

CLINIC TREATMENT FACILITIES

14 NYCRR PART 679

(CL) ACTIVITIES/TABS CODING GUIDELINES

JANUARY 2004

REVISION 12

**Office of Mental Retardation and Developmental Disabilities
Division of Revenue Support**

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES

BILLABLE CL ACTIVITIES

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CLINIC TREATMENT FACILITIES (PART 679)
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INTRODUCTION

A. OVERVIEW

THE CLINIC (CL) ACTIVITIES/TABS CODING GUIDELINES (Revision 12) reflect the latest approved BILLABLE and NON-BILLABLE CL Codes used to report clinical services delivered by clinicians formally assigned to a Clinic Treatment Facility including voluntary operated satellites (also known as clinic joint ventures) certified under Part 679.

- BILLABLE CL Codes represent those activities that are CLAIMABLE under PART 679.
- NON-BILLABLE CL Codes represent those activities necessary or related to the provision of clinical services but are NOT claimable. However, the costs associated with these NON-BILLABLE activities are part of the cost of operating the clinic.
- Activities reporting (via TABS) should be completed as timely as possible but no less than weekly. If more than one (1) activity or service is provided as part of an encounter, the clinician should report each CL activity using the appropriate CL code and duration.
- No GN Codes should be reported as part of Clinic activity reporting.
- Only CL Codes should be used for reporting services provided in a Part 679 Clinic.
- Do not report the CPT Codes reflected in the parentheses preceding the code description.
- CL Codes and CPT codes are crosswalked in TABS for billing other payors.

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B. CODING ISSUES

Supporting Documentation

One of the most important issues related to coding and billing is that you have clinical record support for the procedures and/or services you report in TABS.

Although documentation is a NON-BILLABLE activity, it is essential in supporting BILLABLE activities.

Use the following list to review documentation policies, procedures and standards of practice.

- Are your clinical records maintained in a current, uniform, legible and consistent manner?
- Do all entries include the date, start and end time (“clock time”), clinician name, chief complaint (presenting problem), clinical findings, diagnosis or impression, tests and medications ordered, procedures performed and instructions given to the consumer?
- Are all entries signed or countersigned by the responsible clinician?

NOTE: Clinician signatures should be in accordance with their license as issued by the State Education Department.

- Are consultations and advice given to consumers by telephone documented accurately and consistently?
- Do your entries clearly document the need for the level of service for which you are recording?
- Does the working diagnosis (i.e., ICD-9-CM code) clearly support the need for the procedures or services provided?

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Special Medicare Considerations

To satisfy Medicare requirements, there must be sufficient documentation in the medical record to verify the services billed and the level of care required. Section 1833(e) of Title XVIII, Social Security Act requires “available information that documents a claim.” If there is no documentation to justify the services or level of care, the claim cannot be considered for Medicare benefits.

If there is insufficient documentation to support claims that have already been paid by Medicare, the reimbursement will be considered an overpayment and a refund will be requested by Medicare. Medicare has the authority to review any information, including medical records, when such information pertains to a Medicare claim.

Please refer to current CPT manual documentation guidelines.

Medicare Website Documentation Guidelines

www.hcfa.gov and use the search engine to find the guidelines.

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C. BILLABLE CL ACTIVITIES

- Billable CL Activity Duration is defined as the clinician time spent by the clinician providing DIRECT HANDS-ON CONSUMER CARE or DIRECT CONSUMER CONTACT. Total BILLABLE DURATION determines which TYPE of clinic visit will be CLAIMED in accordance with Part 679. Contact time also includes OBSERVATION time associated with the clinical intervention.
- Non-consumer contact time associated with documentation, administrative or other non-billable activities are reported using the CL9000 coding series on page 16.0.
- If a clinician begins to provide a clinical service to a consumer and the consumer refuses to stay, becomes disruptive or a piece of equipment fails, etc., thus preventing the completion of the service delivery, the ACTUAL time spent with the consumer should be recorded as a BILLABLE CL activity. The clinician should use the appropriate CL Code for the service which was to be rendered. These activities are claimable since there was an "INTENT" to provide the service. This situation needs to be clearly documented in the record to prevent claiming disallowances.
- When selecting ICD-9-CM diagnostic codes, clinicians* will be describing the consumer condition which may include diagnosis as well as symptoms, problems, complaints, or other reasons for the encounter. All clinicians must utilize ICD-9-CM coding to the highest level of specificity when reporting CL services. The ICD-9-CM Diagnostic Code reported should be related to the PRIMARY reason the service was provided. If for some reason this cannot be done, the hierarchy for determining what ICD-9-CM code is as follows:

- 1st: Current (as related to the services provided);
- 2nd: Last known or
- 3rd: MR/DD (Last Resort!)

- * Only a licensed physician, psychiatrist, nurse practitioner or licensed psychologist may issue a formal diagnosis using ICD-9, DSM-IV or other standardized diagnostic coding. Procedure codes are another matter, and are within the purview of the licensed/certified practitioner of the healing arts.

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NOTES:

1. Comprehensive (Discipline Specific) Diagnostic and Evaluation Visit - A single claimed clinic visit (which may require more than one encounter) during which the person receives from a single discipline specific professional, a full range comprehensive assessment protocol sufficient in scope to completely describe and analyze the person's functional status, needs for service and treatment recommendations in that clinical area. Payment for said visit shall include assignment of a treatment coordinator and preparation of a written report setting forth findings and recommendations, forwarding of the report to the referral source and consultation with the referral source, if requested. A provider may claim only one discipline specific assessment visit per discipline per year. The duration of contact and/or observation shall be at least two hours. [Part 679.5(c)(6)]
2. Medicare and Third Party Health Insurance require as part of a testing service that reports of results be completed. For clinic reporting, do not include the time spent in report preparation as part of the billable duration. It should be reported as a NON-BILLABLE service.
3. A ► listed below a billable CL Code represents a key component or an example of a clinical face-to-face intervention which must be provided by a clinician.
4. Nursing/Vaccine Services (CL Codes)
Both the Administration and Vaccine codes MUST be reported together.

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D. MEDICARE/THIRD PARTY HEALTH INSURANCE

Medicare and Third Party Health Insurance (TPHI) are billed using Current Procedural Terminology (CPT) codes which were developed by the American Medical Association. The CPT code which is used for Medicare and TPHI billing is identified in parentheses within the CL code descriptor. Medicare and TPHI billing will occur whenever the CL ACTIVITY CODE, CONSUMER and CLINICIAN are eligible. The appropriateness of a claim is automatically determined based on edits in TABS. All payments received from Medicare or TPHI are credited against the monthly Medicaid claims, eliminating the potential of double reimbursement.

Medicare Eligible Clinicians

- Medical Doctors/Specialists
- Psychiatrists
- Physician Assistants
- Nurse Practitioners
- Licensed Psychologists
- Licensed Social Workers
- Audiologists

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E. “CLAIMABLE” SERVICES VS. “ALLOWABLE” SERVICES

It is important to note the distinction between “allowable” services and “claimable” services. Not all allowable services are claimable for reimbursement, but **ALL** claimable services must be considered allowable. Thus, medical direction and treatment coordination are allowable services pursuant to Part 679. However, such services **MAY NOT** be claimed for reimbursement regardless of their duration, therapeutic potency, or the qualifications of the personnel providing such services.

In general, the following rules apply in determining the legitimacy of submitting a claim for reimbursement. Failure to ensure that all submitted claims conform to these rules could subject the clinic provider to potential future disallowance should there be a CMS look-behind audit.

- **Has a physician deemed the service “medically necessary?”** Note: The sign-off on the treatment plan by the medical director is viewed (by both CMS and OMRDD regulations) as equivalent to this determination.
- **Must the service be delivered by a licensed/certified clinician in a face-to-face contact with the service recipient(s)?** Again, legitimacy of the service is enhanced if the record clearly indicates that, given the consumer’s condition (either overall or in the specific need instance) and the nature of the activity(ies), (including decisions concerning the most appropriate use of either individual or group visits) a qualified clinician is the most appropriate service provider.
- **Is the service within the scope of generally accepted community practice for the clinical discipline designated most appropriate to deliver the service?** This criterion means more than the staff provider having some training and/or interest in providing the service. Rather, it means that the service/intervention requires the professional skills traditionally taught as part of the typical curriculum underlying the staff’s eligibility for, and holding of licensure/certification in his/her designated discipline.

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- **Is there clear linkage specified in the treatment plan between the frequency and type of the service being recommended and delivered, and the consumer's level of participation?** In other words, it is clear from each of the treatment records of the consumer(s) being served that:
 1. The need for the service(s) is supported by a current individualized assessment.
 2. The nature of the intervention is individually tailored.
 3. The frequency, scope and duration of the service reflect each person's needs given the identified specific outcomes to be achieved.

Underlying the above rules is the overall context of the purpose of a Part 679 Clinic Treatment Facility as a provider of habilitation services. As emphasized in §679.1(d) and (d)(1):

“The purpose of a clinic treatment facility is ... providing clinical services of principally a habilitative clinical nature to ameliorate or limit the disabling condition or other disease, illness, or condition through the provision of professional assessments and therapies, to persons, who because of their developmental disability, require such services to remain in or move to the least restrictive residential and/or day setting; or because such services are unavailable or inaccessible in the person's community.” (Emphasis added.)

(Excerpt from JPO memorandum dated 3/28/97)

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F. NON-BILLABLE ACTIVITIES

- All clinicians are to report NON-BILLABLE activities. All the same data elements are required for reporting NON-BILLABLE activities. NON-BILLABLE activities reported are linked to the specific consumer.
- Clinical time associated with preparation of written reports as defined in Part 679.5(6) (i)(ii) (Comprehensive and Diagnostic Evaluation Units) should NOT be included in the DURATION time reported as a BILLABLE service. Report writing should be recorded as a NON-BILLABLE service.
- NURSING TIME ADMINISTERING/GIVING/APPLYING A MEDICATION, TOPICAL OINTMENT OR LOTION ROUTINELY (INCLUDING ROUTINE INSULIN INJECTIONS) IS NOT A CLAIMABLE SERVICE.

G. TABS REPORTS

The following Clinic CL activity reports are currently available from TABS. These reports should be run routinely to monitor and analyze clinician activities reporting.

