



# Affiliated Computer Services, Inc. Certificate of Medical Necessity, Page 1 of 2

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Submitted by: \_\_\_\_\_

Date: \_\_\_\_\_

Recipient Name: \_\_\_\_\_

Ordering Provider's Name: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

Medicaid ID# or AK License #: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Sex: \_\_\_ (M or F)

Telephone #: (\_\_\_) \_\_\_-\_\_\_ Ext. \_\_\_

HT: \_\_\_ (inches) WT: \_\_\_ (pounds)

Retrospective Review? \_\_\_ (Y/N)

Date of last visit: \_\_\_\_\_

### SECTION A: CLINICAL INFORMATION

(THIS SECTION **MUST** BE COMPLETED BY THE ATTENDING PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT OR AUDIOLOGIST.)

**DIAGNOSIS**

**ICD-9-CM**

Estimated Length of Need (# of Months): \_\_\_\_\_ 1 – 99 (99 = Lifetime)

**SECTION B: CLINICAL ASSESSMENT OF NEED FOR PRESCRIBED SERVICES OR ITEM(S) AND PLAN:** Record information indicating the medical necessity of the requested services or items. Attach any additional information pertinent to the necessity of the requested equipment. (THIS SECTION MAY BE COMPLETED BY THE ATTENDING SPECIALIST, INCLUDING THE PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT, PHYSICAL THERAPIST, OCCUPATIONAL THERAPIST, SPEECH LANGUAGE PATHOLOGY THERAPIST, REGISTERED DIETITIAN, AUDIOLOGIST, OR OTHER ATTENDING SPECIALIST WITHIN THE SCOPE OF HIS OR HER SPECIALTY.)

**PLAN:** The plan should list each service or item specifically needed for the treatment of the recipient. Additional information may be attached to this form.

### ATTESTATION, SIGNATURE AND DATE OF AUDIOLOGIST/PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT AND SPECIALIST (Note: Specialist = PT, OT, SLP, RD, MD, NP, PhD, LSW, etc.)

*A physician, nurse practitioner, physician assistant, audiologist or specialist who attests to the medical necessity of the prescribed items, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the services or items requested in this form and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.*

\_\_\_\_\_  
Signature of Specialist – Title

\_\_\_\_\_  
Date

*This must be signed by the specialist if Section B is completed by someone other than the provider in Section A.*

\_\_\_\_\_  
Signature of Audiologist / Physician / Nurse Practitioner / Physician Assistant

\_\_\_\_\_  
Date

*I hereby certify that I am the ordering audiologist/physician/nurse practitioner/physician assistant identified in this form.*



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**Affiliated Computer Services, Inc.  
Certificate of Medical Necessity, Page 2 of 2**

ACS is now a Xerox company

Submitted by: \_\_\_\_\_

Date: \_\_\_\_\_

Recipient Name: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Sex: \_\_\_ (M or F)

Ordering Provider's Name: \_\_\_\_\_

Medicaid ID# or AK License #: \_\_\_\_\_

Telephone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

**SECTION C: REQUESTED SERVICES OR ITEMS**  
*(To Be Completed by DME, P&O, Audiology, or Hearing Aid Providers)*

Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_

Provider Medicaid No.: \_\_\_\_\_

Requester Name: \_\_\_\_\_

Telephone #: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Fax #: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Dates of Need – Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**ACS Use Only**

Your request is:

Approved as requested

Approved as modified  
(Items marked as authorized may be claimed.)

Prior Authorization Number: \_\_\_\_\_

From Date: \_\_\_\_\_ Thru Date: \_\_\_\_\_

Denied

Authorizing Agent Signature & Date: \_\_\_\_\_

Comments: \_\_\_\_\_

	Procedure Code	Mod.	Description	QTY (#)	Charges	Authorized		Approved Quantity	Approved Amount
						Yes	No		
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									

**SECTION D: SUPPLIER ATTESTATION, SIGNATURE AND DATE**

*I certify that those services or items listed in this form are those exact services or items ordered and certified as medically necessary by the ordering audiologist/physician/nurse practitioner/physician assistant specified in this form, and that these exact services or items listed in this form will be supplied to the specified recipient. A provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.*

\_\_\_\_\_  
Signature of Supplier

\_\_\_\_\_  
Date

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**Table I-5.(a) 2010 CPT<sup>1</sup> Fee Schedule for Speech Pathologists**

