

# 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](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](#)

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## 1 DOCUMENT CONTROL PROPERTIES

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## 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 21<sup>st</sup> 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

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

Non-Facility Fee\*  
40.31

92521	Evaluation of speech fluency (eg, stuttering, cluttering)	102.90
92522	Evaluation of speech sound production (eg, articulation phonological process, apraxia, dysarthria);	86.48
92523	with evaluation of language comprehension and expression (eg, receptive and expressive language)	175.13
92524	Behavioral and qualitative analysis of voice and resonance	85.12

## 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), <b>each 15 minutes</b>	17.87
97542	Wheelchair management (e.g., assessment, fitting, training), <b>each 15 minutes</b>	24.76

\*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.