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LCD for Physical Medicine and Rehabilitation Policy (L28290)

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Title XVIII of the Social Security Act, §1862(a)(1)(A) allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act, §1833(e) prohibits Medicare payment for any claim, which lacks the necessary information to process the claim.

Title XVIII of the Social Security Act, §1879 placed a limitation of liability on the beneficiary where Medicare claims are disallowed when both the beneficiary and provider of services did not know and could not reasonably have known the services would not be paid.

Title XVIII of the Social Security Act, §1861(p)(4) defines services for outpatient physical therapy services and conditions of operation.

42CFR 484.4 states personnel qualifications for audiologists, occupational therapists and physical therapists.

42CFR 485.701 states conditions of participation for clinics, rehabilitation agencies as providers of outpatient physical therapy and speech-language pathology services.

42CFR 410.60(c)(i) gives outpatient physical therapy service conditions.

42CFR 410.32 states that supervision levels for outpatient rehabilitation therapy services are the same as those for diagnostic tests.

42CFR 485.729 states the conditions of participation with program evaluation.

CMS Transmittal AB-02-078, CR 2083, Provider Education Article: Medicare Coverage of Rehabilitation Services for Beneficiaries With Vision Impairment, dated May 29, 2002

CMS Transmittal AB-01-135, Change Request 1793, Medical Review of Services for Patients with Dementia, dated September 25, 2001

CMS Manual System, Pub 100-02, Medicare Benefit Policy Manual, Transmittal 36, Change Request 3648, dated June 24, 2005

CMS Transmittal AB-02-080, Change Request 2073, Payment for Services Furnished by Audiologists, dated June 7, 2002.

CMS Manual System, Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, §§220 and 230, therapy personnel qualifications and the timing of recertification of plans of care.

CMS Manual System, Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, §§60.1-60.4.1

CMS Manual System, Pub 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §§10.2, 10.3, 10.4, 20.10, 30.3, 30.3.1 and 30.3.2; Part 2, §§150.1, 150.2, 150.5, 150.8, 160.2, 160.7, 160.7.1, 160.13, 160.15, 160.16, 160.20, 160.23, and 160.24; Part 4, §§240.3, 240.7, 240.8, 250.1, 270.2, 270.6, 280.6, and 280.13

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, §3.4.1.1

CMS Transmittal 1706, Change Request 6407, Manual Clarifications for Skilled Nursing Facilities and Therapy Billing, dated March 27, 2009.

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This policy defines the coverage and limitations under Medicare for physical medicine and rehabilitation (PM&R) modalities and procedures provided by physicians or independent physical therapists, occupational therapists, and speech-language pathologists in home and office settings.

- **Assessment:** Assessment is included in services or procedures and is not separately payable (as distinguished from Current Procedural Terminology (CPT) codes that specify assessment, e.g., 97755, Assistive Technology Assessment which may be payable). Assessment requires professional skill to gather data by observation and patient inquiry and may include limited objective testing and measurement to make clinical judgments regarding the patient's condition(s). Assessment determines, e.g., changes in the patient's status since the last visit/treatment day and whether the planned procedure or service should be modified. Based on these assessment data, the professional may make judgments about progress toward goals and/or determine that a more complete evaluation or reevaluation (see definitions below) is indicated.

- **Certification:** Certification is the physician's/NonPhysician Practitioner's

(NPP) approval of the plan of care.

- **Evaluation:** Evaluation is a separately payable comprehensive service that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities. Evaluation is warranted e.g., for a new diagnosis or when a condition is treated in a new setting. These evaluative judgments are essential to development of the plan of care, including goals and the selection of interventions. The time spent in evaluation does not also count as treatment time.

- **Reevaluation:** Reevaluation is separately payable and is periodically indicated during an episode of care when the professional assessment indicates a significant improvement or decline, or change in the patient's condition or functional status. Some state regulations and state practice acts require reevaluation at specific times. Reevaluation may also be appropriate at a planned discharge. A reevaluation is focused on evaluation of progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment or terminating services. Reevaluation requires the same professional skills as evaluation. Current Procedural Terminology does not define a reevaluation code for speech-language pathology; use the evaluation code.

- **Interval:** Interval of certified treatment (certification interval) consists of **90 calendar days or less based on an individual's needs.**

- **Nonphysician Practitioners (NPP):** Nonphysician Practitioners (NPP) means physician assistants, clinical nurse specialists, and nurse practitioners who may, if state and local laws permit it, and when appropriate rules are followed, provide, certify or supervise therapy services.

- **Physician:** Physician with respect to outpatient rehabilitation therapy services means a doctor of medicine, osteopathy (including an osteopathic practitioner), podiatric medicine (as authorized by applicable state law), or optometry (for low vision rehabilitation only). Chiropractors and doctors of dental surgery or dental medicine are not considered physicians for therapy services and may neither refer patients for rehabilitation therapy services nor establish therapy plans of care.

- **Qualified Professional:** Qualified professional means a physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to perform therapy services, and who also may appropriately perform therapy services under Medicare policies. Qualified professionals may also include physical therapy assistants (PTA) and occupational therapy assistants (OTA) when working under the supervision of a qualified therapist, within the scope of practice allowed by state law. Assistants may not supervise others.

Qualified Physical Therapist Defined: A qualified physical therapist for program coverage purposes is a person who is licensed, if applicable, as a PT by the state in which he or she is practicing unless licensure does not apply, has graduated from an accredited PT education program and passed a national examination approved by the state in which PT services are provided.

Qualified Occupational Therapist Defined: A qualified occupational therapist for program coverage purposes is an individual who is licensed, if licensure applies, or otherwise regulated, if applicable, as an OT by the state in which

practicing, and graduated from an accredited education program for OT's, and is eligible to take or has passed the examination for OT's administered by the National Board of Certification in Occupational Therapy, Inc. (NBCOT).

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

Qualifications of Auxiliary Personnel: Therapy services appropriately billed incident to a physician's/NPP's service shall be subject to the same requirements as therapy services that would be furnished by a physical therapist, occupational therapist or speech-language pathologist in any other outpatient setting with one exception. When therapy services are performed incident to a physician's/NPP's service, the qualified personnel who perform the service do not need to have a license to practice therapy, unless it is required by state law. The qualified personnel must meet all the other requirements except licensure. The person who furnishes the service to the patient must, at least, be a graduate of a program of training for one of the therapy services as described above. Regardless of any state licensing that allows other health professionals to provide therapy services, Medicare is authorized to pay only for services provided by those trained specifically in physical therapy, occupational therapy or speech-language pathology. That means that the services of athletic trainers, massage therapists, recreation therapists, kinesiotherapists, low vision specialists or any other profession may not be billed as therapy services.

- **Signature:** Signature means a legible identifier of any type acceptable signatures.(e.g., hand written or electronic)(stamped signatures are not acceptable).

- **Supervision Levels:** Supervision levels for outpatient rehabilitation therapy services are the same as those for diagnostic tests. Depending on the setting, the levels include personal supervision (in the room), direct supervision (in the office suite), and general supervision (physician/NPP is available but not necessarily on the premises).

- **Suppliers:** Suppliers of therapy services include individual practitioners such as physicians, NPPs, physical therapists, occupational therapists and speech language pathologists who have Medicare provider numbers.

- **Therapist:** Therapist refers only to qualified physical therapists, occupational therapists and speech-language pathologists.

Other Definitions:

- **Provider:** PM&R services may be billed under one of four different practitioner benefits: (1) by physicians as their own professional services or as services of their employees furnished "incident to" their professional services (2) by physical therapists in private practice, (3) by occupational therapists in private practice or (4) by speech language pathologist in private practice. The term "provider" in this policy includes any of these four.

- **Not covered:** This term means that a requirement in Medicare's definition of the benefit category is not met and coverage is denied. No Medicare payment is made.

- **Not medically reasonable and necessary:** Medicare payment is denied

and the provider may not seek reimbursement from the beneficiary unless he/she has signed a waiver (Advanced Beneficiary Notice)(ABN) for the specific service.

• **Incident to:** This term means services that are:

1. furnished as an integral, although incidental, part of a physician's personal professional services;
2. performed under the physician's direct supervision;
3. performed by qualified therapists or other qualified auxiliary personnel who are employees of the physician (as defined above); and
4. furnished during a course of treatment where the physician performs an initial direct, personal, professional service and performs subsequent services at a frequency that reflects his/her continuing active participation in and management of the course of treatment.

5. The services of a PTA or OTA shall not be billed as services incident to a physician/NPP's service, because they do not meet the qualifications of a therapist.

Direct supervision in the office: This term means that the provider must be physically present in the same office suite and immediately available to provide assistance and direction throughout the time the employee is performing services.

Activities of physical therapy assistants (PTA) and/or occupational therapy assistant (OTA) **require general supervision in all settings except private practice which requires direct supervision of the physical therapist or occupational therapist.** Direct supervision is defined as in the room supervision rather than in the same office suite of a physician-directed clinic where responsibility is shared for supervision of medical services performed by employees of the clinic. The physician who orders a service is not necessarily the same physician who provides direct medical supervision while the service is performed.

Services provided by aides, even if under the supervision of a therapist, are **not** therapy services in the outpatient setting and are not covered under Medicare.

A. General PM&R Guidelines:

For evaluations/re-evaluations, physical therapists should use codes 97001 and 97002, and occupational therapists should use codes 97003 and 97004.

1. Intervention with PM&R modalities and procedures is indicated when an assessment and diagnosis by the physician and/or therapist supports utilization of the intervention; there is documentation of objective physical and functional limitations. PM&R services in providers' offices and patients' homes are covered when reasonable and medically necessary for the treatment of the patient's condition (signs and symptoms). The type, frequency and duration of services must be medically necessary for the patient's condition under accepted medical, physical therapy, and occupational therapy practice standards, and relate directly to a written treatment plan. **There must be an expectation that the condition or the level of function will improve significantly within a reasonable and generally predictable period of time.**

2. For all PM&R modalities and therapeutic procedures on a given day, it is usually not medically necessary to have more than one treatment session per discipline. Depending on the severity of the patient's condition, the usual treatment session provided in the home or office setting is from 30 to 60 minutes. The medical necessity of services for a longer length of time must be documented in the treatment plan. Therapy directed at maintenance of current function is not a Medicare benefit.

3. For **incident to** claims submitted by a physician:

- Services performed by individuals who are not employees, not contracted, or not under a physician/nonphysician practitioner's (based upon the individual State's scope of practice) direct supervision, are not covered.
- Services not relating to a written treatment plan that was established by the therapist or by the physician before treatment began are not covered.
- Services that do not require the professional skills of a physician/nonphysician practitioner to perform or supervise are not medically necessary.

4. For claims submitted by a physical or occupational therapist in private practice:

- Claims submitted by anyone other than a Medicare-certified therapist are not covered.
- Medicare-certified therapists include qualified therapists and qualified therapy assistants, but do not include aides.
- Services provided by aides or physical therapy students, regardless of the level of supervision, are not paid for by Medicare Part B.
- Services not performed by or under the direct supervision of the therapist are not covered.
- Services performed by persons who are not employees of the therapist are not covered.
- Services not relating to a written treatment plan that was established by the therapist or by the physician before treatment began are not covered.
- Physical or occupational therapy services that do not require the professional skills of a qualified physical or occupational therapist to perform or supervise and therefore are not covered.

5. Services provided concurrently by a physician and/or physical therapist and/or occupational therapist may be covered if separate and distinct goals are documented in the treatment plans.

6. Because dementia is a diagnostic term with broad clinical implications, it may not support the medical necessity of a Medicare covered benefit when used alone...When a beneficiary with dementia experiences an illness or injury unrelated to the dementia, the provider should submit a claim with the primary diagnosis that most accurately reflects the need for the provided service. For example, following a hip replacement in a patient with Alzheimer's Disease, a physical therapy provider should submit a clean claim using ICD-9 Code V43.64 (Hip joint replacement by artificial or mechanical device or prosthesis) as the primary diagnosis, not ICD-9 code 331.0 (Alzheimer's Disease). If the patient's dementia is so severe that they would not benefit from the therapy, it would be inappropriate to bill for these services.

7. Certifications are required for each interval of treatment based on the patient's needs not to exceed 90 days from the initial therapy treatment. Certifications are timely when the initial certification (of certification of a significantly modified plan of care) is dated within 30 calendar days of the initial treatment under that plan. Recertification is timely when dated during

the duration of the initial plan of care or within 90 calendar days of the initial treatment under that plan, whichever is less. Delayed certification and recertification requirements shall be deemed satisfied where, at any later date, a physician/NPP makes a certification accompanied by a reason for the delay. Certifications are acceptable without justification for 30 days after they are due. Delayed certification should include one or more certifications or recertifications on a single signed and dated document.

B. Therapy for patients with symptoms from chronic disease:

Note: Use the ICD-9-CM code for the sign/symptom/complication diagnosis. The underlying condition may also be coded, but is not required.

1. Periodic evaluations of the patient's condition and response to treatment may be covered when medically necessary if the judgment and skills of a professional provider are required. Examples include:

- Design of a home therapy regimen required to delay or minimize muscular and functional deterioration in patients suffering from chronic disease;
- Instructing the patient or/and family members in carrying out the therapy program; and,
- Infrequent re-evaluations required to assess the patient's condition and adjust the program. **These services should be billed with the appropriate E/M code** (e.g., 99212-99215 for physicians or NPPs; 97001-97004 for PT and OT only). It is expected that these services will be infrequently required.

2. It is not medically reasonable and necessary for a provider to perform or supervise therapy programs that do not require the professional skills of a provider. These situations include:

- Services related to activities for the general good and welfare of patients (i.e., general exercises to promote overall fitness and flexibility in an otherwise healthy patient);
- Repetitive exercises to maintain gait or maintain strength and endurance, and assisted walking such as that provided in support for feeble or unstable patients;
- Range of motion and passive exercises that are not related to restoration of a specific loss of function, but are useful in maintaining range of motion in paralyzed extremities; and
- Continued therapies after the patient has achieved therapeutic goals or for patients who show no further meaningful progress.
- Maintenance therapy is not covered.

C. General Modality Guidelines: (97010-97039)

Note: 97010 is bundled into the payment for other services and is not separately reimbursable.

1. Modality codes 97012-97028 require supervision (but not one-on-one) patient contact by the provider; and 97032-97039 require direct (one-on-one) patient contact by the provider. These services may be provided "incident to" a physician's services and, if so, must be directly supervised by the physician in his/her office.

2. Modalities 97012 and 97018, are not separately payable when used alone and solely to promote healing, relieve muscle spasm, reduce inflammation and edema, or as analgesia. No more than three visits may be medically necessary to determine the effectiveness of treatment and for patient education. If effective, further treatment may be self-administered in the home and it is not medically necessary to continue treatment by the provider. An exception may be 97012 when used in weaning an acute patient

onto a self-administered home program.

3. Generally, adjunctive use of modalities listed in #2 above is required only if the patient cannot tolerate the therapeutic procedures without them. In these circumstances, it may be medically necessary to furnish these modalities in addition to the therapeutic procedures no more than 4 times a week for one month. Continued use of these modalities may be covered if the patient's record documents that continued use contributed significantly to the patient's progress.

4. Generally, one heating modality is sufficient during a physical therapy session. Documentation of the medical necessity of multiple heating modalities (97018, 97024, 97026, 97034, 97035) on the same day must be available for review. Exceptions are rare and usually involve musculoskeletal pathology/injuries in which both superficial and deep structures are impaired or when dealing with particularly severe hand deformities.

5. Modalities 97022 (whirlpool) and 97036 (Hubbard tank) are subject to the guideline in #4 above when the sole purpose of these modalities is to relieve muscle spasm, inflammation or edema. When 97022 or 97036 are used to treat wounds or other skin conditions, other modalities could be necessary to treat other conditions on the same day.

6. Some of the modalities are considered components of other modalities and procedures and will not be separately reimbursed. Please refer to the National Correct Coding Initiative which can be found on the CMS Website (<http://www.cms.hhs.gov>). Documentation must be available supporting the use of multiple modalities as contributing to the patient's progress and restoration of function.

7. Physical agents and modalities, in the absence of documentation justifying use, and in the absence of other skilled therapeutic or educational interventions, should not be considered physical therapy.

D. Specific Modality Guidelines: The following clinical guidelines pertain to the specific modalities listed below. Please refer to the "ICD-9-CM Codes That Support Medical Necessity" section in this policy for appropriate covered diagnoses to be used.

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

- **95992 Epley maneuver** is used for the treatment of benign paroxysmal positional vertigo (BPPV). There is no provision for direct payment to physicians, nonphysician practitioners and audiologist for this therapeutic service. When physical therapist provide this service they should continue to bill CPT code 97112.

- 95992 is a bundled service and is currently being reimbursed as part of an Evaluation and Management (E and M) service.

97010 Application of a modality to one or more areas; hot or cold packs

- **97010 is bundled into the payment for other services and is not separately reimbursable.**

97012 Application of a modality to one or more areas; traction, mechanical

- Supervised treatment would not be expected to exceed up to 4 sessions per week for longer than one month. Patients requiring continued treatment beyond this time are usually trained in the use of a home traction unit. Continued treatment by a provider may require documentation supportive of medical necessity.
- This modality is typically used in conjunction with therapeutic procedures, not as an isolated treatment.

97014 Application of a modality to one or more areas; electrical stimulation (unattended)

- For unattended electrical stimulation HCPCS G0281 for wound care of ulcers should be used and G0283 other than wound care, as part of a therapy plan of care
- For attended electrical stimulation, please refer to CPT 97032.

97016 Application of a modality to one or more areas; vasopneumatic devices

- It may be necessary to reduce edema after acute injury.
- Education for use of lymphedema pump in the home usually requires no more than 2 sessions.
- Further treatment of lymphedema by the provider after the educational visits is generally not medically necessary.
- Supportive documentation for additional visits must be available for review.

97018 Application of a modality to one or more areas; paraffin bath

- Also known as hot wax treatment, this is primarily used for pain relief in chronic joint problems of the wrist, hands, or feet.
- No more than two visits are usually sufficient to educate the patient in home use and to evaluate effectiveness.
- Continued treatment by a provider may require supportive documentation of medical necessity.

97022 Application of a modality to one or more areas; whirlpool

97024 Application of a modality to one or more areas; diathermy

Diathermy coverage criteria and definition are found in the CMS Manual System, Pub. 100-03, Medicare National Coverage Determinations (Internet-Only Manual)

97026 Application of a modality to one or more areas; infrared

NOTE: Monochromatic infrared photo energy (MIRE™), anodyne, anodyne therapy, or similar devices are NOT covered services. Therefore, it is not appropriate to bill using 97026 when utilizing monochromatic infrared photo energy (MIRE™), anodyne, anodyne therapy, or similar devices. Please refer to the procedure code 97799 for further instructions.

