LCD L27513 - Physical Medicine & Rehabilitation Services, Physical Therapy and Occupational Therapy

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LCD Information

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**CMS National Coverage Policy**

Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.

Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.

Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.


CMS Internet-Only Manual (IOM), Publication 100-03, Medicare National Coverage Determinations Manual
Indications and Limitations of Coverage and/or Medical Necessity

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

This LCD provides guidelines for many physical medicine and rehabilitation services. However, this LCD does not address all services, including BUT NOT LIMITED TO:

- Services described with CPT code 96125 (see LCD #L27531)
- Speech-language pathology services for communication disorders (see LCD #L27531)
- Services related to wound care (see LCD #L27547)
- Services related to swallowing problems or dysphagia, including VitalStim therapy (see LCD #L27537)
- Services primarily addressed by CMS National Coverage Determinations (NCDs), including BUT NOT LIMITED TO: cardiac rehabilitation programs (NCD 20.10), manipulation (NCD 150.1), Fluidized Therapy Dry Heat for Certain Musculoskeletal Disorders (NCD 150.8), Treatment of Psoriasis (NCD 250.1), NCD for Neuromuscular Electrical Stimulator (NMES) (NCD 160.12).

Visual Rehabilitation Services

A Medicare beneficiary with vision loss may be eligible for rehabilitation services designed to improve, restore, and / or compensate for loss of functional vision following disease, injury or loss of a body part. Clinicians use the clinical history, systems review, physical examination, and a variety of evaluations to determine the impairments, functional limitations and disabilities of the individual patient. Impairments, functional limitations and disabilities thus identified are then addressed by the design and implementation of a plan of care tailored to the specific needs of the individual patient. Specific interventions are selected, applied, or modified based on the examination data, the evaluation, the diagnosis and prognosis, and the anticipated goals and expected outcomes.

Physical medicine and rehabilitation services are covered when performed with the expectation of improving, restoring, and / or compensating for loss of the patient's level of function which has been lost or reduced by injury or illness. Therapy performed repetitively to maintain the same level of function is not eligible for reimbursement.

A maintenance program consists of activities that preserve the patient's present level of function and prevent regression of that function. During the last visits for rehabilitative treatment, it may be reasonable and medically necessary for the clinician to develop a maintenance program, and instruct the patient, family member(s) or caregiver(s) in carrying out the maintenance program. Further, patients with long term, chronic conditions may occasionally need skilled input to update or revise their home maintenance program; and to assess the need for new, or changes to existing assistive or adaptive equipment.

The level of vision impairment is defined as:

- moderate = best corrected visual acuity is less than 20/60
- severe (legal blindness) = best corrected visual acuity is less than 20/160, or visual field is 20 degrees or less
- profound (moderate blindness) = best corrected visual acuity is less than 20/400, or visual field is 10 degrees or less
• near-total (severe blindness) = best corrected visual acuity is less than 20/1000, or visual field is 5 degrees or less
• total (total blindness) = no light perception.

**EVALUATIONS AND RE-EVALUATIONS (CPT 97001, 97002, 97003, and 97004)**

Medicare provides reimbursement for an evaluation that is reasonable and necessary for the clinician to determine if there is an expectation that the services will be appropriate for the patient's condition. The evaluation of a patient's level of function is focused on identifying what the patient wants and needs to do, and on identifying those factors that help or hinder the performance of those activities. During the first patient contact, the clinician evaluates and documents:

- An impairment-based diagnosis and description of the specific problem evaluated and/or treated. This should include the specific body part(s) evaluated. Include all conditions and complexities that may impact the treatment. A description might include, for example, the pre-morbid function, date of onset of the current problem, and current functional status;
- Objective measurements, that may include standardized patient assessment instruments and/or outcomes measurement tools related to current physical and functional status, when these are available and appropriate to the condition being evaluated;
- Clinician's clinical judgments that describe impairments and the current functional status of the patient; and
- A determination of whether or not the treatment is needed, and a prognosis for return to pre-morbid condition or maximum expected condition with expected time frame and a plan of care.

A re-evaluation is the re-assessment of the patient's performance and goals, after an intervention plan has been established, in order to determine the type and amount of change in treatments if needed. Re-evaluation requires the same professional skill as evaluation. Continuous assessment of the patient's progress is a component of ongoing therapy services, and is not a re-evaluation. A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services.

**MODALITIES**

The use of modalities may be reasonable and necessary in many clinical situations. Documentation in the patient’s medical record should support the use of multiple modalities as contributing to the patient’s progress with improving, restoring, and / or compensating for loss of function, and as per the plan of care. When more than one modality is used during an encounter, whether supervised or constant attendance, or any combination, each modality provided should be reported and reflected in the documentation. This documentation must be made available to Medicare upon request.

Modalities are categorized as either supervised or constant attendance.

**Supervised Modalities (CPT 97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, and 97028)**

Supervised modalities are considered to be the application of a modality that does not require direct (one-on-one) patient contact by the provider. There is no time component that describes supervised codes. The code is reported without regard to the length of time spent performing the service. These services are to be billed only once per encounter regardless of the number of areas treated.

**Hot or cold packs therapy (CPT 97010)**

Hot or cold packs are used primarily in conjunction with therapeutic procedures to provide analgesia, relieve muscle spasm, and reduce inflammation and edema. Typically, cold packs are used for acute, painful conditions, and hot packs are used for sub acute or chronic painful conditions.

Heat or cold treatments ordinarily do not require the skills of a qualified clinician. The skills, knowledge and judgment of a qualified clinician may be required while considering and applying these services in cases where a potential contraindication and /or precaution to the treatment exists.

The application of this modality is considered to be an integral part of a service or visit by CMS. Therefore the service for the application of hot or cold packs (97010) is a status B (bundled) code on the Medicare Fee Schedule Data Base (MFSDB). Separate payment is not allowed for this service.

**Mechanical traction therapy (CPT code 97012)**

Mechanical traction is the force used to create a degree of tension on soft tissues and/or allow for separation between joint surfaces. The degree of traction is controlled through the amount of force (pounds) allowed, duration (time) and angle of pull (degrees) using mechanical means. Terms often used in describing pelvic/cervical traction are intermittent or static (describing the length of time traction is applied), or autotraction (use of the body’s own weight to create the force).
Traction is generally used for joints, especially of the lumbar or cervical spine, with the expectation of relieving pain in or originating from those areas, or increasing the range of motion of the joint. Specific indications for the use of mechanical traction include but are not limited to cervical and/or lumbar radiculopathy, and back disorders such as disc herniation, lumbago, and sciatica.

**Electrical stimulation (unattended), (HCPCS code G0283)**

Unattended electrical stimulation is the use of current to facilitate the reduction of pain, edema, and muscle spasm as well as to increase contractile force in the muscles. The type and frequency of current, placement of electrodes and duration of treatment are determined by the clinician.

HCPCS code G0283 should be used for unattended electrical stimulation, to one or more areas for indications other than wound care. (Note: CPT code 97014 is considered invalid for Medicare effective 01/01/03.)

Electrical stimulation is addressed in several CMS NCDs found in the IOM Pub. 100-03, Medicare National Coverage Determinations Manual.

**Vasopneumatic devices (CPT code 97016)**

The use of vasopneumatic devices may be considered reasonable and necessary for the application of pressure to an extremity, to reduce edema or lymphedema. Specific indications for the use of vasopneumatic devices include the reduction of edema after acute injury, and the treatment of lymphedema of an extremity.

When treating lymphedema with this device, the sessions are for the primary purpose of determining the patient response to treatment, and, if indicated, to teach the patient how to use the lymphedema pump at home.

**Paraffin bath therapy (CPT code 97018)**

Paraffin bath therapy is a wax treatment used to apply superficial heat for a sustained duration for the effects on underlying tissues. Paraffin baths are primarily used for pain relief in joint problems of the hands or feet.

**Whirlpool therapy (CPT Code 97022)**

Whirlpool therapy involves the use of agitated hot or cold water to relieve muscle spasm, control edema after an injury, improve circulation, or cleanse wounds, ulcers, or exfoliative skin conditions; this code is generally used when a single extremity is being immersed.

It is considered not medically necessary to have more than one form of hydrotherapy during a visit (e.g., CPT codes 97022, 97036 or 97113 cannot be billed together).

**Diathermy treatment (CPT code 97024)**

Diathermy is a modality for heating skeletal muscle. The use of diathermy is considered reasonable and necessary for the delivery of heat to deep tissues such as skeletal muscle and joints for the reduction of pain, joint stiffness, and muscle spasm.

High energy pulsed wave diathermy machines have been determined to produce the same therapeutic benefit as standard diathermy; therefore, these treatments are considered reasonable and necessary for the same indications as standard diathermy.

Diathermy is not considered reasonable and necessary for the treatment of asthma, bronchitis, or any other pulmonary condition.

**Infrared therapy (CPT code 97026)**

Infrared therapy is a thermal modality commonly used to provide analgesia, relieve muscle spasm, cause vasodilatation, and reduce inflammation and edema. It is usually used in conjunction with other therapeutic procedures, and rarely with other thermal modalities. Documentation in the medical record must include infrared therapy as part of the plan of care and must clearly justify the medical necessity of the treatment.

As per NCD 270.6 (Pub. 100-03), these nationally non-covered indications are effective for services performed on and after October 24, 2006: The use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy, is non-covered for the treatment, including the symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues.

**Ultraviolet therapy (CPT code 97028)**

Ultraviolet therapy is a form of radiant energy that uses light rays with wavelengths beyond the violet end of the visual spectrum. The ultraviolet therapy modality is used to stimulate a variety of chemical reactions in the skin and mucous membranes. It is used for the treatment of skin conditions and in assisting the healing
process of open wounds.

Please see NCD 250.1 (Pub. 100-03) for specific coverage information related to the treatment of psoriasis.

Documentation in the patient's medical record should include ultraviolet therapy treatment as a part of the plan of care, and support the medical necessity of the treatments.

**Constant Attendance Modalities (CPT codes 97032, 97033, 97034, 97035, 97036 and 97039)**

Constant attendance modalities are considered to be the application of a modality that requires direct (one-on-one) patient contact by the provider. Direct one-on-one contact requires that the provider maintain visual, verbal, and/or manual contact with the patient throughout the procedure. The time frames indicated for the constant attendance modalities describe the total time (i.e., pre-service, intra-service and post-service time) spent performing this modality. Documentation in the medical record for constant attendance modalities must ascertain that the total number of minutes of treatment for services represented by timed codes is consistent with the number of units billed for those services.

**Electrical stimulation (CPT code 97032)**

Electrical stimulation (attended) is addressed in several CMS NCDs found in the IOM Pub. 100-03, Medicare National Coverage Determinations Manual.

**Iontophoresis (CPT code 97033)**

Iontophoresis is an intervention that uses the properties of electricity to introduce ions of soluble salts and medications (such as NSAIDS and/or analgesics) into tissue by means of an electric current. This modality is non-invasive and utilizes polarity differences to push the medication across the cell membranes.

This modality is used to reduce pain and edema caused by an inflammatory process such as tendonitis, bursitis, plantar fasciitis and lateral epicondylitis.

**Contrast baths (CPT code 97034)**

Contrast bath therapy is the alternate immersion of a body part in hot water and cold water. This special form of therapeutic heat and cold is commonly applied to distal extremities. The effectiveness of contrast baths is thought to be due to reflex hyperemia produced by the alternating exposure to heat and cold.

