23.699D	Corrosion of second degree of multiple sites of unspecified wrist and hand, subsequent encounter
T23.699S	Corrosion of second degree of multiple sites of unspecified wrist and hand, sequela
T24.201A	Burn of second degree of unspecified site of right lower limb, except ankle and foot, initial encounter
T24.201D	Burn of second degree of unspecified site of right lower limb, except ankle and foot, subsequent encounter
T24.201S	Burn of second degree of unspecified site of right lower limb, except ankle and foot, sequela
T24.202A	Burn of second degree of unspecified site of left lower limb, except ankle and foot, initial encounter
T24.202D	Burn of second degree of unspecified site of left lower limb, except ankle and foot, subsequent encounter
T24.202S	Burn of second degree of unspecified site of left lower limb, except ankle and foot, sequela
T24.209A	Burn of second degree of unspecified site of unspecified lower limb, except ankle and foot, initial encounter
T24.209D	Burn of second degree of unspecified site of unspecified lower limb, except ankle and foot, subsequent encounter
T24.209S	Burn of second degree of unspecified site of unspecified lower limb, except ankle and foot, sequela
T24.211A	Burn of second degree of right thigh, initial encounter
T24.211D	Burn of second degree of right thigh, subsequent encounter
T24.211S	Burn of second degree of right thigh, sequela
T24.212A	Burn of second degree of left thigh, initial encounter
T24.212D	Burn of second degree of left thigh, subsequent encounter
T24.212S	Burn of second degree of left thigh, sequela
T24.219A	Burn of second degree of unspecified thigh, initial encounter
T24.219D	Burn of second degree of unspecified thigh, subsequent encounter
T24.219S	Burn of second degree of unspecified thigh, sequela
T24.221A	Burn of second degree of right knee, initial encounter
T24.221D	Burn of second degree of right knee, subsequent encounter
T24.221S	Burn of second degree of right knee, sequela

ICD-10 CODE	DESCRIPTION
T24.222A	Burn of second degree of left knee, initial encounter
T24.222D	Burn of second degree of left knee, subsequent encounter
T24.222S	Burn of second degree of left knee, sequela
T24.229A	Burn of second degree of unspecified knee, initial encounter
T24.229D	Burn of second degree of unspecified knee, subsequent encounter
T24.229S	Burn of second degree of unspecified knee, sequela
T24.231A	Burn of second degree of right lower leg, initial encounter
T24.231D	Burn of second degree of right lower leg, subsequent encounter
T24.231S	Burn of second degree of right lower leg, sequela
T24.232A	Burn of second degree of left lower leg, initial encounter
T24.232D	Burn of second degree of left lower leg, subsequent encounter
T24.232S	Burn of second degree of left lower leg, sequela
T24.239A	Burn of second degree of unspecified lower leg, initial encounter
T24.239D	Burn of second degree of unspecified lower leg, subsequent encounter
T24.239S	Burn of second degree of unspecified lower leg, sequela
T24.291A	Burn of second degree of multiple sites of right lower limb, except ankle and foot, initial encounter
T24.291D	Burn of second degree of multiple sites of right lower limb, except ankle and foot, subsequent encounter
T24.291S	Burn of second degree of multiple sites of right lower limb, except ankle and foot, sequela
T24.292A	Burn of second degree of multiple sites of left lower limb, except ankle and foot, initial encounter
T24.292D	Burn of second degree of multiple sites of left lower limb, except ankle and foot, subsequent encounter
T24.292S	Burn of second degree of multiple sites of left lower limb, except ankle and foot, sequela
T24.299A	Burn of second degree of multiple sites of unspecified lower limb, except ankle and foot, initial encounter
T24.299D	Burn of second degree of multiple sites of unspecified lower limb, except ankle and foot, subsequent encounter
T24.299S	Burn of second degree of multiple sites of unspecified lower limb, except ankle and foot, sequela
T24.601A	Corrosion of second degree of unspecified site of right lower limb, except ankle and foot, initial encounter

