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 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**

CMS’ website contains a Therapy Code List (external link) that identifies codes that are sometimes or always considered therapy codes. The Definitions sheet with this list provides a description of the indicators on the list.

**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 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 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 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.