Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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THIS TRANSMITTAL MANUALIZES THE FOLLOWING CHANGE REQUESTS: 483, 540, 842, 1086, 1113, 1155, 1166 and 1491.

REVISED MATERIAL	REVISED PAGES	REPLACED PAGES
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Chapter VII	6-5 - 6-6 (2 pp.)	6-5 - 6-6 (2 pp.)
Sec. 3653	6-304.3 - 6-304.14 (12 pp.)	--------

MANUALIZATION--*EFFECTIVE DATE*: Not Applicable
***IMPLEMENTATION DATE*: Not Applicable**

Section 3653, Prospective Payment for Outpatient Rehabilitation Services and the Financial Limitation, incorporates all instructions previously issued in Program Memorandum (PM) A-99-35, Change Request 540 dated August 1999; PM AB-99-101, Change Request 1086 dated December 1999; PM AB-00-01, Change Request 483 dated January 2000, PM-AB-00-08, Change Request 1113 dated February 2000; PM AB-00-14, Change Request 842 dated March 2000, PM AB-00-39, Change Request 1155 dated May 2000; PM AB-00-117, Change Request 1166, dated November 2000 and PM-AB-01-36, Change Request 1491, dated February 2001.

In addition the following coding changes have been made based on the annual HCPCS update:

- addition of codes 97532, 97533, 97601, G0193, G0194, G0195, G0196, G0l97, G0198, G0l99, G0200 and G0201; and
- deletion of code G0169.

In addition the following codes have also been deleted:

- A4220, A4221, 11040, 11041, 11042, 11043 and 11044.

A clarification of PM-AB-00-14, Change Request 842, dated March 2000 will be provided in a forthcoming instruction.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

Section

Physician Services

Section

Cost Reimbursement Providers

3653. Prospective Payment for Outpatient Rehabilitation Services and the Financial Limitation.--Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) which added §1834(k) (5) to the Social Security Act, requires that all claims for outpatient rehabilitation, certain audiology services and comprehensive outpatient rehabilitation facility (CORF) services, be reported using a uniform coding system. The Health Care Financing Administration Common Procedure Coding System (HCPCS) is the coding system to be used for the reporting of these services. This coding requirement is effective for all claims for outpatient rehabilitation services including certain audiology services and CORF services submitted on or after April 1, 1998. (See subsection A for additional information regarding this coding system.) The BBA also requires payment under a prospective payment system for outpatient rehabilitation services including audiology and CORF services. The Medicare Physician Fee Schedule (MPFS) is the prospective payment system for these services, effective January 1, 1999. (See subsection L for additional information concerning this payment system.) In addition, §4541(c) of the BBA requires application of a financial limitation for all outpatient rehabilitation services. However, with the enactment of §221 of the Balanced Budget Refinement Act (BBRA) of 1999, the application of the financial limitation has been eliminated as described below.

For outpatient rehabilitation claims with dates of service January 1, 2000 through December 31, 2001 the following applies:

- A 2 year moratorium has been placed on the application of the financial limitations for claims for outpatient rehabilitation services with dates of service January 1, 2000 through December 31, 2001;

- During the 2 year moratorium, the Secretary shall conduct a focused medical review for outpatient rehabilitation services (physical therapy, occupational therapy and speech language pathology) with an emphasis on services performed in skilled nursing facilities; and,

- Effective January 1, 2000, optometrists may refer patients for outpatient rehabilitation services as well as established and review the Plan of Treatment (POT).

For outpatient rehabilitation claims with dates of service January 1, 2002 through December 31, 2002, the following applies:

- In accordance with the enactment of the Beneficiary Improvement and Protection Act of 2000, (BIPA) which extends the moratorium on the application of the financial limitation for claims for outpatient rehabilitation services is extended through December 31, 2002.

See subsections Q and R for additional information concerning the financial limitation (prior and post BBRA).

A. HCPCS Coding Requirement.--Effective for claims submitted on or after April 1, 1998, providers must use HCPCS codes to report outpatient rehabilitation, CORF and certain audiology services. This coding requirement assures proper payment under a prospective payment system for these services.

HCPCS codes include CPT-4 codes. Providers report HCPCS codes in FL 44, "HCPCS/Rates" (See §3627 for an explanation of the HCPCS coding system, and §3627.1 and 3627.5 for instructions for informing/educating your providers regarding HCPCS reporting.)

NOTE: Listing of HCPCS codes contained in this instruction does not assure coverage of the specific service. Current coverage criteria still apply.

Outpatient rehabilitation services that require HCPCS coding are outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services.

