



## *Outpatient Therapy Code Modifiers*

### **Renewed Moratorium on Outpatient Therapy Codes**

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, which added §1834(k)(5) to the Social Security Act (the Act), required payment under a prospective payment system for outpatient rehabilitation services. Outpatient rehabilitation services include the following services:

- Physical therapy (which includes outpatient speech-language pathology)
- Occupational therapy

### **Therapy Modifiers**

All claims containing a procedure code from the following list of “Applicable Outpatient Rehabilitation HCPCS Codes” should contain one of the therapy modifiers to distinguish the discipline of the plan of care under which the service is delivered:

- GN** Services delivered under an outpatient speech-language pathology plan of care;
- GO** Services delivered under an outpatient occupational therapy plan of care; or,
- GP** Services delivered under an outpatient physical therapy plan of care.

The exception to this is: Claims from physicians (all specialty codes) and nonphysician practitioners, including specialty codes “50,” “89,” and “97,” may be processed without therapy modifiers for codes marked (+) sometimes only therapy codes.

Use Modifiers to identify therapy services **whether or not financial limitations are in effect**. When limitations are in effect, the national Common Working File (CWF) database tracks the financial limitation based on the presence of therapy modifiers. **Providers/suppliers must continue to report one of these modifiers for any therapy code on the list of applicable therapy codes except as noted above.** These modifiers do not allow a provider to deliver services that they are not qualified and recognized by Medicare to perform.

This is applicable to all claims from physicians, NPPs, PTPPs, OTPPs, CORFs, OPTs, hospitals, SNFs, and any others billing for physical therapy, speech-language pathology or occupational therapy services as noted on the applicable code list below.

Modifiers refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services. For example, respiratory therapy services, or nutrition therapy services shall not be represented by the codes, which require GN, GO, and GP modifiers.

For all other claims submitted by physicians or nonphysician practitioners (as noted above) containing these applicable HCPCS codes without therapy modifiers, the claim will be returned as unprocessable.



If specialty codes “65” and “67” are present on the claim and an applicable HCPCS code is without one of the therapy modifiers (GN, GO, or GP) the claim will be returned as unprocessable.

The CWF will capture the amount and apply it to the limitation whenever a service is billed using the GN, GO, or GP modifier.

**Applicable Outpatient Rehabilitation HCPCS Codes**

Regardless of financial limitation, the Centers for Medicare & Medicaid Services (CMS) identifies the following codes as therapy services. Underlined codes always require therapy modifiers. Codes with + signs need modifiers when they represent therapy services.

- **NOTE: Listing of the following codes does not imply that services are covered or applicable to all provider settings.**

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64550+	90901+	<u>92506</u>	<u>92507</u>	<u>92508</u>	<u>92526</u>
<u>92597</u>	<u>92605</u>	<u>92606</u>	<u>92607</u>	<u>92608</u>	<u>92609</u>
92610+	92611+	92612+	92614+	92616+	95831+
95832+	95833+	95834+	95851+	95852+	95992+
96105+	96110+	96111+	<u>96125</u>	<u>97001</u>	<u>97002</u>
<u>97003</u>	<u>97004</u>	<u>97010</u>	<u>97012</u>	<u>97016</u>	<u>97018</u>
<u>97022</u>	<u>97024</u>	<u>97026</u>	<u>97028</u>	<u>97032</u>	<u>97033</u>
<u>97034</u>	<u>97035</u>	<u>97036</u>	<u>97039</u>	<u>97110</u>	<u>97112</u>
<u>97113</u>	<u>97116</u>	<u>97124</u>	<u>97139</u>	<u>97140</u>	<u>97150</u>
<u>97530</u>	<u>97532</u>	<u>97533</u>	<u>97535</u>	<u>97537</u>	<u>97542</u>
97597+	97598+	97602+	97605+	97606+	<u>97550</u>
<u>97755</u>	<u>97760</u>	<u>97761</u>	<u>97762</u>	<u>97779</u>	<u>G0281</u>
<u>G0283</u>	<u>G0329</u>	0019T+	0029T+	0183T+	

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

+ 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 + 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 the “+” 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, WPS Medicare shall make that determination.

The underlined HCPCS codes on the above list do not have a + sign because they are considered “always therapy” codes and always require a therapy modifier. Therapy services, whether represented by “always therapy” codes, or + codes in the above list performed as outpatient rehabilitation therapy services, must follow all the policies for therapy services (e.g., Pub. 100-04, chapter 5; Pub. 100-02, chapters 12 and 15).

#### **Additional HCPCS Codes**

Some HCPCS/CPT codes that are not on the list of therapy services should not be billed with a modifier. For example, outpatient non-rehabilitation HCPCS codes G0237, G0238, and G0239 should be billed without therapy modifiers. These HCPCS codes describe services for the improvement of respiratory function and may represent either “incident to” services or respiratory therapy services that may be appropriately billed in the CORF setting. When the services described by these G-codes are provided by physical therapists (PTs) or occupational therapists (OTs) treating respiratory conditions, they are considered therapy services and must meet the other conditions for physical and occupational therapy. The PT or OT would use the appropriate HCPCS/CPT code(s) in the 97000 - 97799 series and the corresponding therapy modifier, GP or GO, must be used.

Another example of codes that are not on the list of therapy services and should not be billed with a therapy modifier includes the following HCPCS codes: 95860, 95861, 95863, 95864, 95867, 95869, 95870, 95900, 95903, 95904, and 95934. These services represent diagnostic services - not therapy services; they must be appropriately billed and shall not include therapy modifiers.

Other codes not on the above list, and not paid under another fee schedule, are appropriately billed with therapy modifiers when the services are furnished by therapists or provided under a therapy plan of care and where the services are covered and appropriately delivered (e.g., the therapist is qualified to provide the service). One example of non-listed codes where a therapy modifier is indicated, regards the provision of services described in the CPT code series, 29000 through 29590, for the application of casts and strapping. Some of these codes previously appeared on the above list, but were deleted because CMS determined that they represented services that are most often performed outside a therapy plan of care. However, when these



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services are provided by therapists or as an integral part of a therapy plan of care, the CPT code must be accompanied with the appropriate therapy modifier.

Additional information:

<http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf>