Medicare Claims Processing Manual

Chapter 5 - Part B Outpatient Rehabilitation and CORF Services

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10 - Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General

(Rev. 1, 10-01-03)

A3-3653, B3-2200, A3-3147, HO-241.1, CORF-270 - 272, B3-2215, SNF-532.F, AB-98-63, AB-02-038

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), required that all claims for outpatient rehabilitation, certain audiology services and comprehensive outpatient rehabilitation facility (CORF) services, be reported using a uniform coding system. The CMS chose HCPCS (Healthcare Common Procedure Coding System) as 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.

The BBA also required payment under a prospective payment system for outpatient rehabilitation services including audiology and CORF services. Effective for claims with dates of service on or after January 1, 1999, the Medicare Physician Fee Schedule (MPFS) became the method of payment for outpatient physical therapy (which includes outpatient speech-language pathology) services furnished by:

- Comprehensive Outpatient Rehabilitation Facilities (CORFs);
- Outpatient Physical Therapy Providers (OPTs);
- Other Rehabilitation Facilities (ORFs);
- Hospitals (to outpatients and inpatients who are not in a covered Part A stay);
- Skilled Nursing Facilities (SNFs) (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF); and
- Home Health Agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care (POC)).

The MPFS is used as a method of payment for outpatient rehabilitation services furnished under arrangement with any of these providers.

In addition, the MPFS is used as the payment system for audiology and CORF services identified by the HCPCS codes in §10.2.G 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.

Intermediaries (FIs) process outpatient rehabilitation claims from hospitals, including CAHs, SNFs, CORFs, outpatient rehabilitation agencies, and outpatient physical therapy providers for which they have received a tie in notice from the RO. Carriers process claims from physicians, certain nonphysician practitioners (NPPs), and physical and occupational therapists in private practice (PTPPs and OTPPs). A physician-directed clinic that bills for services furnished incident to a physician's service (see Chapter 15 in the Medicare Benefit Policy Manual for a definition of "incident to") bills the carrier.

There are different fee rates for nonfacility and facility services. Chapter 23 describes the differences in these two rates. (See fields 28 and 29 of the record therein described). Facility rates apply to professional services performed in a facility other than the professional's office. Nonfacility rates apply when the service is performed in the professional's office. The nonfacility rate (that paid when the provider performs the services in its own facility) accommodates overhead and indirect expenses the provider incurs by operating its own facility. Thus it is somewhat higher than the facility rate.

FIs pay the nonfacility rate for services performed in the provider's facility. Carriers may pay the facility or nonfacility rate depending upon where the service is performed (place of service on the claim), and the provider specialty.

Carriers pay the codes in §10.2.G under the MPFS regardless of whether they may be considered rehabilitation services. However, FIs must use this list to determine whether to pay under outpatient rehabilitation rules or whether payment rules for other types of service may apply, e.g., OPPS for hospitals, reasonable costs for CAHs.

Note that because a service is considered an outpatient rehabilitation service does not automatically imply payment for that service. Additional criteria, including coverage, plan of care and physician certification must also be met. These criteria are described in the Medicare Benefit Policy Manual, Chapters 1 and 15.

Payment for rehabilitation services provided to Part A inpatients of hospitals or SNFs is included in the respective PPS rate. Also, for SNFs (but not hospitals), if the beneficiary has Part B, but not Part A coverage (e.g., Part A benefits are exhausted), the SNF must bill the FI for any rehabilitation service (except audiologic function services). Independent audiologists may bill the carrier directly for services rendered to Part B Medicare entitled beneficiaries residing in a SNF, but not in a SNF Part A covered stay. Payment is made based on the MPFS, whether by the carrier or the FI (FI). For beneficiaries not in a covered Part A SNF stay, who are sometimes referred to as beneficiaries in a Part B SNF stay, audiologic function tests are payable under Part B when billed by the SNF as type of bill 22X, or when billed directly to the carrier by the provider or supplier of the service. For tests that include both a professional component

and technical component, the SNF may elect to bill the technical component to the FI, but is not required to bill the service. (The professional component of a service is the direct patient care provided by the physician or other professional, e.g., the physician's interpretation of a test.) See §10.2.G, for a list of audiology codes.

Payment for rehabilitation services provided by home health agencies under a home health plan of care is included in the home health PPS rate. HHAs may submit bill type 34X and be paid under the MPFS if there are no home health services billed under a home health plan of care at the same time, and there is a valid rehabilitation Plan of Care (e.g., the patient is not homebound).

An institutional employer (other than a SNF) of the physical therapists in private practice (PTPPs), occupational therapists in private practice (OTPPs), or physician performing outpatient services, (e.g., hospital, CORF, etc.), or a clinic billing on behalf of the physician or therapist may bill the carrier on Form CMS-1500.