<b>Code</b>	<b>Description</b>	<b>Maximum Allowable</b>
92506	SPEECH/HEARING EVALUATI	\$194.91
92507	SPEECH/HEARING THERAPY	\$83.24
92508	SPEECH/HEARING THERAPY	\$40.99
92526	ORAL FUNCTION THERAPY	\$138.04
92540	BASIC VESTIBULAR EVALUATI	\$135.14
92551	PURE TONE HEARING TEST,	\$12.16
92570	ACOUSTIC IMMITTANCE TEST	\$45.45
92597	ORAL SPEECH DEVICE EVAL	\$142.96
92601	COCHLEAR IMPLT F/UP EXAM	\$212.99
92602	REPROGRAM COCHLEAR IMP	\$131.35
92603	COCHLEAR IMPLT F/UP EXAM	\$198.16
92604	REPROGRAM COCHLEAR IMP	\$115.67
92605	EVAL FOR NONSPEECH DEVI	\$147.73
92606	NON-SPEECH DEVICE SERVIC	\$80.01
92607	EX FOR SPEECH DEVICE RX,	\$185.65
92608	EX FOR SPEECH DEVICE RX	\$37.67
92609	USE OF SPEECH DEVICE SER	\$100.69
92610	EVALUATE SWALLOWING FU	\$152.46
92611	MOTION FLUOROSCOPY/SWA	\$162.88
92626 #	EVAL AUD REHAB STATUS	\$116.79
92627	EVAL AUD STATUS REHAB AD	\$28.07
92630	AUD REHAB PRE-LING HEAR	\$123.55
92633	AUD REHAB POSTLING HEAR	\$122.83
96110	DEVELOPMENTAL TEST, LIM	\$8.33
96111	DEVELOPMENTAL TEST, EXT	\$193.04
96150	ASSESS HLTH/BEHAVE, INIT	\$34.19
96151	ASSESS HLTH/BEHAVE, SUBS	\$33.02
96152	INTERVENE HLTH/BEHAVE, IN	\$31.42
96154	INTERV HLTH/BEHAV, FAM W/	\$30.84
97532	COGNITIVE SKILLS DEVELOP	\$35.79
97533	SENSORY INTEGRATION	\$38.34

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**Speech Pathology Services**  
 Coverage and rates are subject to change  
 Effective 1/1/2010 Dates of Service  
 2/26/2010

**Table I-5.(b) 2010 HCPC Fee Schedule for Speech Pathologists**

<b>Code</b>	<b>Description</b>	<b>Maximum Allowable</b>
V5362	SPEECH SCREENING	\$40.00
V5363	LANGUAGE SCREENING	\$60.00
V5364	DYSPHAGIA SCREENING	\$90.00

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**Speech Pathology Services**  
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Effective 1/1/2010 Dates of Service

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1  
**Table I-4.(a) 2010 CPT Fee Schedule for Independent Physical Therapists**

Code	Description	Maximum Allowable
20979	US BONE STIMULATION	\$66.29
29020	APPLICATION OF BODY CAST	\$264.73
29105	APPLY LONG ARM SPLINT	\$103.87
29125	APPLY FOREARM SPLINT	\$80.10
29126	APPLY FOREARM SPLINT	\$93.43
29130	APPLICATION OF FINGER SPL	\$50.76
29131	APPLICATION OF FINGER SPL	\$62.19
29200	STRAPPING OF CHEST	\$67.12
29240	STRAPPING OF SHOULDER	\$73.18
29260	STRAPPING OF ELBOW OR W	\$63.21
29280	STRAPPING OF HAND OR FIN	\$61.05
95831	LIMB MUSCLE TESTING, MAN	\$35.60
95832	HAND MUSCLE TESTING, MAN	\$34.31
95851	RANGE OF MOTION MEASUR	\$21.95
96110	DEVELOPMENTAL TEST, LIM	\$8.33
96111	DEVELOPMENTAL TEST, EXT	\$193.04
96150	ASSESS HLTH/BEHAVE, INIT	\$34.19
96151	ASSESS HLTH/BEHAVE, SUBS	\$33.02
96152	INTERVENE HLTH/BEHAVE, IN	\$31.42
96154	INTERV HLTH/BEHAV, FAM W/	\$30.84
97001	PT EVALUATION	\$101.86
97002	PT RE-EVALUATION	\$54.33
97010	HOT OR COLD PACKS THERA	\$6.74
97012	MECHANICAL TRACTION THE	\$21.26
97014	ELECTRIC STIMULATION THE	\$18.87
97016	VASOPNEUMATIC DEVICE TH	\$21.42
97018	PARAFFIN BATH THERAPY	\$10.57
97022	WHIRLPOOL THERAPY	\$24.23

