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Payment Policy

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Title	**Physical Medicine and Rehabilitation Services**		
Number	**CP.PP.099.v4.0**		
Last Approval Date	08/18/26	**Original Effective Date**	11/1/00
Cross Reference	• *Manipulation Services* • *Modifier 52-Reduced Services* • *Physical Therapy and Occupational Therapy Assistant Modifiers: CQ and CO*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define the Plan's limitations for Physical Medicine and Rehabilitation modalities and therapeutic services that are submitted on an outpatient or professional claim.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.
Policy	When the following physical medicine and rehabilitation services are covered by member benefits and are clinically appropriate for delivery by a licensed provider, the plan limits these services as follows: **<u>Modalities: Supervised and Constant Attendance:</u>** • **Supervised Modalities (97012 – 97028):** a maximum of one unit of supervised modalities on a single date of service, per provider • **Constant Attendance Modalities (97032 – 97039):** a maximum of two units of constant attendance modalities on a single date of service, per provider **<u>Therapeutic Procedure:</u>** • **Therapeutic Procedures (97110 – 97124, 97139-97140, 97530, 97760 – 97763 and 97129-97130):** a maximum of four units of therapeutic procedures on a single date of service, per provider **<u>Physical Therapy, Occupational Therapy Evaluation and Re-evaluations:</u>** • **Physical/Occupational Therapy Evaluation and Re-evaluation Procedures (97161-97168)**: one unit maximum for evaluation/re-evaluation on a single date of service, per provider. **<u>Physical and Occupational Therapy Assistant Services and Modifiers:</u>** When the services of a Physical Therapy Assistant (PTA) or Occupational Therapy Assistant (OTA) are provided under the direct supervision of a licensed Physical

Therapist or Occupational Therapist, the services are **ONLY** billed by the supervising licensed Physical Therapist or Occupational Therapist.

PTA and OTA billed services must be identified by appending one of the following therapy assistant modifiers:

- **CQ** – Outpatient physical therapy services furnished in whole or part by a physical therapy assistant, or
- **CO** – Outpatient occupational therapy services furnished in whole or part by an occupational therapy assistant.

Services rendered by the PTA or OTA are billed **ONLY** by the supervising physical therapist or supervising occupational therapist on two lines on a claim form and NOT by the individual PTA or OTA:

- **Line one**: Represents the services rendered by the supervising physical therapist or supervising occupational therapist appended with the appropriate plan of care modifier (GP or GO).
- **Line two**: Represents the services rendered by the PTA or OTA appended with the appropriate therapy assistant modifier (CQ or CO) and the appropriate plan of care modifier (GP or GO).

If the PTA or OTA rendered the **entire service** and the supervising physical therapist or supervising occupational therapist did not render any part of the service, the supervising physical therapist or supervising occupational therapist will bill just **one line** for the service rendered by the PTA or OTA appended with the appropriate therapy assistant modifier (CQ or CO) and the appropriate plan of care modifier (GP or GO).

Speech Therapy Services

The Plan limits Speech Therapy services as follows:

- **Individual therapy (92507):** one submission per individual, per date of service, per provider is allowed.
- **Group Therapy (92508):** one submission per individual per date of service, per provider is allowed.
- **Speech evaluations (92521-92524):** one submission per date of service, per provider is allowed.

Plan of Care Modifiers:

Physical Medicine and Rehabilitation services, when submitted by any provider and any specialty, must be submitted with an appropriate plan of care modifier to indicate when the services are performed as part of a therapy plan.

These services, as defined by CMS, which need a plan of care modifier are based on the current CMS "Annual Therapy Update" listing of codes (LINK) under classification "5" which reads:

> "**5** = These codes are "always therapy" services, regardless of who performs them. These codes always require a therapy modifier − GP, GO, or GN − to

indicate that they are furnished under a physical therapy, occupational therapy, or speech-language pathology plan of care, respectively."

Review the "Annual Therapy Code List" classifications for those codes that do and do not require plan of care modifiers.

Plan of care modifiers to append to a therapy code include:

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

These modifiers must be appended **by any provider** who renders one of the "always therapy" designated codes and should be appended **after** any reimbursement modifier. These modifiers should **not** be applied to any services other than those defined as **therapy** services.

Always Therapy Multiple Procedure Reduction

Effective for dates of service on or after December 4, 2026, always therapy services are subject to a multiple therapy reduction of the **practice expense component** (the overhead and non-physician administrative costs required to run a medical or professional practice) Always therapy services are identified by the Multiple Procedure flag of 5 on the current Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value Guide (LINK):

When two or more therapy procedures, subject to the multiple therapy reduction concept, are performed on the same patient by the provider on the same date of service, the following steps will occur to determine allowed amounts:

- The procedure with the highest per procedure allowance will be allowed at either 100% of the procedure fee schedule allowance, or the procedure billed charge, whichever is less.
- All other applicable lesser allowed procedures will be allowed with a 50% reduction of the procedure fee schedule allowance for the practice expense component of the code, or the procedure billed charge, whichever is less.

