

# Behavioral Health Services

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

**2021**

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# Contents

<b>Getting Started with Coding and Payment Guide</b> .....	<b>1</b>	Psychotherapy, Other .....	53
CPT Codes .....	1	Other Psychiatric Services or Procedures.....	76
ICD-10-CM .....	1	Central Nervous System, Assessments/Tests.....	122
Detailed Code Information .....	1	Physical Medicine and Rehabilitation.....	173
Appendix Codes and Descriptions .....	1	Non-Face-to-Face Nonphysician Services .....	181
CCI Edit Updates .....	1	Home Health Procedures/Services .....	184
Index .....	1	Adaptive Behavior Assessments .....	185
General Guidelines .....	1	Adaptive Behavior Treatment .....	192
Sample Page and Key .....	1	Category III .....	206
Reimbursement.....	4	HCPCS Level II .....	214
Medical Records.....	4	Appendix.....	220
<b>Procedure Codes</b> .....	<b>5</b>	<b>Correct Coding Initiative Update (25.3).....</b>	<b>245</b>
Structure of the CPT Book .....	5		
CPT Coding Conventions .....	5	<b>CPT Index.....</b>	<b>255</b>
Unlisted Procedures and Modifiers .....	5		
<b>Behavioral Health Procedure Codes</b> .....	<b>11</b>	<b>Medicare Official Regulatory Information</b> .....	<b>259</b>
E/M Services .....	11	The CMS Online Manual System .....	259
Interactive Complexity .....	37	Pub. 100 References .....	259
Psychiatric Diagnostic Procedures.....	38		
Psychotherapy .....	46	<b>Glossary .....</b>	<b>283</b>

Sample

# 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 management 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, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

## 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 Edit Updates

The *Coding and Payment Guide* series 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 the most current version available at press time. The CCI edits are now located in a section at the back of the book. Optum360 maintains a website to accompany the *Coding and Payment Guide* series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is <https://www.optum360coding.com/ProductUpdates/>. The 2021 edition password is: XXXXXX. Log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

## 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.

# Procedure Codes

The Physicians' 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.

## 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.

Before choosing an unlisted procedure code, carefully review the CPT code list to ensure that a more specific code is not available. Also, check for a HCPCS Level II code if these codes are acceptable to the third-party payer. Unlisted codes are found at the end of the section or subsection of codes and most often end in "99." For example:

#### 90899 Unlisted psychiatric service or procedure

Whenever an unlisted code is reported, it is necessary to include a descriptive narrative of the procedure performed in item 19 of the CMS-1500 claim form, as long as it can be adequately explained in the space provided.

Payers generally require additional documentation (e.g., progress notes, operative notes, consultation report, or history and physical) before considering claims with unlisted procedure codes.

### Modifiers

The CPT coding system also includes modifiers that can be added to codes to describe extenuating or special circumstances or to provide additional information about a procedure that was performed, or a service or supply that was provided. Addition of the modifier does not alter the basic description for the service; it merely qualifies the

# 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

Interactive complexity is to be reported with psychiatric evaluation services (90791–90792), the appropriate psychotherapy code (90832, 90834, or 90837), psychotherapy with evaluation and management services (90833, 90836, 90838, 99201–99255, 99304–99337, and 99341–99350), and group psychotherapy service (90853).

These codes should never be reported with psychotherapy for crisis (90839–90840), an evaluation and management service that was provided without psychotherapy (90833, 90836, 90838), or adaptive behavior assessment/treatment services (97151–97158, 0362T, and 0373T).

## 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

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 2018,Nov,3; 2018,Jul,12; 2018,Jan,8; 2018,Apr,9; 2017,Jan,8; 2016,Jan,13; 2016,Dec,11; 2015,Jan,16; 2013,May,12; 2013,Jun,3-5

## Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90785	0.33	0.08	0.01	0.42
Facility RVU	Work	PE	MP	Total
90785	0.33	0.05	0.01	0.39

	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.** Code representing a procedure performed in addition to the primary procedure and is represented with a + in the CPT book. Add-on codes are never reported for stand-alone services 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.

# 99510

**99510** Home visit for individual, family, or marriage counseling

## Explanation

A home health professional makes an initial visit to the home to evaluate specific needs. If home health care would be of benefit, a plan of care is developed based on medical orders from the patient's provider. For example, a plan might specify one or more visits from a therapist. The provider regularly reviews progress reports.

## Coding Tips

This code is for use by the nonphysician provider. For physician services, see the evaluation and management (E/M) home visits (99341–99350), individual psychotherapy (90832–90840), family psychotherapy (90846–90847), and group psychotherapy (90849–90853). Those nonphysician providers who may report E/M codes may report an E/M service with this code when the E/M service is significant and separately identifiable. Medical record documentation must support the use of both codes.

## Reimbursement Tips

Medicare and other third-party payers may not provide coverage for this service. Check with the payer to determine coverage requirements.

