Physical therapy

1. Can a therapist bill for more than one therapy in the same 15-minute increment?

A therapist may bill for more than one therapy service occurring in the same 15-minute time-period where "supervised modalities" are defined by CPT as untimed and unattended, not requiring the presence of the therapist (97010 to 97028). One or more supervised modalities may be billed in the same 15-minute time-period with any other CPT code, timed or untimed, requiring constant attendance or direct one-on-one patient contact. However, you cannot count any actual time the therapist uses to attend one-on-one to a patient receiving a supervised modality for any other service provided by the therapist.

1. Can physical therapy assistants bill under the group number using their NPI number of the physical therapist?

The group may bill eligible physical therapy assistant services under the physical therapist's NPI when he or she acts at the direction and under the supervision of the treating physical therapist and in accordance with state laws.

1. Does an increase in the time for physical therapy services from 15 to 30 minutes constitute a major change?

A change in long-term goals would be a significant change. An insignificant alteration in the plan would be a decrease in the frequency or duration due to the patient’s illness, or a modification of short-term goals to adjust for improvements made toward the same long-term goals. If a patient achieves a goal and/or had no response to a treatment that is part of the plan, the therapist may delete a specific intervention from the plan of care prior to physician/non-physician practitioner (NPP) approval. Report this to the physician/NPP responsible for the patient’s treatment prior to the next certification. In addition, documentation must address variations in the time and/or number of modalities per session.

1. Are physician's notified that they need to certify the plan of care in a timely manner?

No, as Medicare participating providers, physicians have an obligation to be aware and know the Medicare regulations and guidelines that pertain to the services they are rendering. Physicians can utilize our website and/or the CMS website to obtain information on Medicare regulations and guidelines.

1. If patients are noncompliant with the plan of care, and do not follow the recommended frequency of treatments, i.e., 3 times per week, how do we handle this situation?

The medical record documentation must support the reason why treatments are planned and/or performed only 1 to 2 times per week. The medical record documentation must clearly support the medical necessity for the treatments and why not planned and/or performed more frequently. Such patterns would be the exception and not the rule for therapy services rendered. Contact the referring physician if the patient continues to be non-compliant.

1. Is electrical stimulation a billable service?

Yes, electrical stimulation is a billable service with HCPCS code G0283, unattended electrical stimulation to one or more areas for indications other than wound care. For constant attendance electrical stimulation, report procedure code 97032.

1. What are the KX modifier threshold amounts, formerly known as financial limitations of therapy services?

For calendar year 2025, the KX modifier threshold amounts for outpatient physical therapy (PT) and speech-language pathology (SLP) combined is $2410; the limit for occupational therapy (OT) is $2410.

For calendar year 2024, the KX modifier threshold amounts for outpatient physical therapy (PT) and speech-language pathology (SLP) combined is $2330; the limit for occupational therapy (OT) is $2330.

Note: [Section 50202 of the Bipartisan Budget Act of 2018](https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers/Downloads/Medicare-Expired-Legislative-Provisions-Extended.pdf) repeals the application of the therapy caps while also retaining and adding limitations to ensure appropriate therapy. A provision of section 50202 of the BBA of 2018 adds section 1833(g)(7)(A) of the Act to preserve the former therapy cap amounts as thresholds above which claims must include the KX modifier to confirm that services are medically necessary as justified by appropriate documentation in the medical record. These amounts are now known as the KX modifier thresholds.

Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

1. What is an “automatic exception”?

When documentation indicates that the patient’s condition requires continued skilled therapy, i.e., therapy beyond the amount payable under the KX modifier threshold amounts (formerly known as therapy cap), to achieve their prior functional status or maximum expected functional status within a reasonable amount of time, it may qualify as an exception to the KX modifier threshold amounts (formerly known as therapy cap).

Clinicians may utilize the automatic process for exception for any diagnosis or condition for which they can justify services exceeding the KX modifier threshold amounts (formerly known as cap). Regardless of the diagnosis or condition, the patient must also meet other requirements for coverage. When billing for therapy services, report the diagnosis code that best relates to the reason for the treatment on the claim, unless there is a compelling reason to report another diagnosis code.

Reference

[CMS Pub. 100-04, Claims Processing Manual, Chapter 5, section 10.3B](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf)

1. Do providers need to submit documentation for "automatic" exceptions from the KX modifier threshold, formerly known as therapy cap?

There is no specific documentation to submit for exceptions to the KX modifier threshold amount (formerly known as therapy caps). The clinician is responsible for consulting guidance in the Medicare manuals and in the professional literature to determine if the beneficiary may qualify for the exception process when documentation justifies medically necessary services above the KX modifier threshold amount (formerly known as caps).

