

Coding Policy

Rehabilitation Therapy Services (Physical, Speech, and Occupational Therapy Services)

CODING POLICY NUMBER: 85

Effective Date: 02/1/2026
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Next Annual Review: 2026

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SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”). **The full Company portfolio of current coding policies is available online and can be [accessed here](#).**

POLICY APPLICATION

- Providence Health Plan Participating Providers
- Non-Participating Practitioners
- Commercial
- Medicaid/Oregon Health Plan
- Medicare

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Coding policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

POLICY STATEMENT

- I. Therapy services may be time-based or non-time-based. Time-based therapy services are billed based on the total time-code treatment minutes. (See “Procedure” for details.)
 - A. When a time-based therapy code is reported on the same date as a non-time-based therapy code, the documentation must clearly show distinct time periods for the two services. In addition to showing time for each service performed, the documentation must show total treatment time in minutes, to encompass both the time-based therapy codes and non-time-based therapy codes.
 - B. If two modalities of time-based therapy are rendered simultaneously, only one modality may be reported for that unit of time.

PROCEDURE

GENERAL

Time-Based Codes: Providers should bill outpatient therapy time-based code units based on the total time-code treatment minutes. If the total time of all time-based codes is less than 8 minutes, no therapy codes should be reported.

Table 1: Converting Direct Time Spent with Patients to Billable Units for Time-Based Therapy Services

Units	Time
0 units	Less than 8 minutes
1 unit	≥ 8 minutes through 22 minutes
2 units	≥ 23 minutes through 37 minutes
3 units	≥ 38 minutes through 52 minutes
4 units	≥ 53 minutes through 67 minutes
5 units	≥ 68 minutes through 82 minutes
6 units	≥ 83 minutes through 97 minutes
7 units	≥ 98 minutes through 112 minutes

The expectation remains that a provider’s direct treatment time for each unit billed will average 15 minutes, as this is the RVU used for calculating reimbursement rates for time-based CPT codes for therapy.

The medical record should reflect all the services that were rendered. Modifier -59 (distinct procedural service) should be appended to the separate codes to show there were distinct time periods for each service. If two modalities are rendered simultaneously, only one modality may be reported for that unit of time.

Company requires that modifiers GP, GO, and GN also be added to therapy codes as appropriate. Report only one plan of care therapy modifier per claim line. **Note: These modifiers do not identify distinct procedural services and thus do not preclude the need for modifier -59 when separate services are provided.**

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

Facility claims containing revenue codes 042X, 043X, or 044X should include a plan of care therapy modifier as appropriate. Claims containing lines with revenue codes and modifiers that do not conform to specified combinations or lines that contain more than one therapy modifier will not be considered.

- Revenue Code 042X (physical therapy) lines may only contain modifier GP
- Revenue code 043X (occupational therapy) lines may only contain modifier GO
- Revenue code 044X (speech-language pathology) lines may only contain modifier GN

In the calendar year (CY) 2019 PFS final rule (83 FR 59654 through 59660), CMS created 2 new modifiers for services furnished by therapy assistants, as follows:

- CQ Modifier: Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
- CO Modifier: Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

For dates of service on or after January 1, 2022, Company requires these modifiers to be appended to codes for therapy services, along with GP and GO therapy modifiers, for services in which the PTA or OTA performs more than 8 minutes of a 15-minute unit of timed therapy. These services are reimbursed at 85% of applicable payment rate.

Therapy Practice Expenses (PE)

Procedure codes with a multiple procedure indicator of "5" on the Medicare Physician Fee Schedule (MPFS) are subject to multiple therapy reductions. See Coding Policy 6.0 (Multiple Procedure Reductions).

Documentation Requirements

All of the following documentation is required for each date of service to support therapy services billed:

- Signed and dated daily treatment notes and progress reports.
- Documentation showing total number of minutes for time-based therapy codes.
 - This includes the total minutes providing only time-based code services. The amount of time for each specific intervention/modality must be recorded, as well as the total time

for all time-based codes. Time spent during rest periods or waiting for equipment should not be counted in the total minutes.

- Documentation showing total treatment time in minutes, to encompass both the time-based therapy codes and non-time-based therapy codes.
 - This includes all time spent providing direct services to the patient, for both untimed and time-based codes. Time spent during rest periods or waiting for equipment should not be counted in the total minutes.
- Documentation showing body areas treated, including a description of the specific therapy provided to each body area.
- Legible signature and professional identification of the provider of service.

