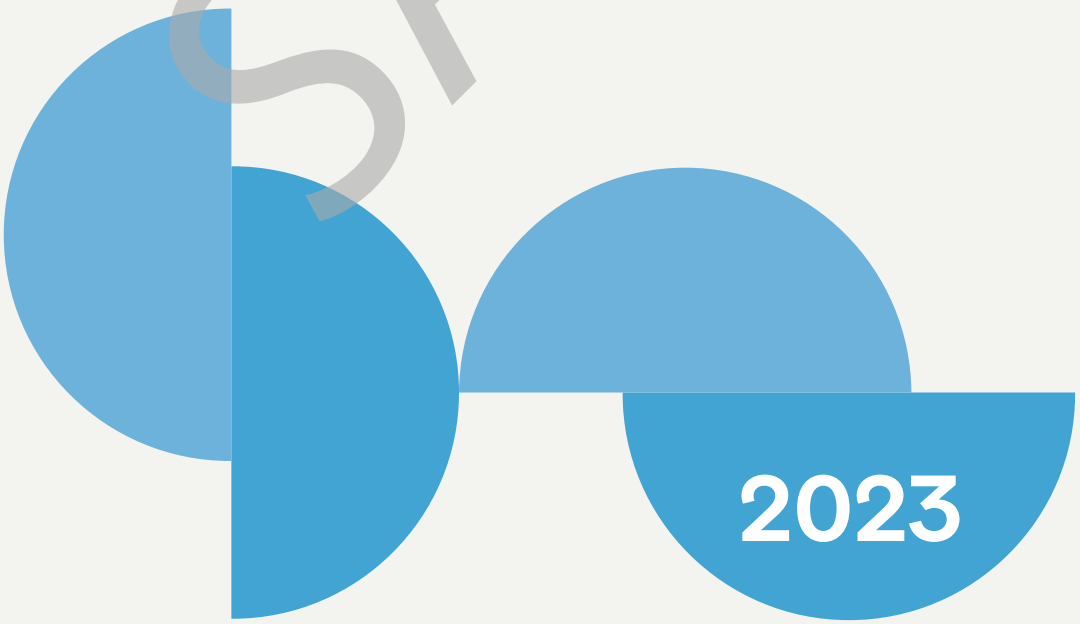
Optum

Coding &
Payment Guide

Behavioral Health Services

An essential coding, billing and reimbursement resource for psychiatrists, psychologists, and clinical social workers



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Contents

Getting Started with Coding and Payment Guide

The *Coding and Payment Guide for Behavioral Health Services* is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT Codes

For ease of use, evaluation and mangement codes related to behavioral health are listed first in the *Coding and Payment Guide*. All other CPT and HCPCS Level II codes related to behavioral health are listed in ascending numeric order. Each CPT code is followed by its official code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed nor had only minimal changes, the AMA has assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence. Codes within the Optum360 *Coding and Payment Guide* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, in the 10th revision of the ICD-10-CM codes, conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. Features include icons to identify newborn, pediatric, adult, male only, female only, and laterality. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service to a series of similar procedures/services. Following the specific HCPCS Level II and CPT code and its narrative, is a combination of features. A sample is shown on page 2. The black boxes with numbers in them correspond to the information on the page following the example.

Appendix Codes and Descriptions

Some procedure codes are presented in a less comprehensive format in the appendix. The CPT and HCPCS Level II codes appropriate to the specialty are included in the appendix with the official code description and associated relative value units, with the exception of the Category II and III CPT Codes. Because no values have been established by CMS for the Category II and Category III codes, no relative value unit and Medicare edits can be identified.

CCI Edits and Other Coding Updates

The Coding and Payment Guide includes the a list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version XX.X, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The CCI edits are located in a section at the back of the book. As other CPT and ICD-10-CM codes relevant to your specialty, including COVID-related vaccine and administration codes, are released, updates will be posted to the Optum360 website.The website address is http://www.optum360coding.com/ProductUpdates/. The 2023 edition password is: **XXXXX**. Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

Brain
Cortex
Magnetic Stimulation, 90867-90869
Mapping, 90867, 96020

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group. Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

Some pathology codes have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

On the following pages are a sample page from the book displaying the format of *Coding and Payment Guide* with each element identified and explained on the opposite page.

90785

+ ★**90785** Interactive complexity (List separately in addition to the code for primary procedure)

Explanation

This code is reported in addition to the code for a primary psychiatric service. It is reported when the patient being treated has certain factors that increase the complexity of treatment rendered. These factors are limited to the following: the need to manage disruptive communication that complicates the delivery of treatment; complications involving the implementation of a treatment plan due to caregiver behavioral or emotional interference; evidence of a sentinel event with subsequent disclosure to a third party and discussion and/or reporting to the patient(s); or use of play equipment or translator to enable communication when a barrier exists.