Specific indications for the use of contrast baths include but are not limited to the patient having rheumatoid arthritis, other inflammatory arthritis, reflex sympathetic dystrophy, or a sprain or strain resulting from an acute injury.

**Ultrasound (CPT code 97035)**

Therapeutic ultrasound is a deep heat modality. It is attenuated by certain tissues and reflected by bone. Thus, tissues lying immediately next to bone can receive an even greater dosage of ultrasound, as much as 30% more. Because of the increased extensibility ultrasound produces in tissues of high collagen content, combined with the close proximity of joint capsules, tendons, and ligaments to cortical bone where they receive a more intense heating, it is an ideal modality for increasing mobility in those tissues with restricted range of motion.

The application of ultrasound is considered reasonable and necessary for patients requiring deep heat to a specific area for reduction of pain, spasm, and joint stiffness, and to increase the flexibility of muscles, tendons and ligaments.

Specific indications for the use of ultrasound application include but are not limited to the patient having neuromas, symptomatic soft tissue calcification or tightened structures limiting joint motion that require an increase in extensibility.

Ultrasound application is not considered to be reasonable and necessary for the treatment of asthma, bronchitis or any other pulmonary condition.

**Hubbard Tank (CPT code 97036)**

This modality involves the patient’s immersion in a full body tank of agitated water in order to relieve muscle spasm, improve circulation, or cleanse wounds, ulcers, or exfoliative skin conditions. One-on-one supervision of this modality by a qualified professional is required. Documentation in the medical record must clearly note that the skills of a qualified professional were necessary in order to treat the patient with this modality.

It is considered not medically necessary to have more than one form of hydrotherapy during a visit (e.g., CPT codes 97022, 97036 or 97113 cannot be billed together).

**Unlisted Modality (CPT code 97039)**
For all claims submitted with this unlisted modality code, a narrative description of the service should be on the claim (detailing the service being performed), and the plan of care supporting the medical necessity of the service should be included in the documentation.

**THERAPEUTIC PROCEDURES (CPT codes 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97530, 97532, 97533, 97535, 97537, 97542, 97545, and 97546)**

Therapeutic procedures are treatments that attempt to reduce impairments and improve, restore, and/or compensate for loss of function through the application of clinical skills and/or services. Use of these procedures requires that the qualified professional have direct (one-on-one) patient contact. Common components of the therapeutic procedures include, but are not limited to, chart reviews and preparation of the equipment and treatment area. Also included is communication with other health care professionals, discussions with family, and calls to the referring physician for additional information or clarification. Subsequent to providing the therapeutic service, the treatment is recorded, and typically the progress is documented.

Therapeutic exercises and neuromuscular reeducation are examples of therapeutic interventions. Documentation must support the use of each treatment or modality as it relates to a specific therapeutic goal. Services provided by qualified health care providers of different types (e.g., physical therapists and occupational therapists) may be covered if separate and distinct goals are documented in the separate treatment plans. Concurrent care cannot be billed at the same time.

**Therapeutic procedure (CPT code 97110)**

Therapeutic procedure, further described as therapeutic exercise, incorporates rehabilitation principles related to strengthening, endurance, flexibility, and range of motion to one or more areas of the body. Therapeutic exercise may be performed with a patient either actively, actively assisted, or passively participating. Examples of therapeutic exercise include treadmill (for endurance), isokinetic exercise (for strengthening), lumbar stabilization exercises (for flexibility and/or trunk strengthening), and gymnastic ball (for stretching and strengthening).

Therapeutic exercise is considered reasonable and necessary if the patient has an identified impairment such as weakness, pain, contracture, muscle imbalance; and/or limitations in mobility, strength, dexterity, range of motion, or endurance. Documentation should include objective findings that support the medical necessity of therapeutic exercise.

**Neuromuscular reeducation (CPT code 97112)**

This therapeutic procedure is provided to improve, restore, and/or compensate for loss of balance, coordination, kinesthetic sense, posture, motor skill, and proprioception. Examples of these treatments include proprioceptive neuromuscular facilitation (PNF), use of Biomechanical Ankle Platform System (BAPS) boards, and desensitization techniques.

Documentation in the medical records must clearly identify the need for these treatments, be part of the plan of care and reflect the patient’s response to treatments.

**Aquatic therapy with therapeutic exercises (CPT code 97113)**

This procedure uses the therapeutic properties of water (e.g., buoyancy, resistance). The procedure may be reasonable and medically necessary for a loss or restriction of joint motion, strength, mobility, or function, which has resulted from a specific disease or injury. This requires direct (one-on-one) patient contact. However, the therapist does not have to be in the water. This code is to be used for any exercise performed in a water environment.

Documentation should include objective findings related to joint motion, strength, or mobility impairments (e.g., degrees of motion, strength grades, levels of assistance) and reflect the medical necessity of the treatment in a water environment. Other forms of exercise therapy may be medically necessary in addition to aquatic therapy. Do not report aquatic therapy (e.g., Hubbard tank, whirlpool), and the type of therapeutic exercise separately. Code ONLY the aquatic therapy with therapeutic exercise (97113). This code should not be used in situations where no exercise is being performed in the water environment (e.g., debridement of ulcers). It is considered not medically necessary to have more than one form of hydrotherapy during a visit (e.g., CPT codes 97022, 97036 or 97113 cannot be billed together).

**Gait training (CPT code 97116)**

Gait training is the training of the biomechanical and kinesiological components of walking, including balance, cadence, symmetry, motor control, speed, and energy efficiency. This procedure may be reasonable and necessary to improve, restore, and/or compensate for impairment of walking ability due to neurological,
muscular, or skeletal abnormalities, or trauma.

