DEFINITION and DISPOSITION – Updated for 2019

Disposition Code	Definition of Disposition Code
1	The Medicare physician fee schedule (MPFS) abstract file does not contain prices for these codes – they are contractor-priced. Proper payment for these codes under the MPFS is determined by the A/B MACs.
2	CPT code 97760 should not be reported with CPT code 97116 for the same extremity.
3	These Healthcare Procedure Coding System/Common Procedural Terminology (HCPCS/CPT) codes are bundled under the MPFS. Regardless of whether they are billed alone or in conjunction with another therapy code, never make payment separately for these codes. If billed alone, these codes shall be denied using the existing MSN language. For remittance advice notices, use group code CO and claim adjustment reason code 97 that says: Payment is included in the allowance for another service/procedure. Use reason code 97 to deny a procedure code that should have been bundled. Alternatively, reason code B15, which has the same intent, may also be used.
4	If billed by a hospital or a Critical Access Hospital (CAH), these HCPCS/CPT codes are always paid as non-therapy services for hospital or CAH outpatients. Payment for these codes is always made using the respective payment methodology, e.g., Outpatient Prospective Payment System (OPPS) for OPPS hospitals or under the applicable cost-based method for CAHs.
5	These codes are “always therapy” services, regardless of who performs them. These codes always require a therapy modifier − GP, GO, or GN − to indicate that they're furnished under a physical therapy, occupational therapy, or speech-language pathology plan of care, respectively.
6	If billed by a hospital or a CAH, these OPPS-designated “sometimes therapy” HCPCS/CPT codes may be paid as non-therapy services for hospital or CAH outpatients. When these “sometimes therapy” codes are furnished by a qualified therapist under a therapy plan of care, the requirements for the MPFS-designated “sometimes therapy” codes, described in disposition ‘7’, apply.
7	These HCPCS/CPT codes represent “sometimes therapy” services. However, these codes are “always therapy” services when furnished by a therapist and in this situation require the use of a therapy modifier − GP, GO or GN − in order to indicate the service is furnished under a physical therapy, occupational therapy, or speech-language pathology plan of care, respectively. When these “sometimes therapy” codes are not considered therapy services, the therapy limits and therapy modifiers do not apply. Codes marked ‘7’ are not therapy services when:

	• It is not appropriate to bill the service under a therapy plan of care, and • They are billed by practitioners who are not therapists, i.e., physicians, clinical nurse specialists, nurse practitioners, physician assistants, and psychologists. While this disposition designates that a particular HCPCS/CPT code will not of itself always indicate that a therapy service was rendered, these codes always represent therapy services when rendered by therapists or by practitioners who are not therapists in situations where the service provided is integral to an outpatient rehabilitation therapy plan of care. For these situations, these codes must always have a therapy modifier. For example, when the service is rendered by either a doctor of medicine or a nurse practitioner (acting within the scope of his or her license when performing such service), with the goal of rehabilitation, a therapy modifier is required. When there is doubt about whether a service should be part of a therapy plan of care, the contractor shall make that determination.
8	**NOTE: Functional Reporting requirements have been discontinued. Effective for dates of service on and after January 1, 2019, these HCPCS codes and their severity modifiers are no longer required to be reported on claims or documented in medical records. The below instructions apply only to dates of service when the Functional Reporting requirements were effective: January 1, 2013 through December 31, 2018. See related Change Request 11120.** These nonpayble HCPCS G-codes are used only for required Functional Reporting. These HCPCS G-codes are considered “always therapy” codes in that they always require the use of a therapy modifier − GP, GO, or GN − to indicate they're furnished under a physical therapy, occupational therapy, or speech-language pathology plan of care, respectively. In addition, these nonpayable G- codes always require a severity modifier, in the range CH through CN, to indicate the applicable percentage of impairment, limitation, or restriction. See the Medicare Claims Processing Manual, Chapter 5, Section 10.6 for more details on Functional Reporting including severity modifier definitions.
9	These evaluation and re-evaluation codes require a specific therapy modifier − GP, GO, or GN − to indicate when the evaluative service is furnished under a physical therapy, occupational therapy, or speech-language pathology plan of care, respectively. See related Change Requests (CR): CR 9698 and CR 10176.