Division of TennCare

MEMO

TO: **TennCare Managed Care Organizations**

FROM: **Keith Gaither, Director Managed Care Operations**

DATE: **October 11, 2021**

SUBJECT: **Current Budget Reductions/Impacts**

This Budget Memo is intended to clarify and provide guidance based on the most current budget appropriations for the state fiscal year as well as clarify previous items that have carried forward.

Often times our guidance includes procedure codes in an effort to be clear and consistent among all MCOs for system configurations. As you are aware, CMS updates CPT and HCPC codes on an annual basis (October 1/January 1 respectively). Our Budget Memos are not intended to be inconsistent with correct coding guidance as provided by CMS. It is our expectation that as referenced codes are deleted and replaced by CMS that each MCO will make the update in order to be consistent with correct coding requirements. We also expect that all updates to referenced codes will be made in such a manner as to remain consistent with the intent of the Budget Memo. We will continue to work closely with you in an effort to keep the memo updated and current with budget appropriations and CMS coding changes.

This memo serves as official notice of programmatic changes to be made by the MCOs as a result of the state fiscal year 2021 budget. We have also included previous budget decisions that are to continue.

CHANGES are as follows:

- **340B Pricing:** Section 2.12.9.60 of the MCO Contract requires the MCO to specify in applicable provider agreements that all providers who participate in the federal 340B program give TennCare MCOs the benefit of 340B pricing. This requirement shall be enforced in accordance with the guidance as provided by TennCare.

- **Assay Drug Testing:** Any combination of confirmatory drug tests represented by G0480, G0481, G0482, and G0483 will be limited to twelve (12) per member per calendar year (See Attachment H).

- **DME Maximum Fee Schedule:** Application Clarification – Surgical Implants shall be exempt from this requirement.

In addition to the budget reductions and/or buybacks as described above, all **other previous reductions** and **limits** remain in effect. In addition to previous across the board rate reductions (see Attachment A), the previous reductions that remain in effect are as follows:

- **Cesarean and Vaginal Delivery Reimbursement (see Attachment C for Crosswalk)**

Cesarean and Vaginal Delivery Reimbursement			
SFY 2012	**SFY 2013**	**SFY 2014**	**SFY 2015 - Forward**
Effective July 1, 2011	**Effective July 1, 2012**	**Effective July 1, 2013**	**Effective July 1, 2014**
Cesarean and vaginal deliveries will be reimbursed at the same rate effective July 1, 2011. MCOs are directed to increase their vaginal delivery rates by 17%. Additionally, MCOs are to pay the vaginal delivery rate for corresponding C-Section deliveries.	Cesarean and vaginal deliveries are reimbursed at the same rate. MCOs pay the current vaginal delivery rate for corresponding C-Section deliveries. MCOs are directed to decrease their vaginal and corresponding C-Section delivery rate by 7% points effective July 1, 2012. This should result in an effective 10% increase from the rates paid before July 1, 2011.	Cesarean and vaginal deliveries are reimbursed at the same rate. MCOs pay the current vaginal delivery rate for corresponding C-Section deliveries. **MCOs are directed to decrease their vaginal and corresponding C-Section delivery rate by 5% points effective July 1, 2013**. This should result in an effective 5% increase from the rates paid before July 1, 2011.	Cesarean and vaginal deliveries are reimbursed at the same rate. MCOs pay the current vaginal delivery rate for corresponding C-Section deliveries. Payment should result in an effective 5% increase from the rates paid before July 1, 2011.

- **Emergency Department Professional Fees SFY 2012 – Effective July 1, 2011**

  Reimbursement for professional claims for non-emergency ED visits will be capped at $50. If the contracted rate is lower than $50 for the service billed, the MCO is to pay the contracted rate.

  Each MCO must provide ED providers with the MCOs policy describing your process for determining Emergent vs. Non-Emergent claims. In addition to your MCOs process for a provider to appeal claims reimbursement, the policy must offer a front end process whereby the provider may submit documentation for review upon consideration of an initial claim.