ICD-10 CODE	DESCRIPTION
T24.601D	Corrosion of second degree of unspecified site of right lower limb, except ankle and foot, subsequent encounter
T24.601S	Corrosion of second degree of unspecified site of right lower limb, except ankle and foot, sequela
T24.602A	Corrosion of second degree of unspecified site of left lower limb, except ankle and foot, initial encounter
T24.602D	Corrosion of second degree of unspecified site of left lower limb, except ankle and foot, subsequent encounter
T24.602S	Corrosion of second degree of unspecified site of left lower limb, except ankle and foot, sequela
T24.609A	Corrosion of second degree of unspecified site of unspecified lower limb, except ankle and foot, initial encounter
T24.609D	Corrosion of second degree of unspecified site of unspecified lower limb, except ankle and foot, subsequent encounter
T24.609S	Corrosion of second degree of unspecified site of unspecified lower limb, except ankle and foot, sequela
T24.611A	Corrosion of second degree of right thigh, initial encounter
T24.611D	Corrosion of second degree of right thigh, subsequent encounter
T24.611S	Corrosion of second degree of right thigh, sequela
T24.612A	Corrosion of second degree of left thigh, initial encounter
T24.612D	Corrosion of second degree of left thigh, subsequent encounter
T24.612S	Corrosion of second degree of left thigh, sequela
T24.619A	Corrosion of second degree of unspecified thigh, initial encounter
T24.619D	Corrosion of second degree of unspecified thigh, subsequent encounter
T24.619S	Corrosion of second degree of unspecified thigh, sequela
T24.621A	Corrosion of second degree of right knee, initial encounter
T24.621D	Corrosion of second degree of right knee, subsequent encounter
T24.621S	Corrosion of second degree of right knee, sequela
T24.622A	Corrosion of second degree of left knee, initial encounter
T24.622D	Corrosion of second degree of left knee, subsequent encounter
T24.622S	Corrosion of second degree of left knee, sequela
T24.629A	Corrosion of second degree of unspecified knee, initial encounter
T24.629D	Corrosion of second degree of unspecified knee, subsequent encounter
T24.629S	Corrosion of second degree of unspecified knee, sequela

ICD-10 CODE	DESCRIPTION
T24.631A	Corrosion of second degree of right lower leg, initial encounter
T24.631D	Corrosion of second degree of right lower leg, subsequent encounter
T24.631S	Corrosion of second degree of right lower leg, sequela
T24.632A	Corrosion of second degree of left lower leg, initial encounter
T24.632D	Corrosion of second degree of left lower leg, subsequent encounter
T24.632S	Corrosion of second degree of left lower leg, sequela
T24.639A	Corrosion of second degree of unspecified lower leg, initial encounter
T24.639D	Corrosion of second degree of unspecified lower leg, subsequent encounter
T24.639S	Corrosion of second degree of unspecified lower leg, sequela
T24.691A	Corrosion of second degree of multiple sites of right lower limb, except ankle and foot, initial encounter
T24.691D	Corrosion of second degree of multiple sites of right lower limb, except ankle and foot, subsequent encounter
T24.691S	Corrosion of second degree of multiple sites of right lower limb, except ankle and foot, sequela
T24.692A	Corrosion of second degree of multiple sites of left lower limb, except ankle and foot, initial encounter
T24.692D	Corrosion of second degree of multiple sites of left lower limb, except ankle and foot, subsequent encounter
T24.692S	Corrosion of second degree of multiple sites of left lower limb, except ankle and foot, sequela
T24.699A	Corrosion of second degree of multiple sites of unspecified lower limb, except ankle and foot, initial encounter
ICD-10 CODE	DESCRIPTION
T24.699D	Corrosion of second degree of multiple sites of unspecified lower limb, except ankle and foot, subsequent encounter
T24.699S	Corrosion of second degree of multiple sites of unspecified lower limb, except ankle and foot, sequela
T25.211A	Burn of second degree of right ankle, initial encounter
T25.211D	Burn of second degree of right ankle, subsequent encounter
T25.211S	Burn of second degree of right ankle, sequela
T25.212A	Burn of second degree of left ankle, initial encounter
T25.212D	Burn of second degree of left ankle, subsequent encounter
T25.212S	Burn of second degree of left ankle, sequela