Coding Tips

Report this code with psychiatric evaluation services (90791–90792), psychotherapy services (90832-90834, 90836-90838), and group psychotherapy (90853). Do not report this code with psychotherapy for crisis (90839–90840), psychological and neuropsychological testing (96130-96134, 96136-96139, 96146), or adaptive behavior assessment/treatment services (97151–97158, 0362T, 0373T). Do not report this code with E/M services provided without psychotherapy.

Documentation Tips

Documentation should clearly indicate the type of interactive methods used such as interpreter, use of play, or physical device used, and that the patient did not have the ability to communicate through normal verbal means. Other catatonic states may be covered if documentation is submitted with the claim. Coverage also includes interactive examinations of patients with primary psychiatric diagnoses (excluding dementias and sleep disorders), and one of the following conditions: developmental speech or language disorders, conductive hearing loss (total), mixed conductive and sensorineural hearing loss (total), deaf mutism, aphasia, voice disturbance, aphonia, and other speech disturbance such as dysarthria or dysphasia. The conditions must be clearly and concisely recorded in the medical record.

Time spent by the clinician providing interactive complexity services should be reflected in the timed service code for the psychotherapy or the psychotherapy add-on code provided in combination with an E/M service and must only be connected to the psychotherapy service.

Reimbursement Tips

Telemedicine services may be reported by the performing provider by adding modifier 95 to this procedure code and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

According to instructions found in the Correct Coding Initiative, "Interactive services (diagnostic or therapeutic) are distinct services for patients who have lost, or have not yet developed either the expressive language communication skills to explain his/her symptoms and response to treatment…" Interactive complexity to psychiatric services is reported with add-on CPT code 90785.

Assignment of benefits is required when this service is provided by a clinical social worker.

Medicare payment is at 75 percent of the physician fee schedule when the service is provided by a clinical social worker.

ICD-10-CM Diagnostic Codes

This/these CPT code(s) are add-on code(s). See the primary procedure code that this code is performed with for your ICD-10-CM code selections.

Associated HCPCS Codes

H0001	Alcohol and/or drug assessment
H0002	Behavioral health screening to determine eligibility for admission to treatment program
H0006	Alcohol and/or drug services; case management
H0007	Alcohol and/or drug services; crisis intervention (outpatient)
H0031	Mental health assessment, by nonphysician
H1011	Family assessment by licensed behavioral health professional for state defined purposes

AMA: **90785** 2020,Aug,3; 2018,Nov,3; 2018,Jul,12; 2018,Jan,8; 2018,Apr,9; 2017,Jan,8; 2016,Jan,13; 2016,Dec,11; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90785	0.33	0.09	0.01	0.43
Facility RVU	**Work**	**PE**	**MP**	**Total**
90785	0.33	0.04	0.01	0.38

	FUD	Status	MUE	Modifiers				IOM Reference
90785	N/A	A	3(3)	N/A	N/A	N/A	N/A	100-02,15,160; 100-02,15,170; 100-03,10.3; 100-03,10.4; 100-04,12,100; 100-04,12,210.1

* with documentation

Terms To Know

add-on code. CPT code representing a procedure performed in addition to the primary procedure and designated with a + symbol in the CPT book. Add-on codes are never reported as a stand-alone service but are reported secondarily in addition to the primary procedure.

aphasia. Partial or total loss of the ability to comprehend language or communicate through speaking, the written word, or sign language. Aphasia may result from stroke, injury, Alzheimer's disease, or other disorder. Common types of aphasia include expressive, receptive, anomic, global, and conduction.

dysarthria. Difficulty pronouncing words.

interactive psychotherapy. Use of physical aids and nonverbal communication to overcome barriers to therapeutic interaction between a clinician and a patient who has not yet developed or has lost either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he or she were to use ordinary adult language for communication.

psychotherapy. Treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

1. CPT Codes and Descriptions

This edition of *Coding and Payment Guide for Behavioral Health Services* is updated with CPT codes for year 2023.

The following icons are used in the *Coding and Payment Guide*:

- ● This CPT code is new for 2023.
- ▲ This CPT code description is revised for 2023.
- ✚ This CPT code is an add-on code.
- ★ This CPT code is identified by CPT as appropriate for telemedicine services.