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**Independent Physical Therapy Services**  
Coverage and rates are subject to change  
Effective 1/1/2010 Dates of Service  
2/26/2010

\* = PA Required  
# = Medical Justification or Written Report Required

1  
**Table I-4.(a) 2010 CPT Fee Schedule for Independent Physical Therapists**

Code	Description	Maximum Allowable
97024	DIATHERMY EG, MICROWAVE	\$7.59
97026	INFRARED THERAPY	\$6.74
97028	ULTRAVIOLET THERAPY	\$8.76
97032	ELECTRICAL STIMULATION	\$23.39
97033	ELECTRIC CURRENT THERAP	\$34.18
97034	CONTRAST BATH THERAPY	\$21.47
97035	ULTRASOUND THERAPY	\$17.22
97036	HYDROTHERAPY	\$36.02
97039	PHYSICAL THERAPY TREATM	\$14.47
97110	THERAPEUTIC EXERCISES	\$40.62
97112	NEUROMUSCULAR REEDUCA	\$42.15
97113	AQUATIC THERAPY/EXERCIS	\$48.97
97116	GAIT TRAINING THERAPY	\$36.00
97124	MASSAGE THERAPY	\$32.64
97139 #	PHYSICAL MEDICINE PROCED	\$19.90
97140	MANUAL THERAPY	\$38.17
97150	GROUP THERAPEUTIC PROC	\$25.83
97530	THERAPEUTIC ACTIVITIES	\$43.01
97532	COGNITIVE SKILLS DEVELOP	\$35.79
97533	SENSORY INTEGRATION	\$38.34
97535	SELF CARE MNGMENT TRAINI	\$43.17
97542	WHEELCHAIR MNGMENT TRAI	\$39.77
97750	PHYSICAL PERFORMANCE TE	\$41.73
97755	ASSISTIVE TECHNOLOGY AS	\$49.55
97760	ORTHOTIC MGMT AND TRAINI	\$45.55
97761	PROSTHETIC TRAINING	\$41.30
97762	C/O FOR ORTHOTIC/PROSTH	\$45.50

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**Table I-4.(b) 2010 HCPC Fee Schedule for Independent Physical Therapists**

<b>Code</b>	<b>Description</b>	<b>Maximum Allowable</b>
A4565 #	SLINGS	\$16.00
A4570 #	SPLINT	\$52.50
L0120 #	CERVICAL, FLEXIBLE, NON-ADJUSTABLE (FOAM COLLAR)	\$36.92
L0130 #	CERVICAL, FLEXIBLE, THERMOPLASTIC COLLAR, MOLDED TO PATIENT	\$133.31
L0140 #	CERVICAL, SEMI-RIGID, ADJUSTABLE (PLASTIC COLLAR)	\$42.06
L1843	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	\$705.03
L3010	FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, LONGITUDINAL ARCH SUPPORT, EACH	\$136.92
L3030	FOOT, INSERT, REMOVABLE, FORMED TO PATIENT FOOT, EACH	\$59.97
L3332	LIFT, ELEVATION, INSIDE SHOE, TAPERED, UP TO ONE-HALF INCH	\$57.97
L3740	ELBOW ORTHOSIS, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, ADJUSTABLE POSITION LOCK WITH ACTIVE CONTROL, CUSTOM-FABRICATED	\$1,515.43
L3760	ELBOW ORTHOSIS, WITH ADJUSTABLE POSITION LOCKING JOINT(S), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENTS, ANY TYPE	\$357.62
L3807	WRIST HAND FINGER ORTHOSIS, WITHOUT JOINT(S), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENTS, ANY TYPE	\$178.81
L3906	WRIST HAND ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	\$398.45
L3908	WRIST HAND ORTHOSIS, WRIST EXTENSION CONTROL COCK-UP, NON MOLDED, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	\$77.07
S9090	VERTEBRAL AXIAL DECOMPRESSION, PER SESSION	\$174.00

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# = Non-Routine Supplies Provided in Physical Therapist's Office