- **DME/Back Brace Reimbursement – SFY 2014 –Effective July 1, 2013**

BACK BRACE REIMBURSEMENT		
Effective July 1, 2013		**1% Reduction Effective July 1, 2014**
HCPC Code	Maximum Allowed Amount	Maximum Allowed Amount
L0637	$ 379.86	$ 376.06
L0631	$ 332.31	$ 328.99
L0627	$ 133.06	$ 131.73

- **Implementation of Medicare standards for coverage of TENS and CLBP - SFY 2014 – Effective July 1, 2013**

  Effective for claims with dates of service on or after June 8, 2012, CMS believes the evidence is inadequate to support coverage of TENS for CLBP as reasonable and necessary. Thus, effective for claims with dates of service on and after June 8, 2012, Medicare will not allow coverage of TENS for CLBP. TennCare has adopted this policy as well. MCOs are expected to implement these guidelines for dates of service July 1, 2013 and thereafter.

- **Benefit Limits listed in Attachment G - SFY 2014 – Effective October 1, 2013 as amended**

- **Diapers – SFY 2015 - Effective July 1, 2014**

  Quantities over 200 per month require Prior Authorization or Post Payment Review for Medical Necessity.

- **MRI – SFY 2015 - Effective July 1, 2014**

  Medical Necessity Criteria for Low Back Pain Diagnostic Testing - Limit spinal (Cervical, Thoracic, and Lumbar) MRIs within the first eight weeks for a primary diagnosis of non-specific spine pain (ICD-9 codes 721.xx-724.xx) in the absence of other serious coexisting diagnoses.

- **Assay Drug Testing Limit –** Effective October 1, 2015 – See Attachment H as amended.

- **Therapy Code Reimbursement –** Effective July 1, 2015, Therapy Codes included in Attachment I shall be reimbursed at the lesser of 1) the MCOs current reimbursement amount for therapy codes, or 2) the current published CMS Medicare reimbursement amount.

- **E&M/Therapy Same Day** –Do not pay a provider for an Evaluation and Management code on the same date of service for which Therapy Services are paid to that same provider.

- **Pharmacy Related Reductions (MCO Provider Education)**

  - **<u>Compounded Prescriptions</u> Effective July 1, 2015**
    As a result of the State of Tennessee's Budget reductions beginning July 1, 2015, TennCare will be implementing clinical criteria and will require prior authorization on compounded prescription medications to ensure that all compounded prescriptions are medically necessary. Effective July 1, 2015, compounds will be approved only when the indication, therapeutic amount, and route of administration of each of the active ingredients in the compound are FDA-approved or CMS-recognized compendia supported. Further details will be available after June 15, 2015 on Magellan Medicaid Administration's website at: https://tenncare.magellanhealth.com.

- **Immunotherapy Guidelines – SFY2017 - Effective October 1, 2016**

  The initial immunotherapy allergen treatment supply claim should be billed with a -GD modifier. Extract refill claims should be billed without the modifier. Initial and refill supplies shall be as medically necessary; however, payment should not be made for more than a three month supply at a time.

  Additionally providers must follow practice guidelines according to the following:

  - **Joint Task Force on Practice Parameters of the American Academy of Allergy, Asthma, and Immunology;**
  - **American College of Allergy, Asthma, and Immunology; and**
  - **Joint Council of Allergy, Asthma, and Immunology.**

- **Member Handbooks: Reduction in paper copies of member handbooks -** In order to satisfy the contractual requirement to provide a member handbook to enrollees, it will be acceptable to mail a notice to enrollees with instructions for accessing the member handbook on the MCO website and a phone number to call and request a paper copy if preferred. We will amend the MCO Contract in the next cycle to reflect this change.

- **DME Maximum Fee Schedule: Effective July 1, 2019 -** MCOs must utilize the attached spreadsheet based on the April 2018 DMEPOS Fee Schedule as a maximum/ceiling for negotiated provider rates unless a lower maximum rate has been specifically described in this memo (e.g., back brace codes listed herein). The attached spreadsheet represents the non-rural (NR) rates from the April 2018 CMS DMEPOS Fee Schedule. We are using the non-rural (NR) rates from the April 2018 CMS DMEPOS Fee Schedule and ignoring the rural (R) column completely. If the NR column has a rate of $0.00, the MCOs are to treat this code as having no fee schedule. This means you will not be required to change whatever your current rate is. To be clear, this does not mean you should set the rate to zero for those categories.

  To clarify, these rates are intended to be a maximum fee schedule. MCOs that are paying rates below the listed fee should make no changes. MCOs that are paying above the fee should renegotiate so that your fee is at or below the maximum allowable amount. Any contracted rates that are below the maximum will not require any action based on this notice. The attached fee schedule (titled DMEPOS_APR_Fee Schedule for July 2018 - Budget Memo Attachment) shall reflect the permanent fee schedule. MCOs will not be required to update rate schedules in the future unless otherwise instructed to do so.