97028 Application of a modality to one or more areas; ultraviolet

- These services, in addition to all other therapy services, must be prescribed by the attending physician.

97032 Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes

This modality includes the following types of electrical stimulation:

- Transcutaneous electrical nerve stimulation (TENS) is used primarily for pain control. No more than a single office session will be allowed for the purpose of training for in-home use.
- Neuromuscular stimulation: Used for retraining weak muscles following surgery or injury.
- Muscle stimulation: This type of stimulation is taken to the point of visible muscle contraction.
- High voltage pulsed current, also called electrogalvanic stimulation, may be useful for reducing swelling and for control of pain.
- Interferential current/medium current: These units use a frequency that allows the current to go deeper. IFC is used to control swelling and pain.
- These uses may be necessary during the initial phase of treatment, but there must be an expectation of improvement in function, and must be utilized with appropriate therapeutic procedures (e.g., 97110) to effect continued improvement.
- Electrical stimulation is typically used in conjunction with therapeutic exercises. A limited number of visits without a therapeutic procedure may be medically necessary for treatment of muscle spasm and swelling.
- Treatment would not be expected to exceed 4 treatments per week, for no longer than one month when used as adjunctive therapy or for muscle retraining.
- When electrical stimulation is used for muscle strengthening or retraining, the nerve supply to the muscle must be intact. It is not medically necessary for motor nerve disorders such as Bell's Palsy. It is not medically necessary when there is limited potential for restoration of function.

• **Microamperage E-stimulation (MENS) has not been proven effective and will be denied as such. It is inappropriate to use the CPT code 97032 or 97039 for MENS therapy.** Please refer to the procedure code 97799 for further instructions.

• **E-Stim (Vital Stim)** has not been proven effective and will be denied as such. It is inappropriate to use the CPT code 97032 for E-Stim (Vital Stim). Please refer to the procedure code 97799 for further instructions.

97033 Application of a modality to one or more areas; iontophoresis, each 15 minutes

1. Iontophoresis is a process in which electrically charged molecules or atoms (i. e., ions) are driven into tissue with an electrical field. Voltage provides the driving force. Parameters such as drug polarity and electrophoretic mobility must be known in order to be able to assess whether iontophoresis can deliver therapeutic concentrations of a medication at sites below the skin.

2. The application of iontophoresis is considered reasonable and necessary for the topical delivery of medications into a specific area of the body.

3. Specific indications for the use of iontophoresis application include:

- a. The patient having tendonitis or calcific tendonitis
- b. The patient having bursitis
- c. The patient having adhesive capsulitis
- d. The patient having hyperhidrosis
- e. Thick adhesive scar(s)

97034 Application of a modality to one or more areas; contrast baths,

each 15 minutes

- This modality may be useful to treat extremities affected by reflex sympathetic dystrophy, acute edema resulting from trauma, or synovitis/tenosynovitis. It is generally used as an adjunct to a therapeutic procedure.
- Treatment would not be expected to exceed 4 treatments per week for longer than one month.

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

- This modality is used primarily to treat inflammation of periarticular structures, neuromas, pain, muscle spasms, contractures, and to soften adhesive scars.
- Treatment would not be expected to exceed 4 treatments per week for longer than one month.

97036 Application of a modality to one or more areas; Hubbard tank, each 15 minutes

- This modality involves the use of agitated water in order to relieve muscle spasm, improve circulation, or cleanse wounds e.g., ulcers, exfoliative skin conditions.
- Physician or therapist supervision of the whirlpool modality is already required but especially for the following indications:
The patient's condition is complicated by circulatory deficiency or
The patient's condition is complicated by areas of desensitization
- Treatment would not be expected to exceed 4 treatments per week for longer than one month.
- It is not medically necessary to have more than one form of hydrotherapy during a visit (CPT codes 97022, 97036, 97113), during the same visit.

97039 Unlisted modality (specify type and time if constant attendance)

For all claims submitted for unlisted services or procedures, the following documentation must be submitted:

- A description of the service or procedure; and,
- A treatment plan including information indicating the medical necessity of the service or procedure.

• Vertebral Axial Decompression (VAX-D®)

Vertebral Axial Decompression (VAX-D®) is not covered by Medicare. Medicare notes that there is insufficient scientific data to support a finding of significant benefits of this technique. If billing for a denial for the provision of this service, you must use procedure code 97799 (Unlisted physical medicine/rehabilitation service or procedure) and enter "VAX-D®" in Item 19 on the CMS 1500 claim form, or electronic equivalent. An Advance Beneficiary Notice (ABN) should be obtained when VAX-D® is utilized. DO NOT bill using 64722, decompression, unspecified nerves, or 97012, application of modality, traction, mechanical

• MedX, SPINEX®, or DRX9000™

This A/B MAC, based on the advice of Physical Therapy consultants, considers MedX or SPINEX® or DRX9000™ treatments to also be non-covered, and such services will be denied as not proven effective. Use procedure code 97799, Unlisted physical medicine/rehabilitation service or

procedure, and enter "MedX" or "SPINEX®" or "DRX9000™" in Item 19 on the CMS 1500 claim form, or electronic equivalent. An Advance Beneficiary Notice (ABN) should be obtained when MedX or SPINEX® or DRX9000™ is utilized.

This A/B MAC will deny VAX-D®, MedX, SPINEX®, DRX9000™ and other similar devices as not proven effective. Providers may not bill the beneficiary unless the provider has previously informed the beneficiary that this service will be denied by Medicare and has obtained his/her signature on a valid Advance Beneficiary Notice (ABN) before providing this service.

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.

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.

Note: Medicare will not cover the electromagnetic energy treatment device (Code **E0761**) used for electromagnetic treatment of wounds, nor will Medicare cover unsupervised home use of electromagnetic therapy.

E. General Guidelines for Therapeutic Procedures 97110-97546:

The following clinical guidelines pertain to the specific therapeutic procedures listed below. Please refer to the "ICD-9-CM Codes That Support Medical Necessity" section in this policy for appropriate covered diagnoses to be used with these therapeutic procedures.

1. Therapeutic procedures are procedures that attempt to reduce impairments and improve function through the application of clinical skills and/or services.
2. Use of these procedures requires that the practitioner have direct (one-on-one) patient contact. In physicians' offices, the "incident to" provisions apply.
3. These procedures describe several different types of therapeutic intervention. The expected goals documented in the treatment plan, effected by the use of each of these procedures, will help define whether these procedures are medically reasonable and necessary. Therefore, since any one or a combination of more than one of these procedures may be used in a treatment plan, documentation must support the use of each code as it relates to a specific therapeutic goal.
4. For 97110-97112, treatment would not be expected to exceed 18 visits within an 8 week period.
5. Services provided concurrently by a physician, physical therapist and occupational therapist may be covered if separate and distinct goals are documented in the treatment plans.
6. For 97110, 97116, 97532, 97533, 97535 and 97537: A Medicare

beneficiary with vision loss may be eligible for rehabilitation services designed to improve functioning, by therapy, to improve performance of activities of daily living, including self-care and home management skills. Evaluation of the patient's level of functioning in activities of daily living, followed by implementation of a therapeutic plan of care aimed at safe and independent living, is critical and should be performed by an occupational or physical therapist. (Physical Therapy and Occupational Therapy assistants cannot perform such evaluations.)

Vision impairment ranging from low vision to total blindness may result from a primary eye diagnosis, such as macular degeneration, retinitis pigmentosa or glaucoma, or as a condition secondary to another primary diagnosis, such as diabetes mellitus or acquired immune deficiency syndrome (AIDS).

In accordance with established conditions, all rehabilitation services to beneficiaries with a primary vision impairment diagnosis must be provided pursuant to a written treatment plan established by a Medicare physician (including Doctors of Optometry where allowed within their State scope of practice for low vision services only), and implemented by approved Medicare providers or incident to physician services. Some of the following rehabilitation programs/services for beneficiaries with vision impairment may include Medicare covered therapeutic services:

- Mobility;
- Activities of Daily Living; and
- Other rehabilitation goals that are medically necessary.

The patient must have a potential for restoration or improvement of lost functions, and must be expected to improve significantly within a reasonable and generally predictable amount of time. Rehabilitation services are not covered if the patient is unable to cooperate in the treatment program or if clear goals are not definable. Most rehabilitation is short term and intensive.

Maintenance therapy - services required to maintain a level of functioning - are **not** covered.

97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility:

- Therapeutic exercise is performed with a patient either actively, active-assisted, or passively (e.g., treadmill, isokinetic exercise, lumbar stabilization, stretching, strengthening). The exercise may be medically reasonable and necessary for a loss or restriction of joint motion, strength, functional capacity or mobility, which has resulted from a specific disease or injury.
- Documentation must show objective loss of joint motion, strength, or mobility (e.g., degrees of motion, strength grades, levels of assistance with exercise).

97112 Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities:

- This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, and proprioception (e.g., proprioceptive neuromuscular facilitation, Feldenkreis, Bobath, BAP's boards and desensitization techniques). The procedure may be medically reasonable and necessary for impairments which affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, hypo/hypertonicity) or which cause loss of

proprioception.

97113 Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises:

- This procedure uses the therapeutic properties of water (e.g., buoyancy, resistance). The procedure may be medically reasonable and necessary for a loss or restriction of joint motion, strength, mobility, or function that has resulted from a specific disease or injury. Documentation must show objective loss of joint motion, strength, or mobility (e.g., degrees of motion, strength grades, levels of assistance).
- This code should not be used in situations where no exercise is being performed in the water environment (e.g., debridement of ulcers).
- Other forms of exercise therapy may be medically necessary in addition to aquatic therapy when the patient cannot perform land-based exercises effectively to treat his/her condition without first undergoing the aquatic therapy, or when aquatic therapy facilitates progress to land-based exercise or increased function. Documentation must be available in the record to support medical necessity.
- It is not medically necessary to have more than one form of hydrotherapy (codes 97022, 97036, 97113) during the same visit.

97116 Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing):

- This procedure may be medically necessary for training patients whose walking abilities have been impaired by neurological, muscular or skeletal abnormalities or trauma.
- This procedure is not medically reasonable and necessary when the patient's walking ability is not expected to improve.
- Repetitive walk-strengthening exercise for feeble or unstable patients or to increase endurance do not require provider supervision and will be denied as not reasonable and necessary.
- The medical record should document the distinct treatments rendered when gait training for a lower extremity is done during the same visit as orthotic fitting and training (97760), prosthetic training (97761), or self care/home management training (97535).

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

- This procedure may be medically necessary as adjunctive treatment to another therapeutic procedure on the same day, which is designed to restore muscle function, reduce edema, improve joint motion, or for relief of muscle spasm.
- In most cases, postural drainage and pulmonary exercises can be carried out safely and effectively by nursing personnel. If the attending physician determines that for the safe and effective administration of these procedures, the professional skills of a physical therapist are required, coverage may be allowed. Documentation of the severity of the pulmonary condition and referral by the physician must be available.

97139 Unlisted therapeutic procedure (specify)

For all claims submitted for unlisted services or procedures, the following documentation must be submitted:

- A description of the service or procedure; and,
- A treatment plan including information indicating the medical necessity of

the service or procedure

97140 Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes

- This procedure may be medically necessary as an adjunctive therapeutic procedure to another therapeutic procedure on the same day, e.g., massage or gait training.
- The above description of 97140 includes different forms of manual therapy. This is not an all inclusive list and not intended to exclude other forms of manual therapy.
- "Manual" entails the use of hands. Thus, 97140 is for hands-on therapy only.

97150 Therapeutic procedure(s), group (2 or more individuals):

- Since many group procedures do not require the professional skills of a provider, the need for skilled intervention must be documented and submitted upon request.
- Documentation must be maintained in the medical record identifying the specific treatment technique(s) used in the group, how the treatment technique will restore function, the frequency and duration of the particular group setting, and the treatment goal in the individualized plan. The number of persons in the group must also be furnished. The medical record must be made available upon request.
- Group therapy is defined as payment for physical therapy services (which includes speech-language pathology services) and occupational therapy services provided simultaneously to two or more individuals by a practitioner. The individuals can be, but need not be, performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.

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

- The medical record should document the distinct treatments rendered when orthotic training for a lower extremity is done during the same visit as gait training (97116), prosthetic training (97761), or self care/home management training (97535).
- It is unusual to require more than 30 minutes of static orthotic training. In some cases, dynamic training may require more additional time and when this occurs the medical record must document the medical necessity of additional time.

Note: The following items are included in the Durable Medical Equipment Medicare Administration Contractors (DMAC) reimbursement for an orthosis within 90 days of delivery of the orthosis and, therefore, are not separately billable to Medicare:

- a. Evaluation of the orthosis and/or gait
- b. Fitting of the orthosis
- c. Cost of base component parts and labor contained in HCPCS base codes
- d. Repairs due to normal wear or tear
- e. Adjustments of the orthosis or the orthotic component made when fitting the orthotic or component when the adjustments are not necessitated by changes in the patient's functional abilities.

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

minutes:

- The medical record should document the distinct goals and service rendered when prosthetic training for a lower extremity is done during the same visit as gait training (97116), orthotics fitting and training (97760) or self care/home management training (97535).
- Periodic revisits beyond the third month may require supportive documentation of medical necessity if requested.
- In some cases, prosthetic training may require more than 30 minutes on a given date and when this occurs the medical record must document the medical necessity of the additional time.

Note: The following items are included in the Durable Medical Equipment Medicare Administration Contractors (DMAC) reimbursement for a prosthesis within 90 days of delivery of the prosthesis and, therefore, are not separately billable to Medicare:

- Evaluation of the residual limb and/or gait
- Fitting of the prosthesis
- Cost of base component parts and labor contained in HCPCS base codes
- Repairs due to normal wear or tear
- Adjustments of the prosthesis or the prosthetic component made when fitting the prosthesis or component when the adjustments are not necessitated by changes in the residual limb or the patient's functional abilities.

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

- This procedure involves using functional activities (e.g., bending, lifting, carrying, reaching, catching and overhead activities) to improve functional performance in a progressive manner.
- The activities are usually directed at a loss or restriction of mobility, strength, balance or coordination. They require the professional skills of a provider and are designed to address a specific functional need of the patient. These dynamic activities must be part of an active treatment plan and directed at a specific outcome.

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

- Compensatory training is provided to make up for a deficiency or loss of cognitive skills resulting from brain injury or psychiatric disorders.
- Cognitive impairments addressed by this code include attentional impairments (loss of focused, sustained, alternating and divided attention), short term memory impairments, and problem solving impairments (inability to initiate a behavioral response, to organize parts or concepts or thoughts into a whole, and to sequence thoughts so as to modify behavior).
- This procedure is not medically reasonable and necessary when the patient's cognitive skills are not expected to improve.
- This therapy may be necessary during the initial phase of treatment, but there must be an expectation of improvement in function, and must be utilized with appropriate therapeutic procedures to effect continued improvement.

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

- These treatments are performed when a deficit in processing input from one of the sensory systems decreases the patient's ability to make adaptive sensory, motor, and behavioral responses to environmental demands.
- These patients may demonstrate sensory defensiveness, over-reactivity to environmental stimuli, attention difficulties, and behavioral problems.
- Sensory integrative interventions enhance sensory processing by persons with deficits in sensory systems (e. g., vestibular, proprioceptive, tactile) by increasing their ability to make adaptive sensory, motor, and behavioral responses to environmental demand.
- Sensory integrative treatments are almost exclusively provided to a pediatric population for responses to environmental demand and are almost exclusively provided for conditions such as autism, developmental disorders, attention deficit hyperactivity disorder, cerebral palsy, and motor apraxia. Similar techniques used in treatment for adults should be coded with 97112.
- This procedure is not medically reasonable and necessary when the patient's sensory processing and adaptive responses are not expected to improve.
- This therapy may be necessary during the initial phase of treatment, but there must be an expectation of improvement in function, and must be utilized with appropriate therapeutic procedures to effect continued improvement.

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

- This procedure is medically necessary only when it requires the professional skills of a provider, is designed to address specific needs of the patient, and must be part of an active treatment plan directed at a specific outcome.
- The patient must have the capacity to learn from instructions.
- Medical treatment may generally require up to 12 visits in 4 weeks. Coverage beyond 12 visits in 4 weeks may require documentation supporting the medical necessity of continued treatment.
- Documentation must relate the training to expected functional goals that are attainable by the patient.
- The medical record should document the distinct goals and service rendered when self-care/home management training is done during the same visit as gait training (97116), orthotics fitting and training (97760) or prosthetic training (97761).

97537 Community/work reintegration training (e.g., 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 by provider, each 15 minutes:

- This training may be medically necessary when performed in conjunction with a patient's individual treatment plan aimed at improving or restoring specific functions which were impaired by an identified illness or injury and when expected outcomes that are attainable by the patient are specified in the plan.
- This training is medically necessary only when it requires the professional skills of a provider. Generally speaking, the professional skills of a provider are not required to effect improvement or restoration of function where a patient suffers a temporary loss or reduction of function which could reasonably be expected to improve as the patient gradually resumes normal

activities. General activity programs and all activities which are primarily social or diversional in nature will be denied because the professional skills of a provider are not required.

- Services which are related solely to specific employment opportunities, work skills or work settings are not reasonable and necessary for the diagnosis and treatment of an illness or injury and are excluded from coverage.
- The CPT code 97537 was expanded to complement the 97755 assessment code. The modification is intended to allow the post-assessment patient fitting and training for use of the advanced technology device/adaptive equipment.
- The patient must have the capacity to learn from instructions.
- Medical treatment may generally require up to 12 visits in 4 weeks.
- Documentation must relate the training to expected functional goals that are attainable by the patient.

97542 Wheelchair management/propulsion training, each 15 minutes:

- This procedure is medically necessary only when it requires the professional skills of a provider, is designed to address specific needs of the patient, and must be part of an active treatment plan directed at a specific goal.
- The patient must have the capacity to learn from instructions.
- Documentation of medical necessity must be available on request for an unusual frequency or duration of training sessions. Typically no more than 4 total sessions are sufficient.
- When billing 97542 for wheelchair propulsion training, documentation must relate the training to expected functional goals that are attainable by the patient.