  More information regarding telehealth can be found on the next page.
- [ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

2. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding and Payment Guide for Behavioral Health Services*, a step-by-step clinical description of the procedure is provided, in simple terms. Technical language that might be used by the physician or other qualified health care provider is included and defined. *Coding and Payment Guide for Behavioral Health Services* describes the most common method of performing each procedure.

3. Coding Tips

Coding tips provide information on how the code should be used, provides related procedure codes, and offers help concerning common billing errors and modifier usage. This information comes from consultants and subject matter experts at Optum360 and from the coding guidelines provided in the CPT book.

4. Documentation Tips

Documentation tips provide code-specific tips to the coder regarding the information that should be noted in the documentation in order to support code assignment.

5. Reimbursement Tips

Medicare and other payer guidelines that could affect the reimbursement of this service or procedure are included in the Reimbursement Tips section.

6. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- 🅽 Newborn: 0
- 🅿 Pediatric: 0-17
- Ⓜ Maternity: 9-64
- 🅰 Adult 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

7. HCPCS Associated Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

8. AMA References

The AMA references *for CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

9. Relative Value Units/Medicare Edits

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice insurance (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first group of RVUs is for nonfacilities, which includes provider services performed in physician offices, patients' homes, or other nonhospital settings. The second group of RVUs is for facilities, which represents provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities.

Medicare Follow-Up Days (FUD)

Information on the Medicare global period is provided here. The global period is the time following a surgery during which routine care by the physician is considered postoperative and included in the surgical fee. Office visits or other routine care related to the original surgery cannot be separately reported if they occur during the global period.

Status

The Medicare status indicates if the service is separately payable by Medicare. The Medicare RBRVS includes:

- A Active code—separate payment may be made
- B Bundled code—payment is bundled into other service
- C Carrier priced—individual carrier will price the code
- I Not valid—Medicare uses another code for this service
- N Non-covered—service is not covered by Medicare
- R Restricted—special coverage instructions apply

Procedure Codes

The *Current Procedural Terminology* (CPT®) coding system was developed and is updated annually by the American Medical Association (AMA). The AMA owns and maintains the CPT coding system and publishes its updates annually under copyright. CPT codes predominantly describe medical services and procedures performed by physicians and nonphysician professionals. The codes are classified as Level I of the Healthcare Common Procedure Coding System (HCPCS).

In general, whenever possible, providers should consider using CPT codes to describe their services for several reasons. Foremost, providers can evaluate patient care by reviewing coded services and procedures. Secondly, procedural coding is a language understood in the provider and payer communities. Consequently, accurate coding can also help an insurer determine coverage eligibility for services provided.

Accurate coding consists of choosing the most appropriate code available for the service provided to the patient. However, the existence of a CPT or HCPCS code does not guarantee that a third-party payer will accept the code or that the service described by the code is covered.

Investigate codes that are denied or downcoded on a claim by the third-party payer, and resubmit with the correct codes if necessary.

Structure of the CPT Book

The CPT book has an introduction, eight main sections, 16 appendixes, and an index.

Category I Codes

The sections considered Category I are:

- Evaluation and Management
- Anesthesia
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine

Category II Codes

Category II CPT codes are a set of codes used for supplemental tracking and performance measurements. Primarily these codes are used to report quality measures when participating in Medicare's Quality Payment Program (QPP). For more information about QPP, see the CMS website at https://qpp.cms.gov.

Category III Codes

Category III codes, which are considered temporary, have been added for reporting the use of new technologies that are not available to report in the existing Category I CPT code set.

CPT Coding Conventions

To code properly, coders must understand and follow the CPT conventions developed by the AMA.

Symbols

The following are several symbols used in the CPT book:

- A bullet (●) before the code means that the code is new to the CPT coding system in the current year.
- A triangle (▲) before the code means that the code narrative has been revised in the current year.
- Codes with a plus (+) symbol indicate an "add-on" code. Procedures described by add-on codes are always performed in addition to the primary procedure and should never be reported alone. This concept applies only to procedures or services performed by the same physician to describe any additional intraservice work, such as a procedure on additional digits or lesions, associated with the primary procedure.
- The symbols ▶◀ indicate new or revised text other than that contained in the code descriptors.
- The symbol ⊘ designates a code that is exempt from the use of modifier 51. These codes have not been designated as add-on codes in the CPT book.
- The lightning bolt (↯) symbol identifies vaccines that are pending FDA approval. These codes were assigned a CPT Category I code by the AMA in anticipation of future approval. Upon revision of the approval status by the FDA, the AMA will post notification on its website at http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-i-vaccine-codes.page.
- The number (#) symbol indicates that a code is out of numeric order or "resequenced." The AMA employs a numbering methodology of resequencing. According to the AMA there are instances where a new code is needed within an existing grouping of codes and an unused code number is not available. In the instance where the existing codes will not be changed or have minimal changes, the AMA will assign a code that is not in numeric sequence with the related codes. However, the code and description will appear in the CPT book with the other related codes.
- Telehealth/Telemedicine services are identified by CPT with the ★ icon at the code level. The Centers for Medicare and Medicaid Services (CMS) have identified additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE) some services have been designated as temporarily appropriate for telehealth. These CMS-approved services are identified in the coding tips where appropriate. Most payers require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home, and modifier 95 appended. If specialized equipment is used at the originating site, code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services.

  Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

  Modifier

  95 Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System

Unlisted Procedures and Modifiers

Unlisted Procedures

Not all medical services or procedures are assigned CPT codes. The code book does not contain codes for infrequently used, new, or experimental procedures. Each code section contains codes set aside specifically for reporting unlisted procedures.

Evaluation and Management Guidelines Common to All E/M Services

Information unique to this section is defined or identified below.

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

Definitions of Commonly Used Terms

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians and other qualified health care professionals. The definitions in the E/M section are provided solely for the basis of code selection.

Some definitions are common to all categories of services, and others are specific to one or more categories only.

New and Established Patient

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report E/M services with a specific CPT® code or codes. A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See the decision tree on the following page.

When a physician/qualified health care professional is on call or covering for another physician/qualified health care professional, the patient's encounter is classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The decision tree on the following page is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the **other** E/M services when counseling and/or coordination of care dominates the service.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Face-to-face time (outpatient consultations [99241, 99242, 99243, 99244, 99245], domiciliary, rest home, or custodial services [99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337], home services [99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350], cognitive assessment and care plan services [99483]): For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, examination, and counseling the patient.

99202-99205

★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are no longer used when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For observation care services, see 99217-99226. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2020,Dec,11; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3 **99203** 2020,Sep,3; 2020,Sep,14; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3 **99204** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,16; 2015,Jan,12; 2015,Dec,3 **99205** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.1	0.09	2.12
99203	1.6	1.51	0.15	3.26
99204	2.6	2.04	0.23	4.87
99205	3.5	2.62	0.31	6.43
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.15	2.42
99204	2.6	1.11	0.23	3.94
99205	3.5	1.54	0.31	5.35

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

 ● New ▲ Revised + Add On ★ Telemedicine AMA: CPT Assist [Resequenced] ☑ Laterality

90791-90792

★**90791** Psychiatric diagnostic evaluation

★**90792** Psychiatric diagnostic evaluation with medical services

Explanation

A psychiatric diagnostic evaluation is performed, which includes the assessment of the patient's psychosocial history, current mental status, review, and ordering of diagnostic studies followed by appropriate treatment recommendations. In 90792, additional medical services such as physical examination and prescription of pharmaceuticals are provided in addition to the diagnostic evaluation. Interviews and communication with family members or other sources are included in these codes.

Coding Tips

These procedures may be performed by a physician or other qualified healthcare professional. Psychiatric diagnostic evaluation with or without medical services include a history, mental status, and other physical examination elements, the prescribing of medications and review and ordering of laboratory or other diagnostic testing. Check with the specific payer to determine coverage. In some cases family members, guardians, or others may be consulted instead of the patient.

Communication factors that complicate the diagnostic evaluation results in the need for interactive complexity (e.g., use of play equipment, involvement of third-parties, etc.); code 90785 may be reported with these procedures.

These services should not be reported with psychotherapy provided at crisis (90839–90840), adaptive behavior assessment/treatment services (97151–97158, 0362T, and 0373T), or evaluation and management (E/M) services (99202–99337, 99341–99350, 99366–99368, or 99401–99443). Diagnostic evaluations may be reported multiple times when performed during separate encounters with the patient and other informants.

For evaluation of psychiatric hospital records reports, psychometric and/projective testing, or other data, see 90885. For interpretation or explanation of psychiatric or other medical examinations and procedures, see 90887. For health and behavior assessment/reassessment, see 96156.

Documentation Tips

Medical record documentation should indicate the need for the interactive complexity services when used. Documentation should clearly indicate the type of interactive methods used such as interpreter, use of play, or physical device used, and that the patient did not have the ability to communicate through normal verbal means. Other catatonic states may be covered if documentation is submitted with the claim. Coverage also includes interactive examinations of patients with primary psychiatric diagnoses (excluding dementias and sleep disorders), and one of the following conditions: developmental speech or language disorders conductive hearing loss (total), mixed conductive and sensorineural hearing loss (total), deaf mutism, aphasia, voice disturbance, aphonia, and other speech disturbance such as dysarthria or dysphasia. The conditions must be clearly and concisely recorded in the medical record.

Reimbursement Tips

Telemedicine services may be reported by the performing provider by adding modifier 95 to this procedure code and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

According to the instructions found in the Correct Coding Initiative, "CPT codes for psychiatric services include diagnostic (CPT codes 90791, 90792) and therapeutic (individual, group, other) procedures. Since psychotherapy includes continuing psychiatric evaluation, CPT codes 90791 and 90792 are not separately reportable with individual psychotherapy codes. CPT code 90791 or 90792 is separately reportable with a group psychotherapy code if the diagnostic interview and group psychotherapy service occur during separate time intervals on the same date of service. Diagnostic services performed during the group therapy session are not separately reportable."

Diagnostic psychiatric evaluation is reported with one of two CPT codes. CPT code 90791 is psychiatric evaluation without medical E/M, and CPT code 90792 is psychiatric evaluation with medical E/M. Evaluation and management codes (e.g., 99201–99215) should not be reported with either of these diagnostic psychiatric codes.

Assignment of benefits is required when this service is provided by a clinical social worker.

Medicare payment is at 75 percent of the physician fee schedule when the service is provided by a clinical social worker.

Diagnostic psychological testing services performed by psychologists who meet these requirements are covered as other diagnostic tests. When, however, the psychologist is not practicing independently, but is on the staff of an institution, agency, or clinic, that entity bills for the diagnostic services.

ICD-10-CM Diagnostic Codes

F01.50	Vascular dementia without behavioral disturbance A
F01.51	Vascular dementia with behavioral disturbance A
F03.90	Unspecified dementia without behavioral disturbance A
F05	Delirium due to known physiological condition
F06.0	Psychotic disorder with hallucinations due to known physiological condition
F06.1	Catatonic disorder due to known physiological condition
F06.2	Psychotic disorder with delusions due to known physiological condition
F06.31	Mood disorder due to known physiological condition with depressive features
F06.32	Mood disorder due to known physiological condition with major depressive-like episode
F06.33	Mood disorder due to known physiological condition with manic features
F06.34	Mood disorder due to known physiological condition with mixed features
F06.4	Anxiety disorder due to known physiological condition
F06.8	Other specified mental disorders due to known physiological condition
F07.0	Personality change due to known physiological condition
F07.81	Postconcussional syndrome
F07.89	Other personality and behavioral disorders due to known physiological condition
F10.10	Alcohol abuse, uncomplicated
F10.11	Alcohol abuse, in remission
F10.120	Alcohol abuse with intoxication, uncomplicated
F10.121	Alcohol abuse with intoxication delirium
F10.131	Alcohol abuse with withdrawal delirium
F10.132	Alcohol abuse with withdrawal with perceptual disturbance
F10.14	Alcohol abuse with alcohol-induced mood disorder
F10.150	Alcohol abuse with alcohol-induced psychotic disorder with delusions
F10.151	Alcohol abuse with alcohol-induced psychotic disorder with hallucinations

90832-90838

★**90832** Psychotherapy, 30 minutes with patient

\+ ★**90833** Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

★**90834** Psychotherapy, 45 minutes with patient

\+ ★**90836** Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

★**90837** Psychotherapy, 60 minutes with patient

\+ ★**90838** Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

Explanation

Psychotherapy is a variety of treatment techniques in which a physician or other qualified healthcare provider helps a patient with a mental illness or behavioral disturbance identify and alleviate any emotional disruptions, maladaptive behavioral patterns, and contributing/exacerbating factors. This treatment also involves encouraging personality growth and development through coping techniques and problem-solving skills. Report 90832 for one half hour of face-to-face time spent with the patient without an additional evaluation and management (E/M) service. Report 90833, 90836, or 90838 if a separate E/M service is performed during the same encounter as the psychotherapy.

Coding Tips

These codes represent individual psychotherapy services although times stated are for face-to-face services with the patient but may also include contact with informants. The patient must be present for the entire, or a majority period of, the encounter.

The appropriate evaluation and management (E/M) service (99202–99255, 99304–93337, and 99341–99350) should be reported in addition to code 90833, 90836, or 90838. However, the time involved with performing the E/M service should not be considered when selecting the psychotherapy code. Time spent providing psychotherapy cannot be used to determine the level of E/M service when time is the determining factor.

