
This content is from the eCFR and is authoritative but unofficial.

Title 42 – Public Health

Chapter IV – Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B – Medicare Program

Part 410 – Supplementary Medical Insurance (SMI) Benefits

Subpart B – Medical and Other Health Services

Authority: 42 U.S.C. 1302, 1395m, 1395hh, 1395rr, and 1395ddd.

Source: 51 FR 41339, Nov. 14, 1986, unless otherwise noted.

Editorial Note: Nomenclature changes to part 410 appear at [62 FR 46037](#), Aug. 29, 1997.

§ 410.60 Outpatient physical therapy services: Conditions.

- (a) **Basic rule.** Except as specified in [paragraph \(a\)\(3\)\(iii\)](#) of this section, Medicare Part B pays for outpatient physical therapy services only if they are furnished by an individual meeting the qualifications in [part 484](#) of this chapter for a physical therapist or an appropriately supervised physical therapist assistant but only under the following conditions:
- (1) They are furnished to a beneficiary while he or she is under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.
 - (2) They are furnished under a written plan of treatment that meets the requirements of [§ 410.61](#).
 - (3) They are furnished—
 - (i) By a provider as defined in [§ 489.2](#) of this chapter, or by others under arrangements with, and under the supervision of, a provider; or
 - (ii) By, or under the general supervision (or as specified otherwise) of, a physical therapist in private practice as described in [paragraph \(c\)](#) of this section; or
 - (iii) By, or incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform physical therapy services under State law. When a physical therapy service is provided incident to the service of a physician, physician's assistant, clinical nurse specialist, or nurse practitioner, by anyone other than a physician, physician assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service must meet the standards and conditions that apply to physical therapy and physical therapists, except that a license to practice physical therapy in the State is not required.
 - (4) Effective for dates of service on and after January 1, 2020, for physical therapy services described in [paragraphs \(a\)\(3\)\(i\)](#) or [\(ii\)](#) of this section, as applicable—
 - (i) Claims for services furnished in whole or in part by a physical therapist assistant must include the prescribed modifier; and
 - (ii) Effective for dates of service on or after January 1, 2022, claims for such services that include the modifier and for which payment is made under sections 1848 or 1834(k) of the Act are paid an amount equal to 85 percent of the amount of payment otherwise applicable for the service.

- (iii) For purposes of this paragraph, “furnished in whole or in part” means when the physical therapist assistant either:
 - (A) Furnishes all the minutes of a service exclusive of the physical therapist; or
 - (B) Except as provided in paragraph (a)(4)(iv) of this section, furnishes a portion of a service, or in the case of a 15-minute (or other time interval) timed code, a portion of a unit of service separately from the part furnished by the physical therapist such that the minutes for that portion of a service (or unit of a service) furnished by the physical therapist assistant exceed 10 percent of the total minutes for that service (or unit of a service).
- (iv) Paragraph (a)(4)(iii)(B) of this section does not apply when determining whether the prescribed modifier applies to the last 15-minute unit of a service billed for a patient on a treatment day, when the physical therapist provides more than the midpoint of a 15-minute timed code, that is, 8 or more minutes, regardless of any minutes for the same service furnished by the physical therapist assistant.
- (v) Where there are two remaining 15-minute units to bill of the same service, and the physical therapist and physical therapist assistant each provided between 9 and 14 minutes of the service with a total time of at least 23 minutes, one unit of the service is billed with the prescribed modifier for the minutes furnished by the physical therapist assistant and one unit is billed without the prescribed modifier for the service provided by the physical therapist.
- (b) **Condition for coverage of outpatient physical therapy services furnished to certain inpatients of a hospital or a CAH or SNF.** Medicare Part B pays for outpatient physical therapy services furnished to an inpatient of a hospital, CAH, or SNF who requires them but who has exhausted or is otherwise + ineligible for benefit days under Medicare Part A.
- (c) **Special provisions for services furnished by physical therapists in private practice –**
 - (1) **Basic qualifications.** In order to qualify under Medicare as a supplier of outpatient physical therapy services, each individual physical therapist in private practice must meet the following requirements:
 - (i) Be legally authorized (if applicable, licensed, certified, or registered) to engage in the private practice of physical therapy by the State in which he or she practices, and practice only within the scope of his or her license, certification, or registration.
 - (ii) Engage in the private practice of physical therapy on a regular basis as an individual, in one of the following practice types: a solo practice, partnership, or group practice; or as an employee of one of these.
 - (iii) Bill Medicare only for services furnished in his or her private practice office space, or in the patient’s home. A therapist’s private practice office space refers to the location(s) where the practice is operated, in the State(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours that the therapist engages in practice at that location. When services are furnished in private practice office space, that space must be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. A patient’s home does not include any institution that is a hospital, a CAH, or a SNF.
 - (iv) Treat individuals who are patients of the practice and for whom the practice collects fees for the services furnished.