The following "providers of services" must bill you for these services using HCPCS codes:

- Hospitals;
- Skilled nursing facilities (SNFs);
- Home health agencies (HHAs);
- Comprehensive outpatient rehabilitation agencies (CORFs); and,
- Outpatient physical therapy providers (OPTs).

Hospitals and SNFs providing outpatient rehabilitation and certain audiology services to their inpatients, who are entitled to benefits under Part A, but who have exhausted benefits for inpatient services during a spell of illness, or to their inpatients who are not entitled to benefits under Part A, are also required to report HCPCS codes.

For HHAs, HCPCS coding for outpatient rehabilitation and certain audiology services only applies when HHAs provide such service to individuals that are not homebound and; therefore, not under a POT.

B. Applicable Bill Types.--The appropriate bill types requiring HCPCS coding under this payment system are: 12X, 13X, 22X, 23X, 34X, 74X, 75X and 83X.

C. Applicable Revenue Codes.--The appropriate revenue codes for reporting outpatient rehabilitation services are 420, 430, and 440. The appropriate revenue code for reporting audiology service is 470. The general classification of revenue codes is all that is needed for billing purposes. If, however, your providers choose to use more specific revenue code classifications, you should accept them. Reporting of CORF services is not limited to specific revenue codes.

Many therapy services, for example, physical therapy modalities or therapy procedures as described by HCPCS codes, are commonly delivered by both physical and occupational therapists. Other services may be delivered by either occupational therapists or speech-language pathologists. Therefore, providers report outpatient rehabilitation HCPCS codes in conjunction with the appropriate outpatient rehabilitation revenue code based on the type of therapist who delivered the service, or, if the service is not delivered by a therapist, then the type of therapy under the POT for which the service is delivered.

D. Applicable Outpatient Rehabilitation HCPCS Codes.--The applicable HCPCS codes for reporting outpatient rehabilitation services are as follows: (**NOTE**: listing of the following codes does not imply that services are covered.)

29065*	29075*	29085*	29105*	29125*	29126	29130*	29131	29200*
29220	29240	29260	29280	29345*	29365*	29405*	29445*	29505*
29515*	29520*	29530*	29540*	29550*	29580*	29590*	64550	90901
90911	92506	92507	92508	92510	92526	95831	95832	95833
95834	95851	95852	96105	96110	96111	96115	97001	
97002	97003	97004	97010****		97012	97014	97016	97018
97020	97022	97024	97026	97028	97032	97033	97034	97035
97036	97039	97110	97112	97113	97116	97122	97124	97139
97140	97150	97504**	97520	97530	97532	97533	97535	97537
97542	97545	97546	97601*****		97602****		97703	97750
97799***		V5362***		V5363***		V5364***		
G0193***		G0194***		G0195***		G0196***		G0197***
G0198***		G0199***		G0200***		G0201***		

*These codes when delivered in an outpatient hospital setting are not considered outpatient rehabilitation services. Therefore, they are not subject to payment under the MPFS. Pay hospitals under the outpatient prospective payment system for these services.

**Code 97504 should not be reported with code 97116. However, if code 97504 was performed on an upper extremity and code 97116 (gait training) was also performed, both codes may be billed with

modifier 59 to denote a separate anatomic site. CWF will reject these claims when modifier 59 is not present indicating that the 97504 service was related to an upper limb orthotic. Utilize Medicare Summary Notice message 16.29 or Explanation of Medicare Benefits message 9.55. For remittance advice notices, use group code CO and claim adjustment reason code 4, the procedure code is inconsistent with the modifier used or a required modifier is missing.

***The physician fee schedule abstract file does not contain a price for codes 97799, V5362, V5363, V5364, G0193 or G0194, since they are priced by the carrier. In addition, it does not contain a price for codes G0195, G0196, G0197, G0198, G0199, G0200 or G0201 since these codes will not be added to the abstract file until the next annual update. Therefore, contact your carrier to obtain the appropriate fee schedule amount (non-facility fee) in order to make proper payment for these codes or obtain these prices from the supplemental file.

****Codes 97010 and 97602 should be bundled. They may be bundled with any therapy code. Regardless of whether they are billed alone or in conjunction with another therapy code, never make payment separately for these codes. If billed alone, this code should be denied using existing EOMB/MSN language. For remittance advice notices, use group code CO and claim adjustment reason code 97, payment is included in the allowance for another service/procedure, to deny a procedure code that should have been bundled.

