

APPENDIX F

OCCUPATIONAL THERAPY & PHYSICAL THERAPY GUIDELINES

At the end of this section there is a complete list of physical medicine evaluations, re-evaluations, modalities and procedures with their related unit limitations and guidelines; please refer to that chart for further information.

The information contained here gives guidelines about services that might be performed by an occupational or physical therapist. This section is not intended to be comprehensive. If there is a service not addressed and you have specific questions about coverage, please call the CSC Provider Benefits Only Line (800-432-0272 or 785-291-4183) to determine coverage of a specific service for a specific patient.

Submit the appropriate procedure code from the AMA-CPT codebook.

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NOTE: The revision date appears in the footer of the document. Links within the document are updated as changes occur throughout the year.

Acupuncture

- Most policies do not cover this service.
- Please call the CSC Provider Benefits Only Line (800-432-0272 or 785-291-4183) to determine coverage by a specific patient's contract.

- When covered you should use the appropriate procedure code from the AMA-CPT codebook:
 - 97810
 - 97811 + Add-on code
 - 97813
 - 97814 + Add-on code

Anodyne Therapy

- This service should be coded using 97799 with a description of "anodyne therapy" in box 19 or the electronic narrative. It should not be confused with Infrared Therapy that is coded 97026.
- It is considered experimental/investigational and is provider write-off unless a Policy Memo #1 Limited Patient Waiver is signed prior to performance of the service.

[Limited Patient Waiver](#)

- Use modifier "GA" to demonstrate waiver on file.

Anti-Gravity Lumbar Traction-Reverse (Inversion)

- Use 97139.
- It is considered experimental/investigational and is provider write-off unless a Policy Memo #1 Limited Patient Waiver is signed prior to performance of the service.

[Limited Patient Waiver](#)

- Use modifier "GA" to demonstrate waiver on file.

Aqua Massage Therapy

- This service should be coded using 97039 with a description of "aqua massage therapy" in box 19 or the electronic narrative. It should not be billed using 97124.
- It is considered experimental/investigational and is provider write-off unless a Policy Memo #1 Limited Patient Waiver is signed prior to performance of the service.

[Limited Patient Waiver](#)

- Use modifier "GA" to demonstrate waiver on file.

Assistants: Certified Physical Therapist Assistant (CPTA) or Certified Occupational Therapy Assistant (COTA)

- Services provided by a certified physical therapist assistant (CPTA) or certified occupational therapy assistant (COTA)

BCBSKS and FEP will only reimburse the above services if a physical therapist or occupational therapist, respectively, are on site at the time of service.

Cold Laser Therapy/Soft Laser Therapy/ Low Laser Therapy

- This service should be coded using 97039. It should not be confused with Infrared Therapy that is coded 97026.
- It is considered experimental/investigational and is provider write-off unless a Policy Memo #1 Limited Patient Waiver is signed prior to performance of the service.

[Limited Patient Waiver](#)

- When using an unspecified code (97039) you must attach a document explaining what the service is.
- Use modifier "GA" to demonstrate waiver on file.

Cryotherapy

- This service should be coded as 97010.
- Do not use procedure code 17340, as this is for direct application of chemicals to the skin.

Dressing Changes

- This service should be coded as 97799 with a description of "dressing change" in box 19 or the electronic narrative.

Extension/Flexion Joint Devices

- **Dynamic**
 - See procedure codes E1800, E1802, E1805, E1810, E1815, E1825, E1830, and E1840.
 - Covered for up to 3 months of rental if:
6 weeks post-operative or 6 weeks post injury and physical therapy has failed to improve ROM.
- **Bi-directional**
 - See procedure codes E1801, E1806, E1811, E1816, and E1818.
 - Covered for up to 3 months of rental if:
6 weeks post-operative or 6 weeks post injury and physical therapy has failed to improve ROM.

- **Content of service procedures**

- Procedure codes E1820 and E1821 are content of service of the device itself and may not be billed separately.

Fluidotherapy

- This service should be coded as 97022.
- Will consider for reimbursement if medically necessary and an integral part of the patient's treatment plan.

Foot Orthotics

- Most policies do not cover this service.
- Please call the CSC Provider Benefits Only Line (800-432-0272 or 785-291-4183) to determine coverage for a specific patient.
- When covered, you should use the appropriate procedure code from the HCPCS procedure code listing.

Functional Electrical Stimulation (FES)

This policy is being revised.

Horizontal Therapy

- This service should be coded using 97014.

Hot and Cold Therapies

- This service will be denied content of service unless it is the only service provided on that date.

Certain therapies are considered duplicative services as follows:

- Infrared (97026) and Ultraviolet (97028)
- Microwave (97024) and Infrared (97026)

Ice Massage/Ice Therapy

The use of ice directly on the patient with direct provider attendance. *This service is not the same as "cold packs"; which are coded 97010.*

- Ice therapy will be denied "content of service" unless it is the only service provided on that date.
- Ice therapy should be coded as 97039 with a description of "ice therapy" in box 19 or the electronic narrative.
- Unit of service is 15 minutes. Indicate units if more than one.
- More than one unit of service on a given date requires medical records.
- Use modifier "22" to indicate attachment to claim.

Ineligible Providers

- The following providers are not considered eligible providers as defined in the local BCBSKS member contracts, or for the Federal Employee Program (FEP). Their services cannot be billed incident to an eligible provider if they provide services.

Athletic trainers, massage therapists, exercise physiologists, occupational therapy aides, physical therapy aides and chiropractic assistants.

- Services performed by these specialties are considered patient responsibility and should not be billed to BCBSKS.

Kinesio Taping

- This service should be coded as 97039 with a description of "Kinesio taping" in box 19 or the electronic narrative.
- It is considered experimental/investigational, and is provider write-off unless a Policy Memo No. 1 Limited Patient Waiver is signed prior to performance of the service.

[Limited Patient Waiver](#)

- Use modifier "GA" to demonstrate waiver on file.

Magnatherm

- This service should be coded as 97024.
- Magnatherm is considered one unit of service per area.

Massage

- This service must be coded as 97124, regardless of delivery.
- This will be denied content of service unless it is the only service provided on date of service.

- **Coverage Criteria**

BCBSKS will consider massage therapy for possible coverage if the following are met.

The massage must be:

- Medical in nature
- Medically necessary
- An integral part of the treatment plan
- Performed by a MD, DO, DC, PA, ARNP, PT, OT
- Performed by a PTA or COTA under the direct supervision (on-site) of the physical or occupational therapist respectively.