Submit documentation justifying the services in response to an additional documentation request for claims selected for medical review. Clinicians may include, at their discretion, a summary that specifically addresses the justification for KX modifier threshold amount (formerly known as therapy cap) exception.

1. How do I submit a request for an “automatic” exception?

When the beneficiary qualifies for a therapy cap exception, the provider shall add a [KX modifier](ddocname:00144500) to the therapy procedure code subject to the KX modifier threshold amount (formerly known as cap limits).

In addition to the KX modifier, continue to use the required GN, GP and GO.

By attaching the KX modifier, the provider is attesting that the services billed:

* Qualified for the cap exception either automatically or by contractor approval.
* Are reasonable and necessary services that require the skills of a therapist; and
* Are justified by appropriate documentation in the medical record.

If this attestation is determined to be inaccurate, the provider/supplier is subject to sanctions resulting from providing inaccurate information on a claim.

Note: [Section 50202 of the Bipartisan Budget Act of 2018](https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers/Downloads/Medicare-Expired-Legislative-Provisions-Extended.pdf) repeals the application of the therapy caps while also retaining and adding limitations to ensure appropriate therapy. A provision of section 50202 of the BBA of 2018 adds section 1833(g)(7)(A) of the Act to preserve the former therapy cap amounts as thresholds above which claims must include the KX modifier to confirm that services are medically necessary as justified by appropriate documentation in the medical record. These amounts are now known as the KX modifier thresholds.

Reference

[CMS Pub. 100-04 Claims Processing Manual, Chapter 5, section 10.3D](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf)

1. Can I just append the KX modifier to all my therapy claims?

No, only when a beneficiary qualifies for a KX modifier threshold amounts (formerly known as therapy cap) exception should the provider append a [KX modifier](ddocname:00144500) to the therapy procedure code that is subject to the KX modifier threshold amounts (formerly known as cap limits). By appending the KX modifier to the procedure code, the provider is attesting that the services billed qualify for the KX modifier threshold amounts (formerly known as cap) exception.

Note: [Section 50202 of the Bipartisan Budget Act of 2018](https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers/Downloads/Medicare-Expired-Legislative-Provisions-Extended.pdf) repeals the application of the therapy caps while also retaining and adding limitations to ensure appropriate therapy. A provision of section 50202 of the BBA of 2018 adds section 1833(g)(7)(A) of the Act to preserve the former therapy cap amounts as thresholds above which claims must include the KX modifier to confirm that services are medically necessary as justified by appropriate documentation in the medical record. These amounts are now known as the KX modifier thresholds.

1. What is the MR threshold, formerly known as therapy services threshold?

Part B therapy services are subject to the medical review (MR) threshold (formerly therapy services threshold). For calendar year 2018 (and each successive calendar year until 2028, at which time it is indexed annually by the MEI), this now-termed MR threshold amount is $3,000 for PT and SLP services combined and $3,000 for OT services. The thresholds apply to services reported with the [KX modifier](ddocname:00144500) and those without the modifier.

References

* [Medicare Expired Legislative Provisions Extended and Other Bipartisan Budget Act of 2018 Provisions](https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers/Downloads/Medicare-Expired-Legislative-Provisions-Extended.pdf)
* [Therapy Services](https://www.cms.gov/Medicare/Billing/TherapyServices/index.html)

1. Are therapy evaluations exceptions to the KX modifier threshold amounts, formerly known as therapy cap?

CMS considers evaluations an exception in the KX modifier threshold amounts (formerly known as therapy cap) process.

When exceptions are in effect and the beneficiary qualifies for a KX modifier threshold amounts (formerly known as therapy cap) exception, the provider shall add a [KX modifier](ddocname:00093712) to the therapy HCPCS code subject to the KX modifier threshold amounts (formerly known as cap limits).

Note: [Section 50202 of the Bipartisan Budget Act of 2018](https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers/Downloads/Medicare-Expired-Legislative-Provisions-Extended.pdf) repeals the application of the therapy caps while also retaining and adding limitations to ensure appropriate therapy. A provision of section 50202 of the BBA of 2018 adds section 1833(g)(7)(A) of the Act to preserve the former therapy cap amounts as thresholds above which claims must include the KX modifier to confirm that services are medically necessary as justified by appropriate documentation in the medical record. These amounts are now known as the KX modifier thresholds.

Reference

[CMS Pub. 100-04, Claims Processing Manual, Chapter 5](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf)