
Program Memorandum Carriers

Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

Transmittal B-03-065

DATE: AUGUST 22, 2003

CHANGE REQUEST 2821

SUBJECT: Changes to Code List for Therapy Services

This Program Memorandum (PM) supplements PM AB-03-018, Change Request 2183 and directs carriers to update the code list for therapy services that will not apply to the financial limitations when billed by physicians and certain non-physician practitioners when not done under a therapy plan of care. This PM supersedes the effective date and implementation dates of PM AB-03-057 (CR 2709) only with respect to the “+” indicators on the list of HCPCS codes.

Background

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, 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); and
- Occupational therapy.

Section 4541(c) of the BBA required application of a financial limitation to all outpatient rehabilitation services (with the exception of outpatient departments of a hospital). These limits were in effect in 1999, but were removed in 2000-2002. Beginning September 1, 2003, the limitations on outpatient therapy services will be implemented again.

Applicable Outpatient Rehabilitation HCPCS Codes

The following is a complete list of the 55 “+” codes. It includes 36 newly designated codes in bold and 19 codes previously designated “+”.

29065+	29075+	29085+	29086+	29105+	29125+	29126+	29130+	29131+	29200+
29220+	29240+	29260+	29280+	29345+	29355+	29365+	29405+	29425+	29445+
29505+	29515+	29520+	29530+	29540+	29550+	29580+	29590+	64550+	90901+
90911+	92610+	92611+	92612+	92614+	92616+	95831+	95832+	95833+	95834+
95851+	95852+	96000+	96001+	96002+	96003+	96105+	96110+	96111+	96115+
97601+	G0279+	G0280+	0020T+	0029T+					

+ These codes will not apply to the financial limits when they are not done under a therapy plan of care and they are billed by providers of services who are represented by any specialty codes except 65 and 67 (PT in Private Practice, OT in Private Practice), also 73 and 74 (which were incorrectly noted in AB-03-018 and have since been reassigned to specialties that are not therapy services). Specialty codes 73 and 74 will be removed in a future instruction. Physicians and non-physician practitioners should only use therapy modifiers (GP, GN, GO) with the above codes when the services are provided under a therapy plan of care.

Provider Education

You must notify your providers/suppliers of this information by posting on your Web site, within 2 weeks of the issuance date of this PM and publishing this information in your next regularly scheduled bulletin. Provider education is essential in order for the financial limitation to be applied correctly. If you have electronic bulletin boards or listserv that are used to communicate with your community, post this message to your providers/suppliers. Instruct providers/suppliers about the above footnote to codes and its use. Remind all providers/suppliers that a plan of care must be on file, when appropriate, for all outpatient therapy services. Advise providers to resubmit claims returned for lack of therapy modifiers (GP, GN, GO) on the above codes newly designated with “+” (bolded) for services provided during July and August 2003. In addition, providers should be advised that therapy modifiers should not be used with claims with HCPCS codes noted with “+” unless that service is performed under a therapy plan of care.

The *effective date* for this PM is July 1, 2003.

The *implementation date* for this PM is September 1, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after July 1, 2005.

If you have any questions, contact your local regional office.