- **Limitation of Units of Massage Therapy per Date of Service**

- Massage therapy 97124 is coded by 15-minute increments.
 - ✓ One unit of service per date of service will be considered for coverage without medical records.
 - ✓ If more than one unit of massage is performed on any given date you must attach medical records to support the care.
 - ✓ Claims paying with one unit of service will be subject to audit procedures.
 - ✓ Processing of claims received without this information may be delayed until such information is provided.
 - ✓ Use modifier "22" when submitting any claim attachment.
 - ✓ Refunds will be required if services were performed by someone other than the licensed eligible provider.

McConnell Strapping/Taping

- This service should be coded as 97039 with a description of "McConnell strapping" or "McConnell taping" in box 19 or the electronic narrative.
- Includes reimbursement for the tape and the taping procedure.
- A separate charge may be billed for the evaluation or re-evaluation; if performed.

Multiple Therapies

- If electrical stimulation, unattended (97014), electrical stimulation, attended (97032) and ultrasound (97035) are provided to the same area at the same session, please append modifier 22 and attach medical records. If medical records are not attached, only 97032 (since it has the highest MAP) will be allowed.
- If infrared (97026) and ultraviolet (97028) are provided to the same area at the same session, please append modifier 22 and attach medical records. If medical records are not attached, only 97028 (since it has the highest MAP) will be allowed.
- If diathermy, e.g., microwave (97024) and infrared (97026) are provided to the same area at the same session, please append modifier 22 and attach medical records. If medical records are not attached, only 97024 (since it has the highest MAP) will be allowed.
- If infrared (97026) and electrical stimulation, attended (97032) are provided to the same area at the same session, please append modifier 22 and attach medical records. If medical records are not attached, only 97032 (since it has the highest MAP) will be allowed.

Muscle Testing and Range of Motion Testing

- Performing routine muscle testing and range of motion or muscle testing (i.e., those tests that are an integral part of the assessment performed each visit to determine the patient's status from one visit to the next and to determine the level of care required for the current visit) are considered content of the evaluation or therapy/ies billed that particular day and should not be billed separately.
- Muscle and range of motion testing that are much more in-depth than the routine tests can be coded separately if they meet the criteria outlined in the AMA-CPT book for each test and all criteria is documented in the medical record. Most of the non-routine testing requires an in-depth written report and review with the patient to be considered an independent service.

Nerve Conduction Studies and Related Services

- **Out-of-State Vendors**

It is in violation of your contract with BCBSKS to use the services of an out-of-state vendor to conduct or read nerve conduction studies, diagnostic ultrasound, or any other related service since your contract indicates you must use the services of a contracting provider when referring services. BCBSKS does not contract with out-of-state vendors for these services.

[Policy Memo No. 1](#)

- **Certification for In-State Providers**

- Reimbursement guidelines are based on the certification of the performing provider.
- For more information see Policy Memo #1.

[Policy Memo No. 1](#)

- **Medical Policy**

To review medical necessity guidelines visit our website and the Medical Policy section.

[Policy Memo No. 1](#)

Posture Pump

- This service should be coded 97139 with a description of "posture pump" in box 19 or the electronic narrative.
- This service is considered not medically necessary and is a provider write-off unless the Policy Memo No. 1 Limited Patient Waiver is signed prior to performance of the service.

[Limited Patient Waiver](#)

- Use modifier "GA" to demonstrate waiver on file.

Strapping

- BCBSKS will consider for reimbursement strapping that is covered under your licensure if this is the only service performed that day.
- You should select the most appropriate code for the strapping from the AMA-CPT procedure codebook.
- Physical medicine modalities and procedures are eligible for reimbursement when billed on the same day.

Codes 29200 – 29280 and 29520 – 29550 will deny as content of service to codes 97001 – 97004, and may not be billed separately.

Sympathetic Therapy

- This service should be coded using 97799 with a description of "Sympathetic therapy" in box 19 or the electronic narrative.
- This service is considered experimental/investigational and is provider write-off unless a Policy Memo #1 Limited Patient Waiver is signed prior to performance of the service.

[Limited Patient Waiver](#)

- Use modifier "GA" to demonstrate waiver on file.

Tiered Reimbursement

- See Policy Memo No. 1, Section XXIV. Tiered Reimbursement and Provider Number Requirements.

[Policy Memo No. 1](#)

- Tiered reimbursement for chiropractors, physical therapists, occupational therapists, CPTAs, and COTAs is defined in the 2011 Competitive Allowance Program (CAP) letter dated July, 2010.

Transcutaneous Electrical Nerve Stimulator (TENS) – 4 Lead

- This service should be coded as E0730.
- *The purchase of E0720 2-Lead is always considered "not medically necessary". A Policy Memo #1 Limited Patient Waiver must be signed by the patient for the patient to be held financially responsible for the 2-Lead TENS. Use modifier "GA" to indicate waiver on file.*

[Limited Patient Waiver](#)

- *If the patient for this item does not sign a waiver, the contracting provider will be held liable for the charge.*
- Rental of E0730 or E0720 is denied not medically necessary.
- Training the patient to use the equipment is reimbursed in the amount allowed for the equipment. If you have an outside vendor supplying the device, you should look to them for the reimbursement of this service.

Vasopneumatic Devices

- This service should be coded 97016.
- This service will be denied content of service unless it is billed with one of the following diagnosis codes: 457.0, 457.1 or 757.0.

Vertebral Axial Decompression Therapy

(i.e., VaxD; IDD; DR 5000; DR 9000; SpinaSystem; etc.)

- This service should be coded using S9090.
- There is a national “S” procedure code assigned to this service. It is as follows:

S9090 Vertebral axial decompression therapy, per session

- All claims for this service must be coded using S9090, with one unit of service per day.
- Based on the lack of scientific evidence (blinded studies, appropriate number participants in studies already conducted, documented long term results) S9090 will be treated as 97012, having the same allowance and unit limitation guidelines.
- This policy will remain in effect until such time that such scientific studies performed within accepted standards are available.

- To ensure correct coding of this service there will be periodic audits performed at random.
- Those claims found to have been coded incorrectly will require appropriate refunds and patients' credits.

Wheelchair Evaluation

- This service should be coded using 97799 with a description of "wheelchair evaluation" in box 19 or the electronic narrative.
- Include length of time in Box 24G.
- If the therapist is an employee of the wheelchair supplier, this service is content of the wheelchair and will be denied as a provider write-off.