## ICD-10-CM Diagnostic Codes

R41.83	Borderline intellectual functioning
Z32.2	Encounter for childbirth instruction
Z32.3	Encounter for childcare instruction
Z60.0	Problems of adjustment to life-cycle transitions
Z60.8	Other problems related to social environment
Z63.4	Disappearance and death of family member
Z64.4	Discord with counselors
Z65.4	Victim of crime and terrorism
Z65.8	Other specified problems related to psychosocial circumstances
Z69.81	Encounter for mental health services for victim of other abuse
Z70.0	Counseling related to sexual attitude
Z70.1	Counseling related to patient's sexual behavior and orientation
Z70.2	Counseling related to sexual behavior and orientation of third party
Z70.3	Counseling related to combined concerns regarding sexual attitude, behavior and orientation
Z70.8	Other sex counseling
Z71.41	Alcohol abuse counseling and surveillance of alcoholic
Z71.42	Counseling for family member of alcoholic
Z71.51	Drug abuse counseling and surveillance of drug abuser
Z71.52	Counseling for family member of drug abuser
Z71.6	Tobacco abuse counseling
Z71.7	Human immunodeficiency virus [HIV] counseling
Z71.81	Spiritual or religious counseling
Z71.89	Other specified counseling
Z73.3	Stress, not elsewhere classified
Z73.6	Limitation of activities due to disability

**AMA:** 99510 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11

## Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
<b>99510</b>	0.0	0.0	0.0	0.0
Facility RVU	Work	PE	MP	Total
<b>99510</b>	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
<b>99510</b>	N/A	I	0(3)	N/A	N/A	N/A	N/A	None

\* with documentation

## Terms To Know

**counseling.** Discussion with a patient and/or family concerning one or more of the following areas: diagnostic results, impressions, and/or recommended diagnostic studies; prognosis; risks and benefits of management (treatment) options; instructions for management (treatment) and/or follow-up; importance of compliance with chosen management (treatment) options; risk factor reduction; and patient and family education.

**evaluation.** Dynamic process in which the clinician makes clinical judgments based on data gathered during the examination.

**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.

# G0442-G0443

**G0442** Annual alcohol misuse screening, 15 minutes

**G0443** Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

## Explanation

Screening and behavioral counseling interventions are used to identify and reduce alcohol misuse.

## Coding Tips

For alcohol abuse structured assessment, see 99408–99409 or HCPCS Level II codes G0396–G0397. For alcohol assessment, see H0001. Code H0001 is not valid for payment under the Medicare physician fee schedule.

## Documentation Tips

Alcohol dependence (i.e., alcoholism) is a chronic disorder characterized by large or frequent consumption of ethanol in which the individual becomes physically and mentally dependent upon to function. Long-term consequences are physical, psychological, and behavioral, some of which are liver disease, undernutrition with electrolyte disorders and vitamin deficiencies, coagulopathy, depression, dementia, psychosis, heart disease, and violent behavior. Criterion denoting dependence is increased tolerance and continued use despite impairment of health, social life, and job performance. Cessation results in withdrawal symptoms, including early seizures.

The provider must state the pattern of harmful usage (i.e., dependence, abuse, or use) and its current clinical state (e.g., uncomplicated, intoxication, remission, etc.) and indicate the relationship to any identified mental, behavioral, or physical disorder, or its relevance to the patient's status or encounter including its clinical significance.

## Reimbursement Tips

Check with third-party payers to determine their reporting requirements.

## ICD-10-CM Diagnostic Codes

- F10.10 Alcohol abuse, uncomplicated
- F10.120 Alcohol abuse with intoxication, uncomplicated
- F10.121 Alcohol abuse with intoxication delirium
- 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
- F10.180 Alcohol abuse with alcohol-induced anxiety disorder
- F10.181 Alcohol abuse with alcohol-induced sexual dysfunction
- F10.182 Alcohol abuse with alcohol-induced sleep disorder
- F10.188 Alcohol abuse with other alcohol-induced disorder
- F10.20 Alcohol dependence, uncomplicated
- F10.21 Alcohol dependence, in remission
- F10.220 Alcohol dependence with intoxication, uncomplicated
- F10.221 Alcohol dependence with intoxication delirium
- F10.230 Alcohol dependence with withdrawal, uncomplicated
- F10.231 Alcohol dependence with withdrawal delirium
- F10.232 Alcohol dependence with withdrawal with perceptual disturbance
- F10.24 Alcohol dependence with alcohol-induced mood disorder

- F10.250 Alcohol dependence with alcohol-induced psychotic disorder with delusions
- F10.251 Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
- F10.26 Alcohol dependence with alcohol-induced persisting amnesic disorder
- F10.27 Alcohol dependence with alcohol-induced persisting dementia
- F10.280 Alcohol dependence with alcohol-induced anxiety disorder
- F10.281 Alcohol dependence with alcohol-induced sexual dysfunction
- F10.282 Alcohol dependence with alcohol-induced sleep disorder
- F10.288 Alcohol dependence with other alcohol-induced disorder