The MPFS is the basis of payment for outpatient rehabilitation services furnished by PTPPs and OTPPs, physicians, and certain nonphysician practitioners or for diagnostic tests provided incident to the services of such physicians or nonphysician practitioners. (See the Medicare Benefit Policy Manual, Chapter 15, for a definition of "incident to.") Such services are billed to the Part B carrier. Assignment is mandatory.

The following table identifies the provider types or physician/nonphysician and to which contractor they may submit bills.

"Provider/Service" Type	**Bill to**	**Bill Type**	**Comment**
Inpatient hospital Part A	FI	11X	Included in PPS
Inpatient SNF Part A	FI	21X	Included in PPS
Inpatient hospital Part B	FI	12X	Hospital may obtain services under arrangements and bill, or rendering provider may bill.
Inpatient SNF Part B except for audiology function tests.	FI	22X	SNF must provide and bill, or obtain under arrangements and bill.
Inpatient SNF Part B audiology function tests only.	FI	22X	SNF may bill the FI or provider of service may bill the carrier.
Outpatient hospital	FI	13X	Hospital may provide and bill or obtain under arrangements and bill, or rendering provider may bill

"Provider/Service" Type	Bill to	Bill Type	Comment
Outpatient SNF	FI	23X	SNF must provide and bill or obtain under arrangements and bill
HHA billing for services rendered under a Part A or Part B home health plan of care.	FI	32X	Service is included in PPS rate. CMS determines whether payment is from Part A or Part B trust fund.
HHA billing for services not rendered under a Part A or Part B home health plan of care, but rendered under a therapy plan of care.	FI	34X	Service not under home health plan of care.
Other Rehabilitation Facility (ORF) with 6-digit provider number assigned by CMS RO	FI	74X	Paid MPFS for outpatient rehabilitation services effective January 1, 1999, and all other services except drugs effective July 1, 2000. Starting April 1, 2002, drugs are paid 95% of the AWP. For claims with dates of service on or after July 1, 2003, drugs and biologicals do not apply in an OPT setting. Therefore, FIs are to advise their OPTs not to bill for them.
CORF with 6-digit provider number assigned by CMS RO	FI	75X	Paid MPFS for outpatient rehabilitation services effective January 1, 1999, and all other services except drugs effective July 1, 2000. Starting April 1, 2002, drugs are paid 95% of the AWP.
Physician, NPPs, PTPPs, OTPPs, and, for diagnostic tests only, audiologists (service in hospital or SNF)	Carrier	See Chapter 26 for place of service, and type of service coding.	Payment may not be made for therapy services to Part A inpatients of hospitals or SNFs, or for Part B SNF residents. Otherwise, carrier billing. Note that physician/ NPP/PTPP/OTPP employee of

"Provider/Service" Type	Bill to	Bill Type	Comment
			facility may assign benefits to the facility, enabling the facility to bill for physician/therapist to carrier
Physician/NPP/PTPP/OTPP office, independent clinic or patient's home	Carrier	See Chapter 26 for place of service, and type of service coding.	Paid via Physician fee schedule.
Practicing audiologist for services defined as diagnostic tests only	Carrier	See Chapter 26 for place of service, and type of service coding.	Some audiologists tests provided in hospitals are considered other diagnostic tests and are subject to HOPPS instead of MPFS for outpatient therapy fee schedule.
Critical Access Hospital - inpatient Part A	FI	85X	Rehabilitation services are paid cost.
Critical Access Hospital - inpatient Part B	FI	85X	Rehabilitation services are paid cost.
Critical Access Hospital - outpatient Part B	FI	85X	Rehabilitation services are paid cost.

Complete Claim form completion requirements are contained in Chapters 25 and 26.

For a list of the outpatient rehabilitation HCPCS codes see §10.2.G.

If an FI receives a claim for one of the these HCPCS codes with dates of service on or after July 1, 2003, that does not appear on the supplemental file it currently uses to pay the therapy claims, it contacts its local carrier to obtain the price in order to pay the claim. When requesting the pricing data, it advises the carrier to provide it with the nonfacility fee.

NOTE: The list of codes in §10.2.G contains commonly utilized codes for outpatient rehabilitation services. FIs 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.

10.1 - New Payment Requirement for Intermediaries (FIs)

(Rev. 1, 10-01-03)

A-03-011

Effective with claims with dates of service on or after July 1, 2003, OPTs/Outpatient Rehabilitation Facilities (ORFs), (74X and 75X bill type) are required to report all their services utilizing HCPCS. FIs are required to make payment for these services under the MPFS unless the item or service is currently being paid under the orthotic fee schedule or the item is a drug, biological, supply or vaccine (see below for an explanation of these services).

The CMS currently provides FIs with a CORF supplemental file that contains all physician fee schedule services and their related prices. FIs use this file to price and pay OPT claims. The format of the record layout is provided in Attachment E of PM A-02-090, dated September 27, 2002. This is located at: http://cms.hhs.gov/manuals/pm_trans/A02090.pdf.

