2026 Physical Therapy CPT Codes Reference Sheet

Complete Billing Cheat Sheet for PT Billing Teams & Front Desk Staff

KEY INSIGHT

CPT 97110 (Therapeutic Exercise) accounts for ~42% of all PT billing — making it the single most important code for your revenue cycle.

Updated for CY 2026 Medicare Fee Schedule • Conversion factor: $33.40 (non-APM) / $33.57 (APM)

WHAT'S INSIDE

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01 Core PT CPT Codes — Timed Procedure Codes

CPT Code	AMA Descriptor	Timed/ Untimed	2026 Medicare Avg. Rate	Key Billing Note
97110	Therapeutic exercise: strength, endurance, ROM, flexibility — direct one-on-one contact	Timed (15 min)	**~$34–$36/unit**	Most billed PT code (~42% of all PT billing). Requires constant clinician attendance.
97530	Therapeutic activities: dynamic activities to improve functional performance — direct one-on-one contact	Timed (15 min)	**~$35–$38/unit**	Use for real-world functional tasks, not isolated exercise. Slightly higher rate than 97110.
97140	Manual therapy techniques: joint mobilization, manipulation, myofascial release, manual lymphatic drainage	Timed (15 min)	**~$34–$37/unit**	Positive rate change in 2026 due to APTA advocacy. Cannot bill with 97530 same body region without Modifier 59.
97112	Neuromuscular reeducation: balance, coordination, posture, kinesthetic sense, proprioception	Timed (15 min)	**~$34–$36/unit**	Requires objective baseline measures (balance scores, coordination data). Under CGS post-payment review.
97116	Gait training: therapeutic ambulation and assistive device use	Timed (15 min)	**~$32–$35/unit**	Document weight-bearing status and specific gait deviation being addressed.
97113	Aquatic therapy: therapeutic exercises in a pool setting	Timed (15 min)	**~$32–$35/unit**	Requires pool facility. Exempted from 2026 efficiency adjustment.
97535	Self-care/home management training: ADL, adaptive equipment	Timed (15 min)	**~$32–$35/unit**	Billable by PT and OT. Discipline identified by modifier (GP = PT, GO = OT).
97542	Wheelchair management training: fitting and propulsion	Timed (15 min)	**~$28–$32/unit**	Document specific wheelchair skills addressed each session.
97032	Electrical stimulation (manual/attended): constant attendance required	Timed (15 min)	**~$18–$22/unit**	Therapist must be in constant attendance throughout treatment.
97033	Iontophoresis: electrically assisted drug delivery	Timed (15 min)	**~$20–$24/unit**	Document medication used and electrode placement site.
97035	Ultrasound therapy: therapeutic ultrasound with direct contact	Timed (15 min)	**~$24–$27/unit**	Document intensity, frequency, and specific area treated. Required for every claim.

02 PT Evaluation & Reevaluation Codes — Untimed

CPT Code	Complexity Level	Typical Duration	History	Examination	Decision-Making	2026 Rate
97161	Low complexity	~20 min	Constrained (1–2 elements)	1–3 body systems	Low complexity	**~$72–$78**
97162	Moderate complexity	~30 min	Expanded (3+ elements)	3–4 body systems	Moderate complexity	**~$104–$110**
97163	High complexity	~45 min	Comprehensive (multifaceted)	4+ body systems	High complexity	**~$142–$150**
97164	Reevaluation	Untimed	Focused on change from baseline	Focused re-examination	Requires documented clinical change	**~$56–$62**

Critical Rule

Code complexity is determined by clinical findings AFTER the evaluation is complete — NOT by time spent. Document first, code second. Codes 97001 and 97002 are retired. Do not use.

97164 Rule

Reevaluation requires documented change in patient's clinical status since the last evaluation. Do not bill at routine intervals without that documented change.