ICD-10 CODE	DESCRIPTION
T25.219A	Burn of second degree of unspecified ankle, initial encounter
T25.219D	Burn of second degree of unspecified ankle, subsequent encounter
T25.219S	Burn of second degree of unspecified ankle, sequela
T25.221A	Burn of second degree of right foot, initial encounter
T25.221D	Burn of second degree of right foot, subsequent encounter
T25.221S	Burn of second degree of right foot, sequela
T25.222A	Burn of second degree of left foot, initial encounter
T25.222D	Burn of second degree of left foot, subsequent encounter
T25.222S	Burn of second degree of left foot, sequela
T25.229A	Burn of second degree of unspecified foot, initial encounter
T25.229D	Burn of second degree of unspecified foot, subsequent encounter
T25.229S	Burn of second degree of unspecified foot, sequela
T25.231A	Burn of second degree of right toe(s) (nail), initial encounter
T25.231D	Burn of second degree of right toe(s) (nail), subsequent encounter
T25.231S	Burn of second degree of right toe(s) (nail), sequela
T25.232A	Burn of second degree of left toe(s) (nail), initial encounter
T25.232D	Burn of second degree of left toe(s) (nail), subsequent encounter
T25.232S	Burn of second degree of left toe(s) (nail), sequela
T25.239A	Burn of second degree of unspecified toe(s) (nail), initial encounter
T25.239D	Burn of second degree of unspecified toe(s) (nail), subsequent encounter
T25.239S	Burn of second degree of unspecified toe(s) (nail), sequela
T25.291A	Burn of second degree of multiple sites of right ankle and foot, initial encounter
T25.291D	Burn of second degree of multiple sites of right ankle and foot, subsequent encounter
T25.291S	Burn of second degree of multiple sites of right ankle and foot, sequela
T25.292A	Burn of second degree of multiple sites of left ankle and foot, initial encounter
T25.292D	Burn of second degree of multiple sites of left ankle and foot, subsequent encounter
T25.292S	Burn of second degree of multiple sites of left ankle and foot, sequela
T25.299A	Burn of second degree of multiple sites of unspecified ankle and foot, initial encounter
T25.299D	Burn of second degree of multiple sites of unspecified ankle and foot, subsequent encounter
T25.299S	Burn of second degree of multiple sites of unspecified ankle and foot, sequela

ICD-10 CODE	DESCRIPTION
T25.611A	Corrosion of second degree of right ankle, initial encounter
T25.611D	Corrosion of second degree of right ankle, subsequent encounter
T25.611S	Corrosion of second degree of right ankle, sequela
T25.612A	Corrosion of second degree of left ankle, initial encounter
T25.612D	Corrosion of second degree of left ankle, subsequent encounter
T25.612S	Corrosion of second degree of left ankle, sequela
T25.619A	Corrosion of second degree of unspecified ankle, initial encounter
T25.619D	Corrosion of second degree of unspecified ankle, subsequent encounter
T25.619S	Corrosion of second degree of unspecified ankle, sequela
T25.621A	Corrosion of second degree of right foot, initial encounter
T25.621D	Corrosion of second degree of right foot, subsequent encounter
T25.621S	Corrosion of second degree of right foot, sequela
T25.622A	Corrosion of second degree of left foot, initial encounter
T25.622D	Corrosion of second degree of left foot, subsequent encounter
T25.622S	Corrosion of second degree of left foot, sequela
T25.629A	Corrosion of second degree of unspecified foot, initial encounter
T25.629D	Corrosion of second degree of unspecified foot, subsequent encounter
T25.629S	Corrosion of second degree of unspecified foot, sequela
T25.631A	Corrosion of second degree of right toe(s) (nail), initial encounter
T25.631D	Corrosion of second degree of right toe(s) (nail), subsequent encounter
T25.631S	Corrosion of second degree of right toe(s) (nail), sequela
T25.632A	Corrosion of second degree of left toe(s) (nail), initial encounter
T25.632D	Corrosion of second degree of left toe(s) (nail), subsequent encounter
T25.632S	Corrosion of second degree of left toe(s) (nail), sequela
T25.639A	Corrosion of second degree of unspecified toe(s) (nail), initial encounter
T25.639D	Corrosion of second degree of unspecified toe(s) (nail), subsequent encounter
T25.639S	Corrosion of second degree of unspecified toe(s) (nail), sequela
T25.691A	Corrosion of second degree of right ankle and foot, initial encounter
T25.691D	Corrosion of second degree of right ankle and foot, subsequent encounter
T25.691S	Corrosion of second degree of right ankle and foot, sequela
T25.692A	Corrosion of second degree of left ankle and foot, initial encounter
T25.692D	Corrosion of second degree of left ankle and foot, subsequent encounter