Fiscal FIs will be notified in a one-time instruction of updates to this file and when it will be available for retrieval.

If an FI receives a claim for one of the above HCPCS codes with dates of service on or after July 1, 2003, that does not appear on the CORF supplemental file it currently uses to pay the CORF claims, it contacts its local carrier to obtain the price in order to pay the claim. When requesting the pricing data, it advises the carrier to provide it with the nonfacility fee.

10.2 - The Financial Limitation

(Rev. 42, 12-08-03)

A3-3653, AB-03-018, AB-03-057, AB-03-097*, B-03-065*

See Business Requirements at http://www.medicaid.com/manuals/pm_trans/R42CP.pdf

A - Financial Limitation Prior to the BBRA

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, which added §1834(k)(5) to the Act, required payment under a prospective payment system for outpatient rehabilitation services. Outpatient rehabilitation services include the following services:

- Physical therapy (which includes outpatient speech-language pathology); and
- Occupational therapy.

Section 4541(c) of the BBA required application of a financial limitation to all outpatient rehabilitation services (with the exception of outpatient departments of a hospital). In 1999, an annual per beneficiary limit of $1,500 applied to all outpatient physical therapy services (including speech-language pathology services). A separate limit applied to all occupational therapy services. The limit is based on incurred expenses and includes applicable deductible ($100) and coinsurance (20 percent). The BBA provided that the limits be indexed by the Medicare Economic Index (MEI) each year beginning in 2002.

The limitation is based on the services the Medicare beneficiary receives, not the type of practitioner who provides the service. Therefore, physical therapists, speech-language pathologists, occupational therapists as well as physicians and certain non-physicians practitioners could render a therapy service.

As a transitional measure, effective in 1999, providers/suppliers were instructed to keep track of the allowed incurred expenses. This process was put in place to assure providers/suppliers did not bill Medicare for patients who exceeded the annual limitations for physical therapy, and for occupational therapy services rendered by individual providers/suppliers.

B - Moratoria on Therapy Claims

Section 221 of the Balanced Budget Refinement Act *(BBRA)* of 1999 placed a 2-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.

Section 421 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act *(BIPA)* of 2000, extended the moratorium on application of the financial limitation to claims for outpatient rehabilitation services with dates of service January 1, 2002, through December 31, 2002. Therefore, the moratorium was for a 3-year period and applied to outpatient rehabilitation claims with dates of service January 1, 2000, through December 31, 2002.

In 2003, there was not a moratorium on therapy caps. Implementation was delayed until September 1, 2003. Therapy caps were in effect for services rendered on September 1, 2003 through December 7, 2003.

Congress re-enacted a moratorium on financial limitations on outpatient therapy services on December 8, 2003 that extends through December 31, 2005.

C - Application of Financial Limitation (FIs and Carriers) ***September 1, 2003 through December 7, 2003.***

Financial limitations on outpatient therapy services began for services *rendered* on or after September 1, 2003 *and continued through December 7, 2003. Limits will not apply*

to claims received on or after December 8, 2003, through December 31, 2005, regardless of the date services were rendered.

For *claims received during the dates when limitations were in effect in* the calendar year 2003, the limit for outpatient physical therapy and speech-language pathology combined *wa*s $1590; the limit for occupational therapy *wa*s $1590. Contractors apply the financial limitation for occupational therapy and physical therapy (including speech-language pathology) service to claims *received* on and after September 1, 2003 through *December 7, 2003.* The full $1590 amount for each limit applies to that time period in 2003.

When the therapy limitations were in effect in 2003, the Common Working File (CWF) track*ed* the physical therapy (which includes speech-language pathology services) and the occupational therapy financial limitation for outpatient rehabilitation services.

NOTE: Shared System Maintainers are not responsible for tracking the dollar amounts of incurred expenses of rehabilitation services for each therapy limitation.

This financial limitation *wa*s an annual per beneficiary limitation. The limitation *wa*s on the allowed incurred expenses, which *we*re defined as the Medicare Physician Fee Schedule (MPFS) amount prior to any application of deductible ($100) and coinsurance (20 percent). If the beneficiary ha*d* already satisfied the Medicare Part B deductible, the maximum amount payable by the Medicare program *wa*s 80 percent of each annual limit. The beneficiary *wa*s responsible for paying the remaining 20 percent co-insurance.

See the following examples, which are based on the 2003 limits of $1590:

EXAMPLE I - Part B Deductible Previously Met:

$1,590 (2003 MPFS total allowed amount) x 80 percent = $1,272 (Medicare reimbursement).

The amount applied to the limitation in this example is $1,590. The Medicare program pays $1,272 and the beneficiary is responsible for $318 co-insurance.