## Associated CPT Codes

- 99408 Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
- 99409 Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes

## Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
<b>G0442</b>	0.18	0.32	0.01	0.51
<b>G0443</b>	0.45	0.26	0.03	0.74
Facility RVU	Work	PE	MP	Total
<b>G0442</b>	0.18	0.08	0.01	0.27
<b>G0443</b>	0.45	0.19	0.03	0.67

	FUD	Status	MUE	Modifiers			IOM Reference	
<b>G0442</b>	N/A	A	1(2)	N/A	N/A	N/A	80*	None
<b>G0443</b>	N/A	A	1(2)	N/A	N/A	N/A	80*	

\* with documentation

## Terms To Know

### alcohol abuse with alcohol-induced psychotic disorder with hallucinations.

Psychosis lasting less than six months with slight or no clouding of consciousness in which auditory hallucinations predominate.

**behavior management.** Education and modification techniques or methodologies aimed at helping a patient change undesirable habits or behaviors.

**counseling.** Discussion with a patient and/or family concerning one or more of the following areas: diagnostic results, impressions, and/or recommended diagnostic studies; prognosis; risks and benefits of management (treatment) options; instructions for management (treatment) and/or follow-up; importance of compliance with chosen management (treatment) options; risk factor reduction; and patient and family education.

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

## 99026-99027

**99026** Hospital mandated on call service; in-hospital, each hour

**99027** out-of-hospital, each hour

### Explanation

These codes report the time for hospital mandated on call service provided by the physician and do not include prolonged physician attendance time for standby services or the time spent performing other reportable procedures or services. Report 99026 for each hour of hospital mandated on call service spent in the hospital and 99027 for each hour of hospital mandated on call service spent outside the hospital.

### Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99026	0.0	0.0	0.0	0.0
99027	0.0	0.0	0.0	0.0
Facility RVU	Work	PE	MP	Total
99026	0.0	0.0	0.0	0.0
99027	0.0	0.0	0.0	0.0

## 99050

**99050** Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service

### Explanation

This code is adjunct to basic services rendered. The physician reports this code to indicate services after posted office hours in addition to basic services.

### Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99050	0.0	0.0	0.0	0.0
Facility RVU	Work	PE	MP	Total
99050	0.0	0.0	0.0	0.0

## 99051

**99051** Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service

### Explanation

This code is adjunct to basic services rendered. The physician reports this code to indicate services provided during posted evening, weekend, or holiday office hours in addition to basic services.

### Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99051	0.0	0.0	0.0	0.0
Facility RVU	Work	PE	MP	Total
99051	0.0	0.0	0.0	0.0

## 99053

**99053** Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service

### Explanation

This code is adjunct to basic services rendered. The physician reports this code to indicate services provided between 10 p.m. and 8 a.m. at a 24-hour facility in addition to basic services.

### Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99053	0.0	0.0	0.0	0.0
Facility RVU	Work	PE	MP	Total
99053	0.0	0.0	0.0	0.0

## 99056

**99056** Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service

### Explanation

This code is adjunct to basic services rendered. The physician reports this code to indicate services typically provided in the office that are provided in a different location at the request of a patient.

### Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99056	0.0	0.0	0.0	0.0
Facility RVU	Work	PE	MP	Total
99056	0.0	0.0	0.0	0.0

## 99058

**99058** Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service

### Explanation

This code is adjunct to basic services rendered. The physician reports this code to indicate services provided in the office on an emergency basis that disrupt other scheduled office services.

### Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99058	0.0	0.0	0.0	0.0
Facility RVU	Work	PE	MP	Total
99058	0.0	0.0	0.0	0.0

## 99060

**99060** Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service

### Explanation

This code is adjunct to basic services rendered. The physician reports this code to indicate services provided on an emergency basis in a location other than the physician's office that disrupt other scheduled office services.



**98972** No CCI edits apply to this code.

**99026** 36591-36592, 96523

**99027** 36591-36592, 96523

**99050** 36591-36592, 96523

**99051** 36591-36592, 96523

**99053** 36591-36592, 96523

**99056** 36591-36592, 96523

**99058** 36591-36592, 96523

**99060** 36591-36592, 96523

**99070** 36591-36592, 96523

**99071** 36591-36592, 96523

**99075** 36591-36592, 96523

**99078** 36591-36592, 96523

**99080** 36591-36592, 96523

**99082** 36591-36592, 96523

**99201** 0362T, 0373T, 0469T, 36591-36592, 43752, 80500-80502, 90863, 90940, 92002-92014, 92227-92228, 92531-92532, 93561-93562, 93792, 93793, 94002-94004, 94660-94662, 95831-95834, 95851-95852, 96020, 96105, 96116, 96125, 96130, 96132, 96136, 96138, 96146-96154, 96523, 97151, 97153-97158, 97802-97804, 99091, 99172-99173, 99174, 99177, 99211-99215, 99408-99409, 99446-99449, 99451-99452, 99605-99606, G0102-G2011

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