PROGRAM MEMORANDUM INTERMEDIARIES/CARRIERS

Department of Health and Human Services (DHHS)

Health Care Financing Administration (HCFA)

Transmittal No. AB-01-68 **Date MAY 1, 2001**

This Program Memorandum re-issues Program Memorandum AB-00-39, Change Request 1155 dated May 2000. The only change is the discard date; all other material remains the same.

CHANGE REQUEST 1155

SUBJECT: Consolidation of Program Memorandums for Outpatient Rehabilitation Therapy Services

This Program Memorandum (PM) consolidates all existing PMs that have been issued on the prospective payment for outpatient rehabilitation services. The following PMs have been consolidated in this instruction; A-99-35, Change Request 540 dated July 1999; PM AB-99-101, Change Request 1086 dated December 1999; PM AB-00-01, Change Request 483 dated January 2000; and PM AB-00-08, Change Request 1113 dated February 2000.

Prospective Payment for Outpatient Rehabilitation Services and the Financial Limitation - Background

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) which added '1834(k) (5) to the Social Security Act, (the 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 used for the reporting of these services. This coding requirement was effective for all claims for the above mentioned services submitted on or after April 1, 1998. The BBA also requires payment under a prospective payment system for outpatient rehabilitation services including certain audiology and CORF services. The Medicare Physician Fee Schedule (MPFS) is the prospective payment system for these services, effective January 1, 1999. In addition, '4541(c) of the BBA required 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.

Section 221 of the Balanced Budget Refinement Act of 1999 Revision of Provisions Relating to Therapy Services - Intermediaries and Carriers

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

A) A 2 year moratorium has been placed on the application of the financial limitations for claims for therapy services with dates of service January 1, 2000 through December 31, 2001.

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

C) Effective January 1, 2000 optometrists may refer patients for outpatient rehabilitation services as well as establish and review the plan of treatment. Carriers and intermediaries should review their policy manuals to ensure this change is effectuated within their operations.

Tracking of Incurred Expenses - Intermediaries and Carriers

From January 1, 1999 to December 31, 1999, providers with the exception of hospital outpatient departments were instructed to keep track of incurred expenses for outpatient rehabilitation services. This process was put in place to assure Medicare was not billed for patients who exceeded the annual $1500 limitations rendered by an individual provider. Effective January 1, 2000, providers are not required to keep track of incurred expenses for services furnished during the period January 1, 2000 through December 31, 2001.

Review to Determine Compliance With Therapy Financial Limitations - Intermediaries and Carriers

For claims with dates of services January 1, 2000 through December 31, 2001, there should be no prepay or postpay review for the purpose of enforcing the financial limitation.

For carrier claims with dates of service prior to January 1, 2000, CWF will continue to apply the financial limitation to claims from privately practicing physical and occupational therapists. When CWF rejects these claims, carriers should continue to deny them.

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.

CWF Removal Of Editing for the Financial Limitation - Carriers

Effective January 31, 2000 there will be no CWF editing for the financial limitations for therapy claims with dates of service January 1, 2000 through December 31, 2001.

Medical Review of Therapy Services - Intermediaries and Carriers

HCFA is currently developing 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.

HCPCS Coding Requirement - Intermediaries

Effective for claims submitted on or after April 1, 1998, institutional providers that bill intermediaries must use HCPCS codes to report outpatient rehabilitation, certain audiology and CORF services. This coding requirement assures proper payment under the MPFS for these services.
HCPCS includes CPT-4 codes. Providers report HCPCS codes in FL 44, HCPCS/rates. (See '3627 of the Medicare Intermediary Manual Part 3, 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 service may 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 services to individuals that are not homebound and, therefore, not under a Plan of Treatment.

Applicable Bill Types - Intermediaries

The appropriate bill types requiring HCPCS coding are: 12X, 13X, 22X, 23X, 34X, 74X, 75X and 83X.