- ◆ AR9 ACTIVITIES BY STAFF
- ◆ AR16 ACTIVITY/CLINICIAN SERVICE REPORT
- ◆ AR18 ACTIVITY AND PHYSICIAN/CLINIC SERVICE REPORT
- ◆ AR21 CLINIC ACTIVITIES BY THERAPY REPORT
- ◆ AR22 CLINIC MANAGEMENT REPORT
- ◆ POTENTIAL CLINIC REVENUE REPORT (aka "CONTROL" Report)

H. CENTRAL OFFICE CONTACTS (Bureau of Central Operations)

- ◆ Dennis Collins (COLLINDM)
- ◆ Joe Meloveck (MELOVEJJ)

Telephone Number: (518) 402-4333

CLINIC TREATMENT FACILITIES (PART 679)
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GENERAL

CODE

CL0001 INTAKE VISIT

A clinician INTAKE VISIT consists of a preliminary clinical interview or assessment of at **LEAST 30 MINUTES** duration of the potential admittee (new consumer) his or her collateral, and/or the referral source by or under the supervision of a licensed professional and/or other "authorized party" (Part 679.99(n)) pursuant to this part, for determining the appropriateness of admissions.

NOTE: If any additional clinical service is provided, the appropriate service (CL) codes(s) should be reported accordingly.

CL0002 ONGOING TREATMENT REVIEW

A billable clinic service consists of a clinical review, assessment or interview of the consumer present to evaluate the need for continued treatment (established consumer) as prescribed or to modify the current treatment plan accordingly. See Part 679.4 (k).

NOTE: If the above service is provided **WITHOUT** the consumer present, this service is a non-billable service.

If any additional clinical service is provided, the appropriate (CL) should be reported.

If the above service is provided to his or her collateral as defined in Part 679.99 (f), this service should be reported as a **COLLATERAL** service.

CL0003 COLLATERAL SERVICE

Part 679.5(c)(5)

A period of counseling lasting at **LEAST 30 MINUTES** duration provided to the collateral(s) of the appropriately admitted person relative to his or her needs, by a licensed/certified professional and/or those authorized pursuant to Part 679.3(m), or other authorized parties as defined pursuant to this Part.

CL0004 **GROUP COLLATERAL VISIT** (3-12 collaterals: 18 years old or older minimum 45 minutes; less than 18 years old minimum 30 minutes.

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OCCUPATIONAL THERAPY

CODE

- CL0010** (97003) **COMPREHENSIVE (DISCIPLINE SPECIFIC) DIAGNOSTIC AND EVALUATION VISIT [Part 679.5(c)(6)]**
A single claimed clinic visit (which may require more than one encounter) during which the person receives from a single discipline specific professional, a full range comprehensive assessment protocol sufficient in scope to completely describe and analyze the person's functional status, needs for service and treatment recommendations in that clinical area. Payment for said visit shall include assignment of a treatment coordinator and preparation of a written report setting forth findings and recommendations, forwarding of the report to the referral source and consultation with the referral source, if requested. A provider may claim only one discipline specific assessment visit per discipline per year. The duration of contact and/or observation shall be at least two hours.
- CL0011** (97003) **INITIAL/SPECIAL ASSESSMENT**
Use of diagnostic tests when possible to establish a clear baseline or current function upon which treatment outcome(s) can be based. Evaluation-based/focused request, if not listed below.
- CL0012** (97004) **O.T. RE-EVALUATION, PERIODIC**
Re-evaluation against the baseline/initial evaluation to determine continued course of treatment.
- CL0050** (95831) **MUSCLE TESTING, MANUAL**
(Separate procedure), WITH REPORT; extremity (excluding hand) or trunk.
- CL0051** (95832) **MUSCLE TESTING, HAND**
With or without comparison with normal side.
- CL0052** (95833) **MUSCLE TESTING, TOTAL EVALUATION OF BODY, EXCLUDING HANDS**
- CL0053** (95834) **MUSCLE TESTING, TOTAL EVALUATION OF BODY, INCLUDING HANDS**

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OCCUPATIONAL THERAPY
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CODE

- CL0054 (95851) RANGE OF MOTION MEASUREMENTS AND REPORT
(Separate procedure); extremity or trunk. Excluding hand.
- CL0055 (95852) RANGE OF MOTION MEASUREMENTS AND REPORT
Hand with or without comparison to normal side.
- CL0056 (92526) EVALUATION OF SWALLOWING & ORAL FUNCTION FOR
FEEDING
- CL0057 (97010) APPLICATION OF A MODALITY TO ONE OR MORE AREAS;
HOT OR COLD PACKS
- CL0058 (97018) USE OF PARAFFIN BATHS
- CL0059 (97110) THERAPEUTIC PROCEDURE, ONE OR MORE AREAS
Therapeutic exercises to develop strength and endurance, range of motion and
flexibility.
- CL0060 (97112) NEUROMUSCULAR RE-EDUCATION OF MOVEMENT,
BALANCE, COORDINATION, KINESTHETIC SENSE, POSTURE AND/
OR PROPRIOCEPTION FOR SITTING AND/OR STANDING
ACTIVITIES
- CL0061 (97113) AQUATIC THERAPY WITH THERAPEUTIC EXERCISE
- CL0062 (97140) MANUAL THERAPY TECHNIQUES
One or more regions.
- CL0020 (97139) TREATMENT PLAN SERVICE DELIVERY
Unlisted therapeutic procedure (specify). On-going implementation of an
authorized plan which is not otherwise identified below.

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OCCUPATIONAL THERAPY
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CODE

- CL0021** (97150) **THERAPEUTIC PROCEDURE(S) GROUPS**
3-12 consumers: 18 years old or older minimum 45 minutes; less than 18 years old minimum 30 minutes.
- CL0018** (97504) **ORTHOTIC(S), FITTING & TRAINING: UPPER/LOWER EXTREMITY(ies), AND/OR TRUNK**
- CL0013** (97530) **THERAPEUTIC ACTIVITIES**
Use of dynamic activities to improve functional performance.
- CL0063** (97532) **DEVELOPMENT OF COGNITIVE SKILLS**
To improve attention, memory, problem-solving (including compensatory training)
- CL0064** (97533) **SENSORY INTEGRATIVE TECHNIQUES**
To enhance sensory processing and promote adaptive responses to environmental demands.
- CL0014** (97535) **SELF CARE/HOME MANAGEMENT TRAINING**
Instruction in use of Assistive Technology Services/Adaptive Equipment.
- CL0015** (97537) **COMMUNITY/WORK REINTEGRATION TRAINING**
Avocational activities and/or work environment analysis or modification.
- CL0016** (97542) **WHEELCHAIR MANAGEMENT/PROPULSION TRAINING**

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NURSING

CODE

CL0200

COMPREHENSIVE ASSESSMENT - NEW PATIENT

Use to report a comprehensive assessment as defined by Part 679.5(c)(6). A single claimed clinic visit (which may require more than one encounter) during which the person receives from a single discipline specific professional, a full range comprehensive assessment protocol sufficient in scope to completely describe and analyze the person's functional status, needs for service and treatment recommendations in that clinical area. Payment for said visit shall include assignment of a treatment coordinator and preparation of a written report setting forth findings and recommendations, forwarding of the report to the referral source and consultation with the referral source, if requested. A provider may claim only one discipline specific assessment visit per discipline per year. The duration of contact and/or observation shall be at least two hours. Also, report any other nursing CL codes which describe additional services using the actual duration(s).

CL0214

INITIAL/ONGOING NURSING ASSESSMENT

Nursing assessment includes a systematic gathering of relevant objective and subjective data that is collected (using appropriate assessment tools and techniques), validated, recorded and organized to determine the nature and extent of nursing problems presented by a consumer for the purpose of establishing a nursing diagnosis and a plan of nursing intervention, or the re-evaluation of a consumer to determine the need for further and/or continuing nursing intervention. Initial assessments should take into consideration all body systems without a specific problem in mind. Ongoing assessments may be focused on specific problems or body area/system.

NOTE: The comprehensive assessment and the initial/ongoing nursing assessment are **NOT** for the purposes of establishing a nursing care plan at a certified residence or family care home.

CL0201

(96110) DEVELOPMENTAL TESTING, LIMITED (DEVELOPMENTAL SCREENING TEST II, EARLY LANGUAGE MILESTONE SCREEN) WITH INTERPRETATION REPORT

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**NURSING
(continued)**

CODE

- CL0202 INTERVENTION/TREATMENT PLAN SERVICE**
An Article 16 clinic nursing service consists of a professional level service that requires the skill or direction of a registered nurse (RN) to perform. A licensed practical nurse (LPN) may provide nursing tasks within his/her scope of practice as defined by the NYS Education Department, under the direction of an RN, licensed physician, dentist, physician assistant and/or nurse practitioner directly employed by the Article 16 clinic.
- Any treatment generally considered first aid, collection of a laboratory specimen (including phlebotomy), or routine medication administration is **NOT** a reimbursable Article 16 nursing service.
 - Medication administration is a reimbursable service only when medication is administered in connection with directly observed therapy for treatment of tuberculosis or for HIV/AIDS.
 - Nursing services required by Administrative Memorandum #2003-01, Registered Nursing Supervision of Unlicensed Direct Care Staff in Residential Facilities Certified by the Office of Mental Retardation and Developmental Disabilities, and **NOT** reimbursable Article 16 nursing services.
- CL0203 (86580) SENSITIVITY TESTING (TUBERCULOUS SKIN TEST AND READING) (MANTOUX)**
- CL0213 GROUP SERVICES**
Focus is to ameliorate (make better or improve) a specific disease related problem (i.e., must be specifically related to a known or new diagnosis).* 3-12 consumers: 18 years old or older minimum 45 minutes; less than 18 years old minimum 30 minutes.

* This service excludes consumer and staff education.

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NURSING
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CODE

IMMUNIZATIONS

When reporting vaccines, two (2) CL codes are required to allow billing for each vaccine and its administration. The same duration should be reported for both CL codes. However, TABS will only roll-up one (1) duration for billing Medicaid.

Influenza virus vaccine (V04.8 is the only valid diagnosis code).