*****Code 97601 was inadvertently omitted from the MPFS abstract file. If you receive a claim that contains this code, obtain the price from the supplemental file. This code replaced G0169.

NOTE: The above list of codes contain commonly utilized codes for outpatient rehabilitation services. You may consider other codes for payment under the MPFS as outpatient rehabilitation services to the extent that such codes are determined to be medically reasonable and necessary and those that could be performed within the scope of practice of the therapist billing the code.

E. Applicable Audiology HCPCS Codes.--In addition to the HCPCS codes listed in Subsection D, the HCPCS codes listed below are paid under the MPFS when performed by an entity primarily engaged in the delivery of outpatient rehabilitation services.

92552	92553	92555	92556	92557	92561	92562	92563	92564
92565	92567	92568	92569	92571	92572	92573	92575	92576
92577	92579	92582	92583	92584	92587	92588	92589	92596
V5299*								

*The physician fee schedule abstract file will not contain a price for this code since it is priced by the carrier. Contact your carrier to obtain the appropriate fee schedule amount in order to make proper payment.

NOTE: The HCPCS codes listed above with the exception of V5299 should not be paid under the MPFS when furnished by hospital outpatient departments. These audiology codes are currently paid under the outpatient prospective payment system (OPPS).

F. HCPCS Coding Requirements for CORFs.--In addition to the HCPCS codes listed in subsections D and E, for outpatient rehabilitation services and audiology, CORFs are required to use HCPCS codes for their full range of services. The applicable HCPCS codes, which have been identified to date, are as follows:

90657*	90658*	90659*	90660*	90732*	90744*	90745*	90746*
90747*	90748*	94664	94665	94667	94668	G0008*	G0009*
G0010*	G0128**						

*These codes are not subject to payment under the MPFS. Pay for these services under the hospital outpatient prospective payment system.

**This code is defined as follows: Direct face-to-face with patient. Skilled nursing services of a registered nurse provided in a comprehensive outpatient rehabilitation facility, each 10 minutes beyond the first 5 minutes. G0128 should be reported only for direct patient care services that are not part of another CPT-4 coded service.

NOTE: The above list is intended to facilitate your ability to pay claims under the MPFS. It is not intended to be a list of all covered CORF services and does not assure coverage of these services.

In almost all cases, HCPCS Level I codes will be used to code CORF services. For some categories of services, HCPCS Level II codes may be used if a HCPCS Level I code does not describe the service.

CORFs continue to bill for orthotic/prosthetic devices and surgical dressings utilizing existing HCPCS codes provided to them by their intermediary. Payment will continue for these items under the orthotic/prosthetic and surgical dressing fee schedule.

G. Discipline Specific Outpatient Rehabilitation Modifiers.--Providers identified in subsection A (including hospital outpatient departments) are required to report one of the following modifiers to distinguish the type of therapist who performed the outpatient rehabilitation service (not the payment designation) or, if the service was not delivered by a therapist, then the discipline of the POT under which the service is delivered should be reported:

GN Service delivered personally by a speech-language pathologist under an outpatient speech-language pathology Plan of Care;

GO Service delivered personally by an occupational therapist or under an outpatient occupational therapy Plan of Care; or,

GP Service delivered personally by a physical therapist or under an outpatient physical therapy Plan of Care.

If an audiology procedure (HCPCS) code listed in subsection E is performed by an audiologist, the above modifiers are not required to be reported.

H. Edit Requirements.-Edit to assure the presence of a HCPCS code when revenue codes 420, 430, 440, or 470 are reported. However, do not edit the matching of revenue code to HCPCS codes or edit to limit provider reporting to only those HCPCS listed in this instruction.

I. Reporting of Service Units.--Effective with claims submitted on or after April 1, 1998, providers are required to report the number of units for outpatient rehabilitation and certain audiology services in FL 46 "Service Units" based on the procedure or service, e.g., based on the HCPCS code reported instead of the revenue code. CORFs will also report their full range of CORF services in the same manner. Units are to be reported based on the number of times the procedure, as described in the HCPCS code definition, is performed. When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe report "1" in FL 46. Visits should no longer be reported as units for these services. Since providers may perform a number of procedures or services during a single visit, the number of units may exceed the number of visits.

EXAMPLE: A beneficiary received occupational therapy (HCPCS code 97530 which is defined in 15 minute intervals) for a total of 60 minutes. The provider would then report revenue code 43X in FL 42, HCPCS code 97530 in FL 44, and "four" units in FL 46.

Providers should report in FLs 39-41 value code 50, 51, or 52 as appropriate the total number of physical therapy, occupational therapy, or speech therapy visits provided from start of care through the billing period.