**Independent Physical Therapy Services**

Coverage and rates are subject to change

Effective 1/1/2010 Dates of Service

2/26/2010

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**Table I-6.(a) 2010 CPT<sup>1</sup> Fee Schedule for Occupational Therapy Services**

<b>Code</b>	<b>Description</b>	<b>Maximum Allowable</b>
29020	APPLICATION OF BODY CAST	\$264.73
29105	APPLY LONG ARM SPLINT	\$103.87
29125	APPLY FOREARM SPLINT	\$80.10
29126	APPLY FOREARM SPLINT	\$93.43
29130	APPLICATION OF FINGER SPLINT	\$50.76
29131	APPLICATION OF FINGER SPLINT	\$62.19
29200	STRAPPING OF CHEST	\$67.12
29240	STRAPPING OF SHOULDER	\$73.18
29260	STRAPPING OF ELBOW OR WRIST	\$63.21
29280	STRAPPING OF HAND OR FINGER	\$61.05
92526	ORAL FUNCTION THERAPY	\$138.04
92610	EVALUATE SWALLOWING FUNCTION	\$152.46
95831	LIMB MUSCLE TESTING, MANUAL	\$35.60
95832	HAND MUSCLE TESTING, MANUAL	\$34.31
95851	RANGE OF MOTION MEASUREMENTS	\$21.95
96110	DEVELOPMENTAL TEST, LIM	\$8.33
96111	DEVELOPMENTAL TEST, EXTEND	\$193.04
96150	ASSESS HLTH/BEHAVE, INIT	\$34.19
96151	ASSESS HLTH/BEHAVE, SUBSEQ	\$33.02
96152	INTERVENE HLTH/BEHAVE, INDIV	\$31.42
96154	INTERV HLTH/BEHAV, FAM W/PT	\$30.84
97003	OT EVALUATION	\$108.06
97004	OT RE-EVALUATION	\$61.98
97010	HOT OR COLD PACKS THERAPY	\$6.74
97014	ELECTRIC STIMULATION THERAPY	\$18.87

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Coverage and rates are subject to change  
Effective 1/1/2010 Dates of Service

\* = PA Required

# = Medical Justification or Written Report Required

2/26/2010

**Table I-6.(a) 2010 CPT<sup>1</sup> Fee Schedule for Occupational Therapy Services**

<b>Code</b>	<b>Description</b>	<b>Maximum Allowable</b>
97018	PARAFFIN BATH THERAPY	\$10.57
97032	ELECTRICAL STIMULATION	\$23.39
97034	CONTRAST BATH THERAPY	\$21.47
97110	THERAPEUTIC EXERCISES	\$40.62
97112	NEUROMUSCULAR REEDUCATION	\$42.15
97113	AQUATIC THERAPY/EXERCISES	\$48.97
97124	MASSAGE THERAPY	\$32.64
97139 #	PHYSICAL MEDICINE PROCEDURE	\$19.90
97140	MANUAL THERAPY	\$38.17
97150	GROUP THERAPEUTIC PROCEDURES	\$25.83
97530	THERAPEUTIC ACTIVITIES	\$43.01
97532	COGNITIVE SKILLS DEVELOPMENT	\$35.79
97533	SENSORY INTEGRATION	\$38.34
97535	SELF CARE MNGMENT TRAINING	\$43.17
97542	WHEELCHAIR MNGMENT TRAINING	\$39.77
97750	PHYSICAL PERFORMANCE TEST	\$41.73
97755	ASSISTIVE TECHNOLOGY ASSESS	\$49.55
97760	ORTHOTIC MGMT AND TRAINING	\$45.55
97761	PROSTHETIC TRAINING	\$41.30
97762	C/O FOR ORTHOTIC/PROSTH USE	\$45.50

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Effective 1/1/2010 Dates of Service

2/26/2010

**Table I-6.(b) 2010 HCPC Fee Schedule for Occupational Therapy Services**

<b>Code</b>	<b>Description</b>	<b>Maximum Allowable</b>
L1843	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	\$705.03
L1845	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	\$628.99
L3010	FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, LONGITUDINAL ARCH SUPPORT, EACH	\$136.92
L3030	FOOT, INSERT, REMOVABLE, FORMED TO PATIENT FOOT, EACH	\$59.97
L3332	LIFT, ELEVATION, INSIDE SHOE, TAPERED, UP TO ONE-HALF INCH	\$57.97
L3740	ELBOW ORTHOSIS, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, ADJUSTABLE POSITION LOCK WITH ACTIVE CONTROL, CUSTOM-FABRICATED	\$1,515.43
L3760	ELBOW ORTHOSIS, WITH ADJUSTABLE POSITION LOCKING JOINT(S), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENTS, ANY TYPE	\$357.62
L3807	WRIST HAND FINGER ORTHOSIS, WITHOUT JOINT(S), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENTS, ANY TYPE	\$178.81
L3906	WRIST HAND ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	\$398.45
L3908	WRIST HAND ORTHOSIS, WRIST EXTENSION CONTROL COCK-UP, NON MOLDED, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	\$77.07