- CL0205 (90471) ADMINISTRATION OF INFLUENZA VIRUS VACCINE
- CL0204 (90657) INFLUENZA VIRUS VACCINE, SPLIT VIRUS
6-35 months dosage, for intramuscular or jet injection use.
- CL0240 (90658) INFLUENZA VIRUS VACCINE, SPLIT VIRUS
3 years and above dosage, for intramuscular or jet injection use.
- CL0241 (90659) INFLUENZA VIRUS VACCINE, WHOLE VIRUS
For intramuscular or jet injection use.
- CL0242 (90660) INFLUENZA VIRUS VACCINE, LIVE, FOR INTRANASAL USE
- CL0250 (90632) HEPATITIS A VACCINE, ADULT DOSAGE FOR IM USE
- CL0251 (90636) HEPATITIS A AND HEPATITIS B VACCINE
- CL0252 (90645) HEMOPHILUS INFLUENZA B VACCINE (Hib) hboc
CONJUGATE - INTRAMUSCULAR
- CL0253 (90646) HEMOPHILUS INFLUENZA B VACCINE (Hib) PRP-D
CONJUGATE - BOOSTER ONLY
- CL0254 (90647) HEMOPHILUS INFLUENZA B VACCINE (Hib) PRP-OMP
- CL0255 (90648) HEMOPHILUS INFLUENZA B VACCINE (Hib) PRP PRP-T

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NURSING
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CODE

- CL0256 (90665) LYME DISEASE VACCINE
- CL0257 (90703) TETANUS TOXOID ABSORBED, FOR IM
- CL0258 (90733) MENINGOCOCCAL POLYSACCHARIDE VACCINE (ANY GROUP)

ALLERGIES: PROFESSIONAL SERVICES FOR ALLERGEN IMMUNOTHERAPY

- CL0259 (95115) SINGLE INJECTION
- CL0260 (95117) TWO (2) OR MORE INJECTIONS

PNEUMOCOCCAL VACCINE (V03.82 IS THE ONLY VALID DIAGNOSIS CODE)

- CL0207 (90471) ADMINISTRATION OF PNEUMOCOCCAL VACCINE
To be used only with CL codes CL0206 and CL0243).
- CL0206 (90732) PNEUMOCOCCAL POLYSACCHARIDE VACCINE
23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use.
- CL0243 (90669) PNEUMOCOCCAL CONJUGATE VACCINE
Polyvalent, for children under five years, for intramuscular use.

HEPATITIS B VACCINE (USE HEPATITIS B CODE V05.3)

- CL0209 (90471) ADMINISTRATION OF HEPATITIS B VACCINE
To be used only with CL codes CL0208, CL0222 and CL0223.
- CL0208 (90744) HEPATITIS B VACCINE, PEDIATRIC/ADOLESCENT DOSAGE
(3 dose schedule), for intramuscular use.
- CL0222 (90746) HEPATITIS B VACCINE, ADULT DOSAGE
For intramuscular use.

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CODE

CL0223 (90747) PATIENT DOSAGE HEPATITIS B VACCINE, DIALYSIS OR IMMUNOSUPPRESSED
(4 dose schedule); for intramuscular use.

THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTIONS

CL0210 (90782) THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTION
(Specify material injected); subcutaneous or intramuscular.

CL0261 (93005) ELECTROCARDIOGRAM, ROUTINE EKG WITH 12 LEADS TRACING ONLY, WITHOUT INTERPRETATION OR REPORT

CL0262 (93041) RHYTHM EKG, 1 TO 3 LEADS, TRACING ONLY

CL0211 (90783) INTRA-ARTERIAL

CL0212 (90784) INTRAVENOUS

NOTE: CL0210, CL0211 and CL0212 do not include injections for Allergen Immunotherapy.

NURSING SUPPORT - NON-BILLABLE (CL9100)

The purpose and intent of Nursing Support (CL Code 9100) on page 16.0 is to discretely report on nursing staff time spent providing clinical assistance to Medical Consultants and/or Primary Care Physicians. The time spent by the nurse is **NOT BILLABLE** to Medicaid since the Consultant and/or Physician bills for the service provided.

NOTE: However, it should be noted that if (BILLABLE) Nursing Services are provided in addition to clinical assistance to Medical Consultants/Primary Care Physicians (before or after a medical appointment), this nursing time (DURATION) should be reported using the appropriate billable Nursing CL codes and not CL9100.

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PSYCHOLOGY

CODE

CL0400 (96100) COMPREHENSIVE (DISCIPLINE SPECIFIC) DIAGNOSTIC AND EVALUATION VISIT [Part 679.5(c)(6)]

A single claimed clinic visit (which may require more than one encounter) during which the person receives from a single discipline specific professional, a full range comprehensive assessment protocol sufficient in scope to completely describe and analyze the person's functional status, needs for service and treatment recommendations in that clinical area. Payment for said visit shall include assignment of a treatment coordinator and preparation of a written report setting forth findings and recommendations, forwarding of the report to the referral source and consultation with the referral source, if requested. A provider may claim only one discipline specific assessment visit per discipline per year. The duration of contact and/or observation shall be at least two hours.

CL0401 (96150) INITIAL/SPECIAL/RE-ASSESSMENT

Clinical assessment of the consumer to determine the biological, psychological, and social factors affecting the consumer's mental health or a re-assessment of the consumer to evaluate the consumer's condition and to determine the need for further treatment. A re-assessment may be performed by a clinician other than the one who conducted the consumer's initial assessment.
(Observation and monitoring)

CL0421 (96100) PSYCHOLOGICAL TESTING

Includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS-R, Rorschach, MMPI, with interpretation and report.

CL0412 (96105) ASSESSMENT OF APHASIA

Includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing e.g., Boston Diagnostic Aphasia Examination, with interpretation and report.

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PSYCHOLOGY
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CODE

- CL0413** (96110) **DEVELOPMENTAL TESTING (LIMITED)**
Developmental Screening Test II, early Language Milestone Screen, with interpretation and report.
- CL0422** (96111) **DEVELOPMENTAL TESTING (EXTENDED)**
Includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments, e.g., Bayley Scales of Infant Development, with interpretation and report.
- CL0414** (96115) **NEUROBEHAVIORAL STATUS EXAM**
Clinical assessment of thinking, reasoning, and judgment, e.g., acquired knowledge, attention, memory, visual spatial abilities, language functions, and planning, with interpretation and report.
- CL0415** (96117) **NEUROPSYCHOLOGICAL TESTING BATTERY**
Example: Halstead-Reitan, Luria, WAIS-R, with interpretation and report.

INDIVIDUAL PSYCHOTHERAPY

- CL0403** (90804) **INDIVIDUAL PSYCHOTHERAPY** (approximately 20 to 30 minutes)
Insight oriented, behavior modifying, and/ or supportive, in an office or outpatient facility.
- CL0404** (90806) **INDIVIDUAL PSYCHOTHERAPY** (approximately 45 to 50 minutes)
- CL0405** (90808) **INDIVIDUAL PSYCHOTHERAPY** (approximately 75 to 80 minutes)

**CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES**

PSYCHOLOGY
(continued)

CODE

CL0406 (90810) **INTERACTIVE PSYCHOTHERAPY** (approximately 20 to 30 minutes)

Interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication.

CL0407 (90812) **INTERACTIVE PSYCHOTHERAPY** (approximately 40 to 50 minutes)

CL0408 (90814) **INTERACTIVE PSYCHOTHERAPY** (approximately 75 to 80 minutes)

FAMILY AND GROUP PSYCHOTHERAPY SERVICES

CL0450 (90846) **FAMILY PSYCHOTHERAPY (WITHOUT CONSUMER PRESENT)** minimum 30 minutes.

Part 679.5(c) (5)

A period of counseling lasting at **LEAST 30 MINUTES** duration provided to the collateral(s) of the appropriately admitted person relative to his or her needs, by a licensed/certified professional and/or those authorized pursuant to Part 679.3(m), or other authorized parties as defined pursuant to this Part.

CL0409 (90847) **FAMILY PSYCHOTHERAPY (CONSUMER PRESENT)**

CL0410 (90853) **GROUP PSYCHOTHERAPY (OTHER THAN OF A MULTIPLE-FAMILY GROUP)**

3-12 consumers: 18 years old or older minimum 45 minutes; less than 18 years old minimum 30 minutes (Part 679). Service includes behavioral observation associated with the clinical intervention as prescribed.

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

PSYCHOLOGY
(continued)

CODE

CL0411 (90857) INTERACTIVE GROUP PSYCHOTHERAPY

3-12 consumers: 18 years old or older minimum 45 minutes; less than 18 years old minimum 30 minutes.

OTHER SERVICES/PROCEDURES/TREATMENT PLAN SERVICES

CL0416 (90899) UNLISTED PSYCHIATRIC SERVICES OR PROCEDURE, INCLUDING OBSERVATION AND CRISIS INTERVENTION

TREATMENT PLAN SERVICES

CL0417 INTERVENTION/TREATMENT PLAN SERVICE

Provided to a consumer to modify/treat the psychological, behavioral, cognitive and/or social factors affecting the consumer's mental health and well being. (Observation connected with the intervention may be included.)

**CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES**

SOCIAL WORK

CODE

CL0600 (96115) COMPREHENSIVE (DISCIPLINE SPECIFIC) DIAGNOSTIC AND EVALUATION VISIT [Part 679.5(c)(6)]

A single claimed clinic visit (which may require more than one encounter) during which the person receives from a single discipline specific professional, a full range comprehensive assessment protocol sufficient in scope to completely describe and analyze the person's functional status, needs for service and treatment recommendations in that clinical area. Payment for said visit shall include assignment of a treatment coordinator and preparation of a written report setting forth findings and recommendations, forwarding of the report to the referral source and consultation with the referral source, if requested. A provider may claim only one discipline specific assessment visit per discipline per year. The duration of contact and/or observation shall be at least two hours.

CL0601 (96150) INITIAL/SPECIAL/RE-ASSESSMENT

Clinical assessment of the consumer to determine the biological, psychological, and social factors affecting the consumer's mental health or a re-assessment of the consumer to evaluate the consumer's condition and to determine the need for further treatment. A re-assessment may be performed by a clinician other than the one who conducted the consumer's initial assessment.
(Observations and monitoring)

INDIVIDUAL PSYCHOTHERAPY

CL0603 (90804) INDIVIDUAL PSYCHOTHERAPY (approximately 20 to 30 minutes)
Insight oriented, behavior modifying, and/or supportive, in an office or outpatient facility.

CL0604 (90806) INDIVIDUAL PSYCHOTHERAPY (approximately 45 to 50 minutes)

CL0605 (90808) INDIVIDUAL PSYCHOTHERAPY (approximately 75 to 80 minutes)

CL0606 (90810) INTERACTIVE PSYCHOTHERAPY (approximately 20 to 30 minutes). Interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication.

**CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES**

SOCIAL WORK
(continued)

CODE

- CL0607** (90812) **INTERACTIVE PSYCHOTHERAPY** (approximately 45 to 50 minutes)
- CL0608** (90814) **INTERACTIVE PSYCHOTHERAPY** (approximately 75 to 80 minutes)

FAMILY AND GROUP PSYCHOTHERAPY SERVICES

- CL0650** (90846) **FAMILY PSYCHOTHERAPY (WITHOUT CONSUMER PRESENT)** minimum 30 minutes.
- CL0609** (90847) **FAMILY PSYCHOTHERAPY (CONSUMER PRESENT)**
- CL0610** (90853) **GROUP PSYCHOTHERAPY (OTHER THAN OF A MULTIPLE-FAMILY GROUP)**
3-12 consumers: 18 years old or older minimum 45 minutes; less than 18 years old minimum 30 minutes (Part 679). Service includes behavioral observation associated with the clinical intervention as prescribed.
- CL0611** (90857) **INTERACTIVE GROUP PSYCHOTHERAPY**
3-12 consumers: 18 years old or older minimum 45 minutes; less than 18 years old minimum 30 minutes.

OTHER SERVICES/PROCEDURES/TREATMENT PLAN SERVICES

- CL0612** (90899) **UNLISTED PSYCHIATRIC SERVICES OR PROCEDURE, INCLUDING OBSERVATION AND CRISIS INTERVENTION**

TREATMENT PLAN SERVICES

- CL0613** **INTERVENTION/TREATMENT PLAN SERVICE**

Provided to a consumer to modify/treat the psychological, behavioral, cognitive and/or social factors affecting the consumer's mental health and well being. (Observation connected with the intervention may be included.)

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

SPEECH

CODE

CL0800 (92506) COMPREHENSIVE (DISCIPLINE SPECIFIC) DIAGNOSTIC AND EVALUATION VISIT [Part 679.5(c)(6)]

A single claimed clinic visit (which may require more than one encounter) during which the person receives from a single discipline specific professional, a full range comprehensive assessment protocol sufficient in scope to completely describe and analyze the person's functional status, needs for service and treatment recommendations in that clinical area. Payment for said visit shall include assignment of a treatment coordinator and preparation of a written report setting forth findings and recommendations, forwarding of the report to the referral source and consultation with the referral source, if requested. A provider may claim only one discipline specific assessment visit per discipline per year. The duration of contact and/or observation shall be at least two hours.

CL0801 (92506) INITIAL/SPECIAL/RE-ASSESSMENT

Evaluation of speech, language, voice, communication, auditory processing and/or aural rehabilitation status. It may be focused to one specific problem and multiples of this code (activity) can occur throughout the year.

CL0850 (92551) HEARING SCREENING TEST

Pure Tone, Air only (pass/fail).

CL0805 (92506) ASSISTANCE WITH AUDIOLOGICAL TESTING

CL0804 (92597) EVALUATION

For use and/or fitting of voice prosthetic or augmentative/alternative communication device to supplement oral speech

CL0851 (92525) EVALUATION OF SWALLOWING AND ORAL FUNCTION FOR FEEDING

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

SPEECH
(continued)

CODE

CL0852 (92526) TREATMENT OF SWALLOWING DYSFUNCTION AND/OR
ORAL FUNCTION FOR FEEDING

CL0802 (92507) INTERVENTION/TREATMENT PLAN SERVICE

Individual treatment of speech, language, voice, communication, and/or auditory
processing disorder (includes aural rehabilitation).

CL0803 (97150) GROUP SERVICES

3-12 consumers: 18 years old or older minimum 45 minutes; less than 18 years
old minimum 30 minutes.

CL0853 (92597) MODIFICATION

Of voice prosthetic or augmentative/alternative speech generating communication
device to supplement oral speech with consumer present.

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

AUDIOLOGY

CODE

CL1000 (92506) **COMPREHENSIVE (DISCIPLINE SPECIFIC) DIAGNOSTIC AND EVALUATION VISIT [Part 679.5(c)(6)]**

A single claimed clinic visit (which may require more than one encounter) during which the person receives from a single discipline specific professional, a full range comprehensive assessment protocol sufficient in scope to completely describe and analyze the person's functional status, needs for service and treatment recommendations in that clinical area. Payment for said visit shall include assignment of a treatment coordinator and preparation of a written report setting forth findings and recommendations, forwarding of the report to the referral source and consultation with the referral source, if requested. A provider may claim only one discipline specific assessment visit per discipline per year. The duration of contact and/or observation shall be at least two hours.

CL1001 (92506) **INITIAL/SPECIAL/RE-ASSESSMENT**

Evaluation of speech, language, voice, communication, auditory processing and/or aural rehabilitation status. It may be focused to one specific problem and multiples of this code (activity) can occur throughout the year.

AUDIOMETRIC TESTS

NOTE: The AUDIOMETRIC TESTS listed below imply the use of calibrated electronic equipment. All descriptors refer to testing both ears. If only ONE ear is tested, documentation in the consumer records must clearly indicate why.

CL1002 (92552) **PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY**

CL1003 (92553) **PURE TONE AUDIOMETRY; AIR AND BONE**

CL1004 (92555) **SPEECH AUDIOMETRY THRESHOLD**

CL1005 (92556) **SPEECH AUDIOMETRY THRESHOLD WITH SPEECH RECOGNITION**

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

AUDIOLOGY

(continued)

CODE

CL1006	(92557) COMPREHENSIVE AUDIOMETRY THRESHOLD EVALUATION AND SPEECH RECOGNITION (CL1003 AND CL1005 COMBINED)
CL1050	(92560) BEKESY AUDIOMETRY (SCREENING)
CL1007	(92561) BEKESY AUDIOMETRY (DIAGNOSTIC)
CL1008	(92562) LOUDNESS BALANCE TEST, ALTERNATE BINAURAL OR MONAURAL
CL1009	(92563) TONE DECAY TEST
CL1010	(92564) SHORT INCREMENT SENSITIVITY INDEX (SIS)
CL1011	(92565) STENGER TEST, PURE TONE
CL1012	(92567) TYMPANOMETRY (IMPEDANCE TESTING)
CL1051	EUSTACHIAN TUBE FUNCTION STUDY
CL1013	(92568) ACOUSTIC REFLEX TESTING
CL1014	(92569) ACOUSTIC REFLEX DECAY TESTING
CL1015	(92571) FILTERED SPEECH TEST
CL1016	(92572) STAGGERED SPONDAIC WORD TEST
CL1017	(92573) LOMBARD TEST
CL1018	(92575) SENSORINEURAL ACUITY LEVEL TEST

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

AUDIOLOGY
(continued)

CODE

- CL1019 (92576) SYNTHETIC SENTENCE IDENTIFICATION TEST
- CL1020 (92577) STENGER TEST SPEECH
- CL1021 (92579) VISUAL REINFORCEMENT AUDIOMETRY (VRA)
- CL1022 (92582) CONDITIONING PLAY AUDIOMETRY
- CL1023 (92583) SELECT PICTURE AUDIOMETRY
- CL1024 (92584) ELECTROCOCHLEOGRAPHY
- CL1025 (92585) AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE
AUDIOMETRY AND/OR TESTING OF THE CENTRAL NERVOUS
SYSTEM
- CL1026 (92587) EVOKED OTOACOUSTIC EMISSIONS; LIMITED (SINGLE
STIMULUS LEVEL, EITHER TRANSIENT OR DISTORTION
PRODUCTS)
- CL1027 (92588) COMPREHENSIVE OTOACOUSTIC EMISSIONS EVALUATION
(COMPARISON OF TRANSIENT AND/OR DISTORTION PRODUCT
OTOACOUSTIC EMISSIONS AT MULTIPLE LEVELS AND
FREQUENCIES)
- CL1028 (92589) CENTRAL AUDITORY FUNCTION TEST(S) (SPECIFY)
- CL1031 (92590) HEARING AID EXAM AND SELECTION, MONAURAL
- CL1032 (92591) HEARING AID EXAM AND SELECTION, BINAURAL
- CL1052 (92594) ELECTROACOUSTIC EVALUATION OF HEARING AID;
MONAURAL

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

AUDIOLOGY
(continued)

CODE

CL1053 (92595) ELECTROACOUSTIC EVALUATION OF HEARING AID;
BINAURAL

CL1033 (92585) AUDITORY BRAINSTEM RESPONSE (ABR) TEST

- ▶ ABR Test
- ▶ Acoustic Immittance
- ▶ Exit Consultation

CL1034 (92507) INTERVENTION/TREATMENT PLAN SERVICE

Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual.

NOTE: This code should be used only when none of the preceding more specific CL codes apply.

CL1035 (92508) GROUP SERVICES

3-12 consumers: 18 years old or older minimum 45 minutes; less than 18 years old minimum 30 minutes.

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

PHYSICAL THERAPY

CODE

EVALUATION AND ASSESSMENT

- CL1200** (97001) **COMPREHENSIVE (DISCIPLINE SPECIFIC) DIAGNOSTIC AND EVALUATION VISIT [Part 679.5(c)(6)]**
A single claimed clinic visit (which may require more than one encounter) during which the person receives from a single discipline specific professional, a full range comprehensive assessment protocol sufficient in scope to completely describe and analyze the person's functional status, needs for service and treatment recommendations in that clinical area. Payment for said visit shall include assignment of a treatment coordinator and preparation of a written report setting forth findings and recommendations, forwarding of the report to the referral source and consultation with the referral source, if requested. A provider may claim only one discipline specific assessment visit per discipline per year. The duration of contact and/or observation shall be at least two hours.
- CL1201** (97001) **PHYSICAL THERAPY EVALUATION/SPECIAL PURPOSE NOT LISTED BELOW**
- CL1202** (97002) **PHYSICAL THERAPY RE-EVALUATION**
- CL1250** (95831) **MUSCLE TESTING, MANUAL**
(Separate Procedure); with report; extremity (excluding hand) or trunk.
- CL1251** (95832) **MUSCLE TESTING, HAND**
With or without comparison to normal side.
- CL1252** (95833) **MUSCLE TESTING, TOTAL EVALUATION OF BODY, EXCLUDING HANDS**
- CL1253** (95834) **MUSCLE TESTING, TOTAL EVALUATION OF BODY, INCLUDING HANDS**
- CL1254** (95851) **RANGE OF MOTION MEASUREMENTS AND REPORT**
(Separate Procedure); extremity or trunk.

**CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES**

**PHYSICAL THERAPY
(continued)**

CODE

- CL1255** (95852) **RANGE OF MOTION MEASUREMENTS AND REPORT**
Hand with or without comparison to normal side
- CL1256** (94667) **MANIPULATION CHEST WALL - INITIAL**
Initial demonstration/evaluation such as cupping, percussing, and vibration to facilitate lung functions.

MODALITIES

NOTE: When reporting multiple physical therapy modalities provided within one visit, list each code and the associated duration.

- CL1203** (97010) **APPLICATION OF A MODALITY TO ONE OR MORE AREAS;
HOT OR COLD PACKS**
- CL1257** (97012) **TRACTION, MECHANICAL**
- CL1205** (97014) **ELECTRICAL STIMULATION**
- CL1258** (97016) **VASOPNEUMATIC DEVICES**
- CL1207** (97018) **PARAFFIN BATH**
- CL1208** (97020) **MICROWAVE**
- CL1209** (97022) **WHIRLPOOL**
- CL1210** (97024) **DIATHERMY**
- CL1259** (97026) **INFRARED**
- CL1212** (97028) **ULTRAVIOLET**

**CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES**

**PHYSICAL THERAPY
(continued)**

CODE

- CL1213** (97032) **APPLICATION OF A MODALITY TO ONE OR MORE AREAS;**
Electrical stimulation, manual. (Minimum 15 minutes)
- CL1214** (97033) **IONTOPHORESIS** (Minimum 15 minutes)
- CL1215** (97034) **CONTRAST BATHS** (Minimum 15 minutes)
- CL1216** (97035) **ULTRASOUND** (Minimum 15 minutes)
- CL1217** (97036) **HUBBARD TANK** (Minimum 15 minutes)
- CL1260** (97039) **UNLISTED MODALITY (Specify Type in Note)** (Minimum 15
minutes)

THERAPEUTIC PROCEDURES

- CL1218** (97110) **THERAPEUTIC PROCEDURE; ONE OR MORE AREAS**
Therapeutic exercises to develop strength and endurance, range of motion and
flexibility. (Minimum 15 minutes duration)
- CL1219** (97112) **NEUROMUSCULAR REEDUCATION OF MOVEMENT,
BALANCE, COORDINATION, KINESTHETIC SENSE, POSTURE,
AND/OR PROPRIOCEPTION**
For sitting and/or standing activities. (Minimum 15 minutes duration)
- CL1220** (97113) **AQUATIC THERAPY WITH THERAPEUTIC EXERCISES**
(Minimum 15 minutes duration)
- CL1261** (94668) **MANIPULATION CHEST WALL - SUBSEQUENT**
Such as cupping, percussing, and vibration to facilitate lung functions.
- CL1221** (97116) **GAIT TRAINING (INCLUDES STAIR CLIMBING)** (Minimum 15
minutes duration)

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

PHYSICAL THERAPY
(continued)

CODE

- CL1223** (97124) **MASSAGE, INCLUDING EFFLEURAGE, PETRISSAGE AND/OR TAPOTEMENT** (Minimum 15 minutes duration)
- CL1262** (97139) **UNLISTED THERAPEUTIC PROCEDURE (Specify Type in Note)** (Minimum 15 minutes duration)
- CL1263** (97140) **MANUAL THERAPY TECHNIQUES**
Example: mobilization/manipulation, manual lymphatic drainage, manual traction. (Minimum 15 minutes duration)
- CL1227** (97504) **ORTHOTICS FITTING AND TRAINING**
Upper and/or lower extremities. (Minimum 15 minutes duration)
- NOTE:** SHOULD NOT BE REPORTED WITH CL1221.
- CL1228** (97520) **PROSTHETIC TRAINING**
Upper and/or lower extremities. (Minimum 15 minutes duration)
- CL1229** (97530) **THERAPEUTIC ACTIVITIES**
Use of dynamic activities to improve functional performance. (Minimum 15 minutes duration)
- CL1230** (97535) **SELF CARE/HOME MANAGEMENT TRAINING**
Instructions in use of assistive technology devices/adaptive equipment. (Minimum 15 minutes duration)
- CL1231** (97537) **COMMUNITY/WORK REINTEGRATION TRAINING**
Example: Work environment/modification analysis, work task analysis. (Minimum 15 minutes duration)
- CL1232** (97542) **WHEELCHAIR MANAGEMENT/PROPULSION TRAINING** (Minimum 15 minutes duration)

**CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES**

**PHYSICAL THERAPY
(continued)**

CODE

- CL1234** (97703) **CHECKOUT FOR ORTHOTIC/PROSTHETIC USE**
Established consumer. (Minimum 15 minutes duration)
- CL1236** (97150) **GROUP SERVICES**
3-12 consumers: 18 years old or older minimum 45 minutes; less than 18 years old minimum 30 minutes.
- CL1264** (97750) **PHYSICAL PERFORMANCE TEST OR MEASUREMENT**
Example: Musculoskeletal, functional capacity, with written report. (Minimum 15 minutes duration)

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

NUTRITION

CODE

CL1400 (97802) COMPREHENSIVE (DISCIPLINE SPECIFIC) DIAGNOSTIC AND EVALUATION VISIT [Part 679.5(c)(6)]

A single claimed clinic visit (which may require more than one encounter) during which the person receives from a single discipline specific professional, a full range comprehensive assessment protocol sufficient in scope to completely describe and analyze the person's functional status, needs for service and treatment recommendations in that clinical area. Payment for said visit shall include assignment of a treatment coordinator and preparation of a written report setting forth findings and recommendations, forwarding of the report to the referral source and consultation with the referral source, if requested. A provider may claim only one discipline specific assessment visit per discipline per year. The duration of contact and/or observation shall be at least two hours.

- ▶ Assessment and Intervention
- ▶ Nutrition Screening
- ▶ Assessment/Interview with Observation
- ▶ Anthropometric/Biochemical Clinical Assessment
- ▶ Environmental Assessment
- ▶ Feeding Assessment

CL1401 (97802) INITIAL OR SPECIAL PURPOSE ASSESSMENT (Minimum 15 minutes duration)

CL1402 (97803) REASSESSMENT/INTERVENTION (Minimum 15 minutes duration)

CL1403 (97804) GROUP NUTRITION THERAPY

3-12 consumers: 18 years old or older minimum 45 minutes; less than 18 years old minimum 30 minutes.

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

NUTRITION
(continued)

CODE

CL1404 (97535) **SELF CARE/HOME MANAGEMENT TRAINING**

Example: Compensatory training, instructions for meal preparation and food safety procedures.

COLLATERAL SERVICE

Part 679.5(c)(5)

A period of counseling lasting at **LEAST 30 MINUTES** duration provided to the collateral(s) of the appropriately admitted person relative to his or her needs, by a licensed/certified professional and/or those authorized pursuant to Part 679.3(m), or other authorized parties as defined pursuant to this Part.

CL1450 (96154) **COLLATERAL SERVICE (WITH CONSUMER PRESENT)**

The intervention service provided to a family member with the consumer present.

CL1451 (96155) **COLLATERAL SERVICE (WITHOUT CONSUMER PRESENT)**

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

PODIATRY

CODE

INTEGUMENTARY SYSTEM

INCISION AND DRAINAGE

CL1500 (10060) **ABSCCESS**
Simple or single I+D.

EXCISION - BENIGN LESIONS

CL1508 (11420) **EXCISION**
Benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less.

NAILS

CL1537 (11730) **AVULSION**
Of nail plate, partial or complete, simple: single.

CL1584 (11720) **DEBRIDEMENT**
Of nails - any method (1-5).

CL1585 (11721) **DEBRIDEMENT**
Of nails - any method 6 or more.

CL1586 (11719) **TRIMMING**
Of nondystrophic nails, any number.

CL1587 **TRIMMING**
Of dystrophic nails, any number.

CL1550 (11765) **WEDGE EXCISION OF SKIN**

PARING OR CUTTING

CL1588 (11055) **PARING OR CUTTING**
Of benign hyperkeratotic lesion (e.g., corn or callus) single lesion.

**CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES**

PODIATRY
(continued)

CODE

- CL1589** (11056) **PARING OR CUTTING**
Of benign hyperkeratotic lesion (e.g., corn or callus) 2-4 lesions.
- CL1590** (11057) **PARING OR CUTTING**
Of benign hyperkeratotic lesion (e.g., corn or callus) more than 4 lesions.

**CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES**

MEDICAL SERVICES

CODE

NOTE: Time reference is not the determining component in choosing a code. It is intended only as an additional guide but the major consideration should be to history, examination, and decision making.

Evaluation and management of a NEW consumer requires all three ► key components.

NEW INDIVIDUALS

CL2003 (99205) COMPREHENSIVE (DISCIPLINE SPECIFIC) DIAGNOSTIC AND EVALUATION VISIT [Part 679.5(c)(6)]

A single claimed clinic visit (which may require more than one encounter) during which the person receives from a single discipline specific professional, a full range comprehensive assessment protocol sufficient in scope to completely describe and analyze the person's functional status, needs for service and treatment recommendations in that clinical area. Payment for said visit shall include assignment of a treatment coordinator and preparation of a written report setting forth findings and recommendations, forwarding of the report to the referral source and consultation with the referral source, if requested. A provider may claim only one discipline specific assessment visit per discipline per year. The duration of contact and/or observation shall be at least two hours.

CL2000 (99201) EVALUATION AND MANAGEMENT

All (3) components required

- Problem focused history
- Problem focused examination
- Straightforward medical decision making

Self limited or minor problems, typically 10 minutes.

**CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES**

**MEDICAL SERVICES
(continued)**

CODE

CL2001 (99202) EVALUATION AND MANAGEMENT

All (3) components required

- ▶ Expanded problem focused history
- ▶ Expanded problem focused examination
- ▶ Straightforward medical decision making

Low to moderate severity problems, typically 20 minutes.

CL2002 (99203) EVALUATION AND MANAGEMENT

All (3) components required

- ▶ Detailed history
- ▶ Detailed examination
- ▶ Low complexity medical decision making

Moderate severity problems, typically 30 minutes.

CL2004 (99204) EVALUATION AND MANAGEMENT

All (3) components required

- ▶ Comprehensive history
- ▶ Comprehensive examination
- ▶ High complexity medical decision making

Moderate to high severity problems, typically 45 minutes.

**CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES**

MEDICAL SERVICES

(continued)

CODE

ESTABLISHED INDIVIDUALS

CL2050 (99215) COMPREHENSIVE (DISCIPLINE SPECIFIC) DIAGNOSTIC AND EVALUATION VISIT [Part 679.5(c)(6)]

A single claimed clinic visit (which may require more than one encounter) during which the person receives from a single discipline specific professional, a full range comprehensive assessment protocol sufficient in scope to completely describe and analyze the person's functional status, needs for service and treatment recommendations in that clinical area. Payment for said visit shall include assignment of a treatment coordinator and preparation of a written report setting forth findings and recommendation, forwarding of the report to the referral source and consultation with the referral source, if requested. A provider may claim only one discipline specific assessment visit per discipline per year. The duration of contact and/or observation shall be at least two hours.

CL2005 (99212) EVALUATION AND MANAGEMENT

At least (2) of (3) components required

- ▶ Problem focused history
- ▶ Problem focused examination
- ▶ Straightforward medical decision making

Self limited or minor problems, typically 10 minutes.

CL2006 (99213) EVALUATION AND MANAGEMENT

At least (2) of (3) components required

- ▶ Expanded problem focused history
- ▶ Expanded problem focused examination
- ▶ Straightforward medical decision making

Low to moderate severity problems, typically 15 minutes.

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

MEDICAL SERVICES
(continued)

CODE

CL2007 (99214) **EVALUATION AND MANAGEMENT**

At least (2) of (3) components required

- ▶ Detailed history
- ▶ Detailed examination
- ▶ Low complexity medical decision making

Moderate severity problems, typically 25 minutes.

CL2008 (99215) **EVALUATION AND MANAGEMENT**

At least (2) of (3) components required

- ▶ Comprehensive history
- ▶ Comprehensive examination
- ▶ Moderate complexity medical decision making

Moderate to high severity problems, typically 40 minutes.

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

DENTAL SERVICES

CODE

CLINICAL ORAL EXAMINATIONS

- CL3000 (D0120) PERIODIC ORAL EVALUATION
CL3001 (D0140) LIMITED ORAL EVALUATION - PROBLEM FOCUSED
CL3002 (D0150) COMPREHENSIVE ORAL EVALUATION
CL3003 (D0160) DETAILED AND EXTENSIVE ORAL EVALUATION -
PROBLEM FOCUSED, BY REPORT

RADIOGRAPHS

- CL3004 (D0210) INTRAORAL - COMPLETE SERIES (INCLUDING BITEWINGS)
CL3005 (D0220) INTRAORAL - PERIAPICAL - FIRST FILM
CL3006 (D0230) INTRAORAL - PERIAPICAL - EACH ADDITIONAL FILM
CL3007 (D0240) INTRAORAL - OCCLUSAL FILM
CL3008 (D0250) EXTRAORAL - FIRST FILM
CL3009 (D0260) EXTRAORAL - EACH ADDITIONAL FILM
CL3010 (D0270) BITEWING - SINGLE FILM
CL0311 (D0272) BITEWINGS - TWO FILMS
CL0312 (D0274) BITEWINGS - FOUR FILMS
CL3018 (D0330) PANORAMIC FILM

TEST AND LABORATORY EXAMINATIONS

- CL3023 (D0470) DIAGNOSTIC CASTS

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

DENTAL SERVICES
(continued)

CODE

CL3026 (D0502) OTHER ORAL PATHOLOGY PROCEDURES, BY REPORT

CL3027 (D0999) UNSPECIFIED DIAGNOSTIC PROCEDURE, BY REPORT

PREVENTATIVE - DENTAL PROCEDURES

CL3028 (D1110) PROPHYLAXIS - ADULT

CL3029 (D1120) PROPHYLAXIS - CHILD

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)

CL3030 (D1201) TOPICAL APPLICATION OF FLUORIDE (INCLUDING PROPHYLAXIS) - CHILD

CL3031 (D1203) TOPICAL APPLICATION OF FLUORIDE (PROPHYLAXIS NOT INCLUDED) - CHILD

CL3032 (D1204) TOPICAL APPLICATION OF FLUORIDE (PROPHYLAXIS NOT INCLUDED) - ADULT

CL3033 (D1205) TOPICAL APPLICATION OF FLUORIDE (INCLUDING PROPHYLAXIS) - ADULT

OTHER PREVENTATIVE SERVICES

CL3036 (D1330) ORAL HYGIENE INSTRUCTION

CL3037 (D1351) SEALANT - PER TOOTH

SPACE MAINTENANCE (PASSIVE APPLIANCES)

CL3038 (D1510) SPACE MAINTAINER - FIXED - UNILATERAL

CL3039 (D1515) SPACE MAINTAINER - FIXED - BILATERAL

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

DENTAL SERVICES

(continued)

CODE

- CL3040 (D1520) SPACE MAINTAINER - REMOVABLE - UNILATERAL
CL3041 (D1525) SPACE MAINTAINER - REMOVABLE - BILATERAL
CL3042 (D1550) RECEMENTATION OF SPACE MAINTAINER

AMALGAM RESTORATIONS

- CL3043 (D2110) AMALGAM - ONE SURFACE, PRIMARY
CL3044 (D2120) AMALGAM - TWO SURFACES, PRIMARY
CL3045 (D2130) AMALGAM - THREE SURFACES, PRIMARY
CL3046 (D2131) AMALGAM - FOUR OR MORE SURFACES, PRIMARY
CL3047 (D2140) AMALGAM - ONE SURFACE, PERMANENT
CL3048 (D2150) AMALGAM - TWO SURFACES, PERMANENT
CL3049 (D2160) AMALGAM - THREE SURFACES, PERMANENT
CL3050 (D2161) AMALGAM - FOUR OR MORE SURFACES, PERMANENT

RESIN RESTORATIONS

- CL3052 (D2330) RESIN - ONE SURFACE, ANTERIOR
CL3053 (D2331) RESIN - TWO SURFACES, ANTERIOR
CL3054 (D2332) RESIN - THREE SURFACES, ANTERIOR
CL3055 (D2335) RESIN - FOUR OR MORE SURFACES OR INVOLVING
INCISAL ANGLE (ANTERIOR)

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

DENTAL SERVICES
(continued)

CODE

- CL3056 (D2336) COMPOSITE RESIN CROWN, ANTERIOR - PRIMARY
- CL3057 (D2380) RESIN - ONE SURFACE, POSTERIOR - PRIMARY
- CL3058 (D2381) RESIN - TWO SURFACES, POSTERIOR - PRIMARY
- CL3059 (D2382) RESIN - THREE OR MORE SURFACES, POSTERIOR -
PRIMARY
- CL3060 (D2385) RESIN - ONE SURFACE, POSTERIOR - PERMANENT
- CL3061 (D2386) RESIN - TWO SURFACES, POSTERIOR - PERMANENT
- CL3062 (D2387) RESIN - THREE OR MORE SURFACES, POSTERIOR -
PERMANENT

CROWNS - SINGLE RESTORATION ONLY

- CL3088 (D2750) CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL
- CL3090 (D2752) CROWN - PORCELAIN FUSED TO NOBLE METAL

OTHER RESTORATIVE SERVICES

- CL3096 (D2920) RECEMENT CROWN
- CL3097 (D2930) PREFABRICATED STAINLESS STEEL CROWN - PRIMARY
TOOTH
- CL3098 (D2931) PREFABRICATED STAINLESS STEEL CROWN - PERMANENT
TOOTH
- CL3099 (D2932) PREFABRICATED RESIN CROWN
- CL3101 (D2940) SEDATIVE FILLING

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

DENTAL SERVICES
(continued)

CODE

- CL3102 (D2950) CORE BUILDUP, INCLUDING ANY PINS
- CL3103 (D2951) PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION
- CL3104 (D2952) CAST POST AND CORE, IN ADDITION TO CROWN
- CL3105 (D2954) PREFABRICATED POST AND CORE, IN ADDITION TO CROWN
- CL3107 (D2960) LABIAL VENEER (LAMINATE) - CHAIRSIDE
- CL3110 (D2970) TEMPORARY (FRACTURED TOOTH)
- CL3111 (D2980) CROWN REPAIR, BY REPORT
- CL3112 (D2999) UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT

ENDODONTIC - PULP CAPPING

- CL3113 (D3110) PULP CAP - DIRECT (EXCLUDING FINAL RESTORATION)
- CL3114 (D3120) PULP CAP - INDIRECT (EXCLUDING FINAL RESTORATION)
- CL3115 (D3220) THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)

ROOT CANAL THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)

- CL3118 (D3310) ANTERIOR (EXCLUDING FINAL RESTORATION)
- CL3119 (D3320) BICUSPID (EXCLUDING FINAL RESTORATION)

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

DENTAL SERVICES
(continued)

CODE

- CL3120 (D3330) MOLAR (EXCLUDING FINAL RESTORATION)
- CL3121 (D3346) RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR
- CL3122 (D3347) RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - BICUSPID
- CL3123 (D3348) RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR

PERIAPICAL SERVICES

- CL3127 (D3410) ANTERIOR APICOECTOMY/PERIRADICULAR SURGERY - ANTERIOR
- CL3128 (D3421) APICOECTOMY/PERIRADICULAR SURGERY - BUCUSPID (FIRST ROOT)
- CL3129 (D3425) MOLAR APICOECTOMY/PERIRADICULAR SURGERY - MOLAR (FIRST ROOT)
- CL3130 (D3426) APICOECTOMY/PERIRADICULAR SURGERY (EACH ADDITIONAL ROOT)
- CL3131 (D3430) RETROGRADE FILLING - PER ROOT
- CL3132 (D3450) ROOT AMPUTATION - PER ROOT
- CL3134 (D3470) INTENTIONAL REPLANTATION (INCLUDING NECESSARY SPLINTING)

OTHER ENDODONTIC PROCEDURES

- CL3138 (D3960) BLEACHING OF DISCOLORED TEETH

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

DENTAL SERVICES

(continued)

CODE

PERIODONTICS - SURGICAL SERVICES (INCLUDING USUAL POST OPERATIVE SERVICES)

- CL3140 (D4210) GINGIVECTOMY OR GINGIVOPLASTY - PER QUADRANT
- CL3141 (D4211) GINGIVECTOMY OR GINGIVOPLASTY - PER TOOTH
- CL3142 (D4220) GINGIVAL CURETTAGE, SURGICAL - PER QUADRANT, BY REPORT
- CL3146 (D4260) OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE) - PER QUADRANT