03 Supervised Modality Codes — Untimed (Bill Once Per Session)

CPT Code	Description	Timed/Untimed	2026 Medicare Avg. Rate	Key Billing Note
97010	Hot or cold packs	Untimed	**~$10–$13**	Bill once per session regardless of application time.
97012	Mechanical traction	Untimed	**~$18–$22**	Document body region and treatment parameters.
97014	Electrical stimulation, unattended	Untimed	**~$10–$13**	**MEDICARE: Use G0283 instead.** Commercial payers accept 97014.
97016	Vasopneumatic devices	Untimed	**~$10–$13**	Verify payer coverage before billing.
97018	Paraffin bath	Untimed	**~$10–$13**	Document clinical indication.

Medicare Alert

Billing 97014 on a Medicare claim generates an automatic denial. Use **G0283** for unattended electrical stimulation on all Medicare Part B outpatient claims. Commercial payers accept 97014.

04 Group Therapy & Unlisted Codes

CPT Code	Description	Timed/Untimed	Key Billing Note
97150	Therapeutic exercise, group (2 or more patients)	**Untimed**	Bill ONCE per session — not per patient, not per hour. Cannot bill same day as individual codes for the same service.
97039	Unlisted modality	Untimed	Use when no other code fits. Document specific modality and rationale. Used for dry needling by some payers.
97545	Work conditioning/hardening, initial 2 hours	Timed	Document functional work capacity goals specifically. Precertification often required.
97546	Work conditioning/hardening, each additional hour	Timed	Bill in addition to 97545. Document progressive work simulation activities.

05 Remote Therapeutic Monitoring Codes — New for 2026

CPT Code	Description	Type	Key Requirement
98975	RTM setup and patient education	Per episode	Initial setup code.
98979 NEW	RTM treatment management, first 10 min/calendar month	Per month	**NEW 2026.** Requires real-time interactive communication with patient or caregiver.
98980	RTM treatment management, first 20 min/calendar month	Per month	Unchanged.
98981	RTM treatment management, each additional 20 min	Per month	Unchanged.
98976	RTM device supply, respiratory, 16–30 days	Per 30-day period	Revised descriptor 2026.
98977	RTM device supply, musculoskeletal, 16–30 days	Per 30-day period	Revised descriptor 2026.
98984 NEW	RTM device supply, respiratory, 2–15 days	Per 30-day period	**NEW 2026.** Fills partial-month billing gap.
98985 NEW	RTM device supply, musculoskeletal, 2–15 days	Per 30-day period	**NEW 2026.** Fills partial-month billing gap.

RTM Modifier Rule

GP modifier required for all PT RTM services. CQ modifier applies to 98975, 98979, 98980, and 98981 (subject to de minimis 10% policy). Device supply codes 98976, 98977, 98984, 98985 are NOT subject to the de minimis policy.

06 The 8-Minute Rule — Unit Calculation Table

Rule: To bill one unit of a timed code, the therapist must provide **at least 8 minutes** of that specific skilled service.

CMS Method for Multi-Code Sessions: Add ALL timed minutes together first, then assign units from the combined total.

Total Timed Minutes	Billable Units
8 – 22 minutes	**1 unit**
23 – 37 minutes	**2 units**
38 – 52 minutes	**3 units**
53 – 67 minutes	**4 units**
68 – 82 minutes	**5 units**
83 – 97 minutes	**6 units**
98 – 112 minutes	**7 units**
113 – 127 minutes	**8 units**

Worked Example

- 97110 (Therapeutic Exercise): 25 minutes
- 97140 (Manual Therapy): 20 minutes

Total timed minutes: 45 → Bill 3 units
Allocate: 2 units to 97110, 1 unit to 97140

Common Error

Count only time spent on skilled intervention. Equipment setup, rest breaks, and patient rest do not count toward timed units. Auditors look for gaps between documented time and billed units.

PTA Rule

When a Physical Therapist Assistant furnishes timed services in whole or in part, CQ modifier is required. Medicare pays **85% of the applicable rate** for those units.