ICD-10 CODE	DESCRIPTION
T25.692S	Corrosion of second degree of left ankle and foot, sequela
T25.699A	Corrosion of second degree of unspecified ankle and foot, initial encounter
T25.699D	Corrosion of second degree of unspecified ankle and foot, subsequent encounter
T25.699S	Corrosion of second degree of unspecified ankle and foot, sequela
T30.0	Burn of unspecified body region, unspecified degree
T30.4	Corrosion of unspecified body region, unspecified degree
T31.0	Burns involving less than 10% of body surface
T31.10	Burns involving 10-19% of body surface with 0% to 9% third degree burns
T31.11	Burns involving 10-19% of body surface with 10-19% third degree burns
T31.20	Burns involving 20-29% of body surface with 0% to 9% third degree burns
T31.21	Burns involving 20-29% of body surface with 10-19% third degree burns
T31.22	Burns involving 20-29% of body surface with 20-29% third degree burns
T31.30	Burns involving 30-39% of body surface with 0% to 9% third degree burns
T31.31	Burns involving 30-39% of body surface with 10-19% third degree burns
T31.32	Burns involving 30-39% of body surface with 20-29% third degree burns
T31.33	Burns involving 30-39% of body surface with 30-39% third degree burns
T31.40	Burns involving 40-49% of body surface with 0% to 9% third degree burns
T31.41	Burns involving 40-49% of body surface with 10-19% third degree burns
T31.42	Burns involving 40-49% of body surface with 20-29% third degree burns
T31.43	Burns involving 40-49% of body surface with 30-39% third degree burns
T31.44	Burns involving 40-49% of body surface with 40-49% third degree burns
T31.50	Burns involving 50-59% of body surface with 0% to 9% third degree burns
T31.51	Burns involving 50-59% of body surface with 10-19% third degree burns
T31.52	Burns involving 50-59% of body surface with 20-29% third degree burns
T31.53	Burns involving 50-59% of body surface with 30-39% third degree burns
T31.54	Burns involving 50-59% of body surface with 40-49% third degree burns
T31.55	Burns involving 50-59% of body surface with 50-59% third degree burns
T31.60	Burns involving 60-69% of body surface with 0% to 9% third degree burns
T31.61	Burns involving 60-69% of body surface with 10-19% third degree burns
T31.62	Burns involving 60-69% of body surface with 20-29% third degree burns
ICD-10 CODE	DESCRIPTION
T31.63	Burns involving 60-69% of body surface with 30-39% third degree burns