Codes 90832 and 90833 describe 30 minutes of psychotherapy; 38 to 52 minutes, report 90834 or 90836; for 53 or more minutes, report 90837–90838. Do not report prolonged services (99354–99357) with 90833. Individual psychotherapy and group psychotherapy may be reported on the same date of service if the two services are performed during separate time intervals. Family psychotherapy (90846, 90847) is separately reportable with psychotherapy (90832–90838) when the services are separate and distinct.

For psychotherapy provided for an urgent assessment and history of a crisis state, including mental status examination and disposition, see 90839–90840. For family psychotherapy, see 90846–90847. For multiple family or group psychotherapy, see 90849 or 90853, respectively.

When it is necessary to perform interactive complexity, 90785 may be reported separately.

Pharmacologic management is included in psychotherapy services that are reported with E/M services or those that include medical services. However, when performed during the same encounter and an evaluation and management service was not provided, management of the patient's medication(s), including review and provision of prescription is reported separately with 90863.

Documentation Tips

Since the psychotherapy codes include time as a component of the code, the total time or the start and stop times of the psychotherapy should be noted in the medical record.

Each psychotherapy note should include the description of at least one of the techniques used to treat the patient's condition. The CPT book describes the techniques specific to psychotherapy as either insight oriented, behavior modifying, and/or supportive techniques. Providers should also include how the patient benefited by the therapy in reaching his or her goals. For example, a note might state, "Supportive psychotherapy was utilized to help alleviate the patient's depression." The major theme of the discussion should also be recorded with consideration to the patient's privacy.

Documentation should specify whether this is a single episode or recurrent, the current degree of depression, the presence of psychotic features or symptoms, and remission status (i.e., partial, full) when applicable.

Documentation should clearly state the reasons requiring interactive complexity when separately reported.

Reimbursement Tips

Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

Most payers will not cover psychotherapy services that are palliative or provided only to maintain functioning level.

These procedures may be performed by a physician or other qualified health care professional. Check with the specific payer to determine coverage. Site of service does not affect code assignment. Assignment of benefits is required when these services are provided by a clinical social worker. Medicare payment is at 75 percent of the physician fee schedule when these services are provided by a clinical social worker.

ICD-10-CM Diagnostic Codes

F04	Amnestic disorder due to known physiological condition
F05	Delirium due to known physiological condition
F06.0	Psychotic disorder with hallucinations due to known physiological condition
F06.2	Psychotic disorder with delusions due to known physiological condition
F06.31	Mood disorder due to known physiological condition with depressive features
F06.32	Mood disorder due to known physiological condition with major depressive-like episode
F06.33	Mood disorder due to known physiological condition with manic features
F06.34	Mood disorder due to known physiological condition with mixed features
F06.4	Anxiety disorder due to known physiological condition
F06.8	Other specified mental disorders due to known physiological condition
F07.0	Personality change due to known physiological condition
F10.10	Alcohol abuse, uncomplicated
F10.11	Alcohol abuse, in remission
F10.120	Alcohol abuse with intoxication, uncomplicated
F10.121	Alcohol abuse with intoxication delirium
F10.131	Alcohol abuse with withdrawal delirium

90863

+ ★**90863** Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)

Explanation

The patient's medications are managed during a psychiatric service, including the patient's current use of medicines, a medical review of the benefits and treatment progression, management of side effects, and review or change of prescription. This is a pharmacologically related service and is reported in addition to noncrisis related psychotherapy when there is no other evaluation and management service performed during the encounter.

Coding Tips

This procedure may be performed by a physician or other qualified healthcare professional.

The appropriate psychotherapy code without evaluation and management (E/M) service (90832, 90834, or 90837) should be reported in addition to 90863. Do not report with an evaluation and management code as the service is included as part of the E/M code. When determining the appropriate psychotherapy code to be reported with this procedure, any time spent providing the medication management should be excluded. For example, if the patient is seen for 45 minutes, and 15 minutes is spent performing medication management, 90832 Psychotherapy, 30 minutes with patient and/or family, and 90863 are reported. Report codes 95970 and 95976–95977 for electronic analysis of vagal nerve neurostimulators, with programming, when performed.

Documentation Tips

The written plan for care should include treatments and medications—specifying frequency and dosage, any referrals and consultations, patient and family education, and specific instructions for follow-up.

Reimbursement Tips

Telemedicine services may be reported by the performing provider by adding modifier 95 to this procedure code and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

This/these CPT code(s) are add-on code(s). See the primary procedure code that this code is performed with for your ICD-10-CM code selections.