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any calendar day** using CPT codes and the appropriate number of units of service. For any single CPT code, providers bill a single 15 minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes, then 2 units should be billed. Time intervals for larger numbers of units are as follows:

3 units	≥ 38 minutes to < 53 minutes
4 units	≥ 53 minutes to < 68 minutes
5 units	≥ 68 minutes to < 83 minutes
6 units	≥ 83 minutes to < 98 minutes
7 units	≥ 98 minutes to < 113 minutes
8 units	≥ 113 minutes to < 128 minutes

The pattern remains the same for treatment times in excess of 2 hours. Providers should not bill for services performed for < 8 minutes. The expectation (based on the work values for these codes) is that your direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

The beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. The time spent delivering each service, described by a timed code, should be recorded. (The length of the treatment to the minute could be recorded instead.) **If more than one CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time**. For example, if 24 minutes of 97112 and 23 minutes of 97110 were furnished, then the total treatment time was 47 minutes, so only 3 units can be billed for the treatment. The correct coding is 2 units of 97112 and one unit of 97110, assigning more units to the service that took the most time.

NOTE: The above schedule of times is intended to provide assistance in rounding time into 15 minute increments. It does not imply that any minute until the eighth should be excluded from the total count. The timing of active treatment counted includes all direct treatment time.

J. Determining What Time Counts Towards 15 Minute Timed Codes.--Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post- delivery services are not to be counted in determining the treatment service time. In other words, the time counted as "intraservice care" begins when the therapist or physician) or an assistant under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment.

The time counted is the time the patient is treated. For example, if gait training in a patient with a recent stroke requires both a therapist and an assistant, or even two therapists, to manage in the parallel bars, each 15 minutes the patient is being treated can only count as one unit of 97116. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.

K. Line Item Date of Service Reporting.--Providers are required to report line item dates of service per revenue code line for outpatient rehabilitation services and audiology services described in subsections D and E. CORFs are also required to report their full range of CORF services by line item date of service. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in FL 45 "Service Date" (MMDDYY). See example below of

reporting line item dates of service. This example is for physical therapy services provided twice during a billing period.

For the UB-92 flat file, report as follows:

Record Type	Revenue Code	HCPCS	Dates of Service	Units	Total Charges
61	420	97001	19981006	1	$60.90
61	420	97110	19981029	2	$44.02

For the hard copy UB-92 (HCFA-1450), report as follows:

FL 42	FL 44	FL 45	FL 46	FL 47
420	97001	100698	1	$60.90
420	97110	102998	2	$44.02

For the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, as well as the 837 Health Care Claim version 4010 (when implemented), report as follows:

LX*1~
SV2*420*HC: 97001*60.9*UN*1~
DTP*472*D8*19981006~
LX*2~
SV2*420*HC: 97110*44.02*UN*2~
DTP*472*D8*19981029~

Return bills that span two or more dates if a line item date of service is not entered for each HCPCS reported. Line item date of service reporting is effective for claims with dates of service on or after October 1, 1998.

Providers report line item dates of service, in revenue code order by date of service. Services that do not require line item date of service reporting, may be reported before or after those services that require line item reporting.

L. Implementation of Medicare Physician Fee Schedule (MPFS).--Effective for claims with dates of service on or after January 1, 1999, the MPFS will be the method of payment when outpatient physical therapy (which includes outpatient speech-language pathology) and occupational therapy services are furnished by rehabilitation agencies (outpatient physical therapy providers and CORFs), hospitals (to outpatients and inpatients who are not in a covered Part A stay), SNFs (to residents not in a covered Part A stay and to non-residents who receive outpatient rehabilitation services from the SNF), and HHAs (to individuals who are not homebound or otherwise are not receiving services under a home health POT). The MPFS will be used as a method of payment for outpatient rehabilitation services furnished under arrangement with any of these providers. In addition, the MPFS will also be used as the payment system for audiology and CORF services identified by the HCPCS codes in subsection E and F. Assignment is mandatory. The Medicare allowed charge for the services is the lower of the actual charge or the MPFS amount. The Medicare payment for the services is 80 percent of the allowed charge after the Part B deductible is met. Coinsurance is made at 20 percent of the lower of the actual charge or the MPFS amount. The general coinsurance rule (20 percent of the actual charges) does not apply when making payment under the MPFS. This is a final payment. The MPFS does not apply to outpatient rehabilitation services furnished by critical access hospitals (CAHs). CAHs are to be paid on a reasonable cost basis.

