2020 CPT® CODES FOR OCCUPATIONAL THERAPY

The following are a sampling of the CPT® codes frequently used by occupational therapy practitioners to report services in various settings. Not all codes available to OT practitioners are listed. It is the responsibility of the practitioner to be aware of coding changes and to bill for services accordingly. *Note that not all codes are accepted by all payers, and state regulations may have limitations on the codes that can be utilized. Refer to CPT® coding book for additional resources.

PHYSICAL MEDICINE & REHABILITATION

OCCUPATIONAL THERAPY EVALUATIONS

Occupational therapy evaluations include an occupational profile, medical and therapy history, relevant assessments, and development of a plan of care, which reflects the therapist's clinical reasoning and interpretation of the data.

97165 Occupational therapy evaluation, **low complexity**
97166 Occupational therapy evaluation, **moderate complexity**
97167 Occupational therapy evaluation, **high complexity**

97168 Occupational therapy **re-evaluation**

(Please refer to the 2019 CPT® coding book for further guidance on the occupational therapy evaluation codes, including the components noted in the code descriptors that must be documented in order to report the selected complexity level of occupational therapy evaluations.)

MODALITIES

Any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.

Supervised
The application of a modality that does not require direct (one-on-one) patient contact.

97010 Application of a modality to one of more areas; hot or cold packs
97012 traction, mechanical
97014 electrical stimulation (unattended)
97016 vasopneumatic devices
97018 paraffin bath
97022 whirlpool
97024 diathermy (e.g., microwave)
97026 infrared
97028 ultraviolet

(97014 is not covered under Medicare. Practitioners should use G0283 under Medicare—see below.)

G0283 Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care as part of a therapy plan of care

Constant Attendance
The application of a modality that requires direct (one-on-one) patient contact.

97032 Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes *(For transcutaneous electrical modulation pain reprocessing [TEMPR/scrambler therapy], use 0278T.)*
97033 Iontophoresis, each 15 minutes Contrast
97034 baths, each 15 minutes Ultrasound, each
97035 15 minutes
97036 Hubbard tank, each 15 minutes
97039 Unlisted modality (specify type and time is constant attendance)

THERAPEUTIC PROCEDURES

A manner of effecting change through the application of clinical skills and/or services that attempt to improve function.

Physician or other qualified health care professional (i.e., therapist) required to have direct (one-on-one) patient contact.

97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112 neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113 aquatic therapy with therapeutic exercises
97116 gait training (includes stair climbing)

97124 massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)

(*Note for myofascial release, use 97140.)*

97129 Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact

+97130 Each additional 15 minutes (List separately inaddition to code for primary procedure.)

97139 Unlisted therapeutic procedure (specify)

97140 Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes

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

(Report for each member of the group)

*(Group therapy procedures involve constant attendance by the physician **or other qualified health care professional** [i.e., therapist], but by definition do not require one-on-one patient contact by the same physician or other health care professional.)*

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

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

97535 Self-care/home management training (e.g., activities of daily living [ADLs] and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment), direct one-on-one contact, each15 minutes

97537 Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/ modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes

97542 Wheelchair management (e.g., assessment, fitting, training), each 15 minutes

97545 Work hardening/conditioning; initial 2 hours

+97546 Each additional hour (List separately in addition to code for primary procedure.) (*Use 97546 in conjunction with 97545.)*

ACTIVE WOUND CARE MANAGEMENT

Active wound care procedures are performed to remove devitalized and/or necrotic tissue and promote healing. Services require direct (one-on-one) contact with the patient.

97597 Debridement (e.g., high pressure water jet with/without suction, sharp selective debridement with scissors, scalpel, and forceps), open wound (e.g., fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm) including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area: first 20 sq. cm. or less

+97598 Each additional 20 sq. cm., or part thereof (list separately in addition to code for primary procedure)

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

97605 Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters

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

97610 Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day

TEST AND MEASUREMENTS

Requires direct one-on-one patient contact

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

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

ORTHOTIC MANAGEMENT AND TRAINING AND PROSTHETIC MANAGEMENT

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

97761 Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes

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

Other Procedures

97799 Unlisted physical medicine/rehabilitation service or procedure

SPECIAL OTORHINOLARYNGOLOGIC SERVICES

92526 Treatment of swallowing dysfunction and/or oral function for feeding

EVALUATIVE AND THERAPEUTIC SERVICES

92605 Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient, first hour

+92618 Each additional 30 minutes (List separately in addition to code for primary procedure.)

