REHABILITATION SERVICES
Procedure Codes & Fee Schedule

eMedNY New York State Medicaid Provider Procedure Codes & Fee Schedule

New York State Medicaid
Office of Health Insurance
Department of Health

CONTACTS and LINKS:

eMedNY URL
https://www.emedny.org/

ePACES Reference Guide
https://www.emedny.org/selfhelp/ePACES/PDFS/5010_ePACES_Professional_Real_Time_Claim_Reference_Guide.pdf

eMedNY Contact Information
(800) 343-9000
eMedNY: Billing Questions, Remittance Clarification, Request for Claim Forms, ePACES Enrollment, Electronic Claim Submission Support (eXchange, FTP), Provider Enrollment, Requests for paper prior approval forms

eMedNY Contacts PDF

Table of Contents

1 DOCUMENT CONTROL PROPERTIES

Control Item	Value
Document Name	**Rehabilitation Service Procedure Codes & Fee Schedule**
Document Control Number	2023-1
Document Type	Procedure Code Manual & Fee Schedule
Document Version	2023-V3
Document Status	
Effective date	October 2023

2 GENERAL RULES AND INFORMATION

Medically necessary occupational therapy, physical therapy, and speech therapy visits in private practitioners' offices, certified hospital out-patient departments, and diagnostic and treatment centers (free-standing clinics) are covered

Services must be ordered, in writing, by a physician, physician assistant, or nurse practitioner so authorized by law. In addition, speech therapy services may be provided based on a written referral from a speech-language pathologist so authorized by law.

Utilization of a prior authorization (PA) process allows both the Department of Health and rehabilitation providers to track the number of therapy visits authorized for each beneficiary.

Prior Authorization/Dispensing Validation System (DVS)

When the procedure code description is preceded by "#", Medicaid Eligibility Verification System (MEVS) dispensing validation is required. The PA request is an attestation that the service is medically necessary and ordered by a licensed physician, physician assistant, or nurse practitioner.

The request for prior authorization should be submitted before the provision of service. A unique prior authorization number must be obtained through the Dispensing Validation System (DVS) for each visit. The DVS operates on "real time" and will give an immediate response to a request for prior authorization. A DVS authorization does not guarantee payment. However, without a prior authorization the claim will be denied. A request for prior authorization should be submitted before the provision of service. The request may be made after the date of service. Further instructions on obtaining a DVS authorization number can be accessed online at:

https://www.emedny.org/ProviderManuals/AllProviders/supplemental.aspx

Exemptions
Certain Medicaid enrollees, settings, and circumstances are exempt from prior authorization. These include:

- Children from birth to age 21 (until their 21st birthday)
- Individuals with a developmental disability (members with R/E code 95)
- Individuals with a traumatic brain injury (TBI) (members with R/E code 81, or having a traumatic brain injury as defined in Public Health Law Article 27-cc: https://codes.findlaw.com/ny/public-health-law/pbh-sect-2741.html)
- Individuals with both Medicare Part B and Medicaid coverage (dually eligible enrollees) when Medicare Part B payment is approved for the therapy service
- Rehabilitation services received as a hospital inpatient
- Individuals receiving rehabilitation services in a nursing home in which they reside
- Rehabilitation services provided by a certified home health agency (CHHA)

Payment in Full
Fees paid in accordance with the allowances in the Rehabilitation Services Manual shall be considered full payment for services rendered. No additional charge shall be made.

3 MODIFIERS

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.
ST	Services delivered to a patient with a traumatic brain injury (TBI) (as defined in Public Health Law Article 27-cc: § 2741

The appropriate modifier must be used for prior authorization requests and reported with therapy procedure codes on Medicaid claims.

Note: The National Correct Coding Initiative (NCCI) associated modifiers are recognized for NCCI code pairs/related edits. For additional information please refer to the CMS website: http://www.cms.hhs.gov/NationalCorrectCodInitEd/

4 OCCUPATIONAL THERAPIST, PHYSICAL THERAPIST AND SPEECH LANGUAGE PATHOLOGIST SERVICES

This section contains the appropriate procedure codes necessary for completion of forms required in submitting claims for Rehabilitation Services.

4.1 SPEECH LANGUAGE PATHOLOGY SERVICES

		Non-Facility Fee*
#92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation): individual. (30 minute minimum session length)	40.31

92521	Evaluation of speech fluency (eg, stuttering, cluttering)	116.43
92522	Evaluation of speech sound production (eg, articulation phonological process, apraxia, dysarthria);	97.85
92523	with evaluation of language comprehension and expression (eg, receptive and expressive language)	198.17
92524	Behavioral and qualitative analysis of voice and resonance	96.32

4.2 PHYSICAL THERAPY SERVICES AND OCCUPATIONAL THERAPY SERVICES

		Non-Facility Fee*
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	18.05
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes	28.02

*The above fees apply to services rendered in a private office setting. If physical therapy, occupational therapy, or speech therapy services are rendered in any other setting (e.g., D&TC, HOPD, nursing home) the therapist cannot bill Medicaid directly and would be paid by the medical institution.