Definitions of Numbered Columns on Therapy Code List Updated for CY 2017

Column - 1

The physician fee schedule 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.

Column - 2

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

Column - 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.

Column - 4

If billed by a hospital or a 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.

Column - 5

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

Column – 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" are furnished by a qualified therapist under a therapy plan of care, the requirements for the PFS-designated "sometimes therapy" codes, described in disposition '7', apply.

Column – 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 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.

Column – 8

These non-payable 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). In addition, these functional G-codes always require a severity modifier.