An example of payment methodology in which the Part B deductible has previously been met is as follows:

EXAMPLE: $150 Provider charge;
$100 MPFS amount.

Payment is 80 percent of the lower of the actual charge or fee schedule amount which in this case is $80.00. ($100.00 X 80 percent).

The result remaining 20 percent or $20 is the patient's coinsurance liability.

You will be provided with a physician fee schedule abstract file which contains non-facility fee schedule payment amounts for the outpatient rehabilitation, audiology and CORF HCPCS codes listed in subsections E and F. These codes are identified in the abstract file by a value of "R" in the fee indicator field. The file will include fee schedule payment amounts by locality and will be available via the HCFA Mainframe Telecommunications System (formerly referred to as the Network Data Mover). You will be responsible for retrieving this file upon notification by HCFA and making payment based on 80 percent of the lower of the actual charge or fee schedule amount indicated on the file after the Part B deductible has been met. You will be notified of updates to the MPFS, file names and when the updated files will be available for retrieval. Upon retrieval, disseminate the fee schedules to your providers. Advise providers requesting the entire MPFS of its availability via HCFA's Mainframe Telecommunications System. The following is the record layout for the physician fee schedule abstract file:

Record Length:	60
Record Format:	FB
Block Size:	6000
Character Code:	EBCDIC
Sort Sequence:	Carrier, Locality HCPCS Code, Modifier

Data Element Name	COBOL Location	Picture	Value
1 -- HCPCS	1-5	X(05)	
2 -- Modifier	6-7	X(02)	
3 -- Filler	8-9	X(02)	
4 -- Non-Facility Fee	10-16	9(05)V99	
5 -- Filler	17-23	X(07)	
6 -- Filler	24-30	X(07)	
7 -- Carrier Number	31-35	X(05)	
8 -- Locality	36-37	X(02)	Identical to the radiology/diagnostic fees
9 -- Filler	38-40	X(03)	
10 -- Fee Indicator	41-41	X(1)	"R" -- Rehab/Audiology/CORF services
11 -- Outpatient Hospital indicator	42-42	X(1)	"0" -- Fee applicable in hospital outpatient setting "1" -- Fee not applicable in hospital outpatient setting
12 -- Filler	43-60	X(18)	

If you determine during the medical review process that a HCPCS code other than those listed in this instruction should be considered for payment as an outpatient rehabilitation service because you consider the service to be medically reasonable and necessary or one that could be performed within the scope of practice of the therapist billing the code, you must contact your carrier to obtain the appropriate fee schedule amount in order to make proper payment.

NOTE: Outpatient occupational therapy (OT) services defined in §1861(g) should not be confused with the "OT" included in the definition of partial hospitalization services by §1861(ff)(2)(B). Partial hospitalization services, including any OT furnished in

that setting, are not payable under the MPFS. Therefore, if a hospital outpatient claim for OT services contains a condition code 41 designating partial hospitalization services, make payment under OPPS. Your system must be able to determine the appropriate payment methodology for OT services based on the presence/non-presence of condition code 41.

M. Additional HCPCS Requirement for CORFs.--Effective with claims with dates of service on or after July 1, 2000, CORFs are required to report all of their services utilizing HCPCS and you are required to make payment for all covered CORF services under the MPFS. Because of systems constraints in installing and making payments under the MPFS, HCFA will provide you with an updated MPFS abstract file in place of the entire MPFS file. This abstract file will contain additional HCPCS codes for CORF services and their related prices. The additional codes are as follows:

90804	90805	90806	90807	90808	90809	90810	90811	90812	90813
90814	90815	90845	90846	90847	90849	90853	90857		

If you receive a claim for a Medicare covered service with dates of service on or after July 1, 2000 that does not appear on the abstract file, you have two options for obtaining pricing information:

Option I: You will be provided with an additional supplemental file that will contain all physician fee schedule services and their related prices. Since this supplemental file contains approximately a million records, we do not anticipate that you would incorporate it into your operational systems, but instead use it as a resource to extract pricing data as needed. The data in the supplemental file will be in the same format as the MPFS abstract file, but the fields defining the fee and outpatient hospital indicators will not be populated, instead they will be filled in with spaces. See subsection L for the format of the record layout.

Option II: Contact your local carrier to obtain the price in order to pay the claim. When requesting the pricing data advise the carrier to provide you with the non-facility fee from the MPFS

The MPFS supplemental file of physician fee schedule services will be available for retrieval through HCFA's Mainframe Telecommunications System formerly known as the Network Data Mover system. You will be notified yearly of the file retrieval names and dates by way of a program memorandum.