Attachment A
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Attachment B
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Attachment C

Vaginal to Cesarean CPT Crosswalk

Description	Vaginal CPT Code	Cesarean CPT Code
Global OB Care	59400	59510
Delivery Only	59409	59514
Delivery and Postpartum	59410	59515
VBAC	59610	N/A
VBAC Delivery Only	59612	59620
VBAC Delivery and Postpartum	59614	59622
Routine OB Care	59400	59618

Vaginal to Cesarean DRG Crosswalk

Vaginal Code	Description	Corresponding Cesarean Code	Description
805	Vaginal Delivery W/O Sterilization/D&C W MCC	786	Cesarean Section W/O Sterilization W MCC
806	Vaginal Delivery W/O Sterilization /D&C W CC	787	Cesarean Section W/O Sterilization W CC
807	Vaginal Delivery W/O Sterilization /D&C W/O CC/MCC	788	Cesarean Section W/O Sterilization W/O CC/MCC
796	Vaginal Delivery W Sterilization /D&C W MCC	783	Cesarean Section W Sterilization W MCC
797	Vaginal Delivery W Sterilization /D&C W CC	784	Cesarean Section W Sterilization W CC
798	Vaginal Delivery W Sterilization /D&C WO CC/MCC	785	Cesarean Section W Sterilization W/O CC/MCC

Attachment D
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Attachment E
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Attachment F
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Attachment G
Benefit Limits Effective October 1, 2013 for Adults
(Effective October 1, 2016 use codes in the Chart on the next page)

Description	Codes	Policy	Comments
Facet/Medial Branch Block Injections	64490 64491 64492 64493 64494 64495	Limit of 4 Diagnostic Medial Branch Block Injections per Calendar Year Therapeutic Facet/Medial Branch Block Injections Not Covered Must be performed by a physician/practitioner as required by State law (Public Chapter No. 961/SB No. 1935 http://www.tn.gov/sos/acts/107/pub/pc0961.pdf	MCO to define supporting documentation that shall be required to accompany a claim in order to be processed. The supporting documentation must demonstrate that the service and provider qualify for payment. 271U will report number of Diagnostic Medical Branch Block Injections paid and apply encounter edits if exceeded
Trigger Point Injections	20552 20553	Limit of **4** per muscle group in any period of **6** consecutive months (counting will start with the first shot on or after October 1)	Post Medical Necessity Review 271U will report number of injections paid for MCO informational purposes to prompt Medical Necessity Review but TennCare will not apply edits
Epidural Steroid Injections	62310 62311 62318 62319 64479 64480 64483 64484	Limit of **3** in any period of **6** consecutive months (counting will start with the first shot on or after October 1)	Limits will not apply in conjunction with Labor and Delivery (codes for L&D should be different) 271U will report number of injections paid and apply encounter edits if exceeded

Attachment G
Benefit Limits Effective October 1, 2016

Description	Codes	Policy	Comments
Facet/Medial Branch Block Injections	64490 64491 64492 64493 64494 64495	Limit of 4 Diagnostic Medial Branch Block Injections per Calendar Year Therapeutic Facet/Medial Branch Block Injections Not Covered Must be performed by a physician/practitioner as required by State law (Public Chapter No. 961/SB No. 1935 http://www.tn.gov/sos/acts/107/pub/pc0961.pdf	MCO to define supporting documentation that shall be required to accompany a claim in order to be processed. The supporting documentation must demonstrate that the service and provider qualify for payment. 271U will report number of Diagnostic Medical Branch Block Injections paid and apply encounter edits if exceeded
Trigger Point Injections	20552 20553	Limit of **4** per muscle group in any period of **6** consecutive months (counting will start with the first shot on or after October 1)	Post Medical Necessity Review 271U will report number of injections paid for MCO informational purposes to prompt Medical Necessity Review but TennCare will not apply edits
Epidural Steroid Injections	62320 62321 62322 62323 62324 62325 62326 62327 64479 64480 64483 64484	Limit of **3** in any period of **6** consecutive months (counting will start with the first shot on or after October 1)	Limits will not apply in conjunction with Labor and Delivery (codes for L&D should be different) 271U will report number of injections paid and apply encounter edits if exceeded