Wound Debridement Billed with Evaluation

- BCBSKS will not cover both services on the same date; unless there is a separate and identifiable service for the exam other than wound assessment.
- The reasoning for this guideline is as follows: The CPT-Assistant indicates "Active wound care procedures include assessment of the wound, the technique of debridement (selective or nonselective) without the use of anesthesia, cleansing of the wound, dressing of the wound (including application of topical ointments, wound bed protection and bulk dressing) and any patient/family instruction. Before beginning the debridement technique, the wound is examined to assess the drainage, color, texture, temperature, vascularity, condition of surrounding tissue, and size of the area to be targeted for debridement of necrotic tissue." (CPT Assistant - May 02:5.)
- Medical records should be submitted for separate and identifiable services.
- Use modifier "22" to indicate attachment to claim.

BOEING

For current information please refer to

[Blue Shield Report S-7-10 dated December 6, 2010](#)

Blue Cross and Blue Shield of Illinois (BCBSIL) is the new benefits administrator for The Boeing Company, previously administered by Regence BlueShield of Washington.

**BCBS of Illinois
Benefits Administrator
Eligibility and Benefits
1-800-676-2583**

Multiple Services, for One Patient, on Same Date of Service, Performed by Multiple Providers

These services must be submitted on the same claim. *If billed on separate claims one service will be denied as a duplicate of the other, or the claim will be sent back for additional information.*

Please review the following chart and the list at the end of this section to determine whether medical records are required (*after the chart are other reasons medical records must be attached; you should also review that*):

Example 1 - One Patient/Same Date of Service/Same Office

PT	97530	3 Units	Submit medical records for both providers to support medical necessity of the 5 units. Use modifier 22.
OT	97530	2 Units	

Example 2 - One Patient/Same Date of Service/Same Office

DC	97035	1 Unit	Medical records not required since the limit for 97035 is 2 for a date of service, and the limit for 97036 is 4 for a date of service
OT	97036	3 Units	

Example 3 - One Patient/Same Date of Service/Same Office

DC	97010	1 Unit	Submit medical records for ALL providers to support medical necessity of the 5 units. Use modifier 22.
PT	97012	1 Unit	
PT	97018	1 Unit	
OT	97022	1 Unit	
OT	97024	1 Unit	

Example 4 - One Patient/Same Date of Service/Same Office

PT	97001	Submit medical records for both providers to support medical necessity of performing 2 initial evaluations on the same day. Use modifier 22.
OT	97003	

Example 5 - One Patient/Same Date of Service/Same Office

PT	97001	Submit medical records for both providers to support medical necessity of performing 2 evaluations (one initial and one re-evaluation) on the same day. Use modifier 22.
OT	97004	

Example 6 - One Patient/Same Date of Service/Same Office		
PT	97002	Submit medical records for both providers to support medical necessity of performing 2 re-evaluations on the same day. Use modifier 22.
OT	97004	

Example 7 - One Patient/Same Date of Service/Same Office		
PT	97002	Submit medical records for both providers to support medical necessity of performing 2 evaluations (one re-evaluation and one initial) on the same day. Use modifier 22.
OT	97003	

Example 8 - One Patient/Re-Evaluation Billed Within 30 Days of the Last Evaluation/Same Office		
PT	97002	Submit medical records to support medical necessity of performing 2 evaluations within 30 days of the last evaluation (initial or re-evaluation). Use modifier 22.
OT	97004	Submit medical records to support medical necessity of performing 2 evaluations within 30 days of the last evaluation (initial or re-evaluation). Use modifier 22.

Multiple Units of Physical Medicine Modalities and Procedures on Same Date of Service

BCBSKS has guidelines that require we review certain services when the units performed on a given date of service exceed the unit limitation placed on the particular physical medicine modalities and/or procedures, regardless of who performed the service.

These guidelines involve more than 4 physical medicine modalities and/or procedures being billed on one date of service; or the guidelines involve the BCBSKS daily unit limit being exceeded. When multiple providers provide service on the same date of service the limitations are accumulated by procedure code and number of units billed, not by the individual provider, each having a separate limit.

- **Units on Time-Based Physical Medicine Codes**

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT

code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 35 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:

- 1 unit: ≥ 8 minutes through 22 minutes
- 2 units: ≥ 23 minutes through 37 minutes
- 3 units: ≥ 38 minutes through 52 minutes
- 4 units: ≥ 53 minutes through 67 minutes
- 5 units: ≥ 68 minutes through 82 minutes
- 6 units: ≥ 83 minutes through 97 minutes
- 7 units: ≥ 98 minutes through 112 minutes
- 8 units: ≥ 113 minutes through 127 minutes

At the end of this section there is a chart that outlines the unit limits for each code, please refer to that for information of when medical records are required.

Physical Medicine Evaluation, Modalities and Procedures

At the end of this section there is a complete list of physical medicine evaluation, re-evaluation, modalities and procedures with their related unit limitations and guidelines; please refer to that chart for further information.

- **97001 through 97004**

These codes are used to report physical and occupation therapy evaluation and re-evaluation. These codes identify a dynamic process in which clinical judgments are made based on data gathered. These evaluations result in the development of a plan for management of a patient's problems as they relate to his or her disease or disability.

Since some of the physical medicine services include an evaluation component as part of pre-service work, use of these codes is dependent on whether the service being provided is a significant, separate service,

or if it is simply a component of the more involved procedure. Since patient circumstances vary, deciding when to use these codes depends on the specific patient encounter and identifying what is actually done.

These codes are to be used for the services of a physical or occupational therapist and should not be used by physicians to bill their evaluations of the patient. Those services must be coded using the appropriate level of E and M code.

- ***97001 (physical therapy initial evaluation)***

The PT examines the patient. This includes taking a comprehensive history, systems review and tests and measures. Tests and measures may include but are not limited to tests of range of motion, motor function, muscle performance, joint integrity, neuromuscular status and review of orthotic or prosthetic devices. The PT formulates an assessment, prognosis and note anticipated intervention.

- ***97002 (physical therapy re-evaluation)***

The PT re-examines the patient to obtain objective measures of progress towards stated goals. Tests and measures include but are not limited to those noted in 97001. The PT modifies the treatment plan as is indicated to support medical necessity of skilled intervention.

- ***97003 (occupational therapy initial evaluation)***

The OT evaluates the patient. Various movements required for activities of daily living are examined. Dexterity, range of movement, and other elements may also be studied.

- ***97004 (occupational therapy re-evaluation)***

The OT re-evaluates the patient to gauge progress of therapy. Dexterity, range of movement, and other elements may also be studied.

- **Utilization Guidelines for Re-evaluations**

- ✓ A re-evaluation is allowed once every 30 days.
- ✓ If an additional re-evaluation is submitted within the 30 days, medical records must be submitted with the second re-evaluation.