ICD-10 CODE	DESCRIPTION
T31.64	Burns involving 60-69% of body surface with 40-49% third degree burns
T31.65	Burns involving 60-69% of body surface with 50-59% third degree burns
T31.66	Burns involving 60-69% of body surface with 60-69% third degree burns
T31.70	Burns involving 70-79% of body surface with 0% to 9% third degree burns
T31.71	Burns involving 70-79% of body surface with 10-19% third degree burns
T31.72	Burns involving 70-79% of body surface with 20-29% third degree burns
T31.73	Burns involving 70-79% of body surface with 30-39% third degree burns
T31.74	Burns involving 70-79% of body surface with 40-49% third degree burns
T31.75	Burns involving 70-79% of body surface with 50-59% third degree burns
T31.76	Burns involving 70-79% of body surface with 60-69% third degree burns
T31.77	Burns involving 70-79% of body surface with 70-79% third degree burns
T31.80	Burns involving 80-89% of body surface with 0% to 9% third degree burns
T31.81	Burns involving 80-89% of body surface with 10-19% third degree burns
T31.82	Burns involving 80-89% of body surface with 20-29% third degree burns
T31.83	Burns involving 80-89% of body surface with 30-39% third degree burns
T31.84	Burns involving 80-89% of body surface with 40-49% third degree burns
T31.85	Burns involving 80-89% of body surface with 50-59% third degree burns
T31.86	Burns involving 80-89% of body surface with 60-69% third degree burns
T31.87	Burns involving 80-89% of body surface with 70-79% third degree burns
T31.88	Burns involving 80-89% of body surface with 80-89% third degree burns
T31.90	Burns involving 90% or more of body surface with 0% to 9% third degree burns
T31.91	Burns involving 90% or more of body surface with 10-19% third degree burns
T31.92	Burns involving 90% or more of body surface with 20-29% third degree burns
T31.93	Burns involving 90% or more of body surface with 30-39% third degree burns
T31.94	Burns involving 90% or more of body surface with 40-49% third degree burns
T31.95	Burns involving 90% or more of body surface with 50-59% third degree burns
T31.96	Burns involving 90% or more of body surface with 60-69% third degree burns
T31.97	Burns involving 90% or more of body surface with 70-79% third degree burns
T31.98	Burns involving 90% or more of body surface with 80-89% third degree burns
T31.99	Burns involving 90% or more of body surface with 90% or more third degree burns
T32.0	Corrosions involving less than 10% of body surface
T32.10	Corrosions involving 10-19% of body surface with 0% to 9% third degree corrosion

ICD-10 CODE	DESCRIPTION
T32.11	Corrosions involving 10-19% of body surface with 10-19% third degree corrosion
T32.20	Corrosions involving 20-29% of body surface with 0% to 9% third degree corrosion
T32.21	Corrosions involving 20-29% of body surface with 10-19% third degree corrosion
T32.22	Corrosions involving 20-29% of body surface with 20-29% third degree corrosion
T32.30	Corrosions involving 30-39% of body surface with 0% to 9% third degree corrosion
T32.31	Corrosions involving 30-39% of body surface with 10-19% third degree corrosion
T32.32	Corrosions involving 30-39% of body surface with 20-29% third degree corrosion
T32.33	Corrosions involving 30-39% of body surface with 30-39% third degree corrosion
T32.40	Corrosions involving 40-49% of body surface with 0% to 9% third degree corrosion
T32.41	Corrosions involving 40-49% of body surface with 10-19% third degree corrosion
T32.42	Corrosions involving 40-49% of body surface with 20-29% third degree corrosion
T32.43	Corrosions involving 40-49% of body surface with 30-39% third degree corrosion
T32.44	Corrosions involving 40-49% of body surface with 40-49% third degree corrosion
T32.50	Corrosions involving 50-59% of body surface with 0% to 9% third degree corrosion
T32.51	Corrosions involving 50-59% of body surface with 10-19% third degree corrosion
T32.52	Corrosions involving 50-59% of body surface with 20-29% third degree corrosion
T32.53	Corrosions involving 50-59% of body surface with 30-39% third degree corrosion
T32.54	Corrosions involving 50-59% of body surface with 40-49% third degree corrosion
T32.55	Corrosions involving 50-59% of body surface with 50-59% third degree corrosion
T32.60	Corrosions involving 60-69% of body surface with 0% to 9% third degree corrosion
T32.61	Corrosions involving 60-69% of body surface with 10-19% third degree corrosion
T32.62	Corrosions involving 60-69% of body surface with 20-29% third degree corrosion
T32.63	Corrosions involving 60-69% of body surface with 30-39% third degree corrosion
T32.64	Corrosions involving 60-69% of body surface with 40-49% third degree corrosion
T32.65	Corrosions involving 60-69% of body surface with 50-59% third degree corrosion
T32.66	Corrosions involving 60-69% of body surface with 60-69% third degree corrosion
T32.70	Corrosions involving 70-79% of body surface with 0% to 9% third degree corrosion
T32.71	Corrosions involving 70-79% of body surface with 10-19% third degree corrosion
T32.72	Corrosions involving 70-79% of body surface with 20-29% third degree corrosion
T32.73	Corrosions involving 70-79% of body surface with 30-39% third degree corrosion
T32.74	Corrosions involving 70-79% of body surface with 40-49% third degree corrosion
T32.75	Corrosions involving 70-79% of body surface with 50-59% third degree corrosion