EXAMPLE II - Part B Deductible Not Met:

$1,590 (2003 MPFS total allowed amount) - $100 (Part B deductible) = $1,490

$1,490 x 80 percent = $1,192 (Medicare reimbursement)

The amount applied to the limitation in this example is $1,590. The Medicare program pays $1,192 and the beneficiary is responsible for $398 ($100 Part B deductible and $298 co-insurance).

EXAMPLE III - Part B Deductible Previously Met:

$800 (MPFS allowed amount) x 80 percent = $640 (Medicare reimbursement).

The amount applied to the limitation in this example is $800. The Medicare program pays $640 and the beneficiary is responsible for $160 coinsurance.

EXAMPLE IV - Part B Deductible Not Met:

$800 (MPFS allowed amount) - $100 (Part B deductible) = $700

$700 x 80 percent = $560 (Medicare reimbursement).

The amount applied to the limitation in this example is $800. The Medicare program pays $560 and the beneficiary is responsible for $240, ($100 Part B Deductible and $140 coinsurance.)

NOTE: In the above examples the MPFS allowed amount is the lower of charges or the MPFS rate times the unit.

D - MSN Messages

Contractors shall provide the following "therapy caps alert" on all MSNs. The MSN change is required as soon as possible, *but within two weeks of issuance of CR 3005.* Contractors shall print the message in bold, to the extent that it is feasible without shared systems changes.

ALERT: Starting with services received on September 1, 2003, through *December 7, 2003,* coverage by Medicare *was* limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services. *When limits were in effect*, the limits *we*re $1,590 for PT and SLP combined and $1,590 for OT. Medicare pays up to 80 percent of the limits. These limits don't apply to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility.

From December 8, 2003 through December 31, 200*5*, *outpatient therapy services (PT, OT,* and SLP) are not limited by *a dollar amount*. If you have questions, please call 1-800-MEDICARE.

Spanish Translation

Alerta: La cubierta de Medicare para servicios ambulatorios de terapia física, patología del habla y terapia ocupacional recibidos entre el 1 de septiembre del 2003 hasta el 7 de diciembre del 2003 era limitada. Durante el período en que los límites estaban en vigencia, el límite combinado para las terapias físicas y del habla era de $1,590. Además, había un límite separado de $1,590 para las terapias ocupacionales. De estos límites, Medicare paga hasta el 80%. Estos límites no se aplican a la terapia que usted recibe como servicio ambulatorio en un hospital, a menos que usted resida en un centro de enfermería especializada y que ocupe una cama certificada por Medicare.

Desde el 8 de diciembre del 2003 hasta el 31 de diciembre del 2005, no se le aplicaran límites a los servicios ambulatorios de las terapias físicas, ocupacionales y del habla. Si tiene preguntas, for favor llame al 1-800-MEDICARE.

Existing MSN messages 17.13, and the new MSN messages 17.18 and 17.*19 have been revised to indicate therapy caps were removed. They* shall be issued on all claims *services received between December 8, 2003 and the earliest date contractors can modify systems to appropriately remove them.*

MSN *messages have* been revised to read:

English 17.13

17.13 - *During the period September 1, 2003 through December 7, 2003, Medicare approved a limited dollar amount each year for physical therapy, speech-language pathology services and occupational therapy services. Therapy services are not limited by dollar amount from December 8, 2003 through December 31, 2005.*

Spanish Translation *17.13*
17.13 - *Medicare había aprobado un límite de dinero para cada año por servicios de terapias físicas, del habla y ocupacionales (en el 2003, el período de la cubierta limitada fue entre el 1 de septiembre del 2003 hasta el 7 de diciembre del 2003). No habrá un límite de dinero para las terapias recibidas entre el 8 de diciembre del 2003 hasta el 31 de diciembre del 2005.*

English 17.18
17.18 - *Physical therapy and speech-language pathology services were limited during part of 2003, but those limits no longer apply. Services will not be denied because of therapy caps.*

Spanish Translation *17.18*
17.18 - *La cobertura de las terapias física y del habla estaba limitada durante parte del año 2003, pero esa limitación ya no es vigente. La cobertura por servicios de terapias no será negada por motivo de los límites del 2003.*

English 17.19
17.19 - *Occupational therapy services were limited during part of 2003, but those limits no longer apply. Services will not be denied because of therapy caps.*

Spanish Translation *17.19*

17.19 - *La cobertura de las terapias ocupacionales estaba limitada durante parte del año 2003, pero esa limitación ya no es vigente. La cobertura por servicios de terapias no será negada por motivo de los límites del 2003.*

Contractors shall use the existing Medicare Summary Notice message 17.6 to inform the beneficiaries that they have reached the financial limitation *in cases where it applies on or prior to December 7, 2003.* Contractors apply this message at the line level:

> 17.6 - Full payment was not made for this service because the yearly limit has been met.

Spanish translation

> 17.6 - Debido a que usted alcanzó su límite anual por este servicio, no se hará un pago completo.