\* = PA Required

# = Medical Justification or Written Report Required

**Occupational Therapy Services**  
Coverage and rates are subject to change

Effective 1/1/2010 Dates of Service

2/26/2010

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1  
**Table I-3.(a) 2010 CPT Fee Schedule for Outpatient Therapy Services**

Code	Description	Maximum Allowable
20979	US BONE STIMULATION	\$66.29
29020	APPLICATION OF BODY CAST	\$264.73
29105	APPLY LONG ARM SPLINT	\$103.87
29125	APPLY FOREARM SPLINT	\$80.10
29126	APPLY FOREARM SPLINT	\$93.43
29130	APPLICATION OF FINGER SPL	\$50.76
29131	APPLICATION OF FINGER SPL	\$62.19
29200	STRAPPING OF CHEST	\$67.12
29240	STRAPPING OF SHOULDER	\$73.18
29260	STRAPPING OF ELBOW OR W	\$63.21
29280	STRAPPING OF HAND OR FIN	\$61.05
92506	SPEECH/HEARING EVALUATI	\$194.91
92507	SPEECH/HEARING THERAPY	\$83.24
92508	SPEECH/HEARING THERAPY	\$40.99
92526	ORAL FUNCTION THERAPY	\$138.04
92540	BASIC VESTIBULAR EVALUATI	\$135.14
92551	PURE TONE HEARING TEST,	\$12.16
92570	ACOUSTIC IMMITTANCE TEST	\$45.45
92597	ORAL SPEECH DEVICE EVAL	\$142.96
92601	COCHLEAR IMPLT F/UP EXAM	\$212.99
92602	REPROGRAM COCHLEAR IMP	\$131.35
92603	COCHLEAR IMPLT F/UP EXAM	\$198.16
92604	REPROGRAM COCHLEAR IMP	\$115.67
92605	EVAL FOR NONSPEECH DEVI	\$147.73
92606	NON-SPEECH DEVICE SERVIC	\$80.01
92607	EX FOR SPEECH DEVICE RX,	\$185.65
92608	EX FOR SPEECH DEVICE RX	\$37.67

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**Outpatient Therapy Services**  
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 Effective 1/1/2010 Dates of Service  
 2/26/2010

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1  
**Table I-3.(a) 2010 CPT Fee Schedule for Outpatient Therapy Services**

Code	Description	Maximum Allowable
92609	USE OF SPEECH DEVICE SER	\$100.69
92610	EVALUATE SWALLOWING FU	\$152.46
92611	MOTION FLUOROSCOPY/SWA	\$162.88
92626 #	EVAL AUD REHAB STATUS	\$116.79
92627	EVAL AUD STATUS REHAB AD	\$28.07
92630	AUD REHAB PRE-LING HEAR	\$123.55
92633	AUD REHAB POSTLING HEAR	\$122.83
95831	LIMB MUSCLE TESTING, MAN	\$35.60
95832	HAND MUSCLE TESTING, MAN	\$34.31
95851	RANGE OF MOTION MEASUR	\$21.95
96110	DEVELOPMENTAL TEST, LIM	\$8.33
96111	DEVELOPMENTAL TEST, EXT	\$193.04
96150	ASSESS HLTH/BEHAVE, INIT	\$34.19
96151	ASSESS HLTH/BEHAVE, SUBS	\$33.02
96152	INTERVENE HLTH/BEHAVE, IN	\$31.42
96154	INTERV HLTH/BEHAV, FAM W/	\$30.84
97001	PT EVALUATION	\$101.86
97002	PT RE-EVALUATION	\$54.33
97003	OT EVALUATION	\$108.06
97004	OT RE-EVALUATION	\$61.98
97010	HOT OR COLD PACKS THERA	\$6.74
97012	MECHANICAL TRACTION THE	\$21.26
97014	ELECTRIC STIMULATION THE	\$18.87
97016	VASOPNEUMATIC DEVICE TH	\$21.42
97018	PARAFFIN BATH THERAPY	\$10.57
97022	WHIRLPOOL THERAPY	\$24.23
97024	DIATHERMY EG, MICROWAVE	\$7.59

