### Workers Compensation Coding Guidelines

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>When are they used?</th>
<th>Able to bill with…</th>
</tr>
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</table>
| New Patient     | **No referral** from another physician.  
• The patient changes treating physicians  
• Referred by family or friends.  
• An established patient develops a new injury that is not related to the existing problem.  
✓ This should be clearly noted in the PR2 form, which is reimbursable. A dictated report is not reimbursable in this situation. | • **Exclude Hand:** 95831 (Muscle Testing) and 95851 (ROM)  
• **Hand:** 95832 (Muscle Testing) and 9585 (ROM)  
✓ Add the **Modifier 25** to the corresponding E&M when billing with ROM and/or Muscle Testing.  
• **99080** only  
✓ When a decision for surgery is made  
✓ When the need for physical therapy are recommended.  
• **20550-20615** (injections)  
✓ When an injection is performed (add the **Modifier 25** to the corresponding E&M to indicate that the patient’s condition required a significant, separate E&M service beyond the injection. |                                                                                                                                                                  |
| 99201-99205     |                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                  |
| Consultations   | • When a patient is **referred** by another physician                                                                                                                                                                                                                                                                                    | • **Exclude Hand:** 95831 (Muscle Testing) and 95851 (ROM)  
• **Hand:** 95832 (Muscle Testing) and 9585 (ROM)  
✓ Add the **Modifier 25** to the corresponding E&M when billing with ROM and/or Muscle Testing.  
• **99080** Reimbursable dictated reports  
✓ Mandatory for consultation codes, and should always be addressed to the referring physician or W/C Company.                                                    |                                                                                                                                                                  |
| 99241-99245     |                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                  |
| Established     | • When a patient is seen for follow-up of an established problem.  
• A post-op patient has unrelated problem (add the **Modifier 24** to the corresponding E&M.)  
✓ Be sure to document this unrelated injury in the PR2 subjective complaints section.  
• If a patient develops a new problem that is related to an existing injury, use one of these codes:  
✓ **99214** if you spend less than 30 minutes on the new problem.  
✓ **99215** if more than 30 minutes is spent. | • **Exclude Hand:** 95831 (Muscle Testing) and 95851 (ROM)  
• **Hand:** 95832 (Muscle Testing) and 9585 (ROM)  
✓ Add the **Modifier 25** to the corresponding E&M when billing with ROM and/or Muscle Testing.  
• **99081:** Reimbursable PR2 chart notes                                                                                                                                                                                                 |                                                                                                                                                                  |
| Patient         | 99211-99215                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                  |
| Permanent and   | • Dr. decides s/he cannot provide any further care for a patient of an established problem.                                                                                                                                                                                                                                                  | • (99080-17) Reimbursable dictated reports  
✓ P&S Report is mandatory to the W/C Company.                                                                                                                                                                                                 |                                                                                                                                                                  |
| Stationary      | 99213-99215                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                  |
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| (Face-to-Face) Prolonged Services 99354-99358 (Be specific with the time spent!) 99354-99358 (Be specific with the time spent!) | - Extended face-to-face visits are used that is beyond the usual E&M services.  
  - Communicate with case management nurse for additional time length.  
  - Use code 99354 when time spent with the patient exceeds the usual E&M service by at least 30 minutes up to one hour.  
  - Code 99355 for each additional 30 minutes. | - (99080) Reimbursable dictated reports  
  - Dictated with details of why the prolonged code is being billed (e.g. spent 20 minutes in review of records, spent 35 minutes in discussion with the Nurse).  
  - The Insurance Company will deny these codes if report does not reflect prolonged service. |
| (Non Face-to-Face) Prolonged Services 99358 (Be specific with the time spent!) | - Extended non face-to-face visits are used that is beyond the usual E&M services.  
  - Use code 99358 for review of patient records, job analysis, evaluation of ergonomic status, work limitations, work capacity or communication with other professionals or the patient/family by each 15 minutes. | - (99080) Reimbursable dictated reports  
  - Dictated with details of why the prolonged code is being billed (e.g. spent 20 minutes in review of records, spent 35 minutes in discussion with the Nurse).  
  - The Insurance Company will deny these codes if report does not reflect prolonged service. |
| Telephone Calls 99371-99373                     | - Report phone calls with the patient/family, adjusters or other health care professionals (e.g. physicians, nurses, therapists, social worker, and pharmacists).  
  - Use 99371 for simple calls (5 minutes or less) such as to report on test results, to clarify or alter previous instructions, or adjust therapy.  
  - Use 99372 for intermediate calls (10-15 minutes in length) such as advice to a patient on a new problem, initiate a new therapy, discuss test results in detail, initiate a new plan of care for an established patient.  
  - Use 99373 for complex or lengthy calls (20 minutes or longer in length) such as with an anxious or distraught patient, detailed or prolonged discussion with family members, lengthy communication necessary to coordinate complex services for a patient. | - (99081) Reimbursable PR2 chart notes with the phone code.  
  - After a phone call, document the patient’s name and which code you want billed on the superbill. Also, document on the PR2 who you spoke with and what was discussed, and length of the call.  
  - Without the PR2 the Insurance Company/ Review Company will deny the charge as need documentation to support charge. |