E - FI Requirements

1. General Requirements

Regardless of financial limits on therapy services, CMS requires modifiers (See Sec. 20.1 of this chapter) on specific codes for the purpose of data analysis. Edit to ensure that the therapy modifiers (See Sec. 20.1 of this chapter) are present on a claim based on the presence of revenue codes 042X, 043X, or 044X. Claims containing revenue codes 042X, 043X, or 044X without a therapy modifier GN, GO, or GP should be returned to the provider.

Beneficiaries may not be simultaneously covered by Medicare as an outpatient of a hospital and as a patient in another facility. They must be discharged from the other setting and registered as a hospital outpatient in order to receive payment for outpatient rehabilitation services in a hospital outpatient setting after the limitation has been reached.

A hospital may bill for services of a facility as hospital outpatient services if that facility meets the requirements of a department of the provider (hospital) under 42 CFR 413.65. Facilities that do not meet those requirements are not considered to be part of the hospital and may not bill under the hospital's provider number, even if they are owned by the hospital. For example, services of a Comprehensive Outpatient Rehabilitation Facility (CORF) must be billed as CORF services and not as hospital outpatient services, even if the CORF is owned by the hospital. Only services billed by the hospital as bill type 12X or 13X are exempt from limitations on therapy services.

2. When financial limits are in effect.

The CWF applies the financial limitation to the following bill types 22X, 23X, 34X, 74X, and 75X, using the MPFS allowed amount (before adjustment for beneficiary liability). The reimbursement field portion of the CWF record is not used by the CWF to track the financial limitation. The CWF creates a new "line-level" field entitled "Financial

Limitation" to be used by Shared Systems to transmit to CWF the amount to be applied to the limitation. The CWF also creates a new line level override code value to be reported in situations where the MPFS allowed amount exceeds the limitation available. This override code can also be used for appeals. (See "FI Action Based on CWF Trailer" below for additional information.)

For SNFs, *the financial* limitation does apply to rehabilitation services furnished to those SNF residents in noncovered stays (bill type 22X) who are in a Medicare-certified section of the facility--i.e., one that is either certified by Medicare alone, or is dually certified (by Medicare as a SNF and by Medicaid as a nursing facility (NF)). For SNF residents, consolidated billing requires all outpatient rehabilitation services be billed to Part B by the SNF. If a resident has reached the financial limitation, and remains in the Medicare-certified section of the SNF, no further payment will be made to the SNF or any other entity. Therefore, SNF residents who are subject to consolidated billing may not obtain services from an outpatient hospital after the cap has been exceeded.

Once the financial limitation has been reached, SNF residents who are in a **non-Medicare certified** section of the facility--i.e., one that is certified only by Medicaid as a NF, or that is not certified at all by either program--FIs use bill type 23X (see CR 2674). For SNF residents in non-Medicare certified portions of the facility and SNF nonresidents who go to the SNF for outpatient treatment (bill type 23X), medically necessary outpatient therapy may be covered at an outpatient hospital facility after the financial limitation has been exceeded.

Limitations do not apply for SNF residents in a covered Part A stay, including swing beds. Rehabilitation services are included within the global Part A per diem payment that the SNF receives under the PPS for the covered stay. Similarly, limitations do not apply to any therapy services billed under PPS Home Health, or inpatient hospitals including critical access hospitals.

F - Carrier Requirements when Financial Limits are in Effect

All claims containing any of the following list of "Applicable Outpatient Rehabilitation HCPCS Codes" should contain one of the therapy modifiers (GN, GO, GP) except as follows: Claims from physicians (all specialty codes) and nonphysician practitioners, including specialty codes "50," "89," and "97" do not have to contain modifiers for the HCPCS codes for casts and splints as noted with a "+" sign below.

For all other claims submitted by physicians or nonphysician practitioners (as noted above) containing these applicable HCPCS codes without therapy modifiers, return the claim as unprocessable.

If specialty codes "65" and "67" are present on the claim and an applicable HCPCS code is without one of the therapy modifiers (GN, GO, or GP) the carrier returns the claim as unprocessable.

The CWF will capture the amount and apply it to the limitation whenever a service is billed using the GN, GO, or GP modifier. The CWF must also disable the edit involving specialty codes "65" and "67" and Type of Service W or U.

Once the financial limitation has been reached, beneficiaries may receive outpatient rehabilitation services furnished directly by or under arrangement with a hospital.

G* - Additional Information for Carriers and FIs *during the time financial limits are in effect.

Once the limitation is reached, if a claim is submitted, CWF returns an error code stating the financial limitation has been met. Over applied lines will be identified at the line level. The outpatient rehabilitation therapy services should be denied. The FIs 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/physician/supplier should advise the beneficiary that a claim for services that exceeds the limitation is being denied pursuant to §1833(g) of the Act (42 U.S.C. §1395(g)). The providers/suppliers should inform the beneficiary that any additional outpatient rehabilitation services in this setting would result in the beneficiary exceeding the financial limitation, but medically necessary services above the limit may be obtained at an outpatient hospital. Such notification will allow the beneficiary to make an informed choice about continuing to receive services from the provider/physician/supplier or to change to a hospital outpatient department. This is advised because the beneficiary is responsible for payment of all outpatient rehabilitation services that exceeded the financial limitation on an annual basis.