- ✓ Use modifier "22" when attaching any document to a claim.
- **97010 through 97799**
 - These codes must be billed separately.
 - If you deliver more than one unit of service the number must be recorded in the units field of the CMS 1500 claim form.
 - Medical records supporting medical necessity must accompany the claim (use modifier "22") when:
 - ✓ Two like modalities (i.e., heat) are billed on the same day.
 - ✓ If the unit limit, that is shown on the chart at the end of this section, is exceeded.
 - When the same modality is applied to two different locations on the same day, always identify the areas (i.e., right shoulder and left elbow) on claim attachment. Use modifier "22" when submitting any claim attachment.
 - When two modalities are performed by one machine at the same time only one modality may be billed.

PLEASE REVIEW THE FOLLOWING GUIDELINES CAREFULLY

Physical Medicine Exams/Modality/Procedure Guidelines

~~More than four (4) modalities or procedures on the same day require medical records~~

Code	Description	Units Allowed Per Day	Special Instructions
A4556	ELECTRODES , (e.g., apnea monitor), per pair	2 PAIRS PER 30 DAYS	NOTE: Do not bill in-office use of electrodes under this code. Those electrodes are content of the modality being performed. Content of service of rental of equipment. Covered if equipment purchased for home use. Submit date purchased and by whom on claim attachment. Use modifier 22 when submitting any claim attachment. Multiple units required in Box 24G if more than one pair 2 pairs = 002 units of service 4 electrodes = 002 units of service
A4557	LEAD WIRES	2 PAIRS EVERY 6 Months	NOTE: Do not bill in-office use of lead wires under this code. Those lead wires are content of the modality being performed. Content of service of rental of equipment. Covered if equipment purchased for home use. Submit date purchased and by whom on claim attachment. Use modifier 22 when submitting any claim attachment. 2 pairs = 002 units of service 4 lead wires = 002 units of service
A9150	NON-PRESCRIPTION DRUG		VITAMINS and NUTRITIONAL SUPPLEMENTS These items are non-covered and should not be billed to BCBSKS. If a patient requires a denial you may submit vitamins and nutritional supplements with procedure code A9150.
64550	APPLICATION OF SURFACE (TRANSCUTANEOUS) NEUROSTIMULATOR		Included in the equipment reimbursement. If using an outside vendor you should look to them for reimbursement of this service.
90901	BIOFEEDBACK training by any modality		Usually non-covered. Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).
90911	BIOFEEDBACK training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry by any modality		Usually non-covered. Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).
95992	CANOLITH REPOSITIONING PROCEDURE(S) (e.g., Epley maneuver, Semont maneuver), per day	ONE	If the diagnosis is other than benign paroxysmal positional vertigo submit office records. Use modifier 22 when submitting any claim attachment. This code is per session, regardless of time spent or areas treated. Submitting medical records will not change the unit limit for this code.

Code	Description	Units Allowed Per Day	Special Instructions
97001	PHYSICAL THERAPY EVALUATION	ONE	MDs, DOs, DCs please use the appropriate E and M procedure code. To be used only by Licensed Physical Therapists. Initial visit for evaluation of treatment.
97002	PHYSICAL THERAPY RE-EVALUATION	ONE	MDs, DOs, DCs please use the appropriate E and M procedure code. To be used only by Licensed Physical Therapists. A re-evaluation is allowed once every thirty days. If an additional re-evaluation is submitted within thirty days, medical records must be submitted with the second re-evaluation. Use modifier 22 when submitting any claim attachment.
97003	OCCUPATIONAL THERAPY EVALUATION	ONE	MDs, DOs, DCs please use the appropriate E and M procedure code. To be used only by Licensed Occupational Therapists. Initial visit for evaluation of treatment.
97004	OCCUPATIONAL THERAPY RE-EVALUATION	ONE	MDs, DOs, DCs please use the appropriate E and M procedure code To be used only by Licensed Occupational Therapists. A re-evaluation is allowed once every thirty days. If an additional re-evaluation is submitted within thirty days, medical records must be submitted with the second re-evaluation. Use modifier 22 when submitting any claim attachment.
97005	ATHLETIC TRAINING EVALUATION		NON-COVERED
97006	ATHLETIC TRAINING RE-EVALUATION		NON-COVERED
97010	HOT OR COLD PACKS Unattended One or more areas is one unit of service The clinician applies heat (dry or moist) or cold to one or more body parts with appropriate padding to prevent skin irritation. The patient is given necessary safety instructions. The treatment requires supervision only.	ONE	This code will be denied content of service unless it is the only service provided on that date. This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated. Sending in medical records will not change the units reimbursed on this code.
97012	TRACTION (MECHANICAL) Unattended One or more areas is one unit of service The clinician applies sustained or intermittent mechanical traction to the cervical and/or lumbar spine. The mechanical force produces distraction between the vertebrae thereby relieving pain and increasing tissue flexibility. Once applied, the treatment requires supervision.	ONE	This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated. Sending in medical records will not change the units reimbursed on this code.

Code	Description	Units Allowed Per Day	Special Instructions
97014	<p>ELECTRICAL STIMULATION, INTERFERENTIAL THERAPY, HORIZONTAL THERAPY</p> <p>Unattended <i>One or more areas is one unit of service</i> The clinician applies electrical stimulation to one or more areas in order to stimulate muscle function, enhance healing, and alleviate pain and/or edema. The clinician chooses which type of electrical stimulation is appropriate. The treatment is supervised after the electrodes are applied.</p>	ONE	<p>This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p> <p>Billing of electrodes The electrodes and other supplies used to administer any modality are content of service of the modality.</p> <p>Do not bill them under A4556.</p> <p>That code is for <u>take home supplies</u> dispensed by a home medical equipment supplier.</p>
97016	<p>VASOPNEUMATIC DEVICES</p> <p>Unattended <i>One or more areas is one unit of service</i> The clinician applies a vasopneumatic device to treat extremity edema (usually lymphedema.) A pressurized sleeve is applied. Girth measurements are taken pre and post treatment. Supervision is required.</p>	ONE	<p>This code will be denied content of service unless it is billed with one of the following diagnosis codes: 457.0, 457.1 or 757.0.</p> <p>This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p>
97018	<p>PARAFFIN BATH</p> <p>Unattended <i>One or more areas is one unit of service</i> The clinician uses a paraffin bath to apply superficial heat to a hand or foot. The part is repeatedly dipped into the paraffin forming a "glove." Use of paraffin facilitates treatment of arthritis and other conditions that cause limitations in joint flexibility. Once the paraffin is applied and the patient instructions provided, the procedure requires supervision</p>	ONE	<p>This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p>
97022	<p>WHIRLPOOL (FLUIDOTHERAPY)</p> <p>Unattended <i>One or more areas is one unit of service</i> The clinician uses a whirlpool to provide superficial heat in an environment that facilitates tissue debridement, wound cleaning and/or exercise. The clinician decides the appropriate water temperature, provides safety instruction and supervises the treatment.</p>	ONE	<p>By accepted professional definition and by description in the AMA-CPT book the treatment provided by the use of an "aqua massage" unit would be appropriately described as a massage (97124) and not whirlpool.</p> <p>Whirlpool (97022) would not be appropriate as whirlpool is descriptive of a specific apparatus and treatment.</p> <p><u>A key component of whirlpool is immersion of the body part in the water.</u></p> <p>By the following descriptions, whirlpools would not correctly describe the use of an aqua massage table.</p> <ol style="list-style-type: none"> 1. The clinician utilizes whirlpool to provide superficial heat in an environment that facilitates tissue debridement, would cleaning, and/or exercise. <p>Warm whirlpool <i>Equipment needed:</i></p> <ol style="list-style-type: none"> a. Towels- these are to be used for padding and drying off. b. Chair- Padding-this is to be placed on the side of the whirlpool.