(2) **Supervision of physical therapy services.** Except as otherwise provided in this paragraph (c)(2), physical therapy services are performed by, or under the general supervision of, a physical therapist in private practice. All services not performed personally by the therapist must be performed by employees of the practice, generally supervised by the therapist, and included in the fee for the therapist's services. Physical therapy services may be performed by a physical therapist assistant under the general supervision of the physical therapist in private practice; services performed by an unenrolled physical therapist must be under the direct supervision of the physical therapist.

(d) **Excluded services.** No service is included as an outpatient physical therapy service if it would not be included as an inpatient hospital service if furnished to a hospital or CAH inpatient.

(e) **Annual limitation on incurred expenses —**

(1) **Amount of limitation.**

(i) In 1999, 2000, and 2001, no more than \$1,500 of allowable charges incurred in a calendar year for outpatient physical therapy services are recognized incurred expenses.

(ii) In 2002 and thereafter, the limitation shall be determined by increasing the limitation in effect in the previous calendar year by the increase in the Medicare Economic Index for the current year.

(iii) The limitation is not applied for services furnished from December 8, 2003 through December 31, 2005.

(iv) Outpatient physical therapy and speech-language pathology services furnished by a CAH directly or under arrangements must be counted towards the annual limitation on incurred expenses as if such services were paid under section 1834(k)(1)(b) of the Act.

(v) Beginning in 2018 and for each successive calendar year, the amount described in paragraph (e)(1)(ii) of this section is not applied as a limitation on incurred expenses for outpatient physical therapy and outpatient speech-language pathology services, but is instead applied as a threshold above which claims for physical therapy and speech-language pathology services must include the KX modifier (the KX modifier threshold) to indicate that the service is medically necessary and justified by appropriate documentation in the medical record; and claims for services above the KX modifier threshold that do not include the KX modifier are denied.

(2) For purposes of applying the KX modifier threshold, outpatient physical therapy includes:

(i) Outpatient physical therapy services furnished under this section;

(ii) Outpatient speech-language pathology services furnished under § 410.62;

(iii) Outpatient physical therapy and speech-language pathology services furnished by a comprehensive outpatient rehabilitation facility;

(iv) Outpatient physical therapy and speech-language pathology services furnished by a physician or incident to a physician's service;

(v) Outpatient physical therapy and speech-language pathology services furnished by a nurse practitioner, clinical nurse specialist, or physician assistant or incident to their services; and

(vi) Outpatient physical therapy and speech-language pathology services furnished by a CAH directly or under arrangements, included in the amount of annual incurred expenses as if such services were furnished and paid under section 1834(k)(1)(B) of the Act.

- (3) A process for medical review of claims for physical therapy and speech-language pathology services applies as follows:
 - (i) For 2012 through 2017, medical review applies to claims for services at or in excess of \$3,700 of recognized incurred expenses as described in paragraph (e)(1)(i) of this section.
 - (A) For 2012, 2013, and 2014 all claims at and above the \$3,700 medical review threshold are subject to medical review; and
 - (B) For 2015, 2016, and 2017 claims at and above the \$3,700 medical review threshold are subject to a targeted medical review process.
 - (ii) For 2018 and subsequent years, a targeted medical review process when the accrued annual incurred expenses reach the following medical review threshold amounts:
 - (A) Beginning with 2018 and before 2028, \$3,000;
 - (B) For 2028 and each year thereafter, the applicable medical review threshold is determined by increasing the medical review threshold in effect for the previous year (starting with \$3,000 for 2017) by the increase in the Medicare Economic Index for the current year.

[63 FR 58906, Nov. 2, 1998, as amended at 67 FR 80041, Dec. 31, 2002; 69 FR 66422, Nov. 15, 2004; 72 FR 66399, Nov. 27, 2007; 77 FR 69363, Nov. 16, 2012; 78 FR 74811, Dec. 10, 2013; 79 FR 68002, Nov. 13, 2014; 83 FR 60073, Nov. 23, 2018; 84 FR 63188, Nov. 15, 2019; 86 FR 65664, Nov. 19, 2021; 88 FR 79527, Nov. 16, 2023; 89 FR 98556, Dec. 9, 2024]