Attachment G
Benefit Limits Effective October 1, 2016

Description	Codes	Policy	Comments
Urine Drug Screens **(Effective January 1, 2016 use codes in the Chart on the next page)**	G0434 G0431	G0434 - Limit of **12** per calendar year G0431 - Limit of **4** per calendar year Limits do not apply in the emergency department (Note: this includes urine drug screens that are sent to an independent lab on the same date of service for the same enrollee on the same day of an emergency department visit.)	Adhere to Medicare Guidelines for billing Urine Drug Screens. Do Not Cover Urine Drug Screens Under 8xxxx series CPT codes Each G code carries its own limit: G0434 = limited to 12 units per member, per calendar year G0431 = limited to 4 units per member in addition to the 12 for G0434 and may be billed on the same date of service 271U will report number of urine drug screens paid and apply encounter edits if exceeded
TENS Units	E0730 64550	Non-Covered for Chronic Low Back Pain (NOTE: This includes multiple specific diagnoses for the symptom of chronic low back pain)	Prior Auth Or Post Medical Necessity Review

Note: 1) Please remember with Benefit Limits, you must provide a Notice of Limit (EOB) to members once a service is billed that exceeds a limit.

2) If a service is requested after a limit is exceeded, a Grier notice of denial must be sent.

Attachment G

Effective January 1, 2016, CMS updated codes related to Urine Drug Screens as follows:

Description	Codes	Code Descriptions	Policy	Comments
Urine Drug Screens **(Effective January 1, 2017 use codes in the Chart on the next page)**	G0477 or	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.	Limit of **12** per member, per calendar year (Any combination of G0477 and G0478 combined limited to a total of 12)	Adhere to Medicare Guidelines for billing Urine Drug Screens. Do Not Cover Urine Drug Screens Under 8xxxx series CPT codes
	G0478	Drug tests, presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) read by instrument - assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation's when performed, per date of service.		G0477 or G0478 (any combination) = limited to 12 units total per member, per calendar year
	G0479	Drug tests, presumptive, any number of drug classes; any number of devices or procedures by instrumental chemistry analyzers (e.g., immunoassay, enzyme assay, TOF, MA LDI, LDTD, DES I, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service.	Limit of **4** per member, per calendar year Limits do not apply in the emergency department (Note: this includes urine drug screens that are sent to an independent lab on the same date of service for the same enrollee on the same day of an emergency department visit.)	G0479 = limited to 4 units per member in addition to the 12 for G0477/G0478 and may be billed on the same date of service 271U will report number of urine drug screens paid and apply encounter edits if exceeded

Note: 1) Please remember with Benefit Limits, you must provide a Notice of Limit (EOB) to members once a service is billed that exceeds a limit.

2) If a service is requested after a limit is exceeded, a Grier notice of denial must be sent.

Attachment G

Effective January 1, 2017, CMS updated codes related to Urine Drug Screens as follows:

Description	Codes	Code Descriptions	Policy	Comments
Urine Drug Screens	80305 or	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.	Limit of **12** per member, per calendar year (Any combination of 80305 and 80306 combined limited to a total of 12)	Adhere to Medicare Guidelines for billing Urine Drug Screens. Crosswalk 80305 to G0477, 80306 to G0478, 80307 to G0479
	80306	Drug tests, presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) read by instrument - assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation's when performed, per date of service.		80305 or 80306 (any combination) = limited to 12 units total per member, per calendar year
	80307	Drug tests, presumptive, any number of drug classes; any number of devices or procedures by instrumental chemistry analyzers (e.g., immunoassay, enzyme assay, TOF, MA LDI, LDTD, DES I, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service.	Limit of **4** per member, per calendar year Limits do not apply in the emergency department (Note: this includes urine drug screens that are sent to an independent lab on the same date of service for the same enrollee on the same day of an emergency department visit.)	80307 = limited to 4 units per member in addition to the 12 for 80305/80306 (G0477/G0478) and may be billed on the same date of service 271U will report number of urine drug screens paid and apply encounter edits if exceeded

Note: 1) Please remember with Benefit Limits, you must provide a Notice of Limit (EOB) to members once a service is billed that exceeds a limit.

2) If a service is requested after a limit is exceeded, a Grier notice of denial must be sent.