Associated HCPCS Codes

H0034 Medication training and support, per 15 minutes

AMA: 90863 2020,Aug,3; 2018,Nov,3; 2018,Jul,12; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90863	0.48	0.23	0.04	0.75
Facility RVU	**Work**	**PE**	**MP**	**Total**
90863	0.48	0.19	0.04	0.71

	FUD	Status	MUE	Modifiers				IOM Reference
90863	N/A	I	1(3)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

medication management. Monitoring and adjusting the use of medications for the treatment of a mental disorder.

medications. Drugs and biologicals that an individual is already taking, that are ordered for the individual during the course of treatment, or that are ordered for an individual after treatment has been provided.

pharmacological agent. Drug used to produce a chemical effect.

psychotherapy. Treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

[96127]

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

Explanation

The physician or other health care professional performs a brief assessment of the patient's emotions and behaviors associated with conditions such as depression or attention-deficit/hyperactivity disorder (ADHD) using an inventory or scale method. The screening is used to determine whether the patient requires additional workup or treatment. This code includes scoring and documentation by standardized instrument.

Coding Tips

For a mini-mental status examination, see the appropriate level of evaluation and management service. For developmental screening, see 96110.

Do not report this service with adaptive behavior assessment/treatment services (97151–97158, 0362T, and 0373T).

Documentation Tips

Documentation may include the completion of standardized tools that include scoring.

Reimbursement Tips

Medicare has provisionally identified this code as a telehealth/telemedicine service. Current Medicare coverage guidelines, including place of service, should be reviewed. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to this procedure code and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

F06.31 Mood disorder due to known physiological condition with depressive features

F06.32 Mood disorder due to known physiological condition with major depressive-like episode

F32.0 Major depressive disorder, single episode, mild

F32.1 Major depressive disorder, single episode, moderate

F32.2 Major depressive disorder, single episode, severe without psychotic features

F32.3 Major depressive disorder, single episode, severe with psychotic features

F32.4 Major depressive disorder, single episode, in partial remission

F32.5 Major depressive disorder, single episode, in full remission

F32.89 Other specified depressive episodes

F33.0 Major depressive disorder, recurrent, mild

F33.1 Major depressive disorder, recurrent, moderate

F33.2 Major depressive disorder, recurrent severe without psychotic features

F33.3 Major depressive disorder, recurrent, severe with psychotic symptoms

F33.41 Major depressive disorder, recurrent, in partial remission

F33.42 Major depressive disorder, recurrent, in full remission

F33.8 Other recurrent depressive disorders

F90.0 Attention-deficit hyperactivity disorder, predominantly inattentive type

F90.1 Attention-deficit hyperactivity disorder, predominantly hyperactive type

F90.2 Attention-deficit hyperactivity disorder, combined type

F90.8 Attention-deficit hyperactivity disorder, other type

F98.8 Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence P

Z13.31 Encounter for screening for depression

Z13.32 Encounter for screening for maternal depression ♀

Z13.39 Encounter for screening examination for other mental health and behavioral disorders

Z13.89 Encounter for screening for other disorder

AMA: **96127** 2018,Oct,5; 2018,Nov,3; 2018,Jan,8; 2018,Feb,11; 2018,Apr,9; 2017,Jan,8; 2017,Feb,14; 2016,Jan,13; 2015,Aug,5

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
96127	0.0	0.13	0.01	0.14
Facility RVU	**Work**	**PE**	**MP**	**Total**
96127	0.0	0.13	0.01	0.14

	FUD	Status	MUE	Modifiers				IOM Reference
96127	N/A	A	2(3)	N/A	N/A	N/A	80*	None

* with documentation

Terms To Know

assessment. Process of reviewing a patient's health status, including collecting and studying information and data such as test values, signs, and symptoms.

attention deficit disorder. Syndrome characterized by short attention span, distractibility, and overactivity without significant disturbance of conduct or delay in specific skills.

depression. Disproportionate depressive state with behavior disturbance that is usually the result of a distressing experience and may include preoccupation with the psychic trauma and anxiety.

other qualified health care professional. Individual who is qualified by education, training, licensure/regulation, and facility privileging to perform a professional service within his or her scope of practice and independently (or as incident-to) report the professional service without requiring physician supervision. Payers may state exemptions in writing or state and local regulations may not follow this definition for performance of some services. Always refer to any relevant plan policies and federal and/or state laws to determine who may perform and report services.

screening test. Exam or study used by a physician to identify abnormalities, regardless of whether the patient exhibits symptoms.