Group Pool Therapy

When a patient is involved in group pool therapy, code 97150 may be billed once for each patient in the pool. The time spent in one-on-one time with each patient in the pool may not be broken out and billed separately, as there is no time specified for CPT code 97150.

Billing Scenario Examples

Example 1

Manual Therapy (CPT 97140) = 20 minutes

Therapeutic Exercises (CPT 97110) = 20 minutes

- Total direct treatment time = 40 minutes.
- Since the treatment minutes for each service are the same, bill two (2) units of one code and one (1) unit of the other code.
- It is inappropriate to bill 3 units of one code only.
- The medical record should reflect all services that were rendered.
- Bill 3 units total:
 - CPT 97140 = 2 units
 - CPT 97110 = 1 unit
 - or*
 - CPT 97110 = 2 units
 - CPT 97140 = 1 unit

Example 2

Manual Therapy (CPT 97140) = 35 minutes

Ultrasound (CPT 97035) = 7 minutes

- Total direct treatment time = 42 minutes.
- The first 30 minutes spent on CPT 97140 is counted as 2 full units (since the work unit for each CPT code is 15 minutes = 1 unit).

- The remaining time spent on CPT 97140 (5 minutes) is compared to the time spent on CPT 97035 (7 minutes) and the service that took more time is the service that should receive the remaining unit.
- The medical record should reflect all services that were rendered.
- Bill 3 units total:
 - CPT 97140 = 2 units
 - CPT 97035 = 1 unit

Example 3

Therapeutic Exercises (CPT 97110) = 37 minutes

Massage (CPT 97124) = 5 minutes

- Total direct treatment time = 42 minutes.
- The first 30 minutes spent on CPT 97110 is counted as 2 full units (since the work unit for each CPT code is 15 minutes = 1 unit).
- The remaining time spent on CPT 97110 (7 minutes) is compared to the time spent on CPT 97124 (5 minutes) and the service that took more time is the service that should receive the remaining unit.
- In this instance, it would not be appropriate to bill separately for the massage using CPT 97124.
- The medical record should reflect all services that were rendered.
- Bill 3 units total.
 - CPT 97110 = 3 units

Example 4

Therapeutic Exercises (CPT 97110) = 25 minutes

Therapeutic Activities (CPT 97530) = 24 minutes

- Total direct treatment time = 49 minutes.
- In this situation, since only two services have been provided, it is appropriate to bill more units for the service with the most direct treatment time. (25 minutes is greater than 24 minutes.)
- The medical record should reflect all services that were rendered.
- Bill 3 units total.
 - CPT 97110 = 2 units
 - CPT 97530 = 1 unit

Example 5

Manual Therapy (CPT 97140) = 20 minutes

Therapeutic Exercises (CPT 97110) = 10 minutes

Gait Training (CPT 97116) = 10 minutes

Ultrasound (CPT 97035) = 8 minutes

- Total direct treatment time = 48 minutes.

- In this situation, it is not appropriate to bill separately for the ultrasound, as the total units that can be billed are constrained by the total timed code treatment minutes.
- The medical record should reflect all services that were rendered.
- Bill 3 units total.
 - CPT 97140 = 1 unit
 - CPT 97110 = 1 unit
 - CPT 97116 = 1 unit

CROSS REFERENCES

- Coding Policy 06.0 (Multiple Procedure Reductions)

REFERENCES

1. Centers for Medicare and Medicaid Services (cms.gov)
2. American Medical Association. Current Procedural Terminology (CPT)
3. Providence Health Plan Clinical Coding Edits

POLICY REVISION HISTORY

Date	Revision Summary
1/2023	Annual review (converted to new template 5/2023). Original policy effective date: 2/2013
1/2024	Annual review. No changes to policy.
1/2025	Annual review. No changes to policy.
8/2025	Interim update. Updated facility revenue code and corresponding modifier requirements, clarified modifiers GN, GO, and GP may be reported only once per claim line. Added therapy PE information. Referenced CP 6.0.
10/2025	Annual Review. Title change. Clarified documentation requirements for time and non-time-based services. Added reimbursement statement for procedures appended with modifier CO or CQ.
12/2025	Interim update. Removed PE reduction methodology.