Attachment G

Effective January 1, 2019, TennCare increased limits for Urine Drug Screens as follows:

Description	Codes	Code Descriptions	Policy	Comments
Urine Drug Screens	80305 or	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.	Limit of **24** per member, per calendar year (Any combination of 80305 and 80306 combined limited to a total of 24)	Adhere to Medicare Guidelines for billing Urine Drug Screens. Crosswalk 80305 to G0477, 80306 to G0478, 80307 to G0479
	80306	Drug tests, presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) read by instrument - assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation's when performed, per date of service.		80305 or 80306 (any combination) = limited to 24 units total per member, per calendar year
	80307	Drug tests, presumptive, any number of drug classes; any number of devices or procedures by instrumental chemistry analyzers (e.g., immunoassay, enzyme assay, TOF, MA LDI, LDTD, DES I, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service.	Limit of **4** per member, per calendar year Limits do not apply in the emergency department (Note: this includes urine drug screens that are sent to an independent lab on the same date of service for the same enrollee on the same day of an emergency department visit.)	80307 = limited to 4 units per member in addition to the 24 for 80305/80306 (G0477/G0478) and may be billed on the same date of service 271U will report number of urine drug screens paid and apply encounter edits if exceeded

Note: 1) Please remember with Benefit Limits, you must provide a Notice of Limit (EOB) to members once a service is billed that exceeds a limit.

2) If a service is requested after a limit is exceeded, a Grier notice of denial must be sent.

Effective October 6, 2021, TennCare increased limits for Urine Drug Screens as follows:

Description	Codes	Code Descriptions	Policy	Comments
Urine Drug Screens	80305 or	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.	Limit of **24** per member, per calendar year (Any combination of 80305 and 80306 combined limited to a total of 24)	Adhere to Medicare Guidelines for billing Urine Drug Screens. Crosswalk 80305 to G0477, 80306 to G0478, 80307 to G0479
	80306	Drug tests, presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) read by instrument - assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation's when performed, per date of service.		80305 or 80306 (any combination) = limited to 24 units total per member, per calendar year
	80307	Drug tests, presumptive, any number of drug classes; any number of devices or procedures by instrumental chemistry analyzers (e.g., immunoassay, enzyme assay, TOF, MA LDI, LDTD, DES I, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service.	Limit of **12** per member, per calendar year Limits do not apply in the emergency department (Note: this includes urine drug screens that are sent to an independent lab on the same date of service for the same enrollee on the same day of an emergency department visit.)	80307 = limited to 12 units per member in addition to the 24 for 80305/80306 (G0477/G0478) and may be billed on the same date of service 271U will report number of urine drug screens paid and apply encounter edits if exceeded

Note: 1) Please remember with Benefit Limits, you must provide a Notice of Limit (EOB) to members once a service is billed that exceeds a limit.

2) If a service is requested after a limit is exceeded, a Grier notice of denial must be sent.

Attachment H

Benefit Limits for Assay Drug Testing – Effective October 1, 2015 for Adults

Description	Codes/Descriptions	Policy
Assay of Opiates	G6056 – Opiate(s), drug and metabolites, each	Limit to two (2) per calendar year
Assay of Methadone	G6053 – Methadone	Limit to two (2) per calendar year
Assay of Amphetamines	G6042 – Amphetamine or methamphetamine	Limit to two (2) per calendar year
Assay of Phencyclidine	83992 Phencyclidine	Limit to two (2) per calendar year
Assay of Cocaine	G6044 – Cocaine or metabolite	Limit to two (2) per calendar year
Assay of Dihydromorphinone	G6046 – Dihydromorphinone	Limit to two (2) per calendar year
Assay of Barbiturates	G6043 – Barbiturates, not elsewhere specified	Limit to two (2) per calendar year
Assay of Dihydrocodeinone	G6045 Dihydrocodeinone	Limit to two (2) per calendar year
Assay of Metanephrines	83835 Metanephrines	Limit to two (2) per calendar year
Assay of Urine Alkaloids	G6041 – Alkaloids, urine, quantitative	Limit to two (2) per calendar year

NOTE: Your policies should prohibit providers from using the 8xxxx codes in instances where CMS has provided a G code. Codes listed above should not be used after December 31, 2015, see chart below.

Effective January 1, 2016, CMS updated codes related to Assay Drug Testing as follows:

Description	Codes	Code Description	Policy
Assay Drug Testing	G0480	Drug tests, definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS [any type, single or tandem and excluding immunoassays (e.g. IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g. alcohol dehyrdrogenase)]; qualitative or quantitative, all sources, include specimen validity testing, per day, 1-7 drug classes, including metabolites if performed	Limit to two (2) per calendar year.
	G0481	8-14 drug classes, including metabolites if performed	Limit to two(2) per calendar year
	G0482	15-21 drug classes, including metabolites if performed	Limit to two (2) per calendar year
	G0483	22 or more drug classes, including metabolites if performed	Limit to two (2) per calendar year

Note: Your policies should prohibit providers from using the 8xxxx codes in instances where CMS has provided a G code.

Attachment H

Effective October 6, 2021, CMS updated codes related to Assay Drug Testing as follows:

Description	Codes	Code Description	Policy
Assay Drug Testing	G0480	Drug tests, definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS [any type, single or tandem and excluding immunoassays (e.g. IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g. alcohol dehyrdrogenase)]; qualitative or quantitative, all sources, include specimen validity testing, per day, 1-7 drug classes, including metabolites if performed	Any combination of confirmatory drug tests represented by G0480, G0481, G0482, and G0483 will be limited to = limited to twelve (12) units total per member, per calendar year
	G0481	8-14 drug classes, including metabolites if performed	
	G0482	15-21 drug classes, including metabolites if performed	
	G0483	22 or more drug classes, including metabolites if performed	

Note: Your policies should prohibit providers from using the 8xxxx codes in instances where CMS has provided a G code.

Attachment I

Therapy Code List/Reimbursement Limit – Effective July 1, 2015

Therapy Code List	Description
92508	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESSING DISORDER (INCLUDES AURAL REHABILITATION); GROUP, TWO OR MORE INDIVIDUALS
92521	Evaluation of speech fluency
92522	Evaluation of speech sound production
92523	Evaluation of speech sound production with evaluation of language comprehension and expression
92524	Behavioral and qualitative analysis of voice and resonance
92597	EVALUATION FOR USE AND/OR FITTING OF VOICE PROSTHETIC DEVICE TO SUPPLEMENT ORAL SPEECH
92607	EVALUATION FOR PRESCRIPTION FOR SPEECH-GENERATING AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICE, FACE-TO-FACE WITH THE PATIENT; FIRST HOUR
97002*	PHYSICAL THERAPY RE-EVALUATION
97004*	OCCUPATIONAL THERAPY RE-EVALUATION
97012	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; TRACTION, MECHANICAL
97016	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; VASOPNEUMATIC DEVICES
97018	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; PARAFFIN BATH
97022	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; WHIRLPOOL
97024	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; DIATHERMY (EG, MICROWAVE)
97026	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; INFRARED
97028	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ULTRAVIOLET
97032	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ELECTRICAL STIMULATION (MANUAL), EACH 15 MINUTES
97033	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; IONTOPHORESIS, EACH 15 MINUTES
97034	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; CONTRAST BATHS, EACH 15 MINUTES
97035	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ULTRASOUND, EACH 15 MINUTES
97112	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; NEUROMUSCULAR REEDUCATION OF MOVEMENT, BALANCE, COORDINATION, KINESTHETIC SENSE, POSTURE, AND/OR PROPRIOCEPTION FOR SITTING AND/OR STANDING ACTIVITIES
97116	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; GAIT TRAINING (INCLUDES STAIR CLIMBING)
97124	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; MASSAGE, INCLUDING EFFLEURAGE, PETRISSAGE AND/OR TAPOTEMENT (STROKING, COMPRESSION, PERCUSSION)
97140	MANUAL THERAPY TECHNIQUES (EG, MOBILIZATION/ MANIPULATION, MANUAL LYMPHATIC DRAINAGE, MANUAL TRACTION), ONE OR MORE REGIONS, EACH 15 MINUTES
97150	THERAPEUTIC PROCEDURE(S), GROUP (2 OR MORE INDIVIDUALS)
97530	THERAPEUTIC ACTIVITIES, DIRECT (ONE-ON-ONE) PATIENT CONTACT (USE OF DYNAMIC ACTIVITIES TO IMPROVE FUNCTIONAL PERFORMANCE), EACH 15 MINUTES
97750	PHYSICAL PERFORMANCE TEST OR MEASUREMENT (EG, MUSCULOSKELETAL, FUNCTIONAL CAPACITY), WITH WRITTEN REPORT, EACH 15 MINUTES
97761	PROSTHETIC TRAINING, UPPER AND/OR LOWER EXTREMITY(S), EACH 15 MINUTES
G0283	ELECTRICAL STIMULATION (UNATTENDED), TO ONE OR MORE AREAS FOR INDICATION(S) OTHER THAN WOUND CARE, AS PART OF A THERAPY PLAN OF CARE

* Effective January 1, 2017 code 97002 is deleted and replaced by code 97164 and code 97004 is deleted and replaced by code 97168.