N. Payment of Drugs, Biologicals and Supplies in a CORF.--Effective April 1, 2001, payment for drugs and biologicals in a CORF setting will no longer be reimbursed on cost. Payment will be made at the lower of the billed charge or 95 percent of the average wholesale price (AWP) as reflected in sources such as the Red Book, Blue Book, or Medispan. For single-source drug or biological, the allowance is 95 percent of the AWP for the single product, or, for multi-source drug or biological, the AWP is the lesser of the median AWP of all generic forms of the drug or biological or the lowest brand name product AWP. The Part B deductible and coinsurances apply. Payment for influenza, pneumococcal pneumonia and hepatitis B vaccines provided in a CORF are made under the outpatient prospective payment system as outlined in PM A-00-36, dated June 2000.

Advise your CORFs to report drugs and biologicals under revenue code 636 with the appropriate HCPCS code identifying the drug. If no specific HCPCS codes are available, use the following codes: J3490, J7599, J7699, J7799, J8999 and J9999.

In order to eliminate duplication of effort by our contractors and to ensure uniform pricing of drugs, carriers will furnish their drug payment allowance for all drugs directly to the intermediaries in their jurisdiction free of charge.

Intermediaries should contact the carriers to determine the preferred method of transmission.

Carriers are to send this information to all intermediaries with whom they routinely deal. If this method of obtaining payment allowance updates does not work for any carrier, contact your appropriate regional office immediately.

CORFs are currently being reimbursed for supplies on the basis of cost. However, since supplies are part of the practice expense of physician's services, separate payment for supplies under the MPFS should not be made. Effective April 1, 2001, CORFs should not bill for the supplies they furnish. The payment for supplies is included in payments made under the MPFS.

O. Application of the Outpatient Mental Health Treatment Limitation.--In accordance with §1833 of the Social Security Act (the Act) payment is made at 62 ½ percent of the approved amount for outpatient mental health treatment services. This provision will continue to be implemented in accordance with the Act when these services are furnished to beneficiaries by CORFs. Therefore, make payment at 62 ½ percent of 80 percent of the approved amount (or in effect 50 percent) for outpatient mental health treatment services. Hence, if the MPFS amount for a mental health treatment service provided in a CORF is $100, this amount is multiplied by 62.5 percent (the mental health treatment limitation). The resulting amount of $62.50 is then multiplied by 80 percent which yields the Medicare payment of $50. The remaining 20 percent or the balance of $12.50, is the coinsurance responsibility of the beneficiary. Report the amount in excess of the mental health limitation amount, $37.50, in the provider remittance advice with group code PR and claim adjustment reason code 122, Psychiatric reduction. This limitation may not be included in the coinsurance amount.

P. CWF and PS&R Requirements.--Report the procedure codes in the financial data section (field 65a-65j). Include revenue code, HCPCS, units, and covered charges in the record. Where more than one HCPCS procedure is applicable to a single revenue code, the provider reports each HCPCS and related charge on a separate line. Report the payment amount before adjustment for beneficiary liability in field 65g "Rate" and the actual charge in field 65h "Covered Charges". The PS&R system includes outpatient rehabilitation, audiology and CORF services listed in subsections E and F on a separate report from cost based payments. See your PS&R guidelines for specific information.

Q. Financial Limitation Prior to the BBRA.--§4541(c) of the BBA required application of a financial limitation to all outpatient rehabilitation services. An annual per beneficiary limit of $1500 applied to all outpatient physical therapy services (including speech-language pathology services). A separate $1500 limit applied to all occupational therapy services. The annual limitations did not apply to services furnished directly or under arrangements by a hospital to an outpatient or to an inpatient who was not in a covered Part A stay. This limitation applied to expenses incurred on or after January 1, 1999. Incurred expenses are equal to the lesser of the actual charge for the services or the appropriate MPFS amount for the service. If the lesser of (1) the actual charge for the service or (2) the MPFS amount was $100, then $100 was the incurred expense and applied towards the limit. Of the $100, 80 percent or $80 was paid by Medicare and 20 percent or $20 was payable as coinsurance by the beneficiary. In other words, $1200 of the $1500 limit was paid by Medicare and $300 was the beneficiary's coinsurance. Beginning 2002, these limits were to be increased by the percentage increase in the Medicare Economic Index. By 2001, a report to Congress is required recommending a revised coverage policy for outpatient rehabilitation services in place of the $1500 limitation. BIPA extended this moritorium on the financial limitation until December 31, 2002.

