Annual Therapy Update

Section 1834(k)(5) of the Act requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility (CORF) services be reported using a uniform coding system. The current Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) is used for the reporting of these services. Payment for all CORF services and outpatient rehabilitation therapy services – including physical therapy, occupational therapy, and speech-language pathology – is made using the Medicare Physician Fee Schedule (MPFS) at the nonfacility rates.

The files on this web page contain the list of codes indicating whether they are "sometimes" or "always therapy" services. The additions, changes, and deletions to the therapy code list reflect those made in the applicable year for the Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4).

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. 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/CPT 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 a therapy modifier (GP, GO, or GN)."

6 "If billed by a hospital, these "sometimes therapy" HCPCS/CPT codes are paid under the OPPS when the service is not furnished by a qualified therapist under a therapy plan of care. When these "sometimes therapy" codes are furnished by a qualified therapist under a therapy plan of care, the requirements for other "sometimes therapy" codes, described below, 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)."

When these “sometimes therapy” codes are not considered therapy services, the therapy limits 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/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 that 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 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. “These nonpayble HCPCS G-codes are used only for required functional reporting. These HCPCS G-codes are considered “always therapy” codes in that they require the use of a therapy modifier (GP, GO, or GN).”