Unit billing for Time Codes

Following CPT coding guidelines for codes that have a time element stated in the code description, a unit of time is attained when the time mid-point is passed.

For many of the above modality or therapeutic codes, the time increment noted is 15 minutes which means the mid-point would be 8 minutes in order to bill a **single unit** for the code. For a specific breakout of unit determination, see the Codes/Coding Guidelines section of this policy.

Modifier 52-*Reduced Services,* is not recognized with timed modality or therapeutic services.

Codes/Coding Guidelines	**Supervised Modalities:** • **97012** – Application of a modality to 1 or more areas; traction, mechanical • **97014** – Application of a modality to 1 or more areas; electrical stimulation (unattended) • **97016** – Application of a modality to 1 or more areas; Vaso pneumatic devices • **97018** – Application of a modality to 1 or more areas; paraffin bath • **97022** – Application of a modality to 1 or more areas; whirlpool • **97024** – Application of a modality to 1 or more areas; diathermy (e.g., microwave) • **97026** – Application of a modality to 1 or more areas; infrared • **97028** - Application of a modality to 1 or more areas; ultraviolet **Constant Attendance Modalities:** • **97032** – Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes • **97033** – Application of a modality to 1 or more areas; iontophoresis, each 15 minutes • **97034** – Application of a modality to 1 or more areas; contract baths, each 15 minutes • **97035** – Application of a modality to 1 or more areas; ultrasound, each 15 minutes • **97036** – Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes • **97037** - Application of a modality to 1 or more areas; low-level laser therapy (i.e., nonthermal and non-ablative) for post-operative pain reduction (effective January 1, 2024) • **97039** – Unlisted modality (specify type and time if constant attendance) **Therapeutic Procedures:** • **97110** – Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility • **97112** – Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities • **97113** – Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises • **97116** – Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing) • **97124** – Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion) • **97129** - Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes

- **+97130** - Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code 97129 for the primary procedure)
- **97139** – Unlisted therapeutic procedure (specify)
- **97140** – Manual therapy techniques (mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
- **97530** – Therapeutic activities, direct (one on one) patient contact (use of dynamic activities to improve functional performance, each 15 minutes
- **97760** – Orthotics management and training (including assessment and fitting when not otherwise reported), upper extremities, lower extremities and/or trunk, initial orthotics encounter, each 15 minutes
- **97661** – Prosthetics training, upper and/or lower extremities, initial prosthetics encounter, each 15 minutes
- **97663** – Orthotics(s)/prosthetic(s) management and/or training, upper extremities, lower extremities and/or trunk, subsequent orthotics/prosthetics encounter, each 15 minutes

Physical and Occupational Therapy Evaluations:

- **97161** – Physical therapy evaluation: low complexity
- **97162** – Physical therapy evaluation: moderate complexity
- **97163** – Physical therapy evaluation: high complexity
- **97164** – Re-evaluation of physical therapy established plan of care
- **97165** – Occupational therapy evaluation; low complexity
- **97166** – Occupational therapy evaluation; moderate complexity
- **97167** – Occupational therapy evaluation; high complexity
- **97168** – Re-evaluation of occupational therapy established plan of care

Speech Therapy and Evaluation:

- **92507** – Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
- **92508** - Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
- **92521** – Evaluation of speech fluency (e.g., stuttering, cluttering)
- **92522** – Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria).
- **92523** – Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive, and expressive language)
- **92524** – Behavioral and qualitative analysis of voice and resonance

Unit Billing for Timed Codes:

In order to bill a unit for a timed code, the incurred time must **exceed** the "halfway" point for the time increment noted in the code description.

	The halfway point for any 15-minute increment timed modality or therapeutic service is 8 minutes. Any modality or therapeutic service rendered for **less than 8 minutes is not billable (0-7 minutes).** A billable unit for a 15-minute increment code is 8-22 minutes or any multiple of this time range. The halfway point for any 30-minute increment timed modality or therapeutic service is 16 minutes. Any modality or therapeutic service rendered for less **than 16 minutes is not billable (0-15)**. A billable unit for a 30-minute increment code is 16-45 minutes or any multiple of this time range.
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties, and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined by the plan.
Exceptions	Exception to the policy may be made when a member's employer group's benefits dictate otherwise.
Laws, Regulations & Standards	N/A
References	• American Medical Association's Current Procedural Terminology (AMA/CPT); Professional Edition codebook • Centers for Medicare and Medicaid Services (CMS) Practitioner MUE Table • Center for Medicare and Medicaid Services (CMS) Annual Therapy Update (LINK) • Center for Medicare and Medicaid Services (CMS) Pub 100-20, Transmittal 826