In situations where a beneficiary is close to reaching the financial limitation and a particular claim might exceed the limitation, the provider should bill the usual and customary charge for the service furnished even though such charge might exceed the limit. For example, using the 2003 limit of $1590, a beneficiary to date received services for which the total amount of payment and the beneficiary co-insurance total $1,575**.** The beneficiary then received 3 services - 1 at $50; 1 at $25; and 1 at $30. The CWF will return an error code/trailer that will identify the line that exceeds the limitation.

When the financial limitation has been exceeded and the beneficiary chooses to continue treatment at a setting other than the outpatient hospital where medically necessary services are covered, the services may be billed at the rate the provider/supplier determines. Services provided in a capped setting after the limitation has been reached are not Medicare benefits and are not governed by Medicare policies.

Beneficiaries may appeal claims denied due to exceeding therapy caps. The beneficiary is to be advised of his or her appeal rights set forth in 42 CFR Part 405, Subpart G. Physicians, therapists, and other suppliers who accept assignment may also appeal denials. Physicians, therapists, and other suppliers who do not accept assignment and institutional providers do not have the right to appeal.

H* - FI Action Based on CWF Trailer *during the time therapy limits are in effect.

Upon receipt of the CWF error code/trailer, FI are responsible for assuring that payment does not exceed the financial limitations*, when the limits are in effect,* (except as noted below).

In cases where a claim line partially exceeds the limit, the FI must adjust the line based on information contained in the CWF trailer. For example, where the MPFS allowed amount is greater than the financial limitation available, always report the MPFS allowed amount in the "Financial Limitation" field of the CWF record and include the CWF override code. See example below for situations where the claim contains multiple lines that exceed the limit.

EXAMPLE (based on 2003 limit of $1590):

Services received to date: $1,575

Incoming claim: Line 1 MPFS allowed amount of $50.00

Line 2 MPFS allowed amount of $25.00

Line 3 MPFS allowed amount of $30.00

Based on this example, lines 1 and 3 are denied and line 2 is paid. The FI reports in the "Financial Limitation" field of the CWF record $25.00 along with CWF override code. The FI always applies the amount that would least exceed the limit. Since the FI systems cannot split the payment on a line, CWF will allow payment on the line that least exceeds the limit and deny other lines.

I* - Provider Notification *for Beneficiaries Exceeding therapy limits September 1, 2003 through claims received on December 7, 2003.

Contractors will advise providers/suppliers that they may use the Notice of Exclusions from Medicare Benefits (NEMB Form No. CMS-20007 & Formulario No. CMS-20007) or a similar form of their own design to notify beneficiaries of the therapy financial limitations and that these limits are applied in all settings except hospital outpatient departments. ABNs cannot be used because of the statutory nature of the financial limitations. Therefore, providers/suppliers should inform beneficiaries that beneficiaries are responsible for 100 percent of the costs of therapy services above each respective therapy limit, unless this outpatient care is furnished directly or under arrangement by a hospital. It is the provider's responsibility to present each beneficiary with accurate information about the therapy limits and that, where necessary, appropriate care above the limit*s* can be obtained at a hospital outpatient therapy department. Advise providers/suppliers to use the Notice of Exclusion from Medicare Benefits (NEMB) form to inform beneficiaries of the therapy financial limitation at their first therapy encounter with the beneficiary. When using the NEMB form, the practitioner checks box number 1 and writes the reason for denial in the space provided at the top of the form. Provide the following reason: "Medicare will not pay for physical therapy and speech-language

pathology services over (add the dollar amount of the cap and the year or the dates of service to which it applies)." This same information is provided for occupational therapy services over the limit for the same time period, as appropriate.

The NEMB form can be found at: http://www.cms.hhs.gov/medlearn/refabn.asp

All providers/suppliers and contractors may access the accrued amount of therapy services from the ELGA and ELGB screens in the HIPAA system. Providers who bill to FIs will also find the amount a beneficiary has accrued toward the financial limitations on the HIQA. Suppliers who do not have access to the HIPAA system may call the contractor to obtain the amount accrued.

20 - HCPCS Coding Requirement

(Rev. 42, 12-08-03)

A3-3653, **SNF-532, AB-00-39**

A. Uniform Coding

Section 1834(k)(5) of the Act requires that all claims for outpatient rehabilitation, certain audiology services and CORF services be reported using a uniform coding system. The HCPCS is the coding system used for the reporting of these services.