ICD-10 CODE	DESCRIPTION
T32.76	Corrosions involving 70-79% of body surface with 60-69% third degree corrosion
T32.77	Corrosions involving 70-79% of body surface with 70-79% third degree corrosion
T32.80	Corrosions involving 80-89% of body surface with 0% to 9% third degree corrosion
T32.81	Corrosions involving 80-89% of body surface with 10-19% third degree corrosion
T32.82	Corrosions involving 80-89% of body surface with 20-29% third degree corrosion
T32.83	Corrosions involving 80-89% of body surface with 30-39% third degree corrosion
T32.84	Corrosions involving 80-89% of body surface with 40-49% third degree corrosion
T32.85	Corrosions involving 80-89% of body surface with 50-59% third degree corrosion
T32.86	Corrosions involving 80-89% of body surface with 60-69% third degree corrosion
T32.87	Corrosions involving 80-89% of body surface with 70-79% third degree corrosion
T32.88	Corrosions involving 80-89% of body surface with 80-89% third degree corrosion
T32.90	Corrosions involving 90% or more of body surface with 0% to 9% third degree corrosion
T32.91	Corrosions involving 90% or more of body surface with 10-19% third degree corrosion
T32.92	Corrosions involving 90% or more of body surface with 20-29% third degree corrosion
T32.93	Corrosions involving 90% or more of body surface with 30-39% third degree corrosion
T32.94	Corrosions involving 90% or more of body surface with 40-49% third degree corrosion
T32.95	Corrosions involving 90% or more of body surface with 50-59% third degree corrosion
T32.96	Corrosions involving 90% or more of body surface with 60-69% third degree corrosion
T32.97	Corrosions involving 90% or more of body surface with 70-79% third degree corrosion
T32.98	Corrosions involving 90% or more of body surface with 80-89% third degree corrosion
T32.99	Corrosions involving 90% or more of body surface with 90% or more third degree corrosion
T81.30XA	Disruption of wound, unspecified, initial encounter
T81.30XD	Disruption of wound, unspecified, subsequent encounter
T81.30XS	Disruption of wound, unspecified, sequela
T81.31XA	Disruption of external operation (surgical) wound, not elsewhere classified, initial

ICD-10 CODE	DESCRIPTION
	encounter
T81.31XD	Disruption of external operation (surgical) wound, not elsewhere classified, subsequent encounter
T81.31XS	Disruption of external operation (surgical) wound, not elsewhere classified, sequela
T81.33XA	Disruption of traumatic injury wound repair, initial encounter
T81.33XD	Disruption of traumatic injury wound repair, subsequent encounter
T81.33XS	Disruption of traumatic injury wound repair, sequela
T81.89XA	Other complications of procedures, not elsewhere classified, initial encounter
T81.89XD	Other complications of procedures, not elsewhere classified, subsequent encounter
T81.89XS	Other complications of procedures, not elsewhere classified, sequela

Additional ICD-10 Information

N/A

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.

N/A

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.

N/A

Other Coding Information

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
10/01/2020	R3	Based on the annual ICD-10 updates for 2021, ICD-10 code J82 has been deleted and replaced by J82.81, J82.82, J82.83 and J82.89 in the list of non-covered diagnoses for CPT code 97035.
01/01/2020	R2	Article corrected to add CPT codes 97545 and 97546 which were inadvertently omitted from the previous revision and to remove CPT code 95933 which was added to the CPT code list in error.
01/01/2020	R1	Article revised for 2020 CPT/HCPCS updates: CPT code 90911 was deleted and replaced by codes 90912 and 90913. CPT codes 95831, 95832, 95833 and 95834 have been deleted. HCPCS code G0515 has been deleted and replaced by CPT codes 97129 and 97130.

Associated Documents

Related Local Coverage Document(s)

LCD(s)

L33631 - Outpatient Physical and Occupational Therapy Services

Related National Coverage Document(s)

N/A

Statutory Requirements URL(s)

N/A

Rules and Regulations URL(s)

N/A

CMS Manual Explanations URL(s)

N/A

Other URL(s)

N/A

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Keywords

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