Prior to January 1, 2000, providers were instructed to keep track of incurred expenses. This process was put in place to assure they did not bill Medicare for patients who exceeded the annual $1500 limitations for therapy services rendered by that individual provider. Effective January 1, 2000, providers are no longer be required to keep track of incurred expenses for claims with dates of service January 1, 2000, and beyond. As a result, §221 of the Balanced Budget Refinement Act (BBRA) of 1999 places a two-year moratorium on the application of the financial limitation for claims for therapy services with dates of service January 1, 2000 through December 31, 2001. During the 2-year moratorium, the Secretary shall conduct focused medical review for physical therapy, occupational therapy and speech language pathology services with an emphasis on services performed in skilled nursing facilities (SNFs).

CWF is not tracking the financial limitation at this time for intermediary processed claims. As a transitional measure, effective for claims with dates of service on or after January 1, 1999, non-hospital providers will be held accountable for tracking incurred expenses for each beneficiary to assure they do not bill Medicare for patients who have met the annual $1500 limitation at their facility for each separate limitation. This is a per provider, per beneficiary financial limitation.

For SNFs, this means that the SNF itself is responsible for the billing of all outpatient rehabilitation services and the tracking of incurred expenses for those services when furnished to a SNF resident not in a covered Part A stay and SNF non-resident receiving outpatient rehabilitation services at the SNF regardless of whether the services are furnished by the SNF itself or by an outside therapist. In addition, SNFs are allowed to send one of their residents to the hospital (or any other facility) once that resident has reached the respective financial limitation at its facility, but is not allowed to bill for services that exceed the limitation.

Providers were expected to make reasonable efforts to determine whether the beneficiary has reached or exceeded the $1500 limit for services. For example, a provider was expected to keep track of the expenses the beneficiary incurred in receiving physical therapy (including speech-language pathology) or occupational therapy services billed by that particular provider. Moreover, it was reasonable to ask a beneficiary whether he or she knew if the limits had been reached. SNFs had particular responsibilities, as described above. While a provider was expected to make these and other reasonable efforts to determine whether the limitations had been reached for a particular beneficiary, it was not expected that a provider would know whether a beneficiary had exceeded the limitation because of services provided at another, non-affiliated provider.

Once the limitation was reached, a claim could be submitted for purposes of receiving a denial notice from Medicare in order to bill Medicaid or other insurers. In this situation, the non-hospital provider reported condition code 21 in FL 24-30 of Form HCFA-1450. Use group code PR and claim adjustment reason code 119, Benefit maximum for this time period has been reached, in the provider remittance advice to establish the reason for denial. The provider should advise the beneficiary that a claim for services that exceeds the $1500 limitation was being denied pursuant to §1833(g) of the Social Security Act (42 U.S.C. §1395(g)). As with other denial of benefit determinations, the beneficiary could appeal Medicare's denial of benefits. The beneficiary was to be advised of his or her appeal rights set forth in 42 CFR Part 405, subpart G. The provider was to notify the beneficiary that any additional outpatient rehabilitation services would result in the beneficiary exceeding the limitation. Such notification allowed the beneficiary to make an informed choice about continuing to receive services from the provider or to change to another provider, practitioner, or hospital outpatient department. This was necessary because the beneficiary was responsible for payment of all outpatient rehabilitation services that exceeded the financial limitation at any given provider.

In situations where a beneficiary was close to reaching the financial limitation and a particular claim might exceed the limitation, the provider was to bill their usual and customary charge for the service furnished even though such charge might exceed the $1500 limit. For example, a beneficiary to date received services for which the total amount of payment and the beneficiary coinsurance total $1480. The beneficiary then received 3 units of services - 1 unit at $50; 1 unit at $25; and 1 unit at $30. The provider was to bill for the unit of service with the $25 charge, i.e., the charge that when added to the total allowed payment would least exceed the limitation. The other two units of service and any services furnished subsequently could be billed only for the purpose of receiving a denial notice (as noted above) that the provider could use to bill the beneficiary's other insurers. This meant that the provider would split the bill for three units of service that total $105.

The appropriate bill types subject to the financial limitation are 22X, 23X, 34X, 74X and 75X.