Effective for claims submitted on or after April 1, 1998, providers that had not previously reported HCPCS for outpatient rehabilitation and CORF services began using HCPCS to report these services and certain audiology services. This requirements does not apply to outpatient rehabilitation and audiology services provided by:

- Critical Access Hospitals, which are paid on a cost basis, not MPFS;
- RHCs, and FQHCs for which therapy is included in the all-inclusive rate; or
- Providers that do not furnish therapy services.

The following "providers of services" must bill the FI for outpatient rehabilitation services using HCPCS codes:

- Hospitals (to outpatients and inpatients who are not in a covered Part A stay);
- Skilled nursing facilities (SNFs) (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF);
- Home health agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care (POC));
- Comprehensive outpatient rehabilitation agencies (CORFs); and

- Outpatient physical therapy providers (OPTs), i.e., outpatient physical therapy facilities.

Note that the requirements for hospitals and SNFs apply to inpatient Part B and outpatient services only. Inpatient Part A is included in the respective PPS rate and not billed separately.

For HHAs, HCPCS coding for outpatient rehabilitation services is required only when the HHA provides such service to individuals that are not homebound and; therefore, not under a Home Health plan of care.

***B* - Applicable Outpatient Rehabilitation HCPCS Codes**

Regardless of financial limitation, CMS identifies the following codes as therapy services. *Codes* without + signs always require *t*herapy modifiers. Codes with + signs need modifiers when the*y* represent therapy services.

The financial *limits (when in effect) apply to services represented by the* following codes, except as noted below. (NOTE: Listing of the following codes does not imply that services are covered.)

29065+	29075+	29085+	29086+	29105+	29125+
29126+	29130+	29131+	29200+	29220+	29240+
29260+	29280+	29345+	29355+	29365+	29405+
29425+	29445+	29505+	29515+	29520+	29530+
29540+	29550+	29580+	29590+	64550+	90901+
90911+	92506	92507	92508	92526	92597
92607	92608	92609	92610+	92611+	92612+
92614+	92616+	95831+	95832+	95833+	95834+
95851+	95852+	96000+	96001+	96002+	96003+
96105+	96110+◆	96111+	96115+	97001	97002
97003	97004	97010****	97012	97016	97018
97020	97022	97024	97026	97028	97032
97033	97034	97035	97036	97039	97110
97112	97113	97116	97124	97139	97140

97150	97504**	97520	97530	97532	97533
97535	97537	97542	97601+	*97602****	97703
97750	97755	97799*	G0279+***	G0280+***	G0281
G0283	0020T+***	0029T+***			

* The physician fee schedule abstract file does not contain a price for codes 96110, 97799, since the carrier prices them. Therefore, the FI must contact the carrier to obtain the appropriate fee schedule amount in order to make proper payment for these codes.

◆ Effective January 1, 2004, 96110 will be an active code on the physician fee schedule. Carriers shall no longer price this code.

** 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.

*** The physician fee schedule abstract file does not contain a price for codes G0279, G0280, 0020T, 0029T since they are priced by the carrier. In addition, the carrier determines coverage for these codes. Therefore, the FI contacts the carrier to obtain the appropriate fee schedule amount.

****Code*s* 97010 *and 97602 are* bundled. *They are* bundled with any therapy code*s*. Regardless of whether *they are* billed alone or in conjunction with another therapy code, never make payment separately for th*ese codes*. If billed alone, *either code* should be denied using the existing EOMB/MSN language. For remittance advice notices, use group code CO and claim adjustment reason code 97 that says: "Payment is included in the allowance for another service/procedure." Use reason code 97 to deny a procedure code that should have been bundled. *Alternatively, reason code B15, which has the same intent, may also be used.*

+ *Codes marked + sometimes represent therapy services. These codes and all codes on the above list always represent therapy services when performed by therapists.*

*There are some circumstances when t*hese codes will not *be considered representative of therapy services and therapy limits (when they are in effect) will not apply. Codes marked + are not therapy services w*hen they are not done under a therapy plan of care *and* they are billed by providers of services who *are not therapists. That is, they* are represented by any specialty codes except 65 and 67 (PT in Private Practice, OT in Private Practice), 73 and 74. *Specialty codes 73 and 74* were incorrectly noted in AB-03-018 and have since been reassigned to specialties that are not therapy services. Since

removal requires system changes, they will be removed in a future (non-emergency) instruction.

The Codes marked + on the above list may not be used by non-therapist practitioners without a therapy modifier in situations where the service provided is integral to an outpatient rehabilitation therapy service.

"Outpatient rehabilitation therapy" refers to skilled PT, OT and SLP services, requiring the skills of qualified professional personnel such as physical therapists, occupational therapists or speech-language pathologists, performed for restorative purposes and generally involving ongoing treatments. In contrast, a non-therapy service (usually a one-time service) is a service performed by non-therapist practitioners, without rehabilitative plan or goals, e.g., application of a cast to stabilize and protect a fracture. Contractors have discretion to determine whether circumstances *require a plan or* describe a therapy service.

