



## Therapy Questions and Answers

### Modifiers

#### 1) What does the 'GP' Modifier indicate - Physical Therapy or Therapy?

The GP Modifier is defined as 'Services delivered under an outpatient physical therapy plan of care.' The GP modifier does not indicate that a physical therapist performed the service. A physician, nurse practitioner, physician's assistant, and other qualified providers can use the modifier.

#### 2) If the GP Modifier is used under the "incident to," does Medicare pay or not when the services were not provided by a PT?

Use of the GP modifier does not affect "incident to" billing. If the service was not provided by the physical therapist, but is being billed under the therapist's number, supervision requirements must be met in order for this to be paid by Medicare. The GP modifier should be appended when the services were delivered under the patient's therapy care plan no matter who provided the service.

#### 3) If my claim denied because it was missing the appropriate modifier, 'GN,' 'GO,' or 'GP' can I appeal the denial?

No, appeals cannot be granted when claims are denied for missing or invalid information. You should correct the claim to reflect the proper modifier and resubmit.

#### 4) When billing Medicare for therapy sessions, are there specific modifiers that should be recorded on a claim? If so, are there any exceptions?

Yes, all claims containing 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: Modifiers are required in item 24D of the CMS 1500 claim form or electronic equivalent.

When submitting services with HCPCS codes for casts and splints, modifiers are not required from physicians (of all specialty codes) nonphysician practitioners, including specialty codes '50,' '89' and '97.' HCPCS codes that do not require any of these three modifiers are indicated with a '+' sign in the list of 'Applicable Outpatient Rehabilitation HCPCS Codes' indicated below:

#### Applicable Outpatient Rehabilitation HCPCS Codes

Regardless of financial limitation, CMS identifies the some HCPCS codes as therapy services. For a complete list of these codes view

<http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf> on page 30 and be sure to read the special character codes that follow,

The financial limits (when in effect) apply to services represented by the following codes, except as noted below. (NOTE: Listing of the following codes does not imply that services are covered.)

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.

#### 5) Are there any guidelines for using modifier 59?



For Medicare purposes, "Modifier 59 is only used for Correct Coding Initiative (CCI)."

**Modifier 59 Description 59 - Distinct Procedural Service:** Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. *Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.*

### Billing/Coding

**1) Can an occupational therapist bill for active wound care procedure codes?**

No. These procedures do not fall under the scope of practice for Occupational Therapists.

**2) When billing multiple therapy sessions, can I submit a claim using one line of service with a range of dates and the corresponding number of days or units?**

No, each session must be billed on a separate line with the number of days or units indicated in item 24G of the CMS 1500 claim form or the electronic equivalent.

**3) A patient presents with bilateral TKA's (Total Knee Arthroplasty) for outpatient physical therapy. An evaluation on both knees is done. Can we bill one PT evaluation for the right knee and a second PT evaluation for the left knee? If yes, what, if any, modifier would be used?**

Since both knees are known to need therapy and have an order for therapy, the evaluation of both knees of a patient, rendered on the same date of service would be billed as one evaluation. The appropriate modifier to distinguish the type of provider who performed the outpatient rehabilitation service should be used, GN (*Services delivered under an outpatient speech-language pathology plan of care*), GO (*Services delivered under an outpatient occupational therapy (OT) plan of care*), or GP (*Service delivered under an outpatient physical therapy (PT) plan of care*).

**4) Is there a providers contact person available that we could call with coding questions rather than customer service?**

Coding questions are best handled by coding professionals. Our Medicare Policy, Medical Review staff, and Outreach staff are not professional coders. We do from time to time help providers with coding questions as they relate to a specific Medicare Policy or specific claim. When necessary we seek clarification from CMS.

**5) Do you need to present a waiver for non-covered exclusions such as frequency?**



www.wpsmedicare.com

Yes. A test that is performed more frequently than allowed will receive a medical necessary denial. ABN's are to be given when a provider thinks Medicare may deny the claim as not medically necessary

**6) What are the guidelines for billing services on a timed procedure when the full 15 minutes are not provided? For example, what should be billed if we perform 9 minutes of the procedure when the procedure has a 15-minute description?**

This is addressed in CMS Pub. 100-4, Ch. 5, §20.2, Rev 1:

"Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any calendar day** using CPT codes and the appropriate number of units of service. For any single CPT code, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes, then 2 units should be billed. Time intervals for larger numbers of units are as follows:"

3 units > 38 minutes to < 53 minutes

4 units > 53 minutes to < 68 minutes

5 units > 68 minutes to < 83 minutes

6 units > 83 minutes to < 98 minutes

7 units > 98 minutes to < 113 minutes

8 units > 113 minutes to < 128 minutes

This information can be accessed on the CMS Website by

[clicking here.](#) 


## **Bundling**

**1) Where can I locate physical therapy services that may be 'bundled' (i.e. may not be paid separately when provided on the same day as another procedure)?**

See the [National Correct Coding Initiatives \(NCCI\) edits by clicking here.](#)

## **Documentation**

**1) What are athletic trainers allowed or not allowed to do for treatment and documentation?**

According to the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) [Pub. 100-02, Chapter 15, Sections 60-60.3 and 220-230.4](#)  1MB:

Athletic Trainers may not personally bill the Medicare Program. In addition, the services of an athletic trainer, massage therapist, recreation therapist, kinesiotherapist, low vision specialist or other like profession may not be billed to Medicare as therapy services incident to physicians services.