97545 Work hardening/conditioning; initial 2 hours:

97546 Work hardening/conditioning; each additional hour:

- These services are related solely to specific work skills and will be denied as not a Medicare benefit

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

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

- Though more than one wound may have been debrided, either code 97597 or 97598 may be billed only once per session.
- Consistent with reasonable and necessary guidelines, providers may bill CPT 11000-11044 codes. However, the providers should not bill 11000-11044 codes and the 97597 or 97598 together. Note that the 11000-11044 codes may be billed only by physicians (MDs and DOs) and qualified nonphysician practitioners (PA, NP, CNS), as defined by CMS and as allowed by individual State scope of practice.
- Billing for 97597 and 97598 entails all of the elements of these codes; i.e., debridement, wound assessment, and instructions for ongoing care.
- The simple removal and replacement of a dressing of any kind is "non-selective" debridement and is always bundled into another service.
- Per 2005 CPT, do not report 97597-97602 in conjunction with 11040-11044.
- If whirlpool is used for the same wound prior to selective debridement, it is

bundled into the new code (97597 or 97598). However, if whirlpool is used for a different body part or body area on the same date of service than the area being debrided, it could be billed.

97601 This code has been deleted, to report use 97597 or 97598

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

97605 Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total

wound(s) surface area less than or equal to 50 square centimeters

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

NOTE: These three codes (97602, 97605, 97606) are "bundled" services and not separately payable by Medicare or billable to the patient.

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

- These assessments may be medically necessary when a device is newly issued or there is a modification or re-issue of the device.
- These assessments may be medically necessary when patients experience loss of function directly related to the orthotic or prosthetic device (e.g., pain, skin breakdown, or falls).
- Requires direct one-on-one patient contact

Note: The following items are included in the Durable Medical Equipment Medicare Administrative Contractors (DMAC) reimbursement for a prosthesis/orthosis within 90 days of delivery of the prosthesis/orthosis and, therefore, are not separately billable to Medicare:

- a. Evaluation of the residual limb and/or gait
- b. Fitting of the prosthesis/orthosis
- c. Cost of base component parts and labor contained in HCPCS base codes
- d. Repairs due to normal wear or tear
- e. Adjustments of the prosthesis/orthosis or the prosthetic component/orthotic component made when fitting the prosthesis/orthosis or component when the adjustments are not necessitated by changes in the residual limb or the patient's functional abilities.

97750 Physical Performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes:

- This testing may be medically necessary for patients with neurological or musculoskeletal conditions when such tests are needed to formulate or evaluate a specific treatment plan, or to determine a patient's capacity.
- The patient's medical record must document the problem requiring tests, the specific tests performed, and measurement report.
- Documentation of the need for more than 30 minutes of time should be submitted upon request.
- Requires direct one-on-one patient contact

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

- This procedure is medically necessary only when it requires the professional skills of a provider, is designed to address specific needs of the patient, and must be part of an active treatment plan directed at a specific outcome.
- The patient must have the capacity to learn from instructions.
- Documentation must relate the training to expected functional goals that are attainable by the patient.
- Requires direct one-on-one patient contact.

97799 Unlisted physical medicine/rehabilitation service or procedure:

For all claims submitted for unlisted services or procedures, the following documentation must be submitted:

- A description of the service or procedure; and,
- A treatment plan including information indicating the medical necessity of the service or procedure

• **Microamperage E-stimulation (MENS) has not been proven effective and will be denied as such.** If MENS therapy is billed to Medicare for a denial, such as in cases of supplemental coverage, providers should bill using procedure code 97799, placing "MENS therapy" in Item 19 on the CMS 1500 form or equivalent electronic field. An Advance Beneficiary Notice (ABN) should be obtained when MENS is utilized.

• **Vertebral Axial Decompression (VAX-D®)**

Vertebral Axial Decompression (VAX-D®) is not covered by Medicare. Medicare notes that there is insufficient scientific data to support a finding of significant benefits of this technique. If billing for a denial for the provision of this service, you must use procedure code 97799, Unlisted physical medicine/rehabilitation service or procedure, and enter "VAX-D®" in Item 19 on the CMS 1500 claim form, or electronic equivalent. An Advance Beneficiary Notice (ABN) should be obtained when VAX-D® is utilized. DO NOT bill using 64722, decompression, unspecified nerves, or 97012, application of modality, traction, mechanical

• **MedX or SPINEX® or DRX9000™**

This A/B MAC, based on the advice of Physical Therapy consultants, considers MedX or SPINEX® or DRX9000™ treatments to also be non-covered, and such services will be denied as not proven effective. Use procedure code 97799, Unlisted physical medicine/rehabilitation service or procedure, and enter "MedX" or "SPINEX®" or "DRX90000™" in Item 19 on the CMS 1500 claim form, or electronic equivalent. An Advance Beneficiary Notice (ABN) should be obtained when MedX or SPINEX® are utilized.

This A/B MAC will deny VAX-D®, MedX, SPINEX® and other similar devices as not proven effective. Providers may not bill the beneficiary unless the provider has previously informed the beneficiary that this service will be denied by Medicare and has obtained his/her signature on a valid Advance Beneficiary Notice (ABN) before providing this service.

• **Monochromatic infrared photo energy (MIRE™), anodyne, anodyne therapy, or similar devices** are **NOT** covered services. Use procedure code 97799, Unlisted physical medicine/rehabilitation service or procedure, and enter "**monochromatic infrared photo energy (MIRE™), anodyne, anodyne therapy, or similar devices**" in Item 19 on the CMS 1500 claim form, or in the equivalent field on the electronic claims. This A/B MAC will

deny this service as not proven effective.

- **E-Stim (Vital Stim) for speech-language therapy for dysphagia or late effects CVA dysphasia has not been proven effective and will be denied as such. Currently there is limited literature supporting the use of E-Stim for dysphagia, therefore, it remains investigational and non-covered by Medicare.**

97810 Acupuncture, one or more needles; without electrical stimulation, initial 15 minutes or personal one-on-one contact with the patient

97811 each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)

97813 Acupuncture, one or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient

97814 each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)

NOTE: These four codes (97810, 97811, 97813, 97814) are **not covered services** by Medicare.

Coding Information

Bill Type Codes: [back to top](#)

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.

999x Not Applicable

Revenue Codes: [back to top](#)

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**.

99999 Not Applicable

CPT/HCPCS Codes [back to top](#)

Please note that the following codes are non-covered for Medicare Part B:

95992 "B" Status - Bundled Service, cannot be separately billed to Medicare
 97005 "I" Status – not valid for Medicare
 97006 "I" Status – not valid for Medicare
 97010 "B Status" – Bundled Service, cannot be separately billed to Medicare
 97014 Replaced with G0281 for wound care and for ulcers and G0283 for other than wound care, as part of a therapy plan of care
 97033 Will be denied as not proven effective
 97545 Restricted code – not covered by Medicare
 97546 Restricted code – not covered by Medicare
 97810 Noncovered Service
 97811 Noncovered Service
 97813 Noncovered Service
 97814 Noncovered Service
 G0282 Noncovered Service

The following CPT/HCPCS codes addressed in this policy are the CPT/HCPCS codes that are considered for reimbursement under the Medicare Part B program.

Consult your current CPT book for complete descriptions.

97001	Pt evaluation
97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy eg, microwave
97028	Ultraviolet therapy
97032	Electrical stimulation
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97039	Physical therapy treatment
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97139	Physical medicine procedure
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities

97532	Cognitive skills development
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97597	Active wound care/20 cm or <
97598	Active wound care > 20 cm
97602	Wound(s) care non-selective
97605	Neg press wound tx, < 50 cm
97606	Neg press wound tx, > 50 cm
97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic mgmt and training
97761	Prosthetic training
97762	C/o for orthotic/prosth use
97799	Physical medicine procedure
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers

ICD-9 Codes that Support Medical Necessity [back to top](#)

138	LATE EFFECTS OF ACUTE POLIOMYELITIS
306.0	MUSCULOSKELETAL MALFUNCTION ARISING FROM MENTAL FACTORS
333.6	GENETIC TORSION DYSTONIA
333.71	ATHETOID CEREBRAL PALSY
333.72	ACUTE DYSTONIA DUE TO DRUGS
333.79	OTHER ACQUIRED TORSION DYSTONIA
333.83	SPASMODIC TORTICOLLIS
333.84	ORGANIC WRITERS' CRAMP
333.85	SUBACUTE DYSKINESIA DUE TO DRUGS
333.91	STIFF-MAN SYNDROME
334.0 - 336.9	FRIEDREICH'S ATAXIA - UNSPECIFIED DISEASE OF SPINAL CORD
337.21	REFLEX SYMPATHETIC DYSTROPHY OF THE UPPER LIMB
337.22	REFLEX SYMPATHETIC DYSTROPHY OF THE LOWER LIMB

337.29	REFLEX SYMPATHETIC DYSTROPHY OF OTHER SPECIFIED SITE
342.00	FLACCID HEMIPLEGIA AND HEMIPARESIS AFFECTING UNSPECIFIED SIDE
342.01	FLACCID HEMIPLEGIA AND HEMIPARESIS AFFECTING DOMINANT SIDE
342.02	FLACCID HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
342.10	SPASTIC HEMIPLEGIA AND HEMIPARESIS AFFECTING UNSPECIFIED SIDE
342.11	SPASTIC HEMIPLEGIA AND HEMIPARESIS AFFECTING DOMINANT SIDE
342.12	SPASTIC HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
342.80	OTHER SPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING UNSPECIFIED SIDE
342.81	OTHER SPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING DOMINANT SIDE
342.82	OTHER SPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
342.90	UNSPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING UNSPECIFIED SIDE
342.91	UNSPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING DOMINANT SIDE
342.92	UNSPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
343.0	CONGENITAL DIPLEGIA
343.1	CONGENITAL HEMIPLEGIA
343.2	CONGENITAL QUADRIPLEGIA
343.3	CONGENITAL MONOPLÉGIA
343.4	INFANTILE HEMIPLEGIA
343.8	OTHER SPECIFIED INFANTILE CEREBRAL PALSY
343.9	INFANTILE CEREBRAL PALSY UNSPECIFIED
344.00	QUADRIPLEGIA UNSPECIFIED
344.01	QUADRIPLEGIA C1-C4 COMPLETE
344.02	QUADRIPLEGIA C1-C4 INCOMPLETE
344.03	QUADRIPLEGIA C5-C7 COMPLETE
344.04	QUADRIPLEGIA C5-C7 INCOMPLETE
344.09	OTHER QUADRIPLEGIA
344.1	PARAPLEGIA
344.2	DIPLEGIA OF UPPER LIMBS
344.30	MONOPLÉGIA OF LOWER LIMB AFFECTING UNSPECIFIED SIDE

344.31	MONOPLÉGIA OF LOWER LIMB AFFECTING DOMINANT SIDE
344.32	MONOPLÉGIA OF LOWER LIMB AFFECTING NONDOMINANT SIDE
344.40	MONOPLÉGIA OF UPPER LIMB AFFECTING UNSPECIFIED SIDE
344.41	MONOPLÉGIA OF UPPER LIMB AFFECTING DOMINANT SIDE
344.42	MONOPLÉGIA OF UPPER LIMB AFFECTING NONDOMINANT SDE
344.5	UNSPECIFIED MONOPLÉGIA
344.60	CAUDA EQUINA SYNDROME WITHOUT NEUROGENIC BLADDER
344.61	CAUDA EQUINA SYNDROME WITH NEUROGENIC BLADDER
344.81	LOCKED-IN STATE
344.89	OTHER SPECIFIED PARALYTIC SYNDROME
344.9	PARALYSIS UNSPECIFIED
346.00	MIGRAINE WITH AURA, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITHOUT MENTION OF STATUS MIGRAINOSUS
346.01	MIGRAINE WITH AURA, WITH INTRACTABLE MIGRAINE, SO STATED, WITHOUT MENTION OF STATUS MIGRAINOSUS
346.02	MIGRAINE WITH AURA, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITH STATUS MIGRAINOSUS
346.03	MIGRAINE WITH AURA, WITH INTRACTABLE MIGRAINE, SO STATED, WITH STATUS MIGRAINOSUS
346.10	MIGRAINE WITHOUT AURA, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITHOUT MENTION OF STATUS MIGRAINOSUS
346.11	MIGRAINE WITHOUT AURA, WITH INTRACTABLE MIGRAINE, SO STATED, WITHOUT MENTION OF STATUS MIGRAINOSUS
346.12	MIGRAINE WITHOUT AURA, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITH STATUS MIGRAINOSUS
346.13	MIGRAINE WITHOUT AURA, WITH INTRACTABLE MIGRAINE, SO STATED, WITH STATUS MIGRAINOSUS
346.20	VARIANTS OF MIGRAINE, NOT ELSEWHERE CLASSIFIED, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITHOUT MENTION OF STATUS MIGRAINOSUS
346.21	VARIANTS OF MIGRAINE, NOT ELSEWHERE CLASSIFIED, WITH INTRACTABLE MIGRAINE, SO STATED, WITHOUT MENTION OF STATUS MIGRAINOSUS
346.22	VARIANTS OF MIGRAINE, NOT ELSEWHERE CLASSIFIED, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITH STATUS MIGRAINOSUS
346.23	VARIANTS OF MIGRAINE, NOT ELSEWHERE CLASSIFIED,

	WITH INTRACTABLE MIGRAINE, SO STATED, WITH STATUS MIGRAINOSUS
346.30	HEMIPLEGIC MIGRAINE, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITHOUT MENTION OF STATUS MIGRAINOSUS
346.31	HEMIPLEGIC MIGRAINE, WITH INTRACTABLE MIGRAINE, SO STATED, WITHOUT MENTION OF STATUS MIGRAINOSUS
346.32	HEMIPLEGIC MIGRAINE, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITH STATUS MIGRAINOSUS
346.33	HEMIPLEGIC MIGRAINE, WITH INTRACTABLE MIGRAINE, SO STATED, WITH STATUS MIGRAINOSUS
346.40	MENSTRUAL MIGRAINE, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITHOUT MENTION OF STATUS MIGRAINOSUS
346.41	MENSTRUAL MIGRAINE, WITH INTRACTABLE MIGRAINE, SO STATED, WITHOUT MENTION OF STATUS MIGRAINOSUS
346.42	MENSTRUAL MIGRAINE, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITH STATUS MIGRAINOSUS
346.43	MENSTRUAL MIGRAINE, WITH INTRACTABLE MIGRAINE, SO STATED, WITH STATUS MIGRAINOSUS
346.50	PERSISTENT MIGRAINE AURA WITHOUT CEREBRAL INFARCTION, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITHOUT MENTION OF STATUS MIGRAINOSUS
346.51	PERSISTENT MIGRAINE AURA WITHOUT CEREBRAL INFARCTION, WITH INTRACTABLE MIGRAINE, SO STATED, WITHOUT MENTION OF STATUS MIGRAINOSUS
346.52	PERSISTENT MIGRAINE AURA WITHOUT CEREBRAL INFARCTION, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITH STATUS MIGRAINOSUS
346.53	PERSISTENT MIGRAINE AURA WITHOUT CEREBRAL INFARCTION, WITH INTRACTABLE MIGRAINE, SO STATED, WITH STATUS MIGRAINOSUS
346.60	PERSISTENT MIGRAINE AURA WITH CEREBRAL INFARCTION, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITHOUT MENTION OF STATUS MIGRAINOSUS
346.61	PERSISTENT MIGRAINE AURA WITH CEREBRAL INFARCTION, WITH INTRACTABLE MIGRAINE, SO STATED, WITHOUT MENTION OF STATUS MIGRAINOSUS
346.62	PERSISTENT MIGRAINE AURA WITH CEREBRAL INFARCTION, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITH STATUS MIGRAINOSUS
346.63	PERSISTENT MIGRAINE AURA WITH CEREBRAL INFARCTION, WITH INTRACTABLE MIGRAINE, SO STATED, WITH STATUS MIGRAINOSUS
346.70	CHRONIC MIGRAINE WITHOUT AURA, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITHOUT MENTION OF STATUS MIGRAINOSUS

346.71	CHRONIC MIGRAINE WITHOUT AURA, WITH INTRACTABLE MIGRAINE, SO STATED, WITHOUT MENTION OF STATUS MIGRAINOSUS
346.72	CHRONIC MIGRAINE WITHOUT AURA, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITH STATUS MIGRAINOSUS
346.73	CHRONIC MIGRAINE WITHOUT AURA, WITH INTRACTABLE MIGRAINE, SO STATED, WITH STATUS MIGRAINOSUS
346.80	OTHER FORMS OF MIGRAINE, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITHOUT MENTION OF STATUS MIGRAINOSUS
346.81	OTHER FORMS OF MIGRAINE, WITH INTRACTABLE MIGRAINE, SO STATED, WITHOUT MENTION OF STATUS MIGRAINOSUS
346.82	OTHER FORMS OF MIGRAINE, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITH STATUS MIGRAINOSUS
346.83	OTHER FORMS OF MIGRAINE, WITH INTRACTABLE MIGRAINE, SO STATED, WITH STATUS MIGRAINOSUS
346.90	MIGRAINE, UNSPECIFIED, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITHOUT MENTION OF STATUS MIGRAINOSUS
346.91	MIGRAINE, UNSPECIFIED, WITH INTRACTABLE MIGRAINE, SO STATED, WITHOUT MENTION OF STATUS MIGRAINOSUS
346.92	MIGRAINE, UNSPECIFIED, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITH STATUS MIGRAINOSUS
346.93	MIGRAINE, UNSPECIFIED, WITH INTRACTABLE MIGRAINE, SO STATED, WITH STATUS MIGRAINOSUS
348.1	ANOXIC BRAIN DAMAGE
351.0	BELL'S Palsy
353.0	BRACHIAL PLEXUS LESIONS
353.1	LUMBOSACRAL PLEXUS LESIONS
353.2	CERVICAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.3	THORACIC ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.4	LUMBOSACRAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.5	NEURALGIC AMYOTROPHY
353.6	PHANTOM LIMB (SYNDROME)
353.8	OTHER NERVE ROOT AND PLEXUS DISORDERS
353.9	UNSPECIFIED NERVE ROOT AND PLEXUS DISORDER
354.0	CARPAL TUNNEL SYNDROME
354.1	OTHER LESION OF MEDIAN NERVE
354.2	LESION OF ULNAR NERVE
354.3	LESION OF RADIAL NERVE
354.4	CAUSALGIA OF UPPER LIMB

354.5	MONONEURITIS MULTIPLEX
354.8	OTHER MONONEURITIS OF UPPER LIMB
354.9	MONONEURITIS OF UPPER LIMB UNSPECIFIED
355.0	LESION OF SCIATIC NERVE
355.1	MERALGIA PARESTHETICA
355.2	OTHER LESION OF FEMORAL NERVE
355.3	LESION OF LATERAL POPLITEAL NERVE
355.4	LESION OF MEDIAL POPLITEAL NERVE
355.5	TARSAL TUNNEL SYNDROME
355.6	LESION OF PLANTAR NERVE
355.71	CAUSALGIA OF LOWER LIMB
355.79	OTHER MONONEURITIS OF LOWER LIMB
355.9	MONONEURITIS OF UNSPECIFIED SITE
356.0	HEREDITARY PERIPHERAL NEUROPATHY
356.1	PERONEAL MUSCULAR ATROPHY
356.2	HEREDITARY SENSORY NEUROPATHY
356.3	REFSUM'S DISEASE
356.4	IDIOPATHIC PROGRESSIVE POLYNEUROPATHY
356.8	OTHER SPECIFIED IDIOPATHIC PERIPHERAL NEUROPATHY
356.9	UNSPECIFIED IDIOPATHIC PERIPHERAL NEUROPATHY
357.0	ACUTE INFECTIVE POLYNEURITIS
357.2	POLYNEUROPATHY IN DIABETES
359.0	CONGENITAL HEREDITARY MUSCULAR DYSTROPHY
359.1	HEREDITARY PROGRESSIVE MUSCULAR DYSTROPHY
359.21	MYOTONIC MUSCULAR DYSTROPHY
359.22	MYOTONIA CONGENITAL
359.23	MYOTONIC CHONDRODYSTROPHY
359.24	DRUG INDUCED MYOTONIA
359.29	OTHER SPECIFIED MYOTONIC DISORDER
359.71	INCLUSION BODY MYOSITIS
359.79	OTHER INFLAMMATORY AND IMMUNE MYOPATHIES, NEC
368.41	SCOTOMA INVOLVING CENTRAL AREA
368.45	GENERALIZED VISUAL FIELD CONTRACTION OR CONSTRICTION
368.46	HOMONYMOUS BILATERAL FIELD DEFECTS
368.47	HETERONYMOUS BILATERAL FIELD DEFECTS
369.01	BETTER EYE: TOTAL VISION IMPAIRMENT; LESSER EYE: TOTAL VISION IMPAIRMENT

369.02	BETTER EYE: NEAR-TOTAL VISION IMPAIRMENT; LESSER EYE: NOT FURTHER SPECIFIED
369.03	BETTER EYE: NEAR-TOTAL VISION IMPAIRMENT; LESSER EYE: TOTAL VISION IMPAIRMENT
369.04	BETTER EYE: NEAR-TOTAL VISION IMPAIRMENT; LESSER EYE: NEAR-TOTAL VISION IMPAIRMENT
369.05	BETTER EYE: PROFOUND VISION IMPAIRMENT; LESSER EYE: NOT FURTHER SPECIFIED
369.06	BETTER EYE: PROFOUND VISION IMPAIRMENT; LESSER EYE: TOTAL VISION IMPAIRMENT
369.07	BETTER EYE: PROFOUND VISION IMPAIRMENT; LESSER EYE: NEAR-TOTAL VISION IMPAIRMENT
369.08	BETTER EYE: PROFOUND VISION IMPAIRMENT; LESSER EYE: PROFOUND VISION IMPAIRMENT
369.11	BETTER EYE: SEVERE VISION IMPAIRMENT; LESSER EYE: BLIND NOT FURTHER SPECIFIED
369.12	BETTER EYE: SEVERE VISION IMPAIRMENT; LESSER EYE: TOTAL VISION IMPAIRMENT
369.13	BETTER EYE: SEVERE VISION IMPAIRMENT; LESSER EYE: NEAR-TOTAL VISION IMPAIRMENT
369.14	BETTER EYE: SEVERE VISION IMPAIRMENT; LESSER EYE: PROFOUND VISION IMPAIRMENT
369.15	BETTER EYE: MODERATE VISION IMPAIRMENT; LESSER EYE: BLIND NOT FURTHER SPECIFIED
369.16	BETTER EYE: MODERATE VISION IMPAIRMENT; LESSER EYE: TOTAL VISION IMPAIRMENT
369.17	BETTER EYE: MODERATE VISION IMPAIRMENT; LESSER EYE: NEAR-TOTAL VISION IMPAIRMENT
369.18	BETTER EYE: MODERATE VISION IMPAIRMENT; LESSER EYE: PROFOUND VISION IMPAIRMENT
369.21	BETTER EYE: SEVERE VISION IMPAIRMENT; LESSER EYE; IMPAIRMENT NOT FURTHER SPECIFIED
369.22	BETTER EYE: SEVERE VISION IMPAIRMENT; LESSER EYE: SEVERE VISION IMPAIRMENT
369.23	BETTER EYE: MODERATE VISION IMPAIRMENT; LESSER EYE: IMPAIRMENT NOT FURTHER SPECIFIED
369.24	BETTER EYE: MODERATE VISION IMPAIRMENT; LESSER EYE: SEVERE VISION IMPAIRMENT
369.25	BETTER EYE: MODERATE VISION IMPAIRMENT; LESSER EYE: MODERATE VISION IMPAIRMENT
369.3	UNQUALIFIED VISUAL LOSS BOTH EYES
369.4	LEGAL BLINDNESS AS DEFINED IN U.S.A.
369.60	BLINDNESS ONE EYE NOT OTHERWISE SPECIFIED
369.61	ONE EYE: TOTAL VISION IMPAIRMENT; OTHER EYE: NOT SPECIFIED

369.62	ONE EYE: TOTAL VISION IMPAIRMENT; OTHER EYE: NEAR-NORMAL VISION
369.63	ONE EYE: TOTAL VISION IMPAIRMENT; OTHER EYE: NORMAL VISION
369.64	ONE EYE: NEAR-TOTAL VISION IMPAIRMENT; OTHER EYE: VISION NOT SPECIFIED
369.65	ONE EYE: NEAR-TOTAL VISION IMPAIRMENT; OTHER EYE: NEAR-NORMAL VISION
369.66	ONE EYE: NEAR-TOTAL VISION IMPAIRMENT; OTHER EYE: NORMAL VISION
369.67	ONE EYE: PROFOUND VISION IMPAIRMENT; OTHER EYE: VISION NOT SPECIFIED
369.68	ONE EYE: PROFOUND VISION IMPAIRMENT; OTHER EYE: NEAR-NORMAL VISION
369.69	ONE EYE: PROFOUND VISION IMPAIRMENT; OTHER EYE: NORMAL VISION
369.70	LOW VISION ONE EYE NOT OTHERWISE SPECIFIED
369.71	ONE EYE: SEVERE VISION IMPAIRMENT; OTHER EYE: VISION NOT SPECIFIED
369.72	ONE EYE: SEVERE VISION IMPAIRMENT; OTHER EYE: NEAR-NORMAL VISION
369.73	ONE EYE: SEVERE VISION IMPAIRMENT; OTHER EYE: NORMAL VISION
369.74	ONE EYE: MODERATE VISION IMPAIRMENT; OTHER EYE: VISION NOT SPECIFIED
369.75	ONE EYE: MODERATE VISION IMPAIRMENT; OTHER EYE: NEAR-NORMAL VISION
369.76	ONE EYE: MODERATE VISION IMPAIRMENT; OTHER EYE: NORMAL VISION
369.8	UNQUALIFIED VISUAL LOSS ONE EYE
369.9	UNSPECIFIED VISUAL LOSS
386.11	BENIGN PAROXYSMAL POSITIONAL VERTIGO
438.0	COGNITIVE DEFICITS
438.10	SPEECH AND LANGUAGE DEFICIT UNSPECIFIED
438.11	APHASIA
438.12	DYSPHASIA
438.13	LATE EFFECTS OF CEREBROVASCULAR DISEASE, DYSARTHRIA
438.14	LATE EFFECTS OF CEREBROVASCULAR DISEASE, FLUENCY DISORDER
438.19	OTHER SPEECH AND LANGUAGE DEFICITS
438.20	HEMIPLEGIA AFFECTING UNSPECIFIED SIDE
438.21	HEMIPLEGIA AFFECTING DOMINANT SIDE

438.22	HEMIPLEGIA AFFECTING NONDOMINANT SIDE
438.30	MONOPLÉGIA OF UPPER LIMB AFFECTING UNSPECIFIED SIDE
438.31	MONOPLÉGIA OF UPPER LIMB AFFECTING DOMINANT SIDE
438.32	MONOPLÉGIA OF UPPER LIMB AFFECTING NONDOMINANT SIDE
438.40	MONOPLÉGIA OF LOWER LIMB AFFECTING UNSPECIFIED SIDE
438.41	MONOPLÉGIA OF LOWER LIMB AFFECTING DOMINANT SIDE
438.42	MONOPLÉGIA OF LOWER LIMB AFFECTING NONDOMINANT SIDE
438.50	OTHER PARALYTIC SYNDROME AFFECTING UNSPECIFIED SIDE
438.51	OTHER PARALYTIC SYNDROME AFFECTING DOMINANT SIDE
438.52	OTHER PARALYTIC SYNDROME AFFECTING NONDOMINANT SIDE
438.53	OTHER PARALYTIC SYNDROME BILATERAL
438.6	ALTERATIONS OF SENSATIONS
438.81	APRAXIA CEREBROVASCULAR DISEASE
438.82	DYSPHAGIA CEREBROVASCULAR DISEASE
438.83	FACIAL WEAKNESS
438.84	ATAXIA
438.85	VERTIGO
438.89	OTHER LATE EFFECTS OF CEREBROVASCULAR DISEASE
438.9	UNSPECIFIED LATE EFFECTS OF CEREBROVASCULAR DISEASE
440.23	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH ULCERATION
440.24	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH GANGRENE
443.0	RAYNAUD'S SYNDROME
454.0	VARICOSE VEINS OF LOWER EXTREMITIES WITH ULCER
454.1	VARICOSE VEINS OF LOWER EXTREMITIES WITH INFLAMMATION
454.2	VARICOSE VEINS OF LOWER EXTREMITIES WITH ULCER AND INFLAMMATION
454.8	VARICOSE VEINS OF LOWER EXTREMITIES WITH OTHER COMPLICATIONS
457.0	POSTMASTECTOMY LYMPHEDEMA SYNDROME
457.1	OTHER LYMPHEDEMA
459.11	POSTPHLEBETIC SYNDROME WITH ULCER

459.13	POSTPHLEBETIC SYNDROME WITH ULCER AND INFLAMMATION
459.31	CHRONIC VENOUS HYPERTENSION WITH ULCER
459.33	CHRONIC VENOUS HYPERTENSION WITH ULCER AND INFLAMMATION
494.0	BRONCHIECTASIS WITHOUT ACUTE EXACERBATION
494.1	BRONCHIECTASIS WITH ACUTE EXACERBATION
496	CHRONIC AIRWAY OBSTRUCTION NOT ELSEWHERE CLASSIFIED
514	PULMONARY CONGESTION AND HYPOSTASIS
524.60	TEMPOROMANDIBULAR JOINT DISORDERS UNSPECIFIED
524.61	TEMPOROMANDIBULAR JOINT DISORDERS ADHESIONS AND ANKYLOSIS (BONY OR FIBROUS)
524.62	TEMPOROMANDIBULAR JOINT DISORDERS ARTHRALGIA OF TEMPOROMANDIBULAR JOINT
524.63	TEMPOROMANDIBULAR JOINT DISORDERS ARTICULAR DISC DISORDER (REDUCING OR NON-REDUCING)
524.64	TEMPOROMANDIBULAR JOINT SOUNDS ON OPENING AND/OR CLOSING THE JAW
524.69	TEMPOROMANDIBULAR JOINT DISORDERS OTHER SPECIFIED TEMPOROMANDIBULAR JOINT DISORDERS
599.82	INTRINSIC (URETHRAL) SPHINCTER DEFICIENCY [ISD]
607.83	EDEMA OF PENIS
607.89	OTHER SPECIFIED DISORDERS OF PENIS
608.86	EDEMA OF MALE GENITAL ORGANS
611.71	MASTODYNIA
624.8	OTHER SPECIFIED NONINFLAMMATORY DISORDERS OF VULVA AND PERINEUM
625.6	STRESS INCONTINENCE FEMALE
665.61	DAMAGE TO PELVIC JOINTS AND LIGAMENTS WITH DELIVERY
665.64	DAMAGE TO PELVIC JOINTS AND LIGAMENTS POSTPARTUM
681.00 - 681.11	UNSPECIFIED CELLULITIS AND ABSCESS OF FINGER - ONYCHIA AND PARONYCHIA OF TOE
682.0 - 682.7	CELLULITIS AND ABSCESS OF FACE - CELLULITIS AND ABSCESS OF FOOT EXCEPT TOES
683	ACUTE LYMPHADENITIS
692.9	CONTACT DERMATITIS AND OTHER ECZEMA UNSPECIFIED CAUSE
696.1	OTHER PSORIASIS AND SIMILAR DISORDERS
701.0	CIRCUMSCRIBED SCLERODERMA
701.4	KELOID SCAR

707.00	PRESSURE ULCER, UNSPECIFIED SITE
707.01	PRESSURE ULCER, ELBOW
707.02	PRESSURE ULCER, UPPER BACK
707.03	PRESSURE ULCER, LOWER BACK
707.04	PRESSURE ULCER, HIP
707.05	PRESSURE ULCER, BUTTOCK
707.06	PRESSURE ULCER, ANKLE
707.07	PRESSURE ULCER, HEEL
707.09	PRESSURE ULCER, OTHER SITE
707.10	UNSPECIFIED ULCER OF LOWER LIMB
707.11 - 707.19	ULCER OF THIGH - ULCER OF OTHER PART OF LOWER LIMB
707.20	PRESSURE ULCER, UNSPECIFIED STAGE
707.21	PRESSURE ULCER, STAGE I
707.22	PRESSURE ULCER, STAGE II
707.23	PRESSURE ULCER, STAGE III
707.24	PRESSURE ULCER, STAGE IV
707.8	CHRONIC ULCER OF OTHER SPECIFIED SITES
707.9	CHRONIC ULCER OF UNSPECIFIED SITE
709.2	SCAR CONDITIONS AND FIBROSIS OF SKIN
711.00	PYOGENIC ARTHRITIS SITE UNSPECIFIED
711.01	PYOGENIC ARTHRITIS INVOLVING SHOULDER REGION
711.02	PYOGENIC ARTHRITIS INVOLVING UPPER ARM
711.03	PYOGENIC ARTHRITIS INVOLVING FOREARM
711.04	PYOGENIC ARTHRITIS INVOLVING HAND
711.05	PYOGENIC ARTHRITIS INVOLVING PELVIC REGION AND THIGH
711.06	PYOGENIC ARTHRITIS INVOLVING LOWER LEG
711.07	PYOGENIC ARTHRITIS INVOLVING ANKLE AND FOOT
711.08	PYOGENIC ARTHRITIS INVOLVING OTHER SPECIFIED SITES
711.09	PYOGENIC ARTHRITIS INVOLVING MULTIPLE SITES
711.10	ARTHROPATHY SITE UNSPECIFIED ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.11	ARTHROPATHY INVOLVING SHOULDER REGION ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.12	ARTHROPATHY INVOLVING UPPER ARM ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.13	ARTHROPATHY INVOLVING FOREARM ASSOCIATED WITH

REITER'S DISEASE AND NONSPECIFIC URETHRITIS	
711.14	ARTHROPATHY INVOLVING HAND ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.15	ARTHROPATHY INVOLVING PELVIC REGION AND THIGH ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.16	ARTHROPATHY INVOLVING LOWER LEG ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.17	ARTHROPATHY INVOLVING ANKLE AND FOOT ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.18	ARTHROPATHY INVOLVING OTHER SPECIFIED SITES ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.19	ARTHROPATHY INVOLVING MULTIPLE SITES ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.20	ARTHROPATHY IN BEHCET'S SYNDROME SITE UNSPECIFIED
711.21	ARTHROPATHY IN BEHCET'S SYNDROME INVOLVING SHOULDER REGION
711.22	ARTHROPATHY IN BEHCET'S SYNDROME INVOLVING UPPER ARM
711.23	ARTHROPATHY IN BEHCET'S SYNDROME INVOLVING FOREARM
711.24	ARTHROPATHY IN BEHCET'S SYNDROME INVOLVING HAND
711.25	ARTHROPATHY IN BEHCET'S SYNDROME INVOLVING PELVIC REGION AND THIGH
711.26	ARTHROPATHY IN BEHCET'S SYNDROME INVOLVING LOWER LEG
711.27	ARTHROPATHY IN BEHCET'S SYNDROME INVOLVING ANKLE AND FOOT
711.28	ARTHROPATHY IN BEHCET'S SYNDROME INVOLVING OTHER SPECIFIED SITES
711.29	ARTHROPATHY IN BEHCET'S SYNDROME INVOLVING MULTIPLE SITES
711.30	POSTDYSENTERIC ARTHROPATHY SITE UNSPECIFIED
711.31	POSTDYSENTERIC ARTHROPATHY INVOLVING SHOULDER REGION
711.32	POSTDYSENTERIC ARTHROPATHY INVOLVING UPPER ARM
711.33	POSTDYSENTERIC ARTHROPATHY INVOLVING FOREARM
711.34	POSTDYSENTERIC ARTHROPATHY INVOLVING HAND
711.35	POSTDYSENTERIC ARTHROPATHY INVOLVING PELVIC REGION AND THIGH
711.36	POSTDYSENTERIC ARTHROPATHY INVOLVING LOWER LEG
711.37	POSTDYSENTERIC ARTHROPATHY INVOLVING ANKLE AND FOOT

711.38	POSTDYSENTERIC ARTHROPATHY INVOLVING OTHER SPECIFIED SITES
711.39	POSTDYSENTERIC ARTHROPATHY INVOLVING MULTIPLE SITES
711.40	ARTHROPATHY SITE UNSPECIFIED ASSOCIATED WITH OTHER BACTERIAL DISEASES
711.41	ARTHROPATHY INVOLVING SHOULDER REGION ASSOCIATED WITH OTHER BACTERIAL DISEASES
711.42	ARTHROPATHY INVOLVING UPPER ARM ASSOCIATED WITH OTHER BACTERIAL DISEASES
711.43	ARTHROPATHY INVOLVING FOREARM ASSOCIATED WITH OTHER BACTERIAL DISEASES
711.44	ARTHROPATHY INVOLVING HAND ASSOCIATED WITH OTHER BACTERIAL DISEASES
711.45	ARTHROPATHY INVOLVING PELVIC REGION AND THIGH ASSOCIATED WITH OTHER BACTERIAL DISEASES
711.46	ARTHROPATHY INVOLVING LOWER LEG ASSOCIATED WITH OTHER BACTERIAL DISEASES
711.47	ARTHROPATHY INVOLVING ANKLE AND FOOT ASSOCIATED WITH OTHER BACTERIAL DISEASE
711.48	ARTHROPATHY INVOLVING OTHER SPECIFIED SITES ASSOCIATED WITH OTHER BACTERIAL DISEASES
711.49	ARTHROPATHY INVOLVING MULTIPLE SITES ASSOCIATED WITH OTHER BACTERIAL DISEASES
711.50	ARTHROPATHY SITE UNSPECIFIED ASSOCIATED WITH OTHER VIRAL DISEASES
711.51	ARTHROPATHY INVOLVING SHOULDER REGION ASSOCIATED WITH OTHER VIRAL DISEASES
711.52	ARTHROPATHY INVOLVING UPPER ARM ASSOCIATED WITH OTHER VIRAL DISEASES
711.53	ARTHROPATHY INVOLVING FOREARM ASSOCIATED WITH OTHER VIRAL DISEASES
711.54	ARTHROPATHY INVOLVING HAND ASSOCIATED WITH OTHER VIRAL DISEASES
711.55	ARTHROPATHY INVOLVING PELVIC REGION AND THIGH ASSOCIATED WITH OTHER VIRAL DISEASES
711.56	ARTHROPATHY INVOLVING LOWER LEG ASSOCIATED WITH OTHER VIRAL DISEASES
711.57	ARTHROPATHY INVOLVING ANKLE AND FOOT ASSOCIATED WITH OTHER VIRAL DISEASES
711.58	ARTHROPATHY INVOLVING OTHER SPECIFIED SITES ASSOCIATED WITH OTHER VIRAL DISEASES
711.59	ARTHROPATHY INVOLVING MULTIPLE SITES ASSOCIATED WITH OTHER VIRAL DISEASES
713.5	ARTHROPATHY ASSOCIATED WITH NEUROLOGICAL DISORDERS

714.0 - 714.89	RHEUMATOID ARTHRITIS - OTHER SPECIFIED INFLAMMATORY POLYARTHROPATHIES
714.9	UNSPECIFIED INFLAMMATORY POLYARTHROPATHY
715.00 - 715.89	OSTEOARTHRISIS GENERALIZED INVOLVING UNSPECIFIED SITE - OSTEOARTHRISIS INVOLVING OR WITH MULTIPLE SITES BUT NOT SPECIFIED AS GENERALIZED
715.90 - 715.98	OSTEOARTHRISIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED INVOLVING UNSPECIFIED SITE - OSTEOARTHRISIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED INVOLVING OTHER SPECIFIED SITES
716.00 - 716.99	KASCHIN-BECK DISEASE SITE UNSPECIFIED - UNSPECIFIED ARTHROPATHY INVOLVING MULTIPLE SITES
717.0 - 717.89	OLD BUCKET HANDLE TEAR OF MEDIAL MENISCUS - OTHER INTERNAL DERANGEMENT OF KNEE
717.9	UNSPECIFIED INTERNAL DERANGEMENT OF KNEE
718.00	ARTICULAR CARTILAGE DISORDER SITE UNSPECIFIED
718.01	ARTICULAR CARTILAGE DISORDER INVOLVING SHOULDER REGION
718.02	ARTICULAR CARTILAGE DISORDER INVOLVING UPPER ARM
718.03	ARTICULAR CARTILAGE DISORDER INVOLVING FOREARM
718.04	ARTICULAR CARTILAGE DISORDER INVOLVING HAND
718.05	ARTICULAR CARTILAGE DISORDER INVOLVING PELVIC REGION AND THIGH
718.07	ARTICULAR CARTILAGE DISORDER INVOLVING ANKLE AND FOOT
718.08	ARTICULAR CARTILAGE DISORDER INVOLVING OTHER SPECIFIED SITES
718.09	ARTICULAR CARTILAGE DISORDER INVOLVING MULTIPLE SITES
718.10	LOOSE BODY IN JOINT SITE UNSPECIFIED
718.11	LOOSE BODY IN JOINT OF SHOULDER REGION
718.12	LOOSE BODY IN UPPER ARM JOINT
718.13	LOOSE BODY IN FOREARM JOINT
718.14	LOOSE BODY IN HAND JOINT
718.15	LOOSE BODY IN JOINT OF PELVIC REGION AND THIGH
718.17	LOOSE BODY IN ANKLE AND FOOT JOINT
718.18	LOOSE BODY IN JOINT OF OTHER SPECIFIED SITES
718.19	LOOSE BODY IN JOINT OF MULTIPLE SITES
718.20 - 718.29	PATHOLOGICAL DISLOCATION OF JOINT SITE UNSPECIFIED - PATHOLOGICAL DISLOCATION OF JOINT OF MULTIPLE SITES
718.30 - 718.39	RECURRENT DISLOCATION OF JOINT SITE UNSPECIFIED - RECURRENT DISLOCATION OF JOINT OF MULTIPLE SITES

718.40	CONTRACTURE OF JOINT SITE UNSPECIFIED
718.41 - 718.49	CONTRACTURE OF JOINT OF SHOULDER REGION - CONTRACTURE OF JOINT OF MULTIPLE SITES
718.50	ANKYLOSIS OF JOINT SITE UNSPECIFIED
718.51 - 718.59	ANKYLOSIS OF JOINT OF SHOULDER REGION - ANKYLOSIS OF JOINT OF MULTIPLE SITES
718.60	UNSPECIFIED INTRAPELVIC PROTRUSION OF ACETABULUM SITE UNSPECIFIED
718.65	UNSPECIFIED INTRAPELVIC PROTRUSION OF ACETABULUM PELVIC REGION AND THIGH
718.70 - 718.79	DEVELOPMENTAL DISLOCATION OF JOINT SITE UNSPECIFIED - DEVELOPMENTAL DISLOCATION OF JOINT MULTIPLE SITES
718.80	OTHER JOINT DERANGEMENT NOT ELSEWHERE CLASSIFIED INVOLVING UNSPECIFIED SITE
718.81 - 718.89	OTHER JOINT DERANGEMENT NOT ELSEWHERE CLASSIFIED INVOLVING SHOULDER REGION - OTHER JOINT DERANGEMENT NOT ELSEWHERE CLASSIFIED INVOLVING MULTIPLE SITES
718.90	UNSPECIFIED DERANGEMENT OF JOINT SITE UNSPECIFIED
718.91	UNSPECIFIED DERANGEMENT OF JOINT OF SHOULDER REGION
718.92	UNSPECIFIED DERANGEMENT OF UPPER ARM JOINT
718.93	UNSPECIFIED DERANGEMENT OF FOREARM JOINT
718.94	UNSPECIFIED DERANGEMENT OF HAND JOINT
718.95	UNSPECIFIED DERANGEMENT OF JOINT OF PELVIC REGION AND THIGH
718.97	UNSPECIFIED DERANGEMENT OF ANKLE AND FOOT JOINT
718.98	UNSPECIFIED DERANGEMENT OF JOINT OF OTHER SPECIFIED SITES
718.99	UNSPECIFIED DERANGEMENT OF JOINT OF MULTIPLE SITES
719.00 - 719.99	EFFUSION OF JOINT SITE UNSPECIFIED - UNSPECIFIED JOINT DISORDER OF MULTIPLE SITES
720.0	ANKYLOSING SPONDYLITIS
720.1	SPINAL ENTHESOPATHY
720.2	SACROILIITIS NOT ELSEWHERE CLASSIFIED
720.81	INFLAMMATORY SPONDYLOPATHIES IN DISEASES CLASSIFIED ELSEWHERE
720.89	OTHER INFLAMMATORY SPONDYLOPATHIES
720.9	UNSPECIFIED INFLAMMATORY SPONDYLOPATHY
721.0 - 721.91	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY - SPONDYLOSIS OF UNSPECIFIED SITE WITH MYELOPATHY
722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC

	WITHOUT MYELOPATHY
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.11	DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.2 - 722.73	DISPLACEMENT OF INTERVERTEBRAL DISC SITE UNSPECIFIED WITHOUT MYELOPATHY - INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY LUMBAR REGION
722.80	POSTLAMINECTOMY SYNDROME OF UNSPECIFIED REGION
722.81	POSTLAMINECTOMY SYNDROME OF CERVICAL REGION
722.82	POSTLAMINECTOMY SYNDROME OF THORACIC REGION
722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
722.90	OTHER AND UNSPECIFIED DISC DISORDER OF UNSPECIFIED REGION
722.91	OTHER AND UNSPECIFIED DISC DISORDER OF CERVICAL REGION
722.92	OTHER AND UNSPECIFIED DISC DISORDER OF THORACIC REGION
722.93	OTHER AND UNSPECIFIED DISC DISORDER OF LUMBAR REGION
723.0	SPINAL STENOSIS IN CERVICAL REGION
723.1	CERVICALGIA
723.2	CERVICOCRANIAL SYNDROME
723.3	CERVICOBRACHIAL SYNDROME (DIFFUSE)
723.4	BRACHIAL NEURITIS OR RADICULITIS NOS
723.5	TORTICOLLIS UNSPECIFIED
723.7	OSSIFICATION OF POSTERIOR LONGITUDINAL LIGAMENT IN CERVICAL REGION
723.8	OTHER SYNDROMES AFFECTING CERVICAL REGION
723.9	UNSPECIFIED MUSCULOSKELETAL DISORDERS AND SYMPTOMS REFERABLE TO NECK
724.1	PAIN IN THORACIC SPINE
724.2	LUMBAGO
724.3	SCIATICA
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED
724.5	BACKACHE UNSPECIFIED
724.6	DISORDERS OF SACRUM
724.70	UNSPECIFIED DISORDER OF COCCYX
724.71	HYPERMOBILITY OF COCCYX
724.79	OTHER DISORDERS OF COCCYX
724.8	OTHER SYMPTOMS REFERABLE TO BACK

724.9	OTHER UNSPECIFIED BACK DISORDERS
725	POLYMYALGIA RHEUMATICA
726.0	ADHESIVE CAPSULITIS OF SHOULDER
726.10	DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION UNSPECIFIED
726.11	CALCIFYING TENDINITIS OF SHOULDER
726.12	BICIPITAL TENOSYNOVITIS
726.19	OTHER SPECIFIED DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION
726.2	OTHER AFFECTIONS OF SHOULDER REGION NOT ELSEWHERE CLASSIFIED
726.30	ENTHESOPATHY OF ELBOW UNSPECIFIED
726.31	MEDIAL EPICONDYLITIS
726.32	LATERAL EPICONDYLITIS
726.33	OLECRANON BURSITIS
726.39	OTHER ENTHESOPATHY OF ELBOW REGION
726.4 - 726.79	ENTHESOPATHY OF WRIST AND CARPUS - OTHER ENTHESOPATHY OF ANKLE AND TARSUS
726.8	OTHER PERIPHERAL ENTHESOPATHIES
726.90 - 726.91	ENTHESOPATHY OF UNSPECIFIED SITE - EXOSTOSIS OF UNSPECIFIED SITE
727.00	SYNOVITIS AND TENOSYNOVITIS UNSPECIFIED
727.01	SYNOVITIS AND TENOSYNOVITIS IN DISEASES CLASSIFIED ELSEWHERE
727.02	GIANT CELL TUMOR OF TENDON SHEATH
727.03	TRIGGER FINGER (ACQUIRED)
727.04	RADIAL STYLOID TENOSYNOVITIS
727.05	OTHER TENOSYNOVITIS OF HAND AND WRIST
727.06	TENOSYNOVITIS OF FOOT AND ANKLE
727.09	OTHER SYNOVITIS AND TENOSYNOVITIS
727.2	SPECIFIC BURSITIDES OFTEN OF OCCUPATIONAL ORIGIN
727.3	OTHER BURSITIS DISORDERS
727.40 - 727.49	SYNOVIAL CYST UNSPECIFIED - OTHER GANGLION AND CYST OF SYNOVIUM TENDON AND BURSA
727.50 - 727.59	RUPTURE OF SYNOVIUM UNSPECIFIED - OTHER RUPTURE OF SYNOVIUM
727.60 - 727.69	NONTRAUMATIC RUPTURE OF UNSPECIFIED TENDON - NONTRAUMATIC RUPTURE OF OTHER TENDON
727.81	CONTRACTURE OF TENDON (SHEATH)
727.82	CALCIUM DEPOSITS IN TENDON AND BURSA

727.83	PLICA SYNDROME
727.89	OTHER DISORDERS OF SYNOVIUM TENDON AND BURSA
727.9	UNSPECIFIED DISORDER OF SYNOVIUM TENDON AND BURSA
728.10 - 728.19	CALCIFICATION AND OSSIFICATION UNSPECIFIED - OTHER MUSCULAR CALCIFICATION AND OSSIFICATION
728.2	MUSCULAR WASTING AND DISUSE ATROPHY NOT ELSEWHERE CLASSIFIED
728.3	OTHER SPECIFIC MUSCLE DISORDERS
728.4	LAXITY OF LIGAMENT
728.5	HYPERMOBILITY SYNDROME
728.6	CONTRACTURE OF PALMAR FASCIA
728.71	PLANTAR FASCIAL FIBROMATOSIS
728.79	OTHER FIBROMATOSES OF MUSCLE LIGAMENT AND FASCIA
728.81 - 728.89	INTERSTITIAL MYOSITIS - OTHER DISORDERS OF MUSCLE LIGAMENT AND FASCIA
729.0	RHEUMATISM UNSPECIFIED AND FIBROSITIS
729.1	MYALGIA AND MYOSITIS UNSPECIFIED
729.2	NEURALGIA NEURITIS AND RADICULITIS UNSPECIFIED
729.4	FASCIITIS UNSPECIFIED
729.5	PAIN IN LIMB
729.71	NONTRAUMATIC COMPARTMENT SYNDROME OF UPPER EXTREMITY
729.72	NONTRAUMATIC COMPARTMENT SYNDROME OF LOWER EXTREMITY
729.81	SWELLING OF LIMB
729.82	CRAMP OF LIMB
729.89	OTHER MUSCULOSKELETAL SYMPTOMS REFERABLE TO LIMBS
729.90 - 729.99	DISORDERS OF SOFT TISSUE, UNSPECIFIED - OTHER DISORDERS OF SOFT TISSUE
731.0	OSTEITIS DEFORMANS WITHOUT BONE TUMOR
731.3	MAJOR OSSEOUS DEFECTS
732.0 - 732.9	JUVENILE OSTEOCHONDROSIS OF SPINE - UNSPECIFIED OSTEOCHONDROPATHY
733.10 - 733.19	PATHOLOGICAL FRACTURE UNSPECIFIED SITE - PATHOLOGICAL FRACTURE OF OTHER SPECIFIED SITE
733.40	ASEPTIC NECROSIS OF BONE SITE UNSPECIFIED
733.41 - 733.49	ASEPTIC NECROSIS OF HEAD OF HUMERUS - ASEPTIC NECROSIS OF OTHER BONE SITES
733.5	OSTEITIS CONDENSANS

733.81	MALUNION OF FRACTURE
733.82	NONUNION OF FRACTURE
733.90	DISORDER OF BONE AND CARTILAGE UNSPECIFIED
733.91	ARREST OF BONE DEVELOPMENT OR GROWTH
733.92	CHONDROMALACIA
733.93	STRESS FRACTURE OF TIBIA OR FIBULA
733.94	STRESS FRACTURE OF THE METATARSALS
733.95	STRESS FRACTURE OF OTHER BONE
733.96	STRESS FRACTURE OF FEMORAL NECK
733.97	STRESS FRACTURE OF SHAFT OF FEMUR
733.98	STRESS FRACTURE OF PELVIS
733.99	OTHER DISORDERS OF BONE AND CARTILAGE
734	FLAT FOOT
735.0 - 735.9	HALLUX VALGUS (ACQUIRED) - UNSPECIFIED ACQUIRED DEFORMITY OF TOE
736.00	UNSPECIFIED DEFORMITY OF FOREARM EXCLUDING FINGERS
736.01	CUBITUS VALGUS (ACQUIRED)
736.02	CUBITUS VARUS (ACQUIRED)
736.03	VALGUS DEFORMITY OF WRIST (ACQUIRED)
736.04	VARUS DEFORMITY OF WRIST (ACQUIRED)
736.05	WRIST DROP (ACQUIRED)
736.06	CLAW HAND (ACQUIRED)
736.07	CLUB HAND ACQUIRED
736.09	OTHER ACQUIRED DEFORMITIES OF FOREARM EXCLUDING FINGERS
736.1	MALLET FINGER
736.20	UNSPECIFIED DEFORMITY OF FINGER
736.21	BOUTONNIERE DEFORMITY
736.22	SWAN-NECK DEFORMITY
736.29	OTHER ACQUIRED DEFORMITIES OF FINGER
736.30	UNSPECIFIED ACQUIRED DEFORMITY OF HIP
736.31	COXA VALGA (ACQUIRED)
736.32	COXA VARA (ACQUIRED)
736.39	OTHER ACQUIRED DEFORMITIES OF HIP
736.41	GENU VALGUM (ACQUIRED)
736.42	GENU VARUM (ACQUIRED)
736.5	GENU RECURVATUM (ACQUIRED)
736.6	OTHER ACQUIRED DEFORMITIES OF KNEE

736.70	UNSPECIFIED DEFORMITY OF ANKLE AND FOOT ACQUIRED
736.71	ACQUIRED EQUINOVARUS DEFORMITY
736.72	EQUINUS DEFORMITY OF FOOT ACQUIRED
736.73	CAVUS DEFORMITY OF FOOT ACQUIRED
736.74	CLAW FOOT ACQUIRED
736.75	CAVOVARUS DEFORMITY OF FOOT ACQUIRED
736.76	OTHER ACQUIRED CALCANEUS DEFORMITY
736.79	OTHER ACQUIRED DEFORMITIES OF ANKLE AND FOOT
736.81	UNEQUAL LEG LENGTH (ACQUIRED)
736.89	OTHER ACQUIRED DEFORMITY OF OTHER PARTS OF LIMB
737.0	ADOLESCENT POSTURAL KYPHOSIS
737.10 - 737.19	KYPHOSIS (ACQUIRED) (POSTURAL) - OTHER KYPHOSIS ACQUIRED
737.20 - 737.9	LORDOSIS (ACQUIRED) (POSTURAL) - UNSPECIFIED CURVATURE OF SPINE ASSOCIATED WITH OTHER CONDITIONS
738.8	ACQUIRED MUSCULOSKELETAL DEFORMITY OF OTHER SPECIFIED SITE
738.9	ACQUIRED MUSCULOSKELETAL DEFORMITY OF UNSPECIFIED SITE
754.1	CONGENITAL MUSCULOSKELETAL DEFORMITIES OF STERNOCLEIDOMASTOID MUSCLE
755.20	UNSPECIFIED REDUCTION DEFORMITY OF UPPER LIMB CONGENITAL
755.21	TRANSVERSE DEFICIENCY OF UPPER LIMB
755.22	LONGITUDINAL DEFICIENCY OF UPPER LIMB NOT ELSEWHERE CLASSIFIED
755.23	LONGITUDINAL DEFICIENCY COMBINED INVOLVING HUMERUS RADIUS AND ULNA (COMPLETE OR INCOMPLETE)
755.24	LONGITUDINAL DEFICIENCY HUMERAL COMPLETE OR PARTIAL (WITH OR WITHOUT DISTAL DEFICIENCIES INCOMPLETE)
755.25	LONGITUDINAL DEFICIENCY RADIOULNAR COMPLETE OR PARTIAL (WITH OR WITHOUT DISTAL DEFICIENCIES INCOMPLETE)
755.26	LONGITUDINAL DEFICIENCY RADIAL COMPLETE OR PARTIAL (WITH OR WITHOUT DISTAL DEFICIENCIES INCOMPLETE)
755.27	LONGITUDINAL DEFICIENCY ULNAR COMPLETE OR PARTIAL (WITH OR WITHOUT DISTAL DEFICIENCIES INCOMPLETE)
755.28	LONGITUDINAL DEFICIENCY CARPALS OR METACARPALS COMPLETE OR PARTIAL (WITH OR WITHOUT INCOMPLETE PHALANGEAL DEFICIENCY)