Applicable Revenue Codes - Intermediaries

The appropriate revenue codes for reporting outpatient rehabilitation services are 420, 430, and 440. The appropriate revenue code for reporting audiology service is 470. 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 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 Plan of Treatment for which the service is delivered.

Applicable Outpatient Rehabilitation HCPCS Codes - Intermediaries

The applicable HCPCS codes for reporting outpatient rehabilitation services are as follows:

11040*	11041*	11042*	11043*	11044*	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	92525	92526	92597	92598	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	97124	97139	97140	97150	97504**
97520	97530	97535	97537	97542	97545	97546	97703	97750

97770*** 97799**** G0169 V5362**** V5363**** V5364****

*These codes when delivered in an outpatient hospital setting are not considered outpatient rehabilitation services if they are performed on beneficiaries who are not receiving services under the outpatient rehabilitation benefit in accordance with an established Plan of Treatment. Therefore, they are not subject to the payment under MPFS. Continue to pay hospitals under current payment methodologies 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.

***Code 97770 is not considered to be an outpatient rehabilitation service when delivered by a clinical psychologist, psychiatrist, or clinical social worker for the treatment of a psychiatric condition.

****The physician fee schedule abstract file described below does not contain a price for codes 97799, V5362, V5363, and V5364 since they are priced by the carrier. Therefore, contact your carrier to obtain the appropriate fee schedule amount in order to make proper payment for these codes.

*****Code 97010 should be bundled. It may be bundled with any therapy code. Regardless of whether code 97010 is billed alone or in conjunction with another therapy code, never make payment separately for this code. If billed alone, this code should be denied using existing EOMB/MSN language.

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.

Applicable Audiology HCPCS Codes - Intermediaries

In addition to the HCPCS codes listed above 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 described below does 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 subject to the blended payment methodology when provided to outpatients of a hospital. For more detailed information see '3631.C1.b of the Medicare Intermediary Manual Part 3.

HCPCS Coding Requirements for CORFs - Intermediaries

In addition to the HCPCS codes listed for outpatient rehabilitation and audiology services, CORFs are required to use HCPCS for the following services:

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. Continue to pay for these services on a reasonable cost basis.

**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.

The following is a list of additional HCPCS codes for the reporting of CORF services beginning with claims with dates of service on or after July 1, 2000.

G0101	G0102	G0169	90804	90805	90806	90807	90808	90809
90810	90811	90812	90813	90814	90815	90845	90846	90847
90849	90853	90857						

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 schedules.

Proper Reporting of Code G0128 by CORFs - Intermediaries

G0128 was created for use by CORFs to report nursing services provided to beneficiaries as part of their Plan of Treatment 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 11040 - 11044) 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 Plan of Treatment 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 include procedures such as insertion of a urinary catheter, intramuscular injections, bowel disimpaction, nursing assessment, and education. Education, for example, would include teaching a patient proper techniques for in-and-out urethral catheterization, skin care for decubitus ulcer, and care/teaching of a colostomy.

Adminstrative tasks or documentation should not be billed under G0128.

Edit Requirements - Intermediaries

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

Reporting of Service Units - Intermediaries and Carriers

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., 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	$\geq$ 38 minutes to < 53 minutes
4 units	$\geq$ 53 minutes to < 68 minutes
5 units	$\geq$ 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 time for each unit will average 15 minutes in length. If a provider has a 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 total 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 was 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 as the timing of active treatment counted includes all time.

Determining What Time Counts Towards 15 Minute Timed Codes - Intermediares

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 delivering 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.

Line Item Date of Service Reporting - Intermediaries

Providers are required to report line item dates of service per revenue code line for outpatient rehabilitation services and audiology services. CORFs are also required to report their services by line item date of service effective. 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 (Form 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, 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.