Code	Description	Units Allowed Per Day	Special Instructions
			<p><i>Treatment:</i></p> <ol style="list-style-type: none"> The patient should be positioned comfortable, allowing the injured part to be immersed in the whirlpool. Direct flow should be 6 to 8 inches from the body segment. Temperature should be 98 to 110 degrees F (37 to 45 degrees C) for treatment of the arm and hand. For treatment of the leg, the temperature should be 98 to 104 degrees F (37 to 40 degrees C), and for full body treatment, the temperature should be 98 to 102 degrees F (37 to 39 degrees C). Time of application should be 15 to 20 minutes. <p><i>Considerations:</i></p> <ol style="list-style-type: none"> Patient positioning should allow for exercise of the injured part. The size of the body segment to be treated will determine whether an upper extremity, lower extremity, or full body whirlpool should be used. Frequency. <p>The above is from "Therapeutic Modalities in Sports Medicine, Third Edition, Mosby-Year Book Inc., 1994.</p> <p>If more than one unit of service attach medical records.</p> <p>Use modifier 22 when submitting any claim attachment.</p>
97024	<p>DIATHERMY (eg, microwave) Magnatherm Unattended One or more areas is one unit of service The clinician uses diathermy as a form of superficial heat for one or more body areas. After application and safety instructions have been provided, the clinician supervises the treatment.</p>	ONE	<p>This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p>
97026	<p>INFRARED Unattended One or more areas is one unit of service The clinician uses infrared light as a form of superficial heat that will increase circulation to one or more localized areas. Once applied and safety instructions have been provided, the treatment is supervised.</p>	ONE	<p>DO NOT USE this code to bill any of the following:</p> <ul style="list-style-type: none"> • Anodyne Therapy • Cold Laser Therapy • Low Laser Therapy • Soft Laser Therapy <p>For information concerning these therapies please refer to information given earlier.</p> <p>This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p>
97028	<p>ULTRAVIOLET Unattended One or more areas is one unit of service The clinician applies ultra light to treat dermatological problems. Once applied and safety instructions have been provided, the treatment is supervised.</p>	ONE	<p>This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p>

Code	Description	Units Allowed Per Day	Special Instructions
97032	<p>ELECTRICAL STIMULATION (MANUAL) Attended One or more areas 15 minutes is one unit of service The clinician applies electrical stimulation to one or more areas to promote muscle function, wound healing edema and/or pain control. This treatment requires direct contact by the provider.</p>	ONE	<p>This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated.</p> <p>Sending in medical records will not change the units reimbursed on this code.</p> <p>Billing of electrodes The electrodes and other supplies used to administer any modality are content of service of the modality.</p> <p>Do not bill them under A4556.</p> <p>That code is for <u>take home supplies</u> dispensed by a home medical equipment supplier.</p>
97033	<p>IONTOPHORESIS Attended One or more areas 15 minutes is one unit of service The clinician uses electrical current to administer medication to one or more areas. Iontophoresis is usually prescribed for soft tissue inflammatory conditions and pain control. This service requires constant attendance by the clinician.</p>	TWO	<p>If more than two units (23 through 37 minutes; not areas treated) of service attach medical records.</p> <p>Use modifier 22 when submitting any claim attachment.</p> <p>Medication may be billed separately, give NDC number, dosage and use the appropriate J procedure code, if within your licensure to dispense prescription drugs.</p> <p>If it is not within your scope of licensure to dispense prescription drugs the patient must obtain the drug from their physician or pharmacy and provide it for use with this procedure.</p> <p>DO NOT use supply code(s) for the medication.</p>
97034	<p>CONTRAST BATHS Attended One or more areas 15 minutes is one unit of service The clinician uses hot and cold baths in a repeated alternating fashion to stimulate the vasomotor response of a localized body part. This service requires constant attendance of the clinician.</p>	ONE	<p>This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated.</p> <p>Sending in medical records will not change the units reimbursed on this code</p>
97035	<p>ULTRASOUND Attended One or more areas 15 minutes is one unit of service The clinician applies ultrasound to increase circulation to one or more areas. A water bath or some form of ultrasound lotion must be used as coupling agent to facilitate the procedure. The delivery of corticosteroid medication via ultrasound is called phonophoresis. This service requires constant attendance of the clinician.</p>	ONE	<p>This code is one or more areas so the unit of service is limited to one regardless of the time spent or the number of areas treated.</p> <p>Sending in medical records will not change the units reimbursed on this code</p> <p>~~~~~ Use 97035 for phonophoresis.</p> <p>Medication may be billed separately, give NDC number, dosage and use the appropriate J procedure code, if within your licensure to dispense prescription drugs.</p> <p>If it is not within your scope of licensure to dispense prescription drugs the patient must obtain the drug from their physician or pharmacy and provide it for use with this procedure.</p> <p>DO NOT use supply code(s) for the medication.</p>