755.29	LONGITUDINAL DEFICIENCY PHALANGES COMPLETE OR PARTIAL
755.30 - 755.39	UNSPECIFIED REDUCTION DEFORMITY OF LOWER LIMB CONGENITAL - LONGITUDINAL DEFICIENCY PHALANGES COMPLETE OR PARTIAL
755.50	UNSPECIFIED ANOMALY OF UPPER LIMB CONGENITAL
755.51	CONGENITAL DEFORMITY OF CLAVICLE
755.52	CONGENITAL ELEVATION OF SCAPULA
755.53	RADIOULNAR SYNOSTOSIS
755.54	MADELUNG'S DEFORMITY
755.55	ACROCEPHALOSYNDACTYLY
755.56	ACCESSORY CARPAL BONES
755.57	MACRODACTYLIA (FINGERS)
755.58	CLEFT HAND CONGENITAL
755.59	OTHER CONGENITAL ANOMALIES OF UPPER LIMB INCLUDING SHOULDER GIRDLE
755.60	UNSPECIFIED CONGENITAL ANOMALY OF LOWER LIMB
755.61	COXA VALGA CONGENITAL
755.62	COXA VARA CONGENITAL
755.63	OTHER CONGENITAL DEFORMITY OF HIP (JOINT)
755.64	CONGENITAL DEFORMITY OF KNEE (JOINT)
756.10 - 756.19	CONGENITAL ANOMALY OF SPINE UNSPECIFIED - OTHER CONGENITAL ANOMALIES OF SPINE
757.0	HEREDITARY EDEMA OF LEGS
780.4	DIZZINESS AND GIDDINESS
781.0	ABNORMAL INVOLUNTARY MOVEMENTS
781.2	ABNORMALITY OF GAIT
781.3	LACK OF COORDINATION
781.4	TRANSIENT PARALYSIS OF LIMB
781.8	NEUROLOGICAL NEGLECT SYNDROME
781.92	ABNORMAL POSTURE
781.93	OCULAR TORTICOLLIS
781.94	FACIAL WEAKNESS
781.99	OTHER SYMPTOMS INVOLVING NERVOUS AND MUSCULOSKELETAL SYSTEMS
782.0	DISTURBANCE OF SKIN SENSATION
782.2	LOCALIZED SUPERFICIAL SWELLING MASS OR LUMP
782.3	EDEMA
782.8	CHANGES IN SKIN TEXTURE

783.3	FEEDING DIFFICULTIES AND MISMANAGEMENT
783.7	ADULT FAILURE TO THRIVE
784.0	HEADACHE
784.40	VOICE AND RESONANCE DISORDER, UNSPECIFIED
784.42	DYSPHONIA
784.49	OTHER VOICE AND RESONANCE DISORDERS
784.51	DYSARTHRIA
784.59	OTHER SPEECH DISTURBANCE
784.61	ALEXIA AND DYSLEXIA
784.69	OTHER SYMBOLIC DYSFUNCTION
785.4	GANGRENE
787.20	DYSPHAGIA, UNSPECIFIED
787.21	DYSPHAGIA, ORAL PHASE
787.22	DYSPHAGIA, OROPHARYNGEAL PHASE
787.23	DYSPHAGIA, PHARYNGEAL PHASE
787.24	DYSPHAGIA, PHARYNGOESOPHAGEAL PHASE
787.29	OTHER DYSPHAGIA
787.6	INCONTINENCE OF FECES
788.31	URGE INCONTINENCE
788.32	STRESS INCONTINENCE MALE
788.33	MIXED INCONTINENCE (MALE) (FEMALE)
788.34	INCONTINENCE WITHOUT SENSORY AWARENESS
788.99	OTHER SYMPTOMS INVOLVING URINARY SYSTEM
794.2	NONSPECIFIC ABNORMAL RESULTS OF FUNCTION STUDY OF PULMONARY SYSTEM
805.01 - 805.08	CLOSED FRACTURE OF FIRST CERVICAL VERTEBRA - CLOSED FRACTURE OF MULTIPLE CERVICAL VERTEBRAE
805.2	CLOSED FRACTURE OF DORSAL (THORACIC) VERTEBRA WITHOUT SPINAL CORD INJURY
805.4	CLOSED FRACTURE OF LUMBAR VERTEBRA WITHOUT SPINAL CORD INJURY
805.6	CLOSED FRACTURE OF SACRUM AND COCCYX WITHOUT SPINAL CORD INJURY
807.01 - 807.08	CLOSED FRACTURE OF ONE RIB - CLOSED FRACTURE OF EIGHT OR MORE RIBS
807.2	CLOSED FRACTURE OF STERNUM
808.0	CLOSED FRACTURE OF ACETABULUM
808.2	CLOSED FRACTURE OF PUBIS
808.41	CLOSED FRACTURE OF ILIUM
808.42	CLOSED FRACTURE OF ISCHIUM

808.43	MULTIPLE CLOSED PELVIC FRACTURES WITH DISRUPTION OF PELVIC CIRCLE
808.49	CLOSED FRACTURE OF OTHER SPECIFIED PART OF PELVIS
809.0	FRACTURE OF BONES OF TRUNK CLOSED
809.1	FRACTURE OF BONES OF TRUNK OPEN
810.00	CLOSED FRACTURE OF CLAVICLE UNSPECIFIED PART
810.01	CLOSED FRACTURE OF STERNAL END OF CLAVICLE
810.02	CLOSED FRACTURE OF SHAFT OF CLAVICLE
810.03	CLOSED FRACTURE OF ACROMIAL END OF CLAVICLE
810.10	OPEN FRACTURE OF CLAVICLE UNSPECIFIED PART
810.11	OPEN FRACTURE OF STERNAL END OF CLAVICLE
810.12	OPEN FRACTURE OF SHAFT OF CLAVICLE
810.13	OPEN FRACTURE OF ACROMIAL END OF CLAVICLE
811.00	CLOSED FRACTURE OF SCAPULA UNSPECIFIED PART
811.01	CLOSED FRACTURE OF ACROMIAL PROCESS OF SCAPULA
811.02	CLOSED FRACTURE OF CORACOID PROCESS OF SCAPULA
811.03	CLOSED FRACTURE OF GLENOID CAVITY AND NECK OF SCAPULA
811.09	CLOSED FRACTURE OF OTHER PART OF SCAPULA
812.00	FRACTURE OF UNSPECIFIED PART OF UPPER END OF HUMERUS CLOSED
812.01 - 812.59	FRACTURE OF SURGICAL NECK OF HUMERUS CLOSED - OTHER FRACTURE OF LOWER END OF HUMERUS OPEN
813.00	CLOSED FRACTURE OF UPPER END OF FOREARM UNSPECIFIED
813.01 - 813.93	FRACTURE OF OLECRANON PROCESS OF ULNA CLOSED - FRACTURE OF UNSPECIFIED PART OF RADIUS WITH ULNA OPEN
814.00 - 814.19	CLOSED FRACTURE OF CARPAL BONE UNSPECIFIED - OPEN FRACTURE OF OTHER BONE OF WRIST
815.00	CLOSED FRACTURE OF METACARPAL BONE(S) SITE UNSPECIFIED
815.01	CLOSED FRACTURE OF BASE OF THUMB (FIRST) METACARPAL
815.02	CLOSED FRACTURE OF BASE OF OTHER METACARPAL BONE(S)
815.03	CLOSED FRACTURE OF SHAFT OF METACARPAL BONE(S)
815.04	CLOSED FRACTURE OF NECK OF METACARPAL BONE(S)
815.09	CLOSED FRACTURE OF MULTIPLE SITES OF METACARPUS
815.10	OPEN FRACTURE OF METACARPAL BONE(S) SITE UNSPECIFIED
815.11	OPEN FRACTURE OF BASE OF THUMB (FIRST)

METACARPAL	
815.12	OPEN FRACTURE OF BASE OF OTHER METACARPAL BONE(S)
815.13	OPEN FRACTURE OF SHAFT OF METACARPAL BONE(S)
815.14	OPEN FRACTURE OF NECK OF METACARPAL BONE(S)
815.19	OPEN FRACTURE OF MULTIPLE SITES OF METACARPUS
816.00 - 816.13	CLOSED FRACTURE OF PHALANX OR PHALANGES OF HAND UNSPECIFIED - OPEN FRACTURE OF MULTIPLE SITES OF PHALANX OR PHALANGES OF HAND
817.0	MULTIPLE CLOSED FRACTURES OF HAND BONES
817.1	MULTIPLE OPEN FRACTURES OF HAND BONES
818.0	ILL-DEFINED CLOSED FRACTURES OF UPPER LIMB
818.1	ILL-DEFINED OPEN FRACTURES OF UPPER LIMB
819.0	MULTIPLE CLOSED FRACTURES INVOLVING BOTH UPPER LIMBS AND UPPER LIMB WITH RIB(S) AND STERNUM
819.1	MULTIPLE OPEN FRACTURES INVOLVING BOTH UPPER LIMBS AND UPPER LIMB WITH RIB(S) AND STERNUM
820.00 - 820.9	FRACTURE OF UNSPECIFIED INTRACAPSULAR SECTION OF NECK OF FEMUR CLOSED - FRACTURE OF UNSPECIFIED PART OF NECK OF FEMUR OPEN
821.00 - 821.39	FRACTURE OF UNSPECIFIED PART OF FEMUR CLOSED - OTHER FRACTURE OF LOWER END OF FEMUR OPEN
822.0	CLOSED FRACTURE OF PATELLA
822.1	OPEN FRACTURE OF PATELLA
823.00 - 823.92	CLOSED FRACTURE OF UPPER END OF TIBIA - OPEN FRACTURE OF UNSPECIFIED PART OF FIBULA WITH TIBIA
824.0	FRACTURE OF MEDIAL MALLEOLUS CLOSED
824.1	FRACTURE OF MEDIAL MALLEOLUS OPEN
824.2	FRACTURE OF LATERAL MALLEOLUS CLOSED
824.3	FRACTURE OF LATERAL MALLEOLUS OPEN
824.4	BIMALLEOLAR FRACTURE CLOSED
824.5	BIMALLEOLAR FRACTURE OPEN
824.6	TRIMALLEOLAR FRACTURE CLOSED
824.7	TRIMALLEOLAR FRACTURE OPEN
824.8	UNSPECIFIED FRACTURE OF ANKLE CLOSED
824.9	UNSPECIFIED FRACTURE OF ANKLE OPEN
825.0 - 825.39	FRACTURE OF CALCANEUS CLOSED - OTHER FRACTURES OF TARSAL AND METATARSAL BONES OPEN
826.0	CLOSED FRACTURE OF ONE OR MORE PHALANGES OF FOOT
826.1	OPEN FRACTURE OF ONE OR MORE PHALANGES OF FOOT
827.0	OTHER MULTIPLE AND ILL-DEFINED FRACTURES OF

LOWER LIMB CLOSED	
827.1	OTHER MULTIPLE AND ILL-DEFINED FRACTURES OF LOWER LIMB OPEN
831.00	CLOSED DISLOCATION OF SHOULDER UNSPECIFIED SITE
831.01	CLOSED ANTERIOR DISLOCATION OF HUMERUS
831.02	CLOSED POSTERIOR DISLOCATION OF HUMERUS
831.03	CLOSED INFERIOR DISLOCATION OF HUMERUS
831.04	CLOSED DISLOCATION OF ACROMIOCLAVICULAR (JOINT)
831.09	CLOSED DISLOCATION OF OTHER SITE OF SHOULDER
831.10	OPEN DISLOCATION OF SHOULDER UNSPECIFIED
831.11	OPEN ANTERIOR DISLOCATION OF HUMERUS
831.12	OPEN POSTERIOR DISLOCATION OF HUMERUS
831.13	OPEN INFERIOR DISLOCATION OF HUMERUS
831.14	OPEN DISLOCATION OF ACROMIOCLAVICULAR (JOINT)
831.19	OPEN DISLOCATION OF OTHER SITE OF SHOULDER
832.00	CLOSED DISLOCATION OF ELBOW UNSPECIFIED SITE
832.01	CLOSED ANTERIOR DISLOCATION OF ELBOW
832.02	CLOSED POSTERIOR DISLOCATION OF ELBOW
832.03	CLOSED MEDIAL DISLOCATION OF ELBOW
832.04	CLOSED LATERAL DISLOCATION OF ELBOW
832.09	CLOSED DISLOCATION OF OTHER SITE OF ELBOW
832.10	OPEN DISLOCATION OF ELBOW UNSPECIFIED SITE
832.11	OPEN ANTERIOR DISLOCATION OF ELBOW
832.12	OPEN POSTERIOR DISLOCATION OF ELBOW
832.13	OPEN MEDIAL DISLOCATION OF ELBOW
832.14	OPEN LATERAL DISLOCATION OF ELBOW
832.19	OPEN DISLOCATION OF OTHER SITE OF ELBOW
832.2	NURSEMAID'S ELBOW
833.00	CLOSED DISLOCATION OF WRIST UNSPECIFIED PART
833.01	CLOSED DISLOCATION OF RADIOULNAR (JOINT) DISTAL
833.02	CLOSED DISLOCATION OF RADIOCARPAL (JOINT)
833.03	CLOSED DISLOCATION OF MIDCARPAL (JOINT)
833.04	CLOSED DISLOCATION OF CARPOMETACARPAL (JOINT)
833.05	CLOSED DISLOCATION OF METACARPAL (BONE) PROXIMAL END
833.09	CLOSED DISLOCATION OF OTHER PART OF WRIST
833.10	OPEN DISLOCATION OF WRIST UNSPECIFIED PART
833.11	OPEN DISLOCATION OF RADIOULNAR (JOINT) DISTAL

833.12	OPEN DISLOCATION OF RADIOCARPAL (JOINT)
833.13	OPEN DISLOCATION OF MIDCARPAL (JOINT)
833.14	OPEN DISLOCATION OF CARPOMETACARPAL (JOINT)
833.15	OPEN DISLOCATION OF METACARPAL (BONE) PROXIMAL END
833.19	OPEN DISLOCATION OF OTHER PART OF WRIST
834.00	CLOSED DISLOCATION OF FINGER UNSPECIFIED PART
834.01	CLOSED DISLOCATION OF METACARPOPHALANGEAL (JOINT)
834.02	CLOSED DISLOCATION OF INTERPHALANGEAL (JOINT) HAND
834.10	OPEN DISLOCATION OF FINGER UNSPECIFIED PART
834.11	OPEN DISLOCATION OF METACARPOPHALANGEAL (JOINT)
834.12	OPEN DISLOCATION INTERPHALANGEAL (JOINT) HAND
835.01	CLOSED POSTERIOR DISLOCATION OF HIP
835.02	CLOSED OBTURATOR DISLOCATION OF HIP
835.03	OTHER CLOSED ANTERIOR DISLOCATION OF HIP
836.0	TEAR OF MEDIAL CARTILAGE OR MENISCUS OF KNEE CURRENT
836.1	TEAR OF LATERAL CARTILAGE OR MENISCUS OF KNEE CURRENT
836.2	OTHER TEAR OF CARTILAGE OR MENISCUS OF KNEE CURRENT
836.3	DISLOCATION OF PATELLA CLOSED
836.51 - 836.59	ANTERIOR DISLOCATION OF TIBIA PROXIMAL END CLOSED - OTHER DISLOCATION OF KNEE CLOSED
837.0	CLOSED DISLOCATION OF ANKLE
838.01 - 838.09	CLOSED DISLOCATION OF TARSAL (BONE) JOINT UNSPECIFIED - CLOSED DISLOCATION OF OTHER PART OF FOOT
839.61	CLOSED DISLOCATION STERNUM
840.0 - 840.9	ACROMIOCLAVICULAR (JOINT) (LIGAMENT) SPRAIN - SPRAIN OF UNSPECIFIED SITE OF SHOULDER AND UPPER ARM
841.0 - 841.9	RADIAL COLLATERAL LIGAMENT SPRAIN - SPRAIN OF UNSPECIFIED SITE OF ELBOW AND FOREARM
842.00	SPRAIN OF UNSPECIFIED SITE OF WRIST
842.01	SPRAIN OF CARPAL (JOINT) OF WRIST
842.02	SPRAIN OF RADIOCARPAL (JOINT) (LIGAMENT) OF WRIST
842.09	OTHER WRIST SPRAIN
842.10 - 842.19	SPRAIN OF UNSPECIFIED SITE OF HAND - OTHER HAND SPRAIN