**2) Should I submit documentation initially with my charges for iontophoresis, bundled charges, 97140 and 97012, to expedite reimbursement?**

Presently, all claims should be submitted electronically, unless the provider is HIPAA exempt. Therefore, you should designate on the electronic claim form that you have "documentation



available upon request." If additional information is required, you will receive a system-generated letter requesting any required documentation before the processing of your claim can be completed. Please contact our EDI department at (866)503-9670 for additional electronic billing information.

## Professional Services

### 1) What is the definition of an independent therapist?

Per CMS [Internet-Only Manual \(IOM\) Pub.100-2, Ch.15, §220-230.4](#), "A therapist in independent (private) practice ordinarily is responsible for the expenses of an office and maintains hours of such frequency and duration that the patients treated can receive services as medically indicated."

### 2) What are the limitations for Physical Therapy Assistants (PTAs) providing services? Does the physical therapist need to be in the clinic when a PTA is treating?

Medicare has no set "limitations" for Physical Therapy Assistants (PTAs) in what they can perform. They would be able to perform services within their own scope of practice. Since PTA's cannot obtain their own provider number from Medicare, the services would need to be billed "incident to" a supervising provider. If you are billing the services of the assistant under the physical therapist's provider number in a private practice, then a qualified physical therapist or occupational therapist needs to be directly supervising the service.

### 3) Are PT license numbers required on evaluations, re-evaluations, and discharge notes?

No. However, if for any reason there has been a gap in licensure, be sure that Provider Enrollment is aware of new license numbers.

### 4) Are independent PTs required to participate in Medicare?

There is no requirement that independent PTs must agree to participation in Medicare. Section 30.3.1 of the Medicare Claims Processing On-line Manual addresses the mandatory assignment guidelines. The manual states, "*For the practitioner services of physicians and independently practicing physical and occupational therapists, the acceptance of assignment is not mandatory.*"

Participation in the Medicare program means that the physician or supplier agrees, **in writing**, to provide all covered services for all Medicare Part B beneficiaries on an assignment basis. This means the provider agrees to accept the Medicare approved amount as payment in full for each service. The participant may not collect more than the applicable deductible and coinsurance for covered services from the beneficiary or other party or organization.

All claims submitted by participating providers must be assigned. The assignment box must be marked "yes." This is true whether Medicare is the primary or secondary insurer. Medicare Secondary Payer (MSP) claims submitted to Medicare must be assigned. A non-participating provider may choose to accept assignment on a claim by claim basis.

Medicare has two fee schedules, a PAR (Participating) and Non-PAR (Non-Participating) fee schedule. The Medicare Physician Fee Schedules are available by visiting



[www.wpsmedicare.com](http://www.wpsmedicare.com)

<http://www.wpsmedicare.com/mac/fees/fees.shtml> on the WPS Medicare Website.

The **PAR Amount column** on the fee schedule shows the Medicare Physician Fee Schedule amount if you choose to participate. This amount will be Medicare's Approved Amount; 80% of this amount will be paid directly to the participating provider. The PAR Fee Schedule amount is 5% more than the Non-Participating (Non-PAR) Fee schedule amount, as participating providers receive this 5% incentive for agreeing to participate in the Medicare program.

The **Non-PAR Amount column** on the fee schedule shows the physician fee schedule amount for non-participating providers. This figure is 5% less than the PAR Fee Schedule column. This amount will be Medicare's Approved Amount; 80% of this amount will be paid to the patient if the provider does not accept assignment. If the provider does choose to accept assignment, 80% of this amount will be paid directly to the provider.

The **Limiting Charge** column shows the maximum amount that can be charged to a Medicare patient if the provider does not participate, and does not accept assignment. For 1998 and later dates of service, this amount can be no more than 115% of the column headed Non-PAR Amount. If you are a participating provider, this column does **NOT** apply to you.

## Miscellaneous

### 1) How often is re-certification of the continuing need for services required for PT/OT Speech Language Pathology services?

Re-certification is required every 30 days.

### 2) How involved must the PT be in the discharge visit? Can PTA/PT consult be enough or must the PT be part of the visit? How is this proved through documentation?

The Physical Therapist's involvement and the content of the discharge notes should be dictated by the therapist's professional rules of conduct. It is recommended that the therapist should follow the guidelines stated in the "Guide to Physical Therapy Practice" published by the American Physical Therapy Association for the termination of PT services.

### 3) Why is nothing for the feet covered unless the patient is diabetic?

Services performed by the Physical Therapist *that are within the Physical Therapist's scope of practice* are covered by Medicare Part B as long as documentation of medical necessity is in the medical record.