Code	Description	Units Allowed Per Day	Special Instructions
97036	HUBBARD TANK Attended One or more areas 15 minutes is one unit of service The Hubbard tank is used when it is necessary to immerse the full body into water. Care of wounds and burns may require use of the Hubbard tank to facilitate tissue cleansing and debridement. This service requires constant attendance of the clinician.	FOUR	If more than four units (61+ minutes; note areas treated) of service attach medical records. Use modifier 22 when submitting any claim attachment.
97039	UNLISTED MODALITY One or more areas 15 minutes is one unit of service This code is used if the clinician performs a modality to one or more areas that is not listed under the current codes.	TWO	Specify type of modality and time on claim attachment. Attach medical records. Use modifier 22 when submitting any claim attachment.
97110	THERAPEUTIC PROCEDURE Attended One or more areas 15 minutes is one unit of service The clinician and/or the patient perform(s) therapeutic exercises to one or more body areas to develop strength, endurance, and flexibility. This service requires direct contact of the clinician.	FOUR	DO NOT USE THIS CODE FOR MASSAGE THERAPY (97124). This code includes: a. General exercise b. Gym equipment c. Open chain bike or treadmill for endurance d. Formulation of or changes to HEP If more than four units (53 through 67 minutes; note areas treated) of service attach medical records. Use modifier 22 when submitting any claim attachment.
97112	NEUROMUSCULAR REEDUCATION Attended One or more areas 15 minutes is one unit of service The clinician and/or the patient perform(s) activities to one or more body areas that facilitate reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception. This service requires direct contact of the clinician.	FOUR	This code includes: a. Closed chain exercise b. BAPS board c. Transitional movement posture training d. Plyometrics e. NDT techniques f. PNF stretches g. Feldenkrais h. Vestibular exercises If more than four units (53 through 67 minutes; note areas treated) of service attach medical records. Use modifier 22 when submitting any claim attachment.
97113	AQUATIC THERAPY Attended One or more areas 15 minutes is one unit of service The clinician directs and/or performs therapeutic exercises with the patient in the aquatic environment. This code requires skilled intervention by the clinician and documentation must support medical necessity of the aquatic environment.	FOUR	This code includes: a. Back stabilization to increase stabilization with lifting b. Exercise to increase ROM, strength c. Exercise to decrease weight bearing If more than four units (53 through 67 minutes; note areas treated) of service attach medical records. Use modifier 22 when submitting any claim attachment.

Code	Description	Units Allowed Per Day	Special Instructions
97116	<p>GAIT TRAINING Attended 15 minutes is one unit of service The clinician instructs the patient in specific activities that will facilitate ambulation and stair climbing with or without an assistive device. Proper sequencing and safety instructions are included when appropriate. This service requires direct contact of the clinician.</p>	TWO	<p>This code includes: a. Gait drills b. Steps c. Crutch training</p> <p>If more than four units (53 through 67 minutes; note areas treated) of service attach medical records.</p> <p>Use modifier 22 when submitting any claim Attachment.</p>
97124	<p>MASSAGE Attended One or more areas 15 minutes is one unit of service The clinician uses massage to provide muscle relaxation, increase localized circulation, soften scar tissue or mobilize mucous secretions in the lung via tapotement and/or percussion. This service requires direct contact of the clinician.</p>	ONE	<p>This code will be denied content of service unless it is the only service provided on that date.</p> <p>General Guidelines: This code includes: a. Stroking b. Compression for pain relief or muscle spasm c. Percussion for pain relief or muscle spasm</p> <p>See previously in this manual a section on massage and the guidelines that are applied.</p> <p>Use modifier 22 when submitting any claim attachment.</p>
97139	<p>UNLISTED THERAPEUTIC PROCEDURE One or more areas 15 minutes is one unit of service This code is used if the clinician performs a therapeutic procedure to one or more areas that is not listed under the current codes.</p>	ONE	<p>Specify type of therapeutic procedure and time on claim attachment.</p> <p>Attach medical records.</p> <p>Use modifier 22 when submitting any claim attachment.</p> <p>i.e., Anti-Gravity Lumbar Traction-reverse (Inversion) Posture Pump Use "GA" modifier Get Limited Patient Waiver</p>
97140	<p>MANUAL THERAPY TECHNIQUES Attended One or more areas 15 minutes is one unit of service The clinician performs manual therapy techniques including soft tissue and joint mobilization, manual traction and/or manual lymphatic drainage to one or more areas. This service requires direct contact of the clinician.</p>	<p>TWO</p> <p>FOUR UNITS WILL BE ALLOWED FOR LYMPHATIC DRAINAGE</p>	<p><u>MDs, DOs, DCs do not use this code for your manipulations, they must be coded under 98925-98943</u></p> <p>DO NOT USE THIS CODE FOR MASSAGE THERAPY (97124)</p> <p>This code includes: a. Lymphatic drainage b. Manual traction c. MFR d. Soft tissue work e. Trigger point therapy f. Joint mobilization</p> <p>If more than two units (23 through 37 minutes; note areas treated) of service attach medical records.</p> <p>Use modifier 22 when submitting any claim attachment.</p>

Code	Description	Units Allowed Per Day	Special Instructions
97150	<p>THERAPEUTIC PROCEDURE(S) One or more areas 15 minutes is one unit of service The clinician supervises the GROUP activities (two or more patients) of therapeutic procedures on land or the aquatic environment. The patients do not have to be performing the same activity simultaneously, however, the need for skilled intervention must be documented.</p>		<p>Usually non-covered.</p> <p>Attach medical records.</p> <p>Use modifier 22 when submitting any claim attachment.</p>
97530	<p>THERAPEUTIC ACTIVITIES Attended 15 minutes is one unit of service The clinician uses dynamic therapeutic activities designed to achieve improved functional performance (e.g., lifting, pulling, bending). This service requires direct contact of the clinician.</p>	FOUR	<p>This code includes:</p> <ul style="list-style-type: none"> a. Body mechanics with functional activities b. Sport related drills c. Dynamic stabilization exercises d. Simulated activities e. Transfers <p>This code should be used for kinetic activity procedure(s).</p> <p>If more than four units (53 through 67 minutes; note areas treated) of service attach medical records.</p> <p>Use modifier 22 when submitting any claim attachment.</p>
97532	<p>DEVELOPMENT OF COGNITIVE SKILLS Attended 15 minutes is one unit of service The clinician uses procedures to improve attention, memory, problem solving, (includes compensatory training). This service requires direct (one on one) patient contact by the clinician.</p>		<p>Usually non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).</p>
97533	<p>SENSORY INTEGRATIVE TECHNIQUES 15 minutes is one unit of service The clinician uses procedures to enhance sensory processing and promote adaptive responses to environmental demands. This service requires direct (one on one) patient contact by the clinician.</p>	FOUR	<p>By Report.</p> <p>Attach medical records.</p> <p>Use modifier 22 when submitting any claim attachment.</p>
97535	<p>SELF CARE/HOME MANAGEMENT TRAINING 15 minutes is one unit of service The clinician instructs and trains the patients in self-care and home management activities (e.g., <i>activities of daily living</i> and use of adaptive equipment in the kitchen, bath and/or car). This service requires direct contact of the clinician.</p>		<p>By Report. May be denied Content of Service.</p> <p>Attach medical records.</p> <p>Use modifier 22 when submitting any claim attachment.</p>