Specific indications for gait training include but are not limited to:

- The patient having suffered a cerebral vascular accident resulting in impairment in the ability to ambulate, now stabilized and ready to begin rehabilitation.
- The patient having recently suffered a musculoskeletal trauma, requiring ambulating reeducation.
- The patient having a chronic, progressively debilitating condition for which safe ambulation has recently become a concern.
- The patient having had an injury or condition that requires instruction in the use of an assistive device, e.g., walker, crutches, or cane.
- The patient having been fitted with a brace/lower limb prosthesis and requires instruction in ambulation.
- The patient having a condition that requires training in stairs/steps or chair transfer in addition to general ambulation.

Gait training is not considered reasonable and necessary when the patient's walking ability is not expected to improve. Supervised ambulation in the absence of the delivery of skilled services is not reportable.

**Massage (CPT code 97124)**

Massage, which is designed to facilitate healing of muscles, reduce edema, improve joint motion, and/or relieve muscle spasm, may be medically necessary as adjunctive treatment to another therapeutic procedure on the same day. Massage includes effleurage, petrissage, and/or tapotement (stroking, compression, percussion). Documentation should support the medical necessity for therapeutic massage.

**Unlisted therapeutic procedure (CPT 97139)**

For all claims submitted with an unlisted procedure code, a narrative description of the service should be on the claim (detailing the service or procedure being performed), and the plan of care supporting the medical necessity of the service or procedure should be included in the documentation.

**Manual therapy techniques (CPT code 97140)**

Manual therapy techniques consist of, but are not limited to, joint mobilization and manipulation, manual lymphatic drainage, manual traction, and soft tissue mobilization. Providers use their hands to administer these techniques. Therefore, code 97140 describes "hands-on" therapy techniques. Typically, the goals of manual therapy are to modulate pain, increase joint range of motion, and reduce or eliminate soft tissue swelling, inflammation, or restriction. These techniques also induce relaxation and improve contractile and non-contractile tissue extensibility.

Manual therapy techniques may be performed on individuals with symptoms that may include a limited range of motion, muscle spasm, pain, scar tissue or contracted tissue, and/or soft tissue swelling, or inflammation.

1. **Manual traction**
   
   This procedure may be considered reasonable and necessary for cervical radiculopathy and cervicalgia.

2. **Joint mobilization (peripheral or spinal)**
   
   This procedure may be considered reasonable and necessary if restricted joint motion is present and documented. It may be reasonable and necessary as an adjunct to therapeutic exercises when loss of articular motion and flexibility impedes the therapeutic procedure.

3. **Soft tissue mobilization, one or more regions**
   
   This procedure may be medically necessary for treatment of restricted motion of soft tissues. Skilled manual techniques (active or passive) are applied to soft tissue to effect changes in the soft tissues, structures, neural or vascular systems. Examples are facilitation of fluid exchange; or stretching of shortened muscular, scar, or connective tissue. This procedure may be medically necessary as an adjunct to other therapeutic procedures such as 97110, 97112, and 97530.

4. **Manual lymphatic drainage** is a manual technique utilized to facilitate the movement of excessive lymphatic fluid. This technique is independent of exercise and compression services that are usually provided on the same date of service. It may be medically necessary when the following conditions are met: there is a physician documented diagnosis of lymphedema; the patient is symptomatic for lymphedema, with limitation of function; and the patient or patient caregiver has the ability to understand and comply with home care continuation of treatment regimen.

5. **Manipulation**

   Please see NCD 150.1, IOM 100-03.

**Group therapeutic procedures (CPT code 97150)**
Group therapy procedures involve the constant attention of the qualified professional but by definition do not require one-on-one patient contact by the qualified professional. CPT code 97150 should be reported for each group member receiving a type of therapeutic procedure when the therapist is working with several patients at the same time, whether on land or in a water environment / pool. The patients do not need to be receiving the same type of therapeutic procedure.

The specific type of therapy provided should not be reported in addition to the group therapy code, unless the services are provided at distinctly different times. The individual therapy codes should be reported when the clinician is providing therapy to only one patient.

The ICD-9 codes that are applicable to the individual patient should be billed with CPT 97150. These ICD-9 codes will identify the condition for which the individual patient received rehabilitation services, and the 97150 will identify that the service was provided under the constant attention of the qualified professional in a group setting.

Documentation in the medical records must clearly identify that the therapy was medically necessary and performed by the qualified professional in a group setting (two or more individuals). Group therapy can be reported on the same date of service as other procedures or modalities that are provided at distinctly different times.

**Therapeutic activities (CPT code 97530)**

Therapeutic activities are considered reasonable and necessary for patients needing a broad range of rehabilitative techniques that involves movement. Movement activities can be for a specific body part or could involve the entire body. This procedure involves the use of functional activities (e.g., bending, lifting, carrying, reaching, catching, overhead activities, and performance of transitional movements or activities) to improve, restore, and / or compensate for loss of functional performance, including, where applicable, performance of transitional movements, in a progressive manner. The activities are usually directed at a loss or restriction of mobility, strength, balance, or coordination. They require the skills of a clinician and are designed to address a specific functional need of the patient.

Therapeutic activities may be medically necessary when the professional skills of a clinician are required, and the activity is designed to address a specific need of the patient. These dynamic activities must be part of a documented treatment plan and intended to result in a specific outcome.

**Development of cognitive skills (CPT code 97532)**

This code describes interventions used to enhance cognitive skills, (e.g., attention, memory, problem solving) with direct (one-on-one) patient contact by the clinician. It may be medically necessary for patients with acquired cognitive impairments from head trauma, acute neurological events (including cerebrovascular accidents), or other neurological disease.

As stated earlier, physical medicine and rehabilitation services are covered when performed with the expectation of improving, restoring, and / or compensating for loss of function due to injury or illness. When used in the setting of generally chronic progressive cognitive disorders, there must be a potential for restoration or improvement. Therapy performed repetitively to maintain a level of function is not eligible for reimbursement.