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**Table I-3.(a) 2010 CPT<sup>1</sup> Fee Schedule for Outpatient Therapy Services**

Code	Description	Maximum Allowable
97026	INFRARED THERAPY	\$6.74
97028	ULTRAVIOLET THERAPY	\$8.76
97032	ELECTRICAL STIMULATION	\$23.39
97033	ELECTRIC CURRENT THERAPY	\$34.18
97034	CONTRAST BATH THERAPY	\$21.47
97035	ULTRASOUND THERAPY	\$17.22
97036	HYDROTHERAPY	\$36.02
97039	PHYSICAL THERAPY TREATMENT	\$14.47
97110	THERAPEUTIC EXERCISES	\$40.62
97112	NEUROMUSCULAR REEDUCATION	\$42.15
97113	AQUATIC THERAPY/EXERCISES	\$48.97
97116	GAIT TRAINING THERAPY	\$36.00
97124	MASSAGE THERAPY	\$32.64
97139 #	PHYSICAL MEDICINE PROCEDURES	\$19.90
97140	MANUAL THERAPY	\$38.17
97150	GROUP THERAPEUTIC PROCEDURES	\$25.83
97530	THERAPEUTIC ACTIVITIES	\$43.01
97532	COGNITIVE SKILLS DEVELOPMENT	\$35.79
97533	SENSORY INTEGRATION	\$38.34
97535	SELF CARE MANAGEMENT TRAINING	\$43.17
97542	WHEELCHAIR MANAGEMENT TRAINING	\$39.77
97750	PHYSICAL PERFORMANCE TESTING	\$41.73
97755	ASSISTIVE TECHNOLOGY ASSESSMENT	\$49.55
97760	ORTHOTIC MANAGEMENT AND TRAINING	\$45.55
97761	PROSTHETIC TRAINING	\$41.30
97762	C/O FOR ORTHOTIC/PROSTHESIS	\$45.50

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**Table I-3.(b) 2010 HCPC Fee Schedule for Outpatient Therapy Services**

<b>Code</b>	<b>Description</b>	<b>Maximum Allowable</b>
A4565 #	SLINGS	\$16.00
A4570 #	SPLINT	\$52.50
L0120 #	CERVICAL, FLEXIBLE, NON-ADJUSTABLE (FOAM COLLAR)	\$36.92
L0130 #	CERVICAL, FLEXIBLE, THERMOPLASTIC COLLAR, MOLDED TO PATIENT	\$133.31
L0140 #	CERVICAL, SEMI-RIGID, ADJUSTABLE (PLASTIC COLLAR)	\$42.06
L1843	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	\$705.03
L3010	FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, LONGITUDINAL ARCH SUPPORT, EACH	\$136.92
L3030	FOOT, INSERT, REMOVABLE, FORMED TO PATIENT FOOT, EACH	\$59.97
L3332	LIFT, ELEVATION, INSIDE SHOE, TAPERED, UP TO ONE-HALF INCH	\$57.97
L3740	ELBOW ORTHOSIS, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, ADJUSTABLE POSITION LOCK WITH ACTIVE CONTROL, CUSTOM-FABRICATED	\$1,515.43
L3760	ELBOW ORTHOSIS, WITH ADJUSTABLE POSITION LOCKING JOINT(S), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENTS, ANY TYPE	\$357.62
L3807	WRIST HAND FINGER ORTHOSIS, WITHOUT JOINT(S), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENTS, ANY TYPE	\$178.81
L3906	WRIST HAND ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	\$398.45
L3908	WRIST HAND ORTHOSIS, WRIST EXTENSION CONTROL COCK-UP, NON MOLDED, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	\$77.07
S9090	VERTEBRAL AXIAL DECOMPRESSION, PER SESSION	\$174.00
V5362	SPEECH SCREENING	\$40.00
V5363	LANGUAGE SCREENING	\$60.00
V5364	DYSPHAGIA SCREENING	\$90.00

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# = Non-Routine Supplies Provided in Physical Therapist's Office

**Outpatient Therapy Services**

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Effective 1/1/2010 Dates of Service

2/26/2010