Code	Description	Units Allowed Per Day	Special Instructions
97537	<p>COMMUNITY/WORK REINTEGRATION TRAINING 15 minutes is one unit of service The clinician instructs and trains the patient in community re-integration activities (e.g., work task analysis and modification, safe accessing of transportation, money management, vocation activities). This service requires direct supervision by the clinician.</p>		<p>Usually non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).</p> <p><u>MDs, DOs, DCs do not use this code unless you are truly performing the services listed.</u></p> <p>This code includes:</p> <ul style="list-style-type: none"> a. Shopping b. Transportation c. Money management d. A vocational activity or work environment/modification analysis e. Work task analysis <p>If more than one unit (16+ minutes; note areas treated) of service attach medical records.</p> <p>Use modifier 22 when submitting any claim attachment.</p>
97542	<p>WHEELCHAIR MANAGEMENT/PROPULSION TRAINING 15 minutes is one unit of service The clinician instructs and trains the patient in proper wheelchair skills (e.g., propulsion, safety techniques). This service requires direct contact by the clinician.</p>		<p>By Report. Specify time.</p> <p>Attach medical records containing pertinent information for review.</p> <p>Use modifier 22 when submitting any claim attachment.</p>
97545	<p>WORK HARDENING/CONDITIONING Initial 2 hours This code is used for a procedure where the injured worker is put through a series of conditioning exercises and job simulation tasks in preparation for return to work. Endurance, strength, and proper body mechanics are emphasized. The patient is also educated in problem solving skills related to job task performance and employing correct lifting and positioning techniques.</p>		<p>Usually non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).</p>
97546	<p>WORK HARDENING AND CONDITIONING Each additional hour This code is used for a procedure where the injured worker is put through a series of conditioning exercises and job simulation tasks in preparation for return to work. Endurance, strength, and proper body mechanics are emphasized. The patient is also educated in problem solving skills related to job task performance and employing correct lifting and positioning techniques.</p>		<p>Usually non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).</p>

Code	Description	Units Allowed Per Day	Special Instructions
97602	REMOVAL OF DEVITALIZED TISSUE NON-SELECTIVE <i>Per session</i> The clinician performs non-selective debridement, without anesthesia, (e.g., wet to moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for on going care.	ONE	This code is per session, regardless of time spent or areas treated. Submitting medical records will not change the unit limit for this code.
97750	PHYSICAL PERFORMANCE TEST OR MEASUREMENT WITH WRITTEN REPORT <i>15 minutes is one unit of service</i> The clinician performs a test of physical performance evaluating function of one or more body areas and evaluates musculoskeletal functional capacity. A written report must be included in this service.	FOUR	This code includes: a. Biodex b. KT1000 tests If more than four units (53 through 67 minutes; note areas tested) of service attach medical records. Use modifier 22 when submitting any claim attachment.
97755	ASSISTIVE TECHNOLOGY ASSESSMENT (e.g., to restore, augment or compensate for existing function, optimize functional task and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes		Usually non-covered Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).
97760	ORTHOTICS MANAGEMENT AND TRAINING <i>15 minutes is one unit of service</i> The clinician fits and/or trains the patient in use of an orthotic device for one or more body parts. This does not include fabrication time, if appropriate, or cost of the materials.	N/A	Content of original dispensing of orthotic/prosthetic.
97761	PROSTHETIC TRAINING <i>15 minutes is one unit of service</i> The clinician fits and/or trains the patient in use of a prosthetic device for one or more body parts. This does not include fabrication time, if appropriate, or cost of the materials.	TWO	Content of original dispensing of orthotic/prosthetic. Covered when billed by different provider from the one supplying orthotic/prosthetic. If more than two units (23 through 37 minutes; note areas treated) of service attach medical records. Use modifier 22 when submitting any claim attachment.
97762	CHECKOUT FOR ORTHOTIC/PROSTHETIC USE Established patients <i>15 minutes is one unit of service</i> The clinician evaluates the effectiveness of an existing orthotic or prosthetic device and makes necessary recommendations for changes, as appropriate.	N/A	Content of original dispensing of orthotic.
97799	UNLISTED PHYSICAL MEDICINE/REHABILITATION SERVICE OR PROCEDURE This code is used if the clinician performs a physical medicine/rehabilitation service or procedure to one or more areas that is not listed under the current codes.		Specify type of service or procedure and time. Attach medical records. Use modifier 22 when submitting any claim attachment. i.e., Anodyne Therapy Use "GA" modifier Specify in Box 19 Get Limited Patient Waiver.

Code	Description	Units Allowed Per Day	Special Instructions
97810	<p>ACUPUNCTURE <i>One or more needles; without electrical stimulation</i> INITIAL 15 minutes of personal one-on-one contact with the patient The physician applies acupuncture using one or more needles. The physician inserts a fine needle as dictated by acupuncture meridians to relieve pain. More than one needle may be used as needed. The needles may be twirled or manipulated.</p>		<p>Usually non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).</p>
97811 Add-on code	<p>ACUPUNCTURE <i>One or more needles; without electrical stimulation</i> EACH ADDITIONAL 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) The physician applies acupuncture using one or more needles. The physician inserts a fine needle as dictated by acupuncture meridians to relieve pain. More than one needle may be used as needed. .</p>		<p>Usually non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).</p>
97813	<p>ACUPUNCTURE <i>One or more needles; with electrical stimulation</i> INITIAL 15 minutes of personal one-on-one contact with the patient The physician applies acupuncture using one or more needles. The physician inserts a fine needle as dictated by acupuncture meridians to relieve pain. More than one needle may be used as needed. Electrical stimulation is employed by energizing the needles with micro-current.</p>		<p>Usually non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to: 1-800-432-0272 (Topeka 291-4183).</p>
97814 Add-on code	<p>ACUPUNCTURE <i>One or more needles; with electrical stimulation</i> EACH ADDITIONAL 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) The physician applies acupuncture using one or more needles. The physician inserts a fine needle as dictated by acupuncture meridians to relieve pain. More than one needle may be used as needed. Electrical stimulation is employed by energizing the needles with micro-current.</p>		<p>Usually non-covered.</p> <p>Questions about whether a BCBSKS member has this coverage may be directed to 1-800-432-0272 (Topeka 291-4183).</p>

Code	Description	Units Allowed Per Day	Special Instructions
S8950 National S Code	COMPLEX LYMPHEDEMA THERAPY (CLT) <i>Each 15 minutes</i> CLT consists of lymphatic drainage, compression bandaging, skin care, and patient specific physical therapy exercises. The basic concept of CLT is to maximize central lymphatic drainage. This is accomplished by opening collateral vessels to channel peripheral lymph into normally functioning lymphotomes. The correct application of this technique requires extensive training.	FOUR	Attach medical records if providing more than 4 units (53 through 67 minutes; note areas treated). Use modifier 22 when submitting any claim attachment.
S9090 National S Code	VERTEBRAL AXIAL DECOMPRESSION THERAPY <i>Per session</i> This service is provided on mechanical traction machines, with provider intervention as appropriate. Some of the brand names for these machines are: VaxD; IDD; DR 5000; DR 9000; SpinaSystem	ONE	This code is per session, regardless of time spent or areas treated. Submitting medical records will not change the unit limit for this code.