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

G0176

G0176 Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)

Explanation

Activity therapy is therapeutic activity such as music, dance, art, or play therapies not for recreation. The activities are related to the care and treatment of a patient's disabling mental health problems and are intended to alter the thought process of a patient in a positive way. Each session should last 45 minutes or more.

Coding Tips

For the use of play equipment, other physical devices, or a translator to communicate with a patient as a means to overcome communication barriers, see 90785.

Documentation Tips

Documentation should clearly indicate the type of interactive methods used, such as the use of play, or physical device used, and that the patient did not have the ability to communicate through normal verbal means. The duration, frequency, goals, and functional outcomes should be recorded.

Reimbursement Tips

This service is for outpatient reporting and is not paid under the Medicare physician fee schedule. Special coverage instructions apply to this service. Check with third-party payers to determine their specific requirements.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0176	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0176	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
G0176	N/A	X	-	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

interactive psychotherapy. Use of physical aids and nonverbal communication to overcome barriers to therapeutic interaction between a clinician and a patient who has not yet developed or has lost either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he or she were to use ordinary adult language for communication.

G0177

G0177 Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)

Explanation

Training and educational services are therapeutic procedures related to the care and treatment of a patient's disabling mental health problems. The goal is to alleviate patient discomfort and allow the patient to cope or control mental health issues. Each session should be 45 minutes or more.

Coding Tips

For training of activities of daily living, see 97535 and 99509. For cognitive skills training, see 97129–97130. For community or work reintegration, see 97537.

Documentation Tips

Documentation should clearly indicate the type of training and educational services provided and it should demonstrate that the services directly relate to the patient's disabling mental health problems. The duration of the training and/or educational services should be recorded including start and stop times with a total period of time of 45 minutes or more involved for these services.

Reimbursement Tips

This service is for both partial hospital and outpatient mental health program reporting and is not paid under the Medicare physician fee schedule. Special coverage instructions apply to this service. Check with third-party payers to determine their specific requirements.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0177	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0177	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
G0177	N/A	X	0(3)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

mental or nervous. Payer term for services rendered to members for emotional problems or chemical dependency.

therapeutic. Act meant to alleviate a medical or mental condition.

N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

Correct Coding Initiative Update

❖Indicates Mutually Exclusive Edit

0362T 0403T, 0488T, 36591-36592, 96105-96110, 96125-96127, 96160-96161, 96523, 97152

0373T 0403T, 0488T, 36591-36592, 96105-96110, 96116, 96125-96127, 96523

0591T 0362T, 0373T, 0403T, 0469T, 0488T, 36591-36592, 90839, 90845, 92002-92014, 93000-93010, 93040-93042, 93792, 93793, 94002-94004, 94660-94662, 95851-95852, 96116, 96127, 96158-96159, 96164-96171, 96523, 97151, 97153-97172, 97802-97804, 99091, 99172-99173, 99174, 99177, 99202-99215❖, 99281-99285❖, 99304-99310❖, 99315-99318❖, 99324-99328❖, 99334-99337❖, 99341-99350❖, 99446-99449, 99451-99452, G0250, G0270-G0271, G0380-G0384❖, G0444, G0459, G0463❖

0592T 0362T, 0373T, 0403T, 0469T, 0488T, 0591T, 36591-36592, 90839, 90845, 92002-92014, 93000-93010, 93040-93042, 93792, 93793, 94002-94004, 94660-94662, 95851-95852, 96116, 96127, 96164-96171, 96523, 97151, 97153-97172, 97802-97804, 99091, 99172-99173, 99174, 99177, 99202-99215❖, 99281-99285❖, 99304-99310❖, 99315-99318❖, 99324-99328❖, 99334-99337❖, 99341-99350❖, 99446-99449, 99451-99452, G0250, G0270-G0271, G0380-G0384❖, G0444, G0459, G0463❖

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0702T No CCI edits apply to this code.

0703T No CCI edits apply to this code.

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80305 0119U, 80500-80502, 81000-81003, 81005, 82542, 82570, 83516-83520, 83789, 83986, 84156, 84311, 96523

80306 0119U, 80305, 80500-80502, 81000-81003, 81005, 82542, 82570, 83516-83520, 83789, 83986, 84156, 84311, 96523

80307 0116U❖, 0119U, 80305-80306, 80500-80502, 81000-81003, 81005, 82542, 82570, 83516-83520, 83789, 83986, 84156, 84311, 96523

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90785 0362T, 0373T, 36591-36592, 96164-96165, 96523, 97151-97157

90791 0362T, 0373T, 0591T-0593T, 36591-36592, 90832-90834, 90836-90840, 90845-90853, 90863-90870, 90875-90889, 96116, 96127, 96156-96171,