**Sensory integrative techniques (CPT code 97533)**

This activity focuses on sensory integrative techniques to enhance sensory processing and to promote adaptive responses to environmental demands, with direct (one-on-one) patient contact by the clinician. When a patient has a deficit in processing input from a sensory system (e.g., vestibular, proprioceptive, tactile), it may decrease the patient's ability to make adaptive sensory, motor, and behavioral responses to environmental demands.

**Self-care/home management training (CPT code 97535)**

This training includes activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment, and requires direct one-on-one contact by the qualified professional. The patient must have a condition for which training in activities of daily living is reasonable and necessary, and such training must be reasonably expected to improve, restore, and / or compensate for loss of functioning of the patient. The patient and/or caregiver must have the capacity to learn from instructions.

This procedure is reasonable and necessary only when it requires the skills of a clinician, is designed to address specific needs of the patient, and is part of an active treatment plan directed at a specific outcome. Documentation must relate the training to expected functional goals that are attainable by the patient.

Services provided by qualified health care providers of different types, (e.g., physical therapists and
occupational therapists), may be covered if separate and distinct goals are documented in the separate treatment plans. Concurrent care cannot be billed at the same time.

**Community/work reintegration training (CPT code 97537)**

Community/work reintegration training includes shopping, transportation, money management, a vocational activities and/or work environment/modification analysis, work task analysis, and direct one-on-one contact by the provider.

Community reintegration procedures for the patient are reasonable and necessary only when they require the specific skills of a clinician, are designed to address specific needs of the patient, and are part of an active treatment plan directed at a specific outcome. The treatment plan may be aimed at improving, restoring, and/or compensating for loss of specific functions that were impaired by an identified illness or injury, and when the expected outcomes, that are attainable by the patient, are specified in the plan. Generally speaking, physical medicine and rehabilitative services are not required to effect improvement or restoration of function where a patient suffers a temporary loss or reduction of function which could be expected to spontaneously improve as the patient gradually resumes normal activities.

Physical medicine and rehabilitative services that 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 by section 1862(a)(1)(A) of the Social Security Act.

**Wheelchair management (CPT code 97542)**

Wheelchair management includes assessment of the need for a wheelchair, determination of the type of wheelchair and wheelchair components, measuring for and fitting the wheelchair, making adjustments, and training in the use of the chair. This service includes training the patient in functional activities that promote optimal safety, mobility and transfers. Patients who are wheelchair bound may occasionally need skilled input on positioning, positioning supplies, and wheelchair modifications; to avoid pressure points, contractures, and other medical complications. The patient and/or caregiver must have the capacity to learn from instructions.

This procedure is reasonable and necessary only when it requires the skills of a qualified professional, is designed to address specific needs of the patient, and is part of an active treatment plan directed at a specific goal. When billing 97542, it is expected that the documentation will relate the training to expected functional goals attainable by the patient and/or caregiver.

**Work hardening/conditioning (CPT codes 97545 and CPT code 97546)**

These services relate solely to specific work skills. They are considered not medically necessary for the diagnosis or treatment of illness or injury.

**TESTS AND MEASUREMENTS (CPT codes 97750 and 97755)**

**Physical performance test or measurement (CPT code 97750)**

The physical performance test or measurement is used to provide additional objective documentation of a patient’s condition or status. (Examples of this type of test include, but are not limited to, isokinetic testing, functional capacity evaluation, and the Tinetti gait and balance assessment.) These tests and measurements are over and above the general therapy evaluation services performed, and they require a separate report from the other evaluations done. This code is reported by the time spent providing the service.

There must be documentation of the problem requiring the test, the specific test performed, the time to administer the test, and the test results. The report should indicate how the information affects the treatment plan.

**Assistive technology assessment (CPT 97755)**

This code is used to represent the provider’s assessment of the need for a technological interface between the patient and their environment or mobility system. The patient’s voluntary motions (e.g. oral motor strength, head/neck range of motion and strength, ocular motor control, quality of voice output) are identified and assessed. Multiple systems/components are tested to determine optimal interface between patient and technology applications.

Appropriateness of commercial (off the shelf) components is determined. The need for modification of commercial components/systems is assessed. Custom components/systems are designed and tested as needed for the patient.

Procedure code 97755 requires direct one-on-one contact by the provider and is to be reported for each fifteen minutes of assessment. This service is not covered if provided by a therapy assistant. In order to bill this code the medical records must clearly contain the provider’s written report of the assessment, which
must include all of the following:

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

ORTHOTIC MANAGEMENT AND PROSTHETIC MANAGEMENT (CPT codes 97760, 97761, and 97762)

Orthotic management and training (CPT code 97760)

Orthotic management includes assessment of the patient and determination of the most appropriate orthotic; design and fabrication of the orthotic; fitting and training required to properly use the orthotic device.

The patient or caregiver must be capable of being trained to use the particular device prescribed in an appropriate manner. In some cases the patient may not be able to perform this function, but a responsible individual can be trained about the use of the device.

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 (CPT code 97116) or self-care/home management training (CPT code 97535).

Prosthetic training (CPT code 97761)

Prosthetic training is the professional instruction necessary for a patient to properly use an artificial device that has been developed to replace a missing body part. This procedure is considered reasonable and necessary if there is an indication for education on the application of the prosthesis, and/or use of the prosthesis, in all applicable environments.

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 (CPT code 97116) or self-care/home management training (CPT code 97535). Periodic revisits beyond the third month would require documentation to support medical necessity of this training.

Checkout for orthotic/prosthetic use (CPT code 97762)

Orthotic/prosthetic checkout is an end-service for an established patient that is used to report the time spent to ensure a correct fit when using the orthotic or prosthetic during functional activities. An example of this is checking for skin integrity where the orthotic/prosthetic device may apply pressure. Any adjustments or repairs may be made to insure alignment, and reinstruction may be required.