843.0 - 843.8	ILIOFEMORAL (LIGAMENT) SPRAIN - SPRAIN OF OTHER SPECIFIED SITES OF HIP AND THIGH
844.0	SPRAIN OF LATERAL COLLATERAL LIGAMENT OF KNEE
844.1	SPRAIN OF MEDIAL COLLATERAL LIGAMENT OF KNEE
844.2	SPRAIN OF CRUCIATE LIGAMENT OF KNEE
844.3	SPRAIN OF TIBIOFIBULAR (JOINT) (LIGAMENT) SUPERIOR OF KNEE
844.8	SPRAIN OF OTHER SPECIFIED SITES OF KNEE AND LEG
845.01	DELTOID (LIGAMENT) ANKLE SPRAIN
845.02	CALCANEOFIBULAR (LIGAMENT) ANKLE SPRAIN
845.03	TIBIOFIBULAR (LIGAMENT) SPRAIN DISTAL
845.09	OTHER ANKLE SPRAIN
846.0	LUMBOSACRAL (JOINT) (LIGAMENT) SPRAIN
846.1	SACROILIAC (LIGAMENT) SPRAIN
846.2	SACROSPINATUS (LIGAMENT) SPRAIN
846.3	SACROTUBEROUS (LIGAMENT) SPRAIN
846.8	OTHER SPECIFIED SITES OF SACROILIAC REGION SPRAIN
847.0	NECK SPRAIN
847.1	THORACIC SPRAIN
847.2	LUMBAR SPRAIN
847.3	SPRAIN OF SACRUM
847.4	SPRAIN OF COCCYX
848.41	STERNOCLAVICULAR (JOINT) (LIGAMENT) SPRAIN
848.42	CHONDROSTERNAL (JOINT) SPRAIN
848.5	PELVIC SPRAIN
850.4	CONCUSSION WITH PROLONGED LOSS OF CONSCIOUSNESS WITHOUT RETURN TO PRE-EXISTING CONSCIOUS LEVEL
875.1	OPEN WOUND OF CHEST (WALL) COMPLICATED
876.1	OPEN WOUND OF BACK COMPLICATED
877.1	OPEN WOUND OF BUTTOCK COMPLICATED
878.1	OPEN WOUND OF PENIS COMPLICATED
878.3	OPEN WOUND OF SCROTUM AND TESTES COMPLICATED
878.5	OPEN WOUND OF VULVA COMPLICATED
879.1	OPEN WOUND OF BREAST COMPLICATED
879.3	OPEN WOUND OF ABDOMINAL WALL ANTERIOR COMPLICATED
879.5	OPEN WOUND OF ABDOMINAL WALL LATERAL COMPLICATED
879.7	OPEN WOUND OF OTHER AND UNSPECIFIED PARTS OF

TRUNK COMPLICATED

879.9	OPEN WOUND(S) (MULTIPLE) OF UNSPECIFIED SITE(S) COMPLICATED
880.00 - 880.29	OPEN WOUND OF SHOULDER REGION WITHOUT COMPLICATION - OPEN WOUND OF MULTIPLE SITES OF SHOULDER AND UPPER ARM WITH TENDON INVOLVEMENT
881.00 - 881.22	OPEN WOUND OF FOREARM WITHOUT COMPLICATION - OPEN WOUND OF WRIST WITH TENDON INVOLVEMENT
882.0	OPEN WOUND OF HAND EXCEPT FINGERS ALONE WITHOUT COMPLICATION
882.1	OPEN WOUND OF HAND EXCEPT FINGERS ALONE COMPLICATED
882.2	OPEN WOUND OF HAND EXCEPT FINGERS ALONE WITH TENDON INVOLVEMENT
883.0	OPEN WOUND OF FINGERS WITHOUT COMPLICATION
883.1	OPEN WOUND OF FINGERS COMPLICATED
883.2	OPEN WOUND OF FINGERS WITH TENDON INVOLVEMENT
884.0	MULTIPLE AND UNSPECIFIED OPEN WOUND OF UPPER LIMB WITHOUT COMPLICATION
884.1	MULTIPLE AND UNSPECIFIED OPEN WOUND OF UPPER LIMB COMPLICATED
884.2	MULTIPLE AND UNSPECIFIED OPEN WOUND OF UPPER LIMB WITH TENDON INVOLVEMENT
885.0	TRAUMATIC AMPUTATION OF THUMB (COMPLETE)(PARTIAL) WITHOUT COMPLICATION
885.1	TRAUMATIC AMPUTATION OF THUMB (COMPLETE)(PARTIAL) COMPLICATED
886.0	TRAUMATIC AMPUTATION OF OTHER FINGER(S) (COMPLETE) (PARTIAL) WITHOUT COMPLICATION
886.1	TRAUMATIC AMPUTATION OF OTHER FINGER(S) (COMPLETE) (PARTIAL) COMPLICATED
887.0 - 887.7	TRAUMATIC AMPUTATION OF ARM AND HAND (COMPLETE) (PARTIAL) UNILATERAL BELOW ELBOW WITHOUT COMPLICATION - TRAUMATIC AMPUTATION OF ARM AND HAND (COMPLETE) (PARTIAL) BILATERAL (ANY LEVEL) COMPLICATED
890.0	OPEN WOUND OF HIP AND THIGH WITHOUT COMPLICATION
890.1	OPEN WOUND OF HIP AND THIGH COMPLICATED
890.2	OPEN WOUND OF HIP AND THIGH WITH TENDON INVOLVEMENT
891.0	OPEN WOUND OF KNEE LEG (EXCEPT THIGH) AND ANKLE WITHOUT COMPLICATION
891.1	OPEN WOUND OF KNEE LEG (EXCEPT THIGH) AND ANKLE COMPLICATED
891.2	OPEN WOUND OF KNEE LEG (EXCEPT THIGH) AND ANKLE

	WITH TENDON INVOLVEMENT
892.0	OPEN WOUND OF FOOT EXCEPT TOE(S) ALONE WITHOUT COMPLICATION
892.1	OPEN WOUND OF FOOT EXCEPT TOE(S) ALONE COMPLICATED
892.2	OPEN WOUND OF FOOT EXCEPT TOE(S) ALONE WITH TENDON INVOLVEMENT
893.0	OPEN WOUND OF TOE(S) WITHOUT COMPLICATION
893.1	OPEN WOUND OF TOE(S) COMPLICATED
893.2	OPEN WOUND OF TOE(S) WITH TENDON INVOLVEMENT
894.1	MULTIPLE AND UNSPECIFIED OPEN WOUND OF LOWER LIMB COMPLICATED
895.0	TRAUMATIC AMPUTATION OF TOE(S) (COMPLETE) (PARTIAL) WITHOUT COMPLICATION
895.1	TRAUMATIC AMPUTATION OF TOE(S) (COMPLETE) (PARTIAL) COMPLICATED
896.0	TRAUMATIC AMPUTATION OF FOOT (COMPLETE) (PARTIAL) UNILATERAL WITHOUT COMPLICATION
896.1	TRAUMATIC AMPUTATION OF FOOT (COMPLETE) (PARTIAL) UNILATERAL COMPLICATED
896.2	TRAUMATIC AMPUTATION OF FOOT (COMPLETE) (PARTIAL) BILATERAL WITHOUT COMPLICATION
896.3	TRAUMATIC AMPUTATION OF FOOT (COMPLETE) (PARTIAL) BILATERAL COMPLICATED
897.0	TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) UNILATERAL BELOW KNEE WITHOUT COMPLICATION
897.1	TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) UNILATERAL BELOW KNEE COMPLICATED
897.2	TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) UNILATERAL AT OR ABOVE KNEE WITHOUT COMPLICATION
897.3	TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) UNILATERAL AT OR ABOVE KNEE COMPLICATED
897.4	TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) UNILATERAL LEVEL NOT SPECIFIED WITHOUT COMPLICATION
897.5	TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) UNILATERAL LEVEL NOT SPECIFIED COMPLICATED
897.6	TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) BILATERAL (ANY LEVEL) WITHOUT COMPLICATION
897.7	TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) BILATERAL (ANY LEVEL) COMPLICATED
905.1 - 905.9	LATE EFFECT OF FRACTURE OF SPINE AND TRUNK WITHOUT SPINAL CORD LESION - LATE EFFECT OF

TRAUMATIC AMPUTATION	
906.0 - 906.9	LATE EFFECT OF OPEN WOUND OF HEAD NECK AND TRUNK - LATE EFFECT OF BURN OF UNSPECIFIED SITE
907.0 - 907.9	LATE EFFECT OF INTRACRANIAL INJURY WITHOUT SKULL FRACTURE - LATE EFFECT OF INJURY TO OTHER AND UNSPECIFIED NERVE
908.6	LATE EFFECT OF CERTAIN COMPLICATIONS OF TRAUMA
909.2	LATE EFFECT OF RADIATION
909.3	LATE EFFECT OF COMPLICATIONS OF SURGICAL AND MEDICAL CARE
925.1 - 929.9	CRUSHING INJURY OF FACE AND SCALP - CRUSHING INJURY OF UNSPECIFIED SITE
941.20 - 941.29	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF FACE AND HEAD UNSPECIFIED SITE - BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF MULTIPLE SITES (EXCEPT WITH EYE) OF FACE HEAD AND NECK
941.30 - 941.39	FULL-THICKNESS SKIN LOSS DUE TO BURN (THIRD DEGREE NOS) OF UNSPECIFIED SITE OF FACE AND HEAD - FULL-THICKNESS SKIN LOSS DUE TO BURN (THIRD DEGREE NOS) OF MULTIPLE SITES (EXCEPT WITH EYE) OF FACE HEAD AND NECK
941.40 - 941.49	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF UNSPECIFIED SITE OF FACE AND HEAD WITHOUT LOSS OF BODY PART - DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF MULTIPLE SITES (EXCEPT WITH EYE) OF FACE HEAD AND NECK WITHOUT LOSS OF A BODY PART
941.50 - 941.59	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF FACE AND HEAD UNSPECIFIED SITE WITH LOSS OF BODY PART - DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF MULTIPLE SITES (EXCEPT EYE) OF FACE HEAD AND NECK WITH LOSS OF A BODY PART
942.20	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF UNSPECIFIED SITE OF TRUNK
942.21 - 942.59	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF BREAST - DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF OTHER AND MULTIPLE SITES OF TRUNK WITH LOSS OF A BODY PART
943.00 - 943.09	BURN OF UNSPECIFIED DEGREE OF UNSPECIFIED SITE OF UPPER LIMB - BURN OF UNSPECIFIED DEGREE MULTIPLE SITES OF UPPER LIMB EXCEPT WRIST AND HAND
943.10 - 943.19	ERYTHEMA DUE TO BURN (FIRST DEGREE) OF UNSPECIFIED SITE OF UPPER LIMB - ERYTHEMA DUE TO BURN (FIRST DEGREE) OF MULTIPLE SITES OF UPPER LIMB EXCEPT WRIST AND HAND
943.20 - 943.59	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF UNSPECIFIED SITE OF UPPER LIMB - DEEP

	NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF MULTIPLE SITES OF UPPER LIMB EXCEPT WRIST AND HAND WITH LOSS OF UPPER LIMB
944.00	BURN OF UNSPECIFIED DEGREE OF UNSPECIFIED SITE OF HAND
944.01	BURN OF UNSPECIFIED DEGREE OF SINGLE DIGIT (FINGER (NAIL) OTHER THAN THUMB
944.02	BURN OF UNSPECIFIED DEGREE OF THUMB (NAIL)
944.03	BURN OF UNSPECIFIED DEGREE OF TWO OR MORE DIGITS OF HAND NOT INCLUDING THUMB
944.04	BURN OF UNSPECIFIED DEGREE OF TWO OR MORE DIGITS OF HAND INCLUDING THUMB
944.05	BURN OF UNSPECIFIED DEGREE OF PALM OF HAND
944.06	BURN OF UNSPECIFIED DEGREE OF BACK OF HAND
944.07	BURN OF UNSPECIFIED DEGREE OF WRIST
944.08	BURN OF UNSPECIFIED DEGREE OF MULTIPLE SITES OF WRIST(S) AND HAND(S)
944.10	ERYTHEMA DUE TO BURN (FIRST DEGREE) OF UNSPECIFIED SITE OF HAND
944.11	ERYTHEMA DUE TO BURN (FIRST DEGREE) OF SINGLE DIGIT (FINGER (NAIL)) OTHER THAN THUMB
944.12	ERYTHEMA DUE TO BURN (FIRST DEGREE) OF THUMB (NAIL)
944.13	ERYTHEMA DUE TO BURN (FIRST DEGREE) OF TWO OR MORE DIGITS OF HAND NOT INCLUDING THUMB
944.14	ERYTHEMA DUE TO BURN (FIRST DEGREE) OF TWO OR MORE DIGITS OF HAND INCLUDING THUMB
944.15	ERYTHEMA DUE TO BURN (FIRST DEGREE) OF PALM OF HAND
944.16	ERYTHEMA DUE TO BURN (FIRST DEGREE) OF BACK OF HAND
944.17	ERYTHEMA DUE TO BURN (FIRST DEGREE) OF WRIST
944.18	ERYTHEMA DUE TO BURN (FIRST DEGREE) OF MULTIPLE SITES OF WRIST(S) AND HAND(S)
944.20	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF UNSPECIFIED SITE OF HAND
944.21 - 944.58	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF SINGLE DIGIT (FINGER (NAIL)) OTHER THAN THUMB - DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF MULTIPLE SITES OF WRIST(S) AND HAND(S) WITH LOSS OF A BODY PART
945.20 - 945.59	BLISTERS EPIDERMAL LOSS (SECOND DEGREE) OF UNSPECIFIED SITE OF LOWER LIMB (LEG) - DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF MULTIPLE SITES OF LOWER LIMB(S) WITH LOSS OF A BODY PART
946.2 - 946.5	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND

	DEGREE) OF MULTIPLE SPECIFIED SITES - DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF MULTIPLE SPECIFIED SITES WITH LOSS OF A BODY PART
948.00 - 948.99	BURN (ANY DEGREE) INVOLVING LESS THAN 10 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF LESS THAN 10 PERCENT OR UNSPECIFIED AMOUNT - BURN (ANY DEGREE) INVOLVING 90 PERCENT OR MORE OF BODY SURFACE WITH THIRD DEGREE BURN OF 90% OR MORE OF BODY SURFACE
949.3	FULL-THICKNESS SKIN LOSS DUE TO BURN (THIRD DEGREE NOS) UNSPECIFIED SITE
949.4	DEEP NECROSIS OF UNDERLYING TISSUE DUE TO BURN (DEEP THIRD DEGREE) UNSPECIFIED SITE WITHOUT LOSS OF A BODY PART
949.5	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE UNSPECIFIED SITE WITH LOSS OF A BODY PART
951.4	INJURY TO FACIAL NERVE
951.6	INJURY TO ACCESSORY NERVE
953.4	INJURY TO BRACHIAL PLEXUS
953.8	INJURY TO MULTIPLE SITES OF NERVE ROOTS AND SPINAL PLEXUS
955.0	INJURY TO AXILLARY NERVE
955.1	INJURY TO MEDIAN NERVE
955.2	INJURY TO ULNAR NERVE
955.3	INJURY TO RADIAL NERVE
955.4	INJURY TO MUSCULOCUTANEOUS NERVE
955.5	INJURY TO CUTANEOUS SENSORY NERVE UPPER LIMB
955.6	INJURY TO DIGITAL NERVE UPPER LIMB
955.7	INJURY TO OTHER SPECIFIED NERVE(S) OF SHOULDER GIRDLE AND UPPER LIMB
955.8	INJURY TO MULTIPLE NERVES OF SHOULDER GIRDLE AND UPPER LIMB
955.9	INJURY TO UNSPECIFIED NERVE OF SHOULDER GIRDLE AND UPPER LIMB
956.0	INJURY TO SCIATIC NERVE
956.1	INJURY TO FEMORAL NERVE
956.2	INJURY TO POSTERIOR TIBIAL NERVE
956.3	INJURY TO PERONEAL NERVE
958.6	VOLKMANN'S ISCHEMIC CONTRACTURE
958.91	TRAUMATIC COMPARTMENT SYNDROME OF UPPER EXTREMITY
958.92	TRAUMATIC COMPARTMENT SYNDROME OF LOWER EXTREMITY

996.40	UNSPECIFIED MECHANICAL COMPLICATION OF INTERNAL ORTHOPEDIC DEVICE, IMPLANT, AND GRAFT
996.41	MECHANICAL LOOSENING OF PROSTHETIC JOINT
996.42	DISLOCATION OF PROSTHETIC JOINT
996.43	BROKEN PROSTHETIC JOINT IMPLANT
996.44	PERI-PROSTHETIC FRACTURE AROUND PROSTHETIC JOINT
996.45	PERI-PROSTHETIC OSTEOLYSIS
996.46	ARTICULAR BEARING SURFACE WEAR OF PROSTHETIC JOINT
996.47	OTHER MECHANICAL COMPLICATION OF PROSTHETIC JOINT IMPLANT
996.49	OTHER MECHANICAL COMPLICATION OF OTHER INTERNAL ORTHOPEDIC DEVICE, IMPLANT, AND GRAFT
996.66	INFECTION AND INFLAMMATORY REACTION DUE TO INTERNAL JOINT PROSTHESIS
996.67	INFECTION AND INFLAMMATORY REACTION DUE TO OTHER INTERNAL ORTHOPEDIC DEVICE IMPLANT AND GRAFT
996.77	OTHER COMPLICATIONS DUE TO INTERNAL JOINT PROSTHESIS
996.78	OTHER COMPLICATIONS DUE TO OTHER INTERNAL ORTHOPEDIC DEVICE IMPLANT AND GRAFT
996.79	OTHER COMPLICATIONS DUE TO OTHER INTERNAL PROSTHETIC DEVICE IMPLANT AND GRAFT
996.91	COMPLICATIONS OF REATTACHED FOREARM
996.92	COMPLICATIONS OF REATTACHED HAND
996.93	COMPLICATIONS OF REATTACHED FINGER(S)
996.94	COMPLICATIONS OF REATTACHED UPPER EXTREMITY OTHER AND UNSPECIFIED
996.95	COMPLICATION OF REATTACHED FOOT AND TOE(S)
996.99	COMPLICATION OF OTHER SPECIFIED REATTACHED BODY PART
997.60	UNSPECIFIED LATE COMPLICATION OF AMPUTATION STUMP
997.61	NEUROMA OF AMPUTATION STUMP
997.62	INFECTION (CHRONIC) OF AMPUTATION STUMP
997.69	OTHER LATE AMPUTATION STUMP COMPLICATION
998.89	OTHER SPECIFIED COMPLICATIONS OF PROCEDURES NOT ELSEWHERE CLASSIFIED
V15.88	HISTORY OF FALL
V43.60 - V43.69	UNSPECIFIED JOINT REPLACEMENT - OTHER JOINT REPLACEMENT
V43.7	LIMB REPLACED BY OTHER MEANS

V45.4	POSTSURGICAL ARTHRODESIS STATUS
V46.3	WHEELCHAIR DEPENDENCE
V48.2	MECHANICAL AND MOTOR PROBLEMS WITH HEAD
V48.3	MECHANICAL AND MOTOR PROBLEMS WITH NECK AND TRUNK
V48.4	SENSORY PROBLEM WITH HEAD
V48.5	SENSORY PROBLEM WITH NECK AND TRUNK
V49.0 - V49.5	DEFICIENCIES OF LIMBS - OTHER PROBLEMS OF LIMBS
V49.60 - V49.77	UNSPECIFIED LEVEL UPPER LIMB AMPUTATION STATUS - HIP AMPUTATION STATUS
V52.0	FITTING AND ADJUSTMENT OF ARTIFICIAL ARM (COMPLETE) (PARTIAL)
V52.1	FITTING AND ADJUSTMENT OF ARTIFICIAL LEG (COMPLETE) (PARTIAL)
V52.4	FITTING AND ADJUSTMENT OF BREAST PROSTHESIS AND IMPLANT
V52.8	FITTING AND ADJUSTMENT OF OTHER SPECIFIED PROSTHETIC DEVICE
V53.7	FITTING AND ADJUSTMENT OF ORTHOPEDIC DEVICES
V53.8	FITTING AND ADJUSTMENT OF WHEELCHAIR
V53.90	FITTING AND ADJUSTMENT OF UNSPECIFIED DEVICE
V54.01 - V54.89	ENCOUNTER FOR REMOVAL OF INTERNAL FIXATION DEVICE - OTHER ORTHOPEDIC AFTERCARE
V54.9	UNSPECIFIED ORTHOPEDIC AFTERCARE
V57.81	CARE INVOLVING ORTHOTIC TRAINING
V58.30	ENCOUNTER FOR CHANGE OR REMOVAL OF NONSURGICAL WOUND DRESSING
V58.31	ENCOUNTER FOR CHANGE OR REMOVAL OF SURGICAL WOUND DRESSING
V58.49	OTHER SPECIFIED AFTERCARE FOLLOWING SURGERY

Diagnoses that Support Medical Necessity [back to top](#)

All diagnoses listed in "ICD-9-CM Codes That Support Medical Necessity" above.