07 Modifier Quick Reference

Modifier	Name	When to Use	What Happens Without It
GP	Physical Therapy	ALL PT services under a PT plan of care — every claim line	CO-4 denial on every affected claim line
GO	Occupational Therapy	All OT services under an OT plan of care	Denial or rejection for missing discipline identifier
GN	Speech-Language Pathology	All SLP services	Denial or rejection for missing discipline identifier
KX	Medical Necessity Above Threshold	When PT + SLP cumulative allowed charges exceed $2,480 (2026)	Automatic denial on every claim above the threshold
CQ	Physical Therapist Assistant	When PTA furnishes service in whole or in part	Claim paid at 100% when correct rate is 85% — creates overpayment/repayment exposure
CO	Occupational Therapist Assistant	When OTA furnishes service in whole or in part	Same overpayment issue as CQ for OT
59	Distinct Procedural Service	When two normally bundled codes are genuinely separate services	Payer bundles them and pays only one code

08 2026 Medicare KX Threshold & Financial Thresholds

Threshold	Amount	Applies To	Action Required
KX Modifier Threshold	**$2,480**	PT + SLP combined (separate $2,480 for OT)	Add KX modifier to every claim line above this amount
Targeted Medical Review Threshold	**$3,000**	PT + SLP combined (separate $3,000 for OT)	Treat documentation as audit-ready. Fixed through 2028.

KX Pre-Submission Checklist (Use for Every Claim Above $2,480)

- [ ] Confirmed patient's year-to-date allowed amount for PT + SLP combined
- [ ] KX modifier applied to each claim line
- [ ] Patient record documents continued medical necessity
- [ ] Plan of care is current and physician-certified
- [ ] Objective functional measures documented with baseline and progress data
- [ ] For patients above $3,000: documentation treated as audit-ready

09 Common Denial Codes & Prevention

Denial Code	Reason	Root Cause	Prevention Action
CO-4	Service inconsistent with modifier	Wrong or missing modifier — most often GP	Audit modifier setup in billing system by payer
CO-16	Claim lacks information	Missing or incomplete data fields	Implement pre-submission claim scrubbing
CO-18	Duplicate claim	Same service billed twice	Track claim status before resubmitting
CO-50	Not medically necessary	Documentation doesn't support service billed	Align clinical notes with CPT requirements before billing
CO-97	Service not covered for this patient	Benefits exhausted or wrong payer billed	Verify eligibility and benefits before each visit

10 NCCI Edit Pairs — Codes That Cannot Be Billed Together Without Modifier 59

Column 1 Code (Comprehensive)	Column 2 Code (Component)	Modifier Allowed	Clinical Note
97530	97110	Yes — Modifier 59	Bill together only if services are to different body regions or clearly distinct in documentation
97140	97530	Yes — Modifier 59	Manual therapy and therapeutic activity can be billed together with documentation of distinct services
97110	97150	**No**	Cannot bill individual therapeutic exercise and group therapy for the same service same day
97161	97140	Yes — Modifier 59	Same-day evaluation and treatment requires Modifier 59 with some payers
97032	97014	**No**	Cannot bill attended and unattended electrical stimulation for the same body area same day

Modifier 59 Rule

Documentation must explicitly state the clinical distinction BEFORE Modifier 59 is applied — different body regions, separate time periods, or separate clinical approaches. Modifier 59 is not a blanket bundling fix.

11 Multiple Procedure Payment Reduction (MPPR)

MPPR applies when a patient receives more than one "always therapy" service in a single session.

Service Sequence in Session	Payment Rate
Highest practice expense (PE) service	**100% of PE component**
Each subsequent service billed same day	**50% of PE component**
Work RVU and Malpractice RVU	**Not affected by MPPR**

Key Facts

MPPR has applied since April 2013 and is **unchanged in 2026**. MPPR is NOT a denial and is NOT appealable. Factor MPPR into revenue projections when designing multi-code session structures.

12 Place of Service Codes for PT Billing

Setting	Key Codes	Primary Payer	POS	Key Note
Outpatient clinic	97110, 97530, 97140, 97161–97164	Medicare Part B	**11**	KX threshold applies. GP required on all lines.
Telehealth (non-home)	98966–98968	Medicare Part B	**02**	Extended through December 31, 2027.
Telehealth (patient at home)	98966–98968	Medicare Part B	**10**	Audio-only requires documented patient consent.
Home health	S9131, 97110, 97530	Medicare Part A	**N/A**	S9131 is NOT a Medicare code. Do not use on Medicare claims.
Inpatient rehab (IRF)	97110, 97530, 97140, 97112	Medicare Part A	**61**	IRF-PAI required. 3 hours therapy/day required.
Skilled nursing facility	97110, 97530, 97140	Medicare Part A	**31**	PDPM system. Therapy not billed by code under Part A.