These assessments are reasonable and necessary when there is a modification or re-issue of a device or a reassessment of a newly issued device. These assessments may be reasonable and necessary when patients experience a loss or change in function directly related to the device (e.g., pain, skin breakdown, or change in edema). Documentation in the medical record should support the medical necessity of the orthotic/prosthetic checkout.

Unlisted physical medicine/rehabilitation service or procedure (CPT code 97799)

For all claims submitted with an unlisted procedure code, a narrative description of the service should be on the claim (detailing the service or procedure being performed), and the plan of care supporting the medical necessity of the service or procedure should be included in the documentation.

Coverage Limitations

Services that are solely palliative in nature are not considered necessary and reasonable. These services would be focused on maintaining function, and generally would not involve complex physical medicine and rehabilitative procedures, nor would they require clinician judgment and skill for safety and effectiveness.

If evaluation of the patient demonstrates that the patient does not have the potential to achieve significant improvement in, restoration of, and/or compensation for loss of function in a reasonable and generally predictable period of time, or would not benefit from the establishment of a maintenance program, services would not be covered because they would not be considered reasonable and necessary.

Services that can be safely and effectively furnished by non-skilled personnel without the supervision of qualified professionals are not rehabilitative therapy services. If at any point in the treatment of an illness it is determined that the treatment is not rehabilitative, or does not legitimately require the services of a qualified professional for management of a maintenance program, the services will no longer be considered reasonable and necessary.

Therapy is not required to effect improvement or restoration of function where a patient suffers a transient
and easily reversible loss or reduction of function (e.g., temporary weakness which may follow a brief period of bed rest following abdominal surgery), which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Therapy furnished in such situations is not considered reasonable and necessary for the treatment of the individual's illness or injury, and the services are not covered.

Services related to activities for the general good and welfare of patients (e.g., general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation) do not constitute physical medicine and rehabilitative services for Medicare purposes.

Reimbursement for an evaluation will be limited to once per episode. Many patients may complete their course of physical medicine and rehabilitative services without ever needing a re-evaluation service, while others may need one or more re-evaluations performed during their course of treatment because of a change in status or needs.

The application of hot and cold packs is considered an integral part of a service or visit by CMS. Therefore, billing for the application of hot or cold packs (97010) will be denied. CPT code 97010 is a status B (bundled) code on the Medicare Fee Schedule Data Base (MFSDB). Separate payment is not allowed for this service.

Heat modalities (97024, 97035) used for the treatment of asthma, bronchitis and other pulmonary conditions are considered not reasonable and necessary and will be denied.

It is not medically necessary to have more than one form of hydrotherapy during a visit. Therefore, CPT codes 97022, 97036 or 97113 cannot be billed together.

Work hardening (97545) and work hardening add-on (97546) services relate solely to specific work skills. They will be denied as not medically necessary for the diagnosis or treatment of illness or injury.

Because manual therapy (97140) includes services other than manipulation, there may be clinical indication for the patient to receive osteopathic manipulation (98925, 98926, 98927, 98928, and 98929) and manual therapy on the same date of service. In this situation, the plan of care and other documentation must clearly support all services.

Certifications and recertifications by doctors of podiatric medicine must be consistent with the scope of the professional services provided by a doctor of podiatric medicine as authorized by applicable state law. Optometrists may order and certify only low vision services. Chiropractors may not certify or recertify plans of care for therapy services.

**Additional Specific Limitation for Visual Rehabilitation Services**

The provision of conventional refraction aids and the immediate instruction in their use are not covered, unless related to the treatment following cataract surgery.

**Coding Information**

**Bill Type Codes**

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

<table>
<thead>
<tr>
<th>Bill Type Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>011x</td>
<td>Hospital Inpatient (Including Medicare Part A)</td>
</tr>
<tr>
<td>012x</td>
<td>Hospital Inpatient (Medicare Part B only)</td>
</tr>
<tr>
<td>013x</td>
<td>Hospital Outpatient</td>
</tr>
<tr>
<td>018x</td>
<td>Hospital - Swing Beds</td>
</tr>
<tr>
<td>021x</td>
<td>Skilled Nursing - Inpatient (Including Medicare Part A)</td>
</tr>
<tr>
<td>022x</td>
<td>Skilled Nursing - Inpatient (Medicare Part B only)</td>
</tr>
<tr>
<td>023x</td>
<td>Skilled Nursing - Outpatient</td>
</tr>
<tr>
<td>074x</td>
<td>Clinic - Outpatient Rehabilitation Facility (ORF)</td>
</tr>
</tbody>
</table>
Revenue Codes
Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>042X</td>
<td>Physical Therapy - General Classification</td>
</tr>
<tr>
<td>043X</td>
<td>Occupational Therapy - General Classification</td>
</tr>
</tbody>
</table>

CPT/HCPCS Codes
Italicized and/or quoted material is excerpted from the American Medical Association, Current Procedural Terminology (CPT) codes.