ADJUNCTIVE PERIODONTAL SERVICES

- CL3157 (D4341) PERIODONTAL SCALING AND ROOT PLANING - PER QUADRANT
- CL3158 (D4355) FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSIS
- CL3159 (D4381) LOCALIZED DELIVERY OF CHEMOTHERAPEUTIC AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE PER TOOTH, BY REPORT
- CL3160 (D4910) PERIODONTAL MAINTENANCE PROCEDURES (FOLLOWING ACTIVE THERAPY)
- CL3161 (D4920) UNSCHEDULED DRESSING CHANGE (BY SOMEONE OTHER THAN TREATMENT DENTIST)

PROSTHODONTICS (REMOVABLE) - COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

- CL3163 (D5110) COMPLETE DENTURE - MAXILLARY

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

DENTAL SERVICES
(continued)

CODE

- CL3164 (D5120) COMPLETE DENTURE - MANDIBULAR
CL3165 (D5130) IMMEDIATE DENTURE - MAXILLARY
CL3166 (D5140) IMMEDIATE DENTURE - MANDIBULAR

PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

- CL3167 (D5211) UPPER PARTIAL - RESIN BASE (INCLUDING ANY
CONVENTIONAL CLASPS, RESTS AND TEETH)
CL3168 (D5212) LOWER PARTIAL - RESIN BASE (INCLUDING ANY
CONVENTIONAL CLASPS, RESTS AND TEETH)
CL3169 (D5213) MAXILLARY PARTIAL DENTURE - CAST METAL
FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY
CONVENTIONAL CLASPS, RESTS AND TEETH)
CL3170 (D5214) MANDIBULAR PARTIAL DENTURE - CAST METAL
FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY
CONVENTIONAL CLASPS, RESTS AND TEETH)
CL3171 (D4281) REMOVABLE UNILATERAL PARTIAL DENTURE - ONE
PIECE CAST METAL (INCLUDING CLASPS AND TEETH)

ADJUSTMENTS TO REMOVABLE PROSTHESES

- CL3172 (D5410) ADJUST COMPLETE DENTURE - MAXILLARY
CL3173 (D5411) ADJUST COMPLETE DENTURE - MANDIBULAR
CL3174 (D5421) ADJUST PARTIAL DENTURE - MAXILLARY
CL3175 (D5422) ADJUST PARTIAL DENTURE - MANDIBULAR

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

DENTAL
(continued)

CODE

REPAIRS TO COMPLETE DENTURES

- CL3176 (D5510) REPAIR BROKEN COMPLETE DENTURE BASE
- CL3177 (D5520) REPLACE MISSING OR BROKEN TEETH - COMPLETE DENTURE (EACH TOOTH)

REPAIRS TO PARTIAL DENTURES

- CL3178 (D5610) REPAIR RESIN DENTURE BASE
- CL3179 (D5620) REPAIR CAST FRAMEWORK
- CL3180 (D5630) REPAIR OR REPLACE BROKEN CLASP
- CL3181 (D5640) REPLACE BROKEN TEETH - PER TOOTH
- CL3182 (D5650) ADD TOOTH TO EXISTING PARTIAL DENTURE
- CL3183 (D5660) ADD CLASP TO EXISTING PARTIAL DENTURE

DENTURE REBASE PROCEDURE

- CL3184 (D5710) REBASE COMPLETE MAXILLARY DENTURE
- CL3185 (D5711) REBASE COMPLETE MANDIBULAR DENTURE
- CL3186 (D5720) REBASE MAXILLARY PARTIAL DENTURE
- CL3187 (D5721) REBASE MANDIBULAR PARTIAL DENTURE

DENTURE RELINE PROCEDURES

- CL3188 (D5730) RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

DENTAL
(continued)

CODE

- CL3189 (D5731) RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)
CL3190 (D5740) RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)
CL3191 (D5741) RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)
CL3192 (D5750) RELINE COMPLETE MAXILLARY DENTURE
(LABORATORY)
CL3193 (D5751) RELINE COMPLETE MANDIBULAR DENTURE
(LABORATORY)
CL3194 (D5760) RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)
CL3195 (D5761) RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)

OTHER REMOVABLE PROSTHETIC SERVICES

- CL3200 (D5850) TISSUE CONDITIONING, MAXILLARY
CL3201 (D5851) TISSUE CONDITIONING, MANDIBULAR
CL3205 (D5899) UNSPECIFIED REMOVABLE PROSTHODONTIC
PROCEDURE, BY REPORT

PROSTHODONTICS, FIXED (EACH ABUTMENT AND EACH PONTIC
CONSTITUTES A UNIT IN A BRIDGE)

- CL3206 (D6210) PONTIC - CAST HIGH NOBLE METAL
CL3207 (D6211) PONTIC - CAST PREDOMINANTLY BASE METAL
CL3208 (D6212) PONTIC - CAST NOBLE METAL

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

DENTAL SERVICES

(continued)

CODE

- CL3209 (D6240) PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL
- CL3210 (D6241) PONTIC - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL
- CL3211 (D6242) PONTIC - PORCELAIN FUSED TO NOBLE METAL

RETAINERS

- CL3219 (D6545) RETAINER - CAST METAL FOR RESIN BONDED FIXED PROSTHESIS

BRIDGE RETAINERS - CROWNS

- CL3223 (D6750) CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL
- CL3224 (D6751) CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASED METAL
- CL3225 (D6752) CROWN - PORCELAIN FUSED TO NOBLE METAL

OTHER FIXED PROSTHETIC SERVICE

- CL3231 (D6930) RECEMENT BRIDGE
- CL3232 (D6949) STRESS BREAKER
- CL3234 (D6970) CAST POST AND CORE IN ADDITION TO BRIDGE RETAINER
- CL3236 (D6972) PREFABRICATED POST AND CORE IN ADDITION TO BRIDGE RETAINER
- CL3237 (D6973) CORE BUILD UP FOR RETAINER INCLUDING ANY PINS
- CL3239 (D6980) BRIDGE REPAIR, BY REPORT

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

DENTAL SERVICES
(continued)

CODE

CL3240 (D6999) UNSPECIFIED FIXED PROSTHODONTIC PROCEDURE, BY REPORT

EXTRACTIONS - INCLUDES LOCAL ANESTHESIA AND ROUTINE POST-OPERATIVE CARE

CL3241 (D7110) SINGLE TOOTH

CL3242 (D7120) EACH ADDITIONAL TOOTH

CL3243 (D7130) ROOT REMOVAL - EXPOSED ROOTS

SURGICAL EXTRACTIONS - INCLUDES LOCAL ANESTHESIA AND ROUTINE POSTOPERATIVE CARE

CL3244 (D7210) SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF BONE AND/OR SECTION OF TOOTH

CL3245 (D7220) REMOVAL OF IMPACTED TOOTH - SOFT TISSUE

CL3246 (D7230) REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY

CL3247 (D7240) REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY

CL3249 (D7250) SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)

OTHER SURGICAL PROCEDURES

CL3250 (D7260) ORAL ANTRAL FISTULA CLOSURE

CL3251 (D7270) TOOTH REIMPLANTATION AND/OR STABILIZATION (OF ACCIDENTLY AVULSED OR DISPLACED TOOTH)

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

DENTAL SERVICES

(continued)

CODE

CL3254 (D7281) SURGICAL EXPOSURE OF IMPACTED OR UNERUPTED TOOTH TO AID ERUPTION

CL3255 (D7285) BIOPSY OF ORAL TISSUE - HARD

CL3256 (D7286) BIOPSY OF ORAL TISSUE - SOFT

ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES

CL3259 (D7310) ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - PER QUADRANT

CL3260 (D7320) ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - PER QUADRANT

REMOVAL OF TUMORS, CYSTS AND NEOPLASMS

CL3265 (D7430) EXCISION OF BENIGN TUMOR - LESION DIAMETER UP TO 1.25 CM.

CL3266 (D7431) EXCISION OF BENIGN TUMOR - LESION DIAMETER OVER 1.25 CM.

CL3267 (D7440) EXCISION OF MALIGNANT TUMOR - LESION DIAMETER UP TO 1.25 CM.

CL3268 (D7441) EXCISION OF MALIGNANT TUMOR - LESION DIAMETER OVER 1.25 CM.

CL3269 (D7450) REMOVAL OF ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM.

CL3270 (D7451) REMOVAL OF ODONTOGENIC CYST OR TUMOR - LESION DIAMETER OVER 1.25 CM.

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

DENTAL SERVICES
(continued)

CODE

- CL3271 (D7460) REMOVAL OF NONODONTOGENIC CYST OR TUMOR -
LESION DIAMETER UP TO 1.25 CM.
- CL3272 (D7461) REMOVAL OF NONODONTOGENIC CYST OR TUMOR -
LESION DIAMETER OVER 1.25 CM.