REVISIONS

01/01/2011	Changed revision date to "January 2011" from "August 3, 2010."
	Updated all references to the copyright date of <i>Current Procedural Terminology</i> . Changed from "© 2009" to "© 2010."
	Page F-3 Under Assistants: Certified Physical Therapist Assistant (CPTA) or Certified Occupational Therapy Assistant (COTA) , 2 nd paragraph, added "and FEP" after BCBSKS.
	Page F-6 Added a first bullet under "Ice Massage/Ice Therapy:" <ul style="list-style-type: none"> • Ice therapy will be denied "content of service" unless it is the only service provided on that date."
	Page F-15 Changed BOEING provider from Washington State Health Insurance to BCBS of Illinois.
	Page F-20 Removed the first bulleted item under "Medical records . . ." <ul style="list-style-type: none"> ✓ More than 4 modalities/procedures are billed on the same day. Your evaluation/re-evaluation does not count as one of the 4.
05/10/2011	Page F-15 Added a link to <i>Blue Shield Report S-7-10</i> dated December 6, 2010, which provides complete contact information for the Boeing Company.
	Page F-18 First line of page, corrected typing error: "bail" should read "bill."
	Page F-21 Under 90901 <ul style="list-style-type: none"> • In "Units Allowed Per Day" column, removed "ONE."
	Page F-21 Under 90911 <ul style="list-style-type: none"> • In "Units Allowed Per Day" column, removed "ONE."
	Page F-21 Under 95992 <ul style="list-style-type: none"> • Removed "Per visit one" from "Description" column • In "Description" column, added "PROCEDURE(S)" • In "Description" column, added "(e.g., Epley maneuver, Semont maneuver), per day" In "Units Allowed Per Day" column, changed "TWO" to "ONE."
	Page F-24 Under 97022 – Last line of cell, corrected typing error, "attachment."
	Page F-25 Under 97032 – Replaced language in "Special Instructions" column. Language did read: <p style="margin-left: 40px;">If more than one unit (16+ minutes; note areas treated) of service; attach medical records.</p> <p style="margin-left: 40px;">Use modifier 22 when submitting any claim attachment.</p> <p>Billing of electrodes The electrodes and other supplies used to administer any modality are content of service of the modality.</p> <p style="margin-left: 40px;">Do not bill them under A4556.</p> <p style="margin-left: 40px;">That code is for <u>take home supplies</u> dispensed by a home medical equipment supplier.</p>
	Page F-25 Under 97033 – Under "Special Instructions" column, changed "31+" to "23 through 37."

REVISIONS, continued

05/10/2011, continued	<p>Page F-25 Under 97034 – Replaced language in “Special Instructions” column. Language did read:</p> <p style="padding-left: 40px;">If more than one unit (16+ minutes; not areas treated) of service attach medical records.</p> <p style="padding-left: 40px;">Use modifier 22 when submitting any claim attachment.</p>
	<p>Page F-25 Under 97035 – Under “Special Instructions” column, replaced language above wavy lines. Language did read:</p> <p style="padding-left: 40px;">If more than one unit (16+ minutes; note areas treated) of service attach medical records.</p> <p style="padding-left: 40px;">Use modifier 22 when submitting any claim attachment.</p>
	Page F-26 Under 97110 – Under “Special Instructions” column, changed number of minutes from “61+” to “53 through 67.”
	Page F-26 Under 97112 – Under “Special Instructions” column, changed number of minutes from “61+” to “53 through 67.”
	Page F-26 Under 97113 – Under “Special Instructions” column, changed number of minutes from “61+” to “53 through 67.”
	Page F-27 Under 97116 – Under “Special Instructions” column, changed number of minutes from “61+” to “53 through 67.”
	Page F-27 Under 97139 – Under “Special Instructions” column, changed “GET” to “Get” on last line.
	Page F-27 Under 97140 – Under “Special Instructions” column, changed number of minutes from “31+” to “23 through 37.”
	Page F-28 Under 97530 – Under “Special Instructions” column, changed number of minutes from “61+” to “53 through 67.”
	Page F-28 Under 97532 – Under “Units Allowed Per Day” column, deleted “FOUR.”
	Page F-29 Under 97545 – Under “Units Allowed Per Day” column, deleted “ONE.”
	Page F-30 Under 97750 – Under “Special Instructions” column, changed number of minutes from “61+” to “53 through 67.”
	Page F-30 Under 97761 – Under “Special Instructions” column, changed number of minutes from “31+” to “23 through 37.”
	Page F-30 Under 97799 – Under “Special Instructions” column, changed “GET” to “Get” on last line.
	Page F-31 Under 97810 – Under “Units Allowed Per Day” column, deleted “ONE.”
	Page F-31 Under 97813 – Under “Units Allowed Per Day” column, deleted “ONE.”
	Page F-32 Under S8950 – Under “Special Instructions” column, changed number of minutes from “61+” to “53 through 67.”
	Page F-32 Under S9090 – Under “Units Allowed Per Day” column, added “ONE.”

REVISIONS, continued

6/17/2011	Changed revision date in the footer to “June, 2011” from “May, 2011.”
	Page F-28 Under 97150 – Under “Special Instructions” column, deleted “Specify type and time on claim attachment.”
	Page F-28 Under 97533 – Under “Special Instructions” column, deleted “Specify time,” and deleted the words “containing pertinent information for review” from the sentence beginning “Attach medical records.”
	Page F-28 Under 97535 – Under “Special Instructions” column, deleted “Denied Content of Service,” and added the current verbiage.
7/15/2011	Changed revision date in the footer to “July, 2011” from “June, 2011.”
	Page F-8 Under heading, McConnell Taping, added the word “Strapping/.” Also added “McConnell strapping or” to the verbiage under the first bullet.