Code 97010 is a status B (bundled) code on the Medicare Fee Schedule Data Base (MFSDB). Separate payment is not allowed for this service.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97001</td>
<td>Pt evaluation</td>
</tr>
<tr>
<td>97002</td>
<td>Pt re-evaluation</td>
</tr>
<tr>
<td>97003</td>
<td>Ot evaluation</td>
</tr>
<tr>
<td>97004</td>
<td>Ot re-evaluation</td>
</tr>
<tr>
<td>97010</td>
<td>Hot or cold packs therapy</td>
</tr>
<tr>
<td>97012</td>
<td>Mechanical traction therapy</td>
</tr>
<tr>
<td>97014</td>
<td>Electric stimulation therapy</td>
</tr>
<tr>
<td>97016</td>
<td>Vasopneumatic device therapy</td>
</tr>
<tr>
<td>97018</td>
<td>Paraffin bath therapy</td>
</tr>
<tr>
<td>97022</td>
<td>Whirlpool therapy</td>
</tr>
<tr>
<td>97024</td>
<td>Diathermy eg microwave</td>
</tr>
<tr>
<td>97026</td>
<td>Infrared therapy</td>
</tr>
<tr>
<td>97028</td>
<td>Ultraviolet therapy</td>
</tr>
<tr>
<td>97032</td>
<td>Electrical stimulation</td>
</tr>
<tr>
<td>97033</td>
<td>Electric current therapy</td>
</tr>
<tr>
<td>97034</td>
<td>Contrast bath therapy</td>
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<tr>
<td>97035</td>
<td>Ultrasound therapy</td>
</tr>
<tr>
<td>97036</td>
<td>Hydrotherapy</td>
</tr>
<tr>
<td>97039</td>
<td>Physical therapy treatment</td>
</tr>
<tr>
<td>97110</td>
<td>Therapeutic exercises</td>
</tr>
<tr>
<td>97112</td>
<td>Neuromuscular reeducation</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>97113</td>
<td>Aquatic therapy/exercises</td>
</tr>
<tr>
<td>97116</td>
<td>Gait training therapy</td>
</tr>
<tr>
<td>97124</td>
<td>Massage therapy</td>
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<td>97139</td>
<td>Physical medicine procedure</td>
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<td>97140</td>
<td>Manual therapy 1/2 regions</td>
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<td>97150</td>
<td>Group therapeutic procedures</td>
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<tr>
<td>97155</td>
<td>Therapeutic activities</td>
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<tr>
<td>97132</td>
<td>Cognitive skills development</td>
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<tr>
<td>97133</td>
<td>Sensory integration</td>
</tr>
<tr>
<td>97135</td>
<td>Self care management training</td>
</tr>
<tr>
<td>97137</td>
<td>Community/work reintegration</td>
</tr>
<tr>
<td>97142</td>
<td>Wheelchair management training</td>
</tr>
<tr>
<td>97145</td>
<td>Work hardening</td>
</tr>
<tr>
<td>97146</td>
<td>Work hardening add-on</td>
</tr>
<tr>
<td>97170</td>
<td>Physical performance test</td>
</tr>
<tr>
<td>97175</td>
<td>Assistive technology assessment</td>
</tr>
<tr>
<td>97176</td>
<td>Orthotic management and training</td>
</tr>
<tr>
<td>971761</td>
<td>Prosthetic training</td>
</tr>
<tr>
<td>971762</td>
<td>C/o for orthotic/prosthetic use</td>
</tr>
<tr>
<td>971799</td>
<td>Physical medicine procedure</td>
</tr>
<tr>
<td>G0283</td>
<td>Electric stimulation other than wound</td>
</tr>
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</table>

**ICD-9 Codes that Support Medical Necessity**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>XX000</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

**ICD-9 Codes that DO NOT Support Medical Necessity**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>XX000</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

**ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>XX000</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

**Diagnoses that DO NOT Support Medical Necessity**

N/A

**Other Information**

**Documentation Requirements**

1. All documentation must be maintained in the patient's medical record and available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The record must include the physician or non-physician practitioner responsible for providing the care of the patient.
3. The submitted medical record should support the use of the selected ICD-9-CM code(s). The submitted
CPT/HCPCS code should describe the service performed.

4. Documentation of physical medicine and rehabilitative services includes any entry into a patient’s medical record such as a consultation report, initial examination report, patient informed consent notation, progress note, flow sheet/checklist that identifies the care/service that was provided, reexamination report or summation of care.

5. The medical record must identify the physician or non-physician practitioner responsible for the general medical care of the patient and the dates and outcomes of the clinical visits to this provider for continued evaluation during the course of therapy. Please refer to the documentation requirements in the CMS Medicare Benefit Policy Manual (100-02) regarding plan of care requirements (chapter 15, section 220.1.2).

6. Refer to the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy for additional guidelines pertaining to the documentation requirements for the individual treatments/modalities.

7. Procedure codes that require supervision and/or time documentation will be denied if the medical record does not clearly support these services as billed.

Appendices

N/A

Utilization Guidelines

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

See the “Indications and Limitations of Coverage and/or Medical Necessity" section of this LCD for specific utilization parameters.

Sources of Information and Basis for Decision

Contractor is not responsible for the continued viability of websites listed.


American Occupational Therapy Association (2002b), Roles and responsibilities of the occupational therapist and the occupational therapy assistant during the delivery of occupational therapy services. OT Practice, 7(15), 9-10.


Lymphedema Therapy, Oncology, September 1994, page 94.


Lymphedema can be treated. Health Facts, Oct 1994 V19 N 185 P 1(2).


Occupational Therapy School of Health Related Professions website @ shrp.umc.edu.


The American Occupational Therapy Association, Inc. website @ www.aota.org.