R. Financial Limitation Post BBRA and BIPA.--A 2- year moratorium has been placed on the application of the financial limitation for claims with dates of service January 1, 2000 through December 31, 2001. During this period, HCFA will develop strategies for conducting medical

review of therapy services in 2000 and 2001 to determine if services billed are covered (including being reasonable and necessary). HCFA will provide additional direction at a later date. In the interim, conduct coverage reviews of therapy services for only the following places of service:

- SNF PPS claims in accordance with SNF PPS medical review instructions issued in relevant PM; and,

- HHA PPS claims in accordance with HHA PPS medical review instructions to be issued later this year.

However, as always, if in the course of data analysis you identify serious problems (egregious over utilization or fraud) in other settings you should take appropriate action.

There should be no prepay or postpay review for the purpose of enforcing the financial limitation.

You may continue to edit claims to ensure compliance with the financial limitation for pre-2000 dates of service. However, be judicious in your use of resources for this purpose, particularly in manual efforts consuming resources at the cost of priority reviews for 2000 and 2001.

Financial limitation denials are benefit category denials; therefore, the limitations on liability protections do not apply.

In addition, optometrists may refer patients for therapy services as well as establish and review the POT. Review your policy manuals to ensure this change is effectuated within your operations.

BIPA has extended the moratorium on the financial limitation until December 31, 2002.

S. Coding Guidance for Certain Physical Medicine CPT Codes.--The following provides guidance about the use of codes 96105, 97150, 97545, 97546, and G0128.

- CPT Codes 96105, 97545 and 97546.

Providers report code 96105, assessment of aphasia with interpretation and report in 1-hour units. This code represents formal evaluation of aphasia with an instrument such as the Boston Diagnostic Aphasia Examination. If this formal assessment is performed during treatment, it is typically performed only once during treatment and its medical necessity should be documented. If the test is repeated during treatment, the medical necessity of the repeat administration of the test must also be documented. It is common practice for regular assessment of a patient's progress in therapy to be documented in the chart, and this may be done using test items taken from the formal examinations. This is considered to be part of the treatment and should not be billed as 96105 unless a full, formal assessment is completed.

Other timed physical medicine codes are 97545 and 97546. The interval for 97545 is 2 hours and for 97546, 1 hour. These are specialized codes to be used in the context of rehabilitating a worker to return to a job. The expectation is that the **entire** time period specified in the codes 97545 or 97546 would be the treatment period, since a shorter period of treatment could be coded with another code such as 97110, 97112, or 97114, or 97537. (Codes 97545 and 97546 were developed for reporting services to persons in the Worker's Compensation program, thus we do not expect to see them reported for Medicare patients except under very unusual circumstances.)

Proper Reporting of Code G0128 by CORFs.

G0128 was created for use by CORFs to report nursing services provided to beneficiaries as part of their POT but not bundled into other services billed to the beneficiary (either by the CORF or by a physician or other practitioner associated with the CORF). The definition of this code is as follows:

G0128 Direct (face-to-face with the patient) skilled nursing services of a registered nurse provided in a comprehensive outpatient rehabilitation facility, each 10 minutes beyond the first 5 minutes.

Thus, G0128 is used to bill for services that are specified in the beneficiary's Plan of Treatment that are not part of other services. Examples of services that cannot be billed under G0128 are:

(1) If a nurse participates in a physician service, e.g., taking the history or reviewing medication as part of an evaluation and management visit (HCPCS codes 99201-99275) or as part of a service during the global surgical period, assisting in a procedure, teaching the patient regarding a procedure or treatment suggested during the physician or other practitioner visit, providing information to the patient about consequences or complications of a treatment, or responding to telephone calls resulting from the physician visit, then the nursing services are part of the physician visit and cannot be separately billed by the CORF.

(2) If a nurse takes vital signs (pulse, blood pressure, weight, respiratory rate) associated with a physician or therapy visit, this time cannot be billed using G0128.

(3) If a wound dressing is required after a debridement (HCPCS 97601) or whirlpool treatment (HCPCS 97022) and the nurse dresses the wound, the payment for the dressing change is included in the code for debridement or whirlpool and cannot be separately billed under G0128.

(4) Collecting a laboratory specimen, including phlebotomy.

Co-treatment by a nurse with a physical or occupational therapist or speech and language pathologist will generally not be allowed unless a separate nursing service is clearly identifiable in the POT and in the documentation.

The definition of skilled services is that it generally requires the skill of a registered nurse to perform the service. Some examples would include procedures such as insertion of a urinary catheter, intramuscular injections, bowel disimpaction, nursing assessment, and education.

Examples would be teaching a patient proper techniques for "in-and-out" urethral catheterization, skin care for decubitus ulcer, and care and teaching of a colostomy.

Administrative tasks or documentation should not be billed under G0128.