EXCISION OF BONE TISSUE

- CL3274 (D7470) REMOVAL OF EXOSTOSIS - MAXILLA OR MANDIBLE

SURGICAL INCISION

- CL3277 (D7510) INCISION & DRAINAGE INTRAORAL OF ABSCESS
INTRAORAL SOFT TISSUE
- CL3278 (D7520) INCISION & DRAINAGE EXTRAORAL OF ABSCESS
EXTRAORAL SOFT TISSUE

REPAIR OF TRAUMATIC WOUNDS

- CL3283 (D7910) SUTURE OF RECENT SMALL WOUNDS UP TO 5CM
- CL3284 (D7911) SUTURE OF WOUNDS COMPLICATED UP TO 5CM
- CL3285 (D7912) SUTURE OF WOUNDS COMPLICATED OVER 5CM

ADJUNCTIVE GENERAL SERVICES

- CL3286 (D9110) PALLIATIVE EMERGENCY TREATMENT OF DENTAL PAIN -
MINOR PROCEDURES

ANESTHESIA

- CL3287 (D9210) LOCAL ANESTHESIA NOT IN CONJUNCTION WITH
OPERATIVE OR SURGICAL PROCEDURES

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

DENTAL SERVICES

(continued)

CODE

- CL3290 (D9215) LOCAL ANESTHESIA
- CL3291 (D9220) GENERAL ANESTHESIA
- CL3292 (D9221) GENERAL ANESTHESIA - EACH ADDITIONAL
Typically 15 minutes.
- CL3293 (D9230) ANALGESIA

PROFESSIONAL VISITS

- CL3295 (D9140) HOUSE CALL
- CL3296 (D9420) HOSPITAL CALL
- CL3297 (D9430) OFFICE VISIT FOR OBSERVATION (DURING REGULARLY
SCHEDULED HOURS) - NO OTHER SERVICES PERFORMED
- CL3298 (D9440) OFFICE VISIT - AFTER REGULARLY SCHEDULED HOURS

DRUGS

- CL3300 (D9630) OTHER DRUGS AND/OR MEDICAMENTS, BY REPORT

MISCELLANEOUS SERVICES

- CL3301 (D9910) APPLICATION OF DESENSITIZING MEDICAMENT
- CL3302 (D9920) BEHAVIOR MANAGEMENT, BY REPORT
- CL3303 (D9930) TREATMENT OF COMPLICATIONS (POSTSURGICAL)
UNUSUAL CIRCUMSTANCES, BY REPORT

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

DENTAL SERVICES
(continued)

CODE

CL3304	(D9940) OCCLUSAL GUARDS, BY REPORT
CL3305	(D9941) FABRICATION OF ATHLETIC MOUTHGARD
CL3306	(D9950) OCCLUSAL ANALYSIS - MOUNTED CASE
CL3307	(D9951) OCCLUSAL ADJUSTMENT - LIMITED
CL3308	(D9952) OCCLUSAL ADJUSTMENT - COMPLETE
CL3309	(D9970) ENAMEL MICROABRASION

NOTE: Additional informational needs (i.e., tooth number and side) will be required when requested by the TPHI payors. There will be no TABS CL entry available at this time.

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

PHYSIATRY SERVICES

CODE

NEW INDIVIDUALS

- CL4050 (99202) ASSESSMENT FOR PHYSICAL THERAPY TESTS AND MEASUREMENTS (Typically 20 Minutes)
- CL4051 (99203) ASSESSMENT FOR PHYSICAL THERAPY TESTS AND MEASUREMENTS (Typically 30 Minutes)
- CL4052 (99204) ASSESSMENT FOR PHYSICAL THERAPY TESTS AND MEASUREMENTS (Typically 45 Minutes)

ESTABLISHED INDIVIDUALS

- CL4000 (99212) ASSESSMENT FOR PHYSICAL THERAPY TESTS AND MEASUREMENTS (Typically 10 Minutes)
- CL4053 (99213) ASSESSMENT FOR PHYSICAL THERAPY TESTS AND MEASUREMENTS (Typically 15 Minutes)
- CL4054 (99214) ASSESSMENT FOR PHYSICAL THERAPY TESTS AND MEASUREMENTS (Typically 25 Minutes)
- CL4001 (97703) EVALUATION
- ▶ Wheelchair
 - ▶ Brace
 - ▶ Shoe
 - ▶ Splint
- CL4002 (97750) PHYSICAL PERFORMANCE TEST OR MEASUREMENT

Example: musculoskeletal, functional capacity.

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

PSYCHIATRY

CODE

CL6000 (90801) COMPREHENSIVE (DISCIPLINE SPECIFIC) DIAGNOSTIC AND EVALUATION VISIT [Part 679.5(c)(6)]

A single claimed clinic visit (which may require more than once encounter) during which the person receives from a single discipline specific professional, a full range comprehensive assessment protocol sufficient in scope to completely describe and analyze the person's functional status, needs for service and treatment recommendations in that clinical area. Payment for said visit shall include assignment of a treatment coordinator and preparation of a written report setting forth findings and recommendations, forwarding of the report to the referral source and consultation with the referral source, if requested. A provider may claim only one discipline specific assessment visit per discipline per year. The duration of contact and/or observation shall be at least two hours.

CL6001 (90801) INTENSIVE ASSESSMENT

Diagnostic interview examination including history, mental status and disposition, which may include communication with family and other sources, ordering and medical interpretation of lab or other medical diagnostic studies. This assessment must address all presenting symptoms and diagnoses. This service should not generally be provided more than once a year.

CL6002 (90802) INTENSIVE ASSESSMENT - NON VERBAL-INTERACTIVE

Interactive diagnostic interview examination (primarily non-verbal). Interactive procedures are distinct forms of diagnostic procedures which predominantly use physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a consumer who has lost, or has not yet developed, 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/she were to use ordinary adult language for communication.

NOTE: Special assessments should be reported using individual therapy codes.

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

PSYCHIATRY
(continued)

CODE

INDIVIDUAL PSYCHOTHERAPY

- CL6003** (90804) **INDIVIDUAL PSYCHOTHERAPY**
- Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes.
- CL6021** (90805) **INDIVIDUAL PSYCHOTHERAPY WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES**
- Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes.
- CL6004** (90806) **INDIVIDUAL PSYCHOTHERAPY**
- Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes.
- CL6022** (90807) **INDIVIDUAL PSYCHOTHERAPY WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES**
- Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes.
- CL6005** (90808) **INDIVIDUAL PSYCHOTHERAPY**
- Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes.
- CL6023** (90809) **INDIVIDUAL PSYCHOTHERAPY WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES**
- Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes.

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

PSYCHIATRY
(continued)

CODE

- CL6006** (90810) **INDIVIDUAL PSYCHOTHERAPY INTERACTIVE**
- Using physical aids and non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes.
- CL6024** (90811) **INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES**
- Using physical aids and non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes.
- CL6007** (90812) **INDIVIDUAL PSYCHOTHERAPY INTERACTIVE**
- Using physical aids and non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes.
- CL6025** (90813) **INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES**
- Using physical aids and non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes.
- CL6008** (90814) **INDIVIDUAL PSYCHOTHERAPY INTERACTIVE**
- Using physical aids and non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes.
- CL6026** (90815) **INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES**
- Using physical aids and non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes.

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

PSYCHIATRY
(continued)

CODE

FAMILY AND GROUP PSYCHOTHERAPY

- CL6009 (90846) FAMILY PSYCHOTHERAPY WITHOUT CONSUMER PRESENT
(COLLATERAL)
- CL6010 (90847) FAMILY PSYCHOTHERAPY WITH CONSUMER PRESENT
(COLLATERAL)
- CL6050 (90849) MULTIPLE-FAMILY GROUP THERAPY
- CL6051 (90853) GROUP PSYCHOTHERAPY OTHER THAN OF A MULTIPLE-
FAMILY GROUP
- CL6052 (90857) INTERACTIVE GROUP THERAPY

OTHER PSYCHOTHERAPY

- CL6011 (90862) PHARMACOLOGIC MANAGEMENT
- Including prescription use and review of medication with no more than minimal
medical psychotherapy (approximately 20 minutes).
- CL6053 (90887) COLLATERAL SERVICE
- Interpretation or explanation of results of psychiatric, other medical examinations
and procedures, or other accumulated data to family or other responsible persons,
or advising them how to assist consumer.
- CL6054 (90899) UNLISTED PSYCHIATRIC SERVICE OR PROCEDURE,
INCLUDING OBSERVATION AND CRISIS INTERVENTION

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

REHABILITATION COUNSELING

CODE

**CL7000 COMPREHENSIVE (DISCIPLINE SPECIFIC) DIAGNOSTIC AND
EVALUATION VISIT [Part 679.5(c)(6)]**

A single claimed clinic visit (which may require more than one encounter) during which the person receives from a single discipline specific professional, a full range comprehensive assessment protocol sufficient in scope to completely describe and analyze the person's functional status, needs for service and treatment recommendations in that clinical area. Payment for said visit shall include assignment of a treatment coordinator and preparation of a written report setting forth findings and recommendations, forwarding of the report to the referral source and consultation with the referral source, if requested. A provider may claim only one discipline specific assessment visit per discipline per year. The duration of contact and/or observation shall be at least two hours.

CL7001 INITIAL/SPECIAL/RE-ASSESSMENT

- ▶ Job Skills Assessment
- ▶ Work Environment Evaluation
- ▶ Pre-Placement Job Screening
- ▶ Job Equipment Assessment

CL7002 TREATMENT PLAN SERVICE

- ▶ Individual Counseling
- ▶ Intervention with Observation
- ▶ Impulse Control
- ▶ Job Related Stress
- ▶ Social Skills
- ▶ Behavior Management

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
BILLABLE ACTIVITIES

REHABILITATION COUNSELING
(continued)

CODE

NOTE: CL0074 - CL0079 MUST RELATE TO SKILL DEVELOPMENT NECESSARY TO MAINTAIN OR OBTAIN EMPLOYMENT.

CL7004 SELF CARE/HOME MANAGEMENT TRAINING

Example: activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment/Assistive Technology Services.

CL7005 COMMUNITY WORK REINTEGRATION TRAINING

Example: shopping, transportation, money management, avocational activities and/or work environment/modifications analysis, work task analysis/Assistive Technology Services.

CL7006 DEVELOPMENT OF COGNITIVE SKILL

To improve attention, memory, problem solving (includes compensatory training).

CL7009 GROUP SERVICES

3-12 consumers: 18 years old or older minimum 45 minutes; less than 18 years old minimum 30 minutes.

CLINIC TREATMENT FACILITIES (PART 679)
ACTIVITIES/TABS CODING GUIDELINES
NON-BILLABLE ACTIVITIES

CODE

CL9000	Report Writing/Documentation
CL9001	Travel Time
CL9002	Staff Consultations (Internal/External)
CL9003	Review Medical Record/History
CL9004	Cancellation/Consumer
CL9005	Cancellation/Clinician
CL9006	No Show
CL9007	Telephone Follow-up
CL9008	Internal Treatment Coordination
CL9009	Clinician Advocacy for Individual/Collateral
CL9010	Telephone Counseling
CL9011	Discharge Planning
CL9012	Miscellaneous
CL9050	Non-Claimable Nursing Services
CL9100	Nursing Support - Clinical Assistance to Medical Consultants and/or Primary Care Physicians.

The purpose and intent of Nursing Support (CL Code 9100) is to discretely report on nursing staff time spent providing clinical assistance to Medical Consultants and/or Primary Care Physicians. The time spent by the nurse is not BILLABLE to Medicaid since the Consultant and/or Physician bills for the service provided.

NOTE: However, it should be noted that if (BILLABLE) Nursing Services are provided in addition to clinical assistance to Medical Consultants/Primary Care Physicians (prior to or after medical appointment), this nursing time (DURATION) should be reported using the appropriate billable Nursing CL Code(s) and not CL9100.