Other Contractor(s) Policies

Novitas Solutions Contractor Medical Directors

**Advisory Committee Meeting Notes**

N/A

**Start Date of Comment Period**

N/A

**End Date of Comment Period:**

N/A

**Start Date of Notice Period**

N/A

### Revision History

**Revision History Number**

L27513

**Revision History Explanation**

<table>
<thead>
<tr>
<th>Date</th>
<th>Policy #</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/13/2013</td>
<td>L27513</td>
<td>LCD updated 06/20/2013. The ICD-9 diagnoses have been removed from the policy. Effective for dates of service on and after 06/13/2013, there will no longer be a requirement to report a specific ICD-9 code chosen from a select list in the LCD as was previously directed. The medical record must continue to contain the documentation supporting medical necessity for each service as described in the policy.</td>
</tr>
<tr>
<td>04/02/2012</td>
<td>L27513</td>
<td>LCD revised to remove procedure code ranges and individually list each applicable CPT/HCPCS code.</td>
</tr>
<tr>
<td>04/02/2012</td>
<td>L27513</td>
<td>LCD revised to reflect contractor name change from Highmark Medicare Services to Novitas Solutions, Inc.</td>
</tr>
<tr>
<td>10/01/2011</td>
<td>L27513</td>
<td>LCD revised effective 10/01/2011 to reflect the ICD-9-CM update. The following codes have been deleted: 173.0-173.9, 516.3, and 718.60. The following codes have been added 173.00-173.02, 173.09-173.12, 173.19-173.22, 173.29-173.32, 173.39-173.42, 173.49-173.52, 173.59-173.62, 173.69-173.72, 173.79-173.82, 173.89-173.92, 294.20-294.21, 331.6, 358.30-358.31, 358.39, 488.81-488.82, 488.89, 508.2, 516.30-516.37, 516.4, 516.5, 516.61-516.64, 516.69, 726.13, 808.44, 808.54, 996.88, and V54.82. The following code descriptors have been revised: 317, 318.0-318.2, 319, 323.41, 323.42, 808.43, and 808.53. Some of these changes may be within code ranges. The title has been revised to spell out Physical Therapy and Occupational Therapy.</td>
</tr>
</tbody>
</table>
| 02/21/2011 | L27513   | Per Change Request 7135, this LCD is effective for dates of service on and after 02/21/2011 for those providers in the states of Delaware, Maryland, New Jersey, Pennsylvania and the District of Columbia serviced by Wisconsin Physicians Service (WPS), contractor number 52280, that are
being transitioned to Highmark Medicare Services, contractor number 12901, effective 02/21/2011.

10/27/2010   L27513   LCD revised effective 10/27/2010. The following changes are per the annual ICD-9-CM code update and are effective for dates of service on and after 10/01/2010. ICD-9-CM code 276.6 was removed in both groups of ICD-9-CM codes. The following ICD-9-CM codes were added for coverage in both groups of ICD-9-CM codes: 276.61, 276.69, 447.70, 447.71, 447.72, 447.73, 724.03, 799.51-799.55 and 799.59. ICD-9-CM code V13.68 was added only to the first group of ICD-9-CM codes. The descriptors for ICD-9-CM codes 724.02 and 781.8 were revised in both groups of ICD-9-CM codes. Most of these changes are in code ranges.

09/08/2010   L27513   LCD revised effective 09/09/2010. The descriptions have changed for the following bill type codes: 11, 12, 13, 18, 21, 22, 23, 74, 75, 83, and 85 with an effective date of 07/01/2010. The descriptions have changed for the following revenue codes: 0420, 0421, 0422, 0423, 0424, 0429, 0430, 0431, 0432, 0433, 0434, and 0439 with an effective date of 07/01/2010. Some or all of these changes may be in code ranges. Sources of Information and Basis for Decision section reordered and formatted for clarification.

10/08/2009   L27513   LCD revised effective 10/09/2009. LCD revised due to ICD-9-CM annual updates. The following ICD-9-CM code changes are effective 10/01/2009: Deleted codes in both groups of ICD-9-CM codes: 274.0, 453.8. Revised codes in both groups of ICD-9-CM codes: 041.86, 453.40, 453.41, 453.42, 584.5, 584.6, 584.7, 584.8, 584.9, 813.45, 996.43. New codes in both groups of ICD-9-CM codes: 274.00, 274.01, 274.02, 274.03, 359.71, 359.79, 453.50, 453.51, 453.52, 453.6, 453.7. 453.71, 453.72, 453.73, 453.74, 453.75, 453.76, 453.77, 453.79, 453.81, 453.82, 453.83, 453.84, 453.85, 453.86, 453.87, 453.89, 756.72, 756.73, 813.46, 813.47, 832.2. Most of these changes are within code ranges. Also items added to CMS National Coverage Policy section for clarification.

02/11/2009   L27513   LCD revised to include ICD-9-CM code 386.03 per LCD Reconsideration Request. This code update is retroactive to 12/13/2008.

12/12/2008   L27513   LCD effective 12/12/2008 for Pennsylvania Part B. LCD is now effective for DC Part A and DCMA Part B; Delaware Part A and Part B; Maryland Part A and Part B; New Jersey Part A and Part B; Pennsylvania Part A and Part B. The following CPT/HCPCS code changes will be effective 01/01/2009: Code description changes: 97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028.

11/14/2008   L27513   LCD effective 11/14/2008 for New Jersey Part B and Delaware Part A. LCD is now effective for DC Part A and DCMA Part B; Delaware Part A and Delaware Part B; Maryland Part A and Maryland Part B; New Jersey Part A and New Jersey Part B; Pennsylvania Part A.

09/24/2008   L27513   The following ICD-9 code changes will be effective 10/01/2008 due to ICD-9-CM annual updates. Revised code descriptors for 038.11; 041.11; codes in the 203-207 ranges have revised descriptors for the 20x.x0 fifth digit: 482.41, and 707.00-707.09. Added new codes 038.12, 041.12, 482.42, and 707.20-707.25. Some of these changes are within a code range. LCD revision effective 09/25/2008.

08/29/2008   L27513   LCD effective 09/01/2008 for New Jersey Part A. Effective 09/01/2008, New Jersey Part A will be added to the other jurisdictions already effective: DC Part A and DCMA Part B; Maryland Part A and Maryland Part B; Pennsylvania Part A; and Delaware Part B.

08/01/2008   L27513   LCD effective 08/01/2008 for DC Part A, Maryland Part A, and Pennsylvania Part A. LCD is now effective for DC Part A and DCMA Part B; Maryland Part A and Maryland Part B; Pennsylvania Part A; and Delaware Part B.

05/23/2008   L27513   Original LCD posted for notice. LCD to become effective 07/11/2008 for Maryland Part B, DCMA Part B and Delaware Part B.

04/01/2008   Draft J12-D36   Original LCD posted for comment.

**Reason for Change**

Reconsideration Request
Related Documents
This LCD has no Related Documents.

LCD Attachments
There are no attachments for this LCD.