13 Specialty PT Billing Quick Reference

Specialty Service	CPT Code(s) Used	Key Billing Note
Pelvic floor therapy	**97110, 97530, 97140, 97112**	No unique pelvic floor code exists. Use standard codes. Documentation must specify pelvic floor as treatment area.
Dry needling	**97039 or 20560–20561**	Coverage varies widely. Many commercial payers exclude dry needling. Verify coverage before billing.
Aquatic therapy	**97113**	Requires pool facility. Exempted from 2026 efficiency adjustment. Document water temp, depth, clinical rationale.
Work conditioning	**97545, 97546**	Document functional work capacity goals. Precertification often required.
Group therapy	**97150**	Untimed. Bill once per session. Cannot bill with individual codes for same service.

14 Documentation Requirements Checklist

Every Timed Code Requires:

- [ ] Specific service performed
- [ ] Body region treated
- [ ] Time in minutes (skilled intervention time only)
- [ ] Connection to a documented functional goal in the plan of care

Medicare Additional Requirements:

- [ ] Current, physician-certified plan of care
- [ ] Objective functional measures with baseline and progress data
- [ ] Skilled intervention rationale (why a licensed therapist is required)
- [ ] Correct therapist credentials on the claim

Manual Therapy (97140) Specifically Requires:

- [ ] Technique used
- [ ] Body region treated
- [ ] Clinical rationale tied to a functional goal
- [ ] Patient's response to treatment

Neuromuscular Reeducation (97112) Specifically Requires:

- [ ] Objective balance, coordination, or proprioception test scores
- [ ] Baseline data for comparison
- [ ] Documentation of patient progress toward functional goals

15 2026 Medicare Fee Schedule Rates at a Glance

National averages using CY 2026 conversion factor of $33.40 (non-APM) / $33.57 (APM participants). Actual rates vary by geographic locality. Use CMS MPFS Lookup Tool for exact locality-adjusted rates.

CPT Code	Service	Per Unit Rate	Timed
97110	Therapeutic exercise	**~$34–$36**	Yes
97530	Therapeutic activities	**~$35–$38**	Yes
97140	Manual therapy	**~$34–$37**	Yes
97112	Neuromuscular reeducation	**~$34–$36**	Yes
97116	Gait training	**~$32–$35**	Yes
97035	Ultrasound therapy	**~$24–$27**	Yes
97161	PT evaluation, low complexity	**~$72–$78**	No
97162	PT evaluation, moderate complexity	**~$104–$110**	No
97163	PT evaluation, high complexity	**~$142–$150**	No
97164	PT reevaluation	**~$56–$62**	No
97010	Hot or cold packs	**~$10–$13**	No
97014/ G0283	Electrical stimulation, unattended	**~$10–$13**	No

Quick Reference: Medicare-Specific Rules Summary

Rule	Detail
Discipline modifier	GP required on ALL PT claim lines
KX threshold (2026)	$2,480 PT + SLP combined; $2,480 OT separate
Targeted review threshold	$3,000 PT + SLP combined; fixed through 2028
Unattended e-stim	Use G0283 — NOT 97014 — on all Medicare Part B claims
PTA billing	CQ modifier required; 85% payment rate applies
MPPR	50% reduction on PE component for 2nd+ services in same session
Telehealth extension	Through December 31, 2027 (CAA 2026 Section 6209)
8-minute rule	CMS total-minutes method for multi-code sessions
Conversion factor	$33.40 non-APM / $33.57 APM participants

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This reference sheet is intended as a quick-reference tool and does not replace official CMS guidance, payer-specific policies, or legal/compliance counsel. Rates are 2026 national averages and vary by locality.

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