Definitions of Numbered Columns

1 The physician fee schedule abstract file does not contain a price for this code,therefore, the FI must contact the carrier to obtain the appropriate fee schedule amount in order to make proper payment for these codes.

2 CPT code 97760 should not be reported with CPT code 97116 for the same extremity.

3 These HCPCS/CPT codes are bundled under the MPFS. They are bundled with any therapy codes. 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 outpatient hospital department, these HCPCS codes are paid using the Outpatient Prospective Payment System (OPPS).

5 These codes are "always therapy" services, regardless of who performs them. These codes always require therapy modifiers (GP, GO, GN).

6 If billed by a hospital subject to OPPS for an outpatient service, these HCPCS codes –also indicated as "sometimes therapy" services - will be paid under the OPPS when the service is not performed by a qualified therapist and it is inappropriate to bill the service under a therapy plan of care. The requirements for other "sometimes therapy" codes, described below, apply.

7 These HCPCS/CPT codes sometimes represent therapy services. However, these codes always represent therapy services and require the use of a therapy modifier when performed by therapists.
There are some circumstances when these codes will not be considered representative of therapy services and therapy limits (when they are in effect) will 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/providers of services who are not therapists, i.e., physicians, clinical nurse specialists, nurse practitioners and psychologists; or they are billed to fiscal intermediaries by hospitals for outpatient services which are performed by non-therapists.

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 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.