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	08/18/26; 12/29/25; 11/04/25; 11/12/24; 02/05/24; 03/13/23; 10/13/22; 06/06/22; 08/10/21; 02/25/21; 03/05/20; 02/10/20; 02/18/19; 08/09/18; 01/15/18; 01/24/17; 11/08/16; 06/26/16; 07/13/15; 07/14/14; 07/16/13; 07/16/12; 08/04/11; 05/13/11; 05/21/10; 07/20/09; 08/21/08; 08/24/07; 08/29/05; 04/12/05; 10/08/04; 04/14/04; 01/09/03; 10/19/99	
Version History	01/15/18	Listed codes in the "Codes/Coding Guidelines" section and added descriptions to all referenced codes in the Policy section
	08/09/18	Pulled out code 97127 as a separate code with a different time maximum unit value
	02/18/19	Revised the segment on Physical/Occupational Therapy Evaluations and Re-evaluation Procedures since the runout period has been exceeded for submission of old codes; Also revised the section in the Policy statement to identify the source for the calculation of time units for the codes in the policy
	02/10/20	Terminated code 97127 as of 12/31/2019; Added new codes 97129 and 97130 effective as of 01/01/2020 and explained their usage
	03/05/20	Combined new codes 97129 and 97130 into the third bullet "Therapeutic Procedures" section in the Policy statement
	02/25/21	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P electronic claim

		forms. Identified unit limits for the timed codes noted in the Policy section
	08/10/21	Added a cross-reference entry to the new Payment Policy on Physical Therapy and Occupational Therapy Assistant modifiers. In the Policy section, added the following new sections: • Therapy Assistant Modifiers • Plan of Care Modifiers
	06/06/22	Policy title revised to include Speech Therapy. Removed from the policy code 97127 which was terminated effective December 31, 2019. Added a new section in the Policy for Speech Therapy Services. Added modifier GN to the Plan of Care Modifiers section for Speech Therapy services. Added Speech Therapy procedure codes and descriptions to the Codes/Coding Guidelines section.
	10/13/22	Added clarification to the "Plan of Care Modifiers" section of the Policy and a link to the list of applicable codes. As stated in the July 2022 PROVIDER NEWS *June Payment Policy Updates*, effective with claims processed on and after August 15, 2022, a "Plan of Care modifier" (GN, GO, GP) must be appended to applicable therapy services.
	03/13/23	• The title of the policy changed to be more reflective of the category of procedure codes as defined in the CPT Codebook. From "*Physical, Occupational and Speech Therapy Services*" to "*Physical Medicine and Rehabilitation Services*" • The Purpose statement was changed to reflect the new policy title. • Policy section divided into the categories of codes as defined in the CPT Codebook: o *Modalities: Supervised and Constant Attendance* o *Therapeutic Procedure* o *Physical Therapy, Occupational Therapy Evaluation and Re-evaluations* • Plan of Care modifier section introductory paragraph changed to reflect the type of services subject to the requirement for modifiers.
	02/05/24	The following updates and clarifications were made to sections of the Policy statement: o Clarified the maximum number of units for the Supervised Modalities, Constant Attendance Modalities, Therapeutic Procedures and Physical/Occupational Therapy Evaluation and Re-Evaluation sections. o In the Plan of Care Modifiers section, added third paragraph urging providers to review the Annual Therapy Code list. o In the Codes/Coding Guidelines section, under the Constant Attendance Modalities, added new code 97037 which is effective January 1, 2024

		○ In the Unit Billing for Timed Codes, revised the second and third paragraphs on determining the halfway point of time for codes noted in the policy
	11/12/24	Annual review; no changes
	11/04/25	• Added clarifying time statement to policy section: "When calculating the number of billable units for a particular date of service, add the total minutes of skilled, one-on-one therapy and divide that total by 15. If eight or more minutes are left over, bill for one more unit; if seven or fewer minutes remain, an additional unit is not supported. The total billed therapy units must be supported by the documented total time spent on therapeutic activities." • Added *Manipulation Services* to cross reference section
	12/29/25	• Removed previous clarifying statement due to confusion: "When calculating the number of billable units for a particular date of service, add the total minutes of skilled, one-on-one therapy and divide that total by 15. If eight or more minutes are left over, bill for one more unit; if seven or fewer minutes remain, an additional unit is not supported. **The total billed therapy units must be supported by the documented total time spent on therapeutic activities."**
	08/18/26	• In the related claims section added "outpatient" claims. • In the policy section added "Always Therapy Multiple Procedure Reduction" information: ○ **Effective for dates of service on or after December 4, 2026,** always therapy services are subject to a multiple therapy reduction of the **practice expense component** (the overhead and non-physician administrative costs required to run a medical or professional practice) Always therapy services are identified by the Multiple Procedure flag of 5 on the current Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value Guide (LINK) ○ When two or more therapy procedures, subject to the multiple therapy reduction concept, are performed on the same patient by the same physician or other qualified healthcare professional at the same session.

This policy was published on August 25, 2026