92606 Therapeutic service(s) for the use of non-speech- generating device, including programming and modification

92610 Evaluation of oral and pharyngeal swallowing

92611 Motion fluoroscopic evaluation of swallowing function by cine or video recording

92612 Flexible endoscopic evaluation of swallowing by cine or video recording

92613 interpretation and report only

92614 Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording

92615 interpretation and report only

NEUROLOGY AND NEUROMUSCULAR PROCEDURES

95851 Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)

95852 hand, with or without comparison with normal side

OTHER PROCEDURES

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

CENTRAL NERVOUS SYSTEM ASSESSMENT/TESTS (E.G., NEURO-COGNITIVE, MENTAL STATUS, SPEECH TESTING)

96110 Developmental screening (e.g., developmental milestone survey, speech and language delay screen) with scoring and documentation, per standardized instrument

(For an emotional/behavioral assessment, use (96127)

96112 Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed),

+96113 each additional 30 minutes (List separately in addition to code for primary procedure)

96125 Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

96127 Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

(For developmental screening, use 96110)

HEALTH AND BEHAVIOR ASSESSMENT/INTERVENTION

(Not covered under Medicare for OT—See CPT® book for additional instructions for use of these codes.)

96156 Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making)

96158 Health behavior intervention, individual, face-

+96159 Each additional 15 minutes (List separately in addition to code for primary procedure.)

96164 Health behavior intervention, group (2 or more patients) face-to-face; initial 30 minutes

+96165 Each additional 15 minutes (List separately in addition to code for primary procedure.)

96167 Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes

+96168 Each additional 15 minutes (List separately in addition to code for primary procedure.)

96170 Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes

+96171 Each additional 15 minutes (List separately in addition to code for primary procedure.)

ADAPTIVE BEHAVIOR ASSESSMENTS/TREATMENT

(Please refer to the 2019 CPT® coding book for further guidance on the adaptive behavior assessment and adaptive behavior treatment codes.)

97151 Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan

97152 Behavior identification–supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes

0362T Behavior identification supporting assessment, each 15 minutes of technician's time face-to-face with a patient

(For behavior identification supporting assessment with four required components, use 0362T.)

ADAPTIVE BEHAVIOR TREATMENT

Adaptive behavior treatment codes 97153, 97154, 97155, 97156, 97157, 97158, 0373T describe services that address specific treatment targets and goals based on results of previous assessments (see 97151, 97152, 0362T), and include ongoing assessment and adjustment of treatment protocols, targets, and goals.

97153 Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes

97154 Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes

97155 Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes

97156 Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes

97157 Multi family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes

97158 Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes

0373T Adaptive behavior treatment with protocol modification, each 15 minutes of technician's time face-to-face with a patient

(*For adaptive behavior treatment with protocol modification with four required components, use 0373T.)*

QUALIFIED NONPHYSICIAN HEALTH CARE PROFESSIONAL ONLINE DIGITAL EVALUATION AND MANAGEMENT SERVICE

98970 Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes

98971 11–20 minutes

98972 21 or more minutes

(Do not bill 98970-98972 to Medicare. Bill GNPP1–GNPP3

G2061 Qualified nonphysician health care professional online assessment, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes

G2062 11–20 minutes

G2063 21 or more minutes

MEDICAL TEAM CONFERENCE

99366 Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional

99368 Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by non-physician qualified health care professional

Virtual Care Services
Refers to a service provided to a patient from a remote location, or a location different from where the patient is located. This may include Telehealth visits, E-visits, Virtual check-ins, and/or Telephone visits. Therapists must reach out to individual payers (Medicare, Medicaid, or other private insurance) to determine the billing preferences for virtual care services. Some payers require a specific modifier code be used for any services furnished virtually.

Place of Service (POS) Codes for Professional Claims
Therapists must refer to individual payers (Medicare, Medicaid, other private insurance) for policies regarding which place of service code is required for a particular therapy service. Certain payers require that claims specify the location(s) where services are rendered through a particular POS code.