Payment - Carriers

The MPFS is currently the basis of payment for outpatient rehabilitation services furnished by physical therapists in independent practice and occupational therapists in independent practice, physicians, and certain nonphysician practitioners or incident to the services of such physicians or nonphysician practitioners. Such services are billed to the Part B carrier. Assignment is mandatory for the following providers: Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialist. The mandatory provision does not apply to therapy services furnished by a physician, physical therapist in private practice or an occupational therapist in private practice. The MPFS has been the method of payment for outpatient rehabilitation therapy services provided by these suppliers for several years and will continue to be so.

Implementation of MPFS - Intermediaries

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 Plan of Treatment). 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 certain CORF services identified by the HCPCS codes above. 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.

HCFA will provide you with a MPFS abstract file which will contain non-facility fee schedule payment amounts for the outpatient rehabilitation (including audiology) and CORF HCPCS codes listed in this PM. These codes are identified in the abstract file by a value of R in the fee indicator field. See attachment for the record layout of this file. 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. HCFA will notify you of updates to the MPFS 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 website at www.hcfa.gov.

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 PM 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 or access the supplemental file as described in ANew CORF Requirement@ below 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 on a reasonable cost basis. Your system must be able to determine the appropriate payment methodology for OT services based on the presence/non-presence of condition code 41.

Application of the Outpatient Mental Health Treatment Limitation - Intermediaries

In accordance with '1833 of the Act payment is made at 62 1/2 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 1/2 percent of 80 percent of the approved amount (or in effect 50 percent) for outpatient mental health treatment services.

CWF and PS&R Requirements - Intermediaries

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 will include outpatient rehabilitation and CORF services on a separate report from cost based payments. See your PS&R guidelines for specific information.

Discipline Specific Outpatient Rehabilitation Modifiers - Intermediaries and Carriers

Providers are required to continue 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 Plan of Treatment 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.

Reporting of the above modifications is for data collection purposes only.

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

New CORF Requirement - Intermediaries

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 listed under AHCPCS Coding Requirements for CORFs@ above.

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 PM AB-00-01 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 abstract file and the new supplemental file of physician fee schedule services will be available for retrieval on May 17, 2000 through HCFA=s Mainframe Telecommunications System formerly known as the Network Data Mover system.

The new MPFS abstract file which contains the additional CORF HCPCS codes and related prices is named:

MU00.@BF12390.MFS2000.ABSTR.V0517.FI

The new supplemental file which contains pricing amounts for all physician fee schedule services is named:

MU00.@BF12390.MFS2000.SUPLPHYS.V0517.FI

To facilitate any systems changes that you may have, test files will be available for your retrieval on March 14, 2000.

The test MPFS abstract file, which contains additional CORF HCPCS codes and related prices, is named:

MU00.@BF12390.MFS2000.ABSTR.TST0314.FI

The test supplemental file, which contains pricing amounts for all physician fee schedule services, is named:

MU00.@B12390.MFS2000.SUPLPHYS.TST0314.FI

Coding Guidance for Certain Physical Medicine CPT Codes - Intermediaries and Carriers

The following provides guidance about the use of codes 96105, 97150, 97545, 97546, and G0128.

- o CPT Codes 96105, 97545 and 97546

Providers report code 96105, assessment of aphasia with interpretation and report in one 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 could be coded with another code such as 97110, 97112, or 97114, or 97537. (These codes 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.)

These instructions should be implemented within your current operating budget.

Contact persons for coverage and payment issues in this PM are Roberta Epps on (410) 786-4503, Gail Addis on (410) 786-4522 or Terri Harris on (410) 786-6830. For HCPCS CPT-4 Issues and Physical Medicine CPT Codes Coding Guidance Section, contact Laurie Feinberg, M.D. on (410) 786-7069. Intermediary billing issues contact Faith Ashby on (410) 786-6145 or Linda Gregory on (410) 786-6138. Carrier billing issues contact Joan Proctor-Young on (410) 786-0949.

***Implementation date* for this PM is not applicable.**

***Effective date* for this PM is not applicable.**

The implementation dates and effective dates for all the PMs cited on the first page remain in effect. This PM was a consolidation of the PMs only.

This PM may be discarded April 30, 2002.