ICD-9 Codes that DO NOT Support Medical Necessity [back to top](#)

All ICD-9-CM codes **not** listed in this policy under "ICD-9-CM Codes That Support Medical Necessity" above.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk**Explanation** [back to top](#)**Diagnoses that DO NOT Support Medical Necessity** [back to top](#)

All ICD-9-CM codes **not** listed in this policy under "ICD-9-CM Codes That Support Medical Necessity" above.

General Information**Documentation Requirements** [back to top](#)

1. The medical record must identify the physician or qualified nonphysician who has prescribed the physical medicine and rehabilitation services for the patient.
2. The services are to be furnished according to a written treatment plan determined by the physician, or by the therapist who will provide the treatment, after an appropriate assessment of the condition. All providers rendering therapy must document the appropriate history, examination, diagnosis, functional assessment, measurable goals, type of treatment, the body areas to be treated, the date the therapy was initiated, and expected frequency and number of treatments. This documentation must be maintained in the patient's file.
3. Documentation should indicate the prognosis for potential restoration of function in a reasonable and generally predictable period of time.
4. Documentation in the medical record must support the medical necessity, type, frequency and duration of services provided. Documentation must be available on request to indicate the medical necessity of any and all treatments, especially continued treatment beyond the provisions of this policy.
5. Patients receiving services from private physical or occupational therapists require reviews (dated and signed) of the treatment plan by the attending physician at least once within 90 days or any time the patient's condition changes significantly, making a revision of long term goals necessary.
6. Documentation of the medical necessity of multiple heating modalities (97018, 97024, 97026, 97034) on the same date of service must be available for review. Such use must show all were needed toward the restoration of function.
7. Documentation for 97597 or 97598, removal of devitalized tissue must include the fact that devitalized tissue was present, and the specific selective debridement technique used. This code may be billed once per session of debridement regardless of the number and extent of the wounds debrided. If whirlpool is used for the same wound prior to selective debridement, it is bundled into the new code (97597 or 97598). However, if whirlpool is used for a different body part or body area on the same date of service than the area being debrided, it could be billed.
8. Medicare requires a legible identity (including professional degree) and date for services provided/ordered. The method used (e.g. hand written or electronic) to sign an order or other medical record documentation for

medical review purposes in determining coverage is not a relevant factor. Rather, an indication of a signature in some form needs to be present. Stamped signatures are not acceptable. Providers using alternative signature methods should recognize that there is a potential for misuse or abuse. For example, providers need a system and software products which are protected against modification, etc. and should apply administrative procedures which are adequate and correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bears the responsibility for the authenticity of the information being attested to. Physicians should check with their attorneys and malpractice insurers in regard to the use of alternative signature methods. All State licensure and State practice regulations continue to apply. Where State law is more restrictive than Medicare, the State law standard will apply. The signature requirements described here do not assure compliance with Medicare conditions of participation. Note that this instruction does not supersede the prohibition for Certificates of Medical Necessity (CMN). CMNs are a term of specifically describing particular Durable Medical Equipment forms. As stated on CMN forms, signature and date stamps are not acceptable for use on CMNs.

9. When, the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary.

10. The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

11. When requesting a written redetermination (formerly appeal), providers must include all relevant documentation with the request.

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Sources of Information and Basis for Decision [back to top](#)

Duthie. *Practice of Geriatrics*. 3rd ed. W.B. Saunders Company; 1998.

Noble. *Textbook of Primary Care Medicine*. 3rd ed. Mosby, Inc; 2001.

Harris. *Kelley's Textbook of Rheumatology*. 7th ed. Elsevier; 2005.

Goetz. *Textbook of Clinical Neurology*. 2nd ed. Elsevier; 2003.

Goldman C. *Textbook of Medicine*. 22nd ed. W.B. Saunders Company; 2004.

Frontera. *Essentials of Physical Medicine and Rehabilitation*. 1st ed. Hanley and Belfus; 2002.

American Academy of Physical Medicine and Rehabilitation

Coders' Desk Reference. 9th ed. Ingenix, Inc; 2004. 10th ed. Ingenix, Inc;

2005.

American Physical Therapy Association

American Occupational Therapy Association

Board Certified Physical Medicine and Rehabilitation physicians

Licensed Physical Therapist consultants

Licensed Occupational Therapist consultants

Carrier Medical Directors PM&R Clinical Workgroup

Other carriers' policies

Advisory Committee Meeting Notes [back to top](#)

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which include representatives from the affected provider community.

Contractor Advisory Committee meeting dates:

California -

Hawaii -

Nevada -

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06/16/2008

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Revision #9

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Revision #9 effective for dates of service on or after 10/18/2009
Revisions made: Under "Indications and Limitations of Coverage and or Medical Necessity" the opening statement added speech-language pathologist to list of providers affected by this LCD practicing in the home and office setting. Under subheading Suppliers, added Speech-Language Pathologist to list of practitioners who have Medicare provider numbers. Removed statement that Speech language pathologist are not suppliers because the ACT does not provide coverage of any speech-language pathology services

furnished by a speech language pathologist as an independent practitioner. Under subheading Other Definitions, Speech-language pathologist in private practice whose services may be billed under one of four different practitioner benefits was added to this section of the LCD. Annual validation completed.

Revision #8 effective for dates of service on or after 10/01/2009.

Revisions made: Under "Indications and Limitations of Coverage and/or Medical Necessity" expanded coverage of iontophoresis (97033) for the following conditions: patient having tendonitis or calcific tendonitis, having bursitis, adhesive capsulitis, hyperhidrosis and/or thick adhesive scar(s). Removed duplicative statement regarding MENS and added CPT code 97039 to original statement regarding MENS in that section. The statement regarding the need for two ICD-9-CM codes on a claim to support the causal pathological condition was removed. The example for the need for two ICD-9 codes was also removed. Under "ICD-9 codes that Support Medical Necessity" the following ICD-9 codes were revised 813.45 and 996.43. The following ICD-9 codes were added 359.71, 359.79, 438.13, 438.14, 784.42, 784.51, 784.59, 813.46, 813.47, and 832.2 per the 2009-2010 Annual ICD-9-CM Code Annual Update CR 6520, Transmittal 1770 dated July 10, 2009. The following ICD-9 codes were added to consolidate Part B Physical Medicine and Rehabilitation LCD with Part A Out-Patient Physical Therapy LCD, Part A Out-Patient Occupational Therapy LCD and Out Patient Speech and Language Pathology LCD: 334.0-336.9, 351.0, 357.2, 438.10, 438.11, 438.12, 438.19, 496, 717.0-717.89, 717.9, 719.00-719.09, 719.90-719.99, 723.7, 724.9, 726.5-726.79, 726.90-726.91, 727.00, 727.01, 727.02, 727.06, 727.09, 728.10-728.19, 728.86, 728.88, 729.4, 729.89, 732.0-732.7, 732.9, 733.42-733.49, 733.5, 734, 735.1-735.9, 737.0, 737.10-737.19, 737.20-737.9, 756.10-756.19, 780.4, 784.40, 784.41, 784.49, 794.2, 925.1- 926.9, 928.00-928.9, V15.88.

Revision #7 effective for dates of service on or after 04/27/2009.

Revisions made: Under "CMS National Coverage Policy" added reference to CR 6407, Transmittal 1706. Under "Indications and Limitations of Coverage and/or Medical Necessity" removed instructions to use CPT code 97530 when performing the Epley maneuver and inserted CPT code 95992 and its description with the statement that there is no provision for direct payment to physicians, nonphysician practitioners and audiologist for this therapeutic service. When physical therapists provide this service they should continue to bill CPT code 97112. Also stated that 95992 is a bundled service and is currently being reimbursed as part of an Evaluation and Management (E and M) service. Added CPT code 95992 to the CPT/HCPCS Paragraph which states why CPT code 95992 would be denied as a bundled service. Under "ICD-9 Codes that Support Medical Necessity" added ICD-9 code 607.83, 608.86 and 624.8.

Revision #6, 02/26/2009

This LCD is being revised to implement the streamlining of the Part B LCDs per the published article "Palmetto Team to Streamline Part B LCDs in Jurisdiction 1 (J1)." This article can be viewed at www.PalmettoGBA.com by searching for the above article name. This revision will become effective on 02/26/2009.

Revision #5 effective for dates of service on or after 01/09/2009.

Revisions Made: Under "CPT/HCPCS Codes" the following CPT code descriptors were revised: 97012, 97016, 97018, 97022, 97024 and 97028. The CPT codes descriptors are effective for dates of service on or after 01/01/2009.

Revision #4, 10/17/2008

Under CMS National Coverage Policy changed the date cited for CMS

Transmittal AB-01-135, Change Request 1793, Medical Review of Services for Patients with Dementia from September 24, 2001 to now read September 25, 2001. Revised CMS Transmittal 34, Change Request 3648, dated May 6, 2005 to now read CMS Transmittal 36, Change Request 3648, dated June 24, 2005. Deleted Change Request 2083 that was redundant. Verbiage changes were made to the cited references. Under Indications and Limitations of Coverage and/or Medical Necessity –General PM&R Guidelines #5 deleted the following statements: “ Services furnished to a patient who has not been seen by a physician once in 30 days from the initial treatment day” and “Services not furnished in a therapist’s office or in the patient’s home are not covered.” Under Indications and Limitations of Coverage and/or Medical Necessity –Specific Modality Guidelines deleted verbiage. Under ICD-9 Codes That Support Medical Necessity deleted CPT code sections. Added ICD-9 codes 138, 333.85, 333.91, 344.5, 344.81, 344.9, 346.00, 346.01, 346.02, 346.03, 346.10, 346.11, 346.12, 346.13, 346.20, 346.21, 346.22, 346.23, 346.30, 346.31, 346.32, 346.33, 346.40, 346.41, 346.42, 346.43, 346.50, 346.51, 346.52, 346.53, 346.60, 346.61, 346.62, 346.63, 346.70, 346.71, 346.72, 346.73, 346.80, 346.81, 346.82, 346.83, 346.90, 346.91, 346.92, 346.93, 353.0, 353.1, 353.2, 353.3, 353.4, 353.5, 353.6, 353.8, 353.9, 354.0, 354.1, 354.2, 354.3, 354.5, 354.8, 354.9, 355.0, 355.2, 355.3, 355.4, 355.5, 355.6, 355.79, 355.9, 356.0, 356.1, 356.2, 356.3, 356.4, 356.8, 356.9, 357.0, 359.0, 359.1, 359.21, 359.22, 359.23, 359.24, 359.29, 438.20, 438.21, 438.22, 438.30, 438.31, 438.32, 438.40, 438.41, 438.42, 438.50, 438.51, 438.52, 438.53, 438.6, 438.81, 438.82, 438.83, 438.84, 438.85, 438.89, 438.9, 443.0, 459.11, 459.13, 459.31, 459.33, 494.0, 494.1, 514, 524.60, 524.61, 524.62, 524.63, 524.64, 524.69, 607.89, 611.71, 665.61, 665.64, 681.00, 681.01, 681.02, 681.10, 681.11, 682.0, 682.1, 682.2, 682.3, 682.4, 682.5, 682.6, 682.7, 683, 701.0, 701.4, 707.00, 707.10, 707.20, 707.21, 707.9, 711.00, 711.01, 711.02, 711.03, 711.04, 711.05, 711.06, 711.07, 711.08, 711.09, 711.10, 711.11, 711.12, 711.13, 711.14, 711.15, 711.16, 711.17, 711.18, 711.19, 711.20, 711.21, 711.22, 711.23, 711.24, 711.25, 711.26, 711.27, 711.28, 711.29, 711.30, 711.31, 711.32, 711.33, 711.34, 711.35, 711.36, 711.37, 711.38, 711.39, 711.40, 711.41, 711.42, 711.43, 711.44, 711.45, 711.46, 711.47, 711.48, 711.49, 711.50, 711.51, 711.52, 711.53, 711.54, 711.55, 711.56, 711.57, 711.58, 711.59, 713.5, 714.0, 714.1, 714.2, 714.30, 714.31, 714.32, 714.33, 714.4, 714.81, 714.89, 714.9, 715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98, 716.00, 716.01, 716.02, 716.03, 716.04, 716.05, 716.06, 716.07, 716.08, 716.09, 716.10, 716.11, 716.12, 716.13, 716.14, 716.15, 716.16, 716.17, 716.18, 716.19, 716.20, 716.21, 716.22, 716.23, 716.24, 716.25, 716.26, 716.27, 716.28, 716.29, 716.30, 716.31, 716.32, 716.33, 716.34, 716.35, 716.36, 716.37, 716.38, 716.39, 716.40, 716.41, 716.42, 716.43, 716.44, 716.45, 716.46, 716.47, 716.48, 716.49, 716.50, 716.51, 716.52, 716.53, 716.54, 716.55, 716.56, 716.57, 716.58, 716.59, 716.60, 716.61, 716.62, 716.63, 716.64, 716.65, 716.66, 716.67, 716.68, 716.80, 716.81, 716.82, 716.83, 716.84, 716.85, 716.86, 716.87, 716.88, 716.89, 716.90, 716.91, 716.92, 716.93, 716.94, 716.95, 716.96, 716.97, 716.98, 716.99, 718.00, 718.01, 718.02, 718.03, 718.04, 718.05, 718.07, 718.08, 718.09, 718.10, 718.11, 718.12, 718.13, 718.14, 718.15, 718.17, 718.18, 718.19, 718.20, 718.21, 718.22, 718.23, 718.24, 718.25, 718.26, 718.27, 718.28, 718.29, 718.30, 718.40, 718.50, 718.51, 718.52, 718.53, 718.54, 718.55, 718.56, 718.57, 718.58, 718.59, 718.60, 718.65, 718.70, 718.71, 718.72, 718.73, 718.74, 718.75, 718.76, 718.77, 718.78, 718.79, 718.80, 718.81, 718.82, 718.83, 718.84, 718.85, 718.86, 718.87, 718.88, 718.89, 718.90, 718.91, 718.92, 718.93, 718.94, 718.95, 718.97, 718.98, 718.99, 719.10, 719.11, 719.12, 719.13, 719.14, 719.15, 719.16, 719.17, 719.18,

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Revision #3, 10/01/2008

This LCD is being revised due to the annual FY2009 ICD-9-CM code update. Under the "ICD-9 Codes that Support Medical Necessity" section the following ICD-9 codes were added 707.22, 707.23 and 707.24 for CPT/HCPCS codes 97022, 97036, 97597, 97598 and G0329. The verbiage for ICD-9 codes 707.01, 707.02, 707.03, 707.04, 707.05, 707.06, 707.07 and 707.09 was revised. "CMS National Coverage Policy" several citations were added to this section they were the following: CMS Benefit Policy Manual citations, CMS Program Integrity Manual citation, Federal Register citations and SSA citations. In the "Indications and Limitations of Coverage and/or Medical Necessity" duplicative SSA, Federal Regulations, CMS Manual citations were removed. Under the "Sources of Information and Basis for Decision" section references were placed in the AMA citation format. Under the "Documentation Requirements" section removed duplicate SSA and CMS Manual citations. This revision will become effective 10/01/2008.

Revision #2, 09/02/2008

Under Indications and Limitations of Coverage and/or Medical Necessity-A. General PM&R Guidelines #8 corrected spelling errors. Under Documentation Requirements #5 changed "30 days" to now read "90 days" to support manual instruction. This revision becomes effective 09/02/2008.

Revision #1, 09/02/2008

This LCD is being revised to add Bill Type 999X because the automated system transcription process was incomplete.

11/09/2008 - The description for CPT/HCPCS code 97012 was changed in group 1

11/09/2008 - The description for CPT/HCPCS code 97016 was changed in group 1

11/09/2008 - The description for CPT/HCPCS code 97018 was changed in group 1

11/09/2008 - The description for CPT/HCPCS code 97022 was changed in group 1

11/09/2008 - The description for CPT/HCPCS code 97024 was changed in group 1

11/09/2008 - The description for CPT/HCPCS code 97028 was changed in group 1

08/08/2009 - This policy was updated by the ICD-9 2009-2010 Annual Update.

11/15/2009 - The description for CPT/HCPCS code 97032 was changed in group 1

11/15/2009 - The description for CPT/HCPCS code 97034 was changed in group 1

11/15/2009 - The description for CPT/HCPCS code 97035 was changed in group 1

11/15/2009 - The description for CPT/HCPCS code 97036 was changed in group 1

11/15/2009 - The description for CPT/HCPCS code 97110 was changed in group 1

11/15/2009 - The description for CPT/HCPCS code 97112 was changed in group 1

11/15/2009 - The description for CPT/HCPCS code 97113 was changed in group 1

11/15/2009 - The description for CPT/HCPCS code 97116 was changed in group 1

11/15/2009 - The description for CPT/HCPCS code 97124 was changed in group 1

11/15/2009 - The description for CPT/HCPCS code 97140 was changed in group 1

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Related Documents [back to top](#)

This LCD has no Related Documents.

LCD Attachments [back to top](#)

There are no attachments for this LCD.

All Versions [back to top](#)

[Updated on 04/01/2010 with effective dates 05/24/2010 - N/A](#)

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