Physicians and non-physician practitioners who can appropriately provide the services represented by the codes marked + on the above list should only use therapy modifiers (GP, GN, GO) with the above codes when the services are outpatient rehabilitation therapy services provided under a therapy plan of care.

Codes on the above list that do not have a + sign are considered "always therapy" codes and always require a therapy modifier. Therapy services, whether represented by "always therapy" codes, or + codes in the above list performed as outpatient rehabilitation therapy services, must follow all the policies for therapy services (e.g., Pub. 100-04, Chapter 5; Pub. 100-02, Chapter 15).

C - Additional HCPCS Codes

OPTs may also bill for the following outpatient non-rehabilitation HCPCS codes:

95860, 95861, 95863, 95864, 95867, 95869, 95870, 95900, 95903, 95904, 95934, G0237, G0238*, G0239*

*The physician fee schedule abstract file described below does not contain a price for codes G0238 and G0239, since the carrier prices them. Therefore, the FI contacts its carrier to obtain the appropriate fee schedule amount in order to make proper payment for these codes.

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

20.1 - Discipline Specific Outpatient Rehabilitation Modifiers - All Claims

(Rev. 42, 12-08-03)

A3-3653, AB-00-01, SNF-532.G, AB-03-057

Modifiers are used to identify therapy services whether or not financial limitations are in effect. When limitations are in effect, the CWF tracks the financial limitation based on the presence of therapy modifiers. Providers/suppliers must continue to report one of these modifiers for any therapy code on the list of applicable therapy codes except as noted in §10.2 of this chapter. These modifiers do not allow a provider to deliver services that they are not qualified and recognized by Medicare to perform. Therapy modifiers should never be used with codes that are not on the list of applicable therapy codes.

The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered:

GN Services delivered under an outpatient speech-language pathology plan of care;

GO Services delivered under an outpatient occupational therapy plan of care; or,

GP Services delivered under an outpatient physical therapy plan of care.

This is applicable to all claims from physicians, NPPs, PTPPs, OTPPs, CORFs, OPTs, hospitals, SNFs, and any others billing for physical therapy, *speech-language pathology or occupational therapy services as noted on the applicable code list in §10.2 of this chapter.*

Modifiers refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services. For example, respiratory therapy services, or nutrition therapy services shall not be represented by the codes, which require GN, GO, and GP modifiers.

20.2 - Reporting of Service Units With HCPCS - Form CMS-1500 and Form CMS-1450

(Rev. 1, 10-01-03)

A3-3653, SNF-532.C, AB-00-39

Effective with claims submitted on or after April 1, 1998, providers billing on Form CMS-1450 are required to report the number of units for outpatient rehabilitation and

certain audiology services based on the procedure or service, e.g., based on the HCPCS code reported instead of the revenue code. This was already in effect for billing on the Form CMS-1500. CORFs report their full range of CORF services on the Form CMS-1500. Units are 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, the provider enters "1" in units. Since providers may perform a number of procedures or services during a single visit, the number of units may exceed the number of visits. Visits should not be reported as units for these services.

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 043X in FL 42, HCPCS code 97530 in FL 44, and 4 units in FL 46.

Providers billing on Form CMS-1450 (UB-92) should report Value Code 50, 51, or 52, as appropriate in FLs 39-41, the total number of physical therapy, occupational therapy, or speech therapy visits provided from start of care through the billing period. This item is visits; not service units. This is not required on the Form CMS-1500.

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:

Units Reported on the Claim	Number Minutes
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	$\geq$ 83 minutes to < 98 minutes
7 units	$\geq$ 98 minutes to < 113 minutes
8 units	$\geq$ 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 less than 8 minutes. The expectation (based on the work values for these codes) is that a provider's 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 code 97112 and 23 minutes of code 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 code 97112 and one unit of code 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.

20.3 - Determining What Time Counts Towards 15-Minute Timed Codes - All Claims

(Rev. 1, 10-01-03)

A3-3653, SNF-532.C, AB-00-39

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 "intra-service 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 count as only one unit of code 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.

20.4 - Coding Guidance for Certain Physical Medicine CPT Codes - All Claims

(Rev. 1, 10-01-03)

AB-00-39

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 code 97545 is 2 hours and for code 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 codes 97110, 97112, 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. Further, we would not expect to see code 97546 without also seeing code 97545 on the same claim. Code 97546, when used, is used in conjunction with 97545.)

30 - Special Claims Processing Rules for Outpatient Rehabilitation Claims - Form CMS-1500

(Rev. 1, 10-01-03)

Rules for completing a Form CMS-1500 and electronic formats are in Chapter 26. Instructions in §§10.1, 20.1, 20.2, 20.3 and 20.4 above also apply.

30.1 - Determining Payment Amounts

(Rev. 1, 10-01-03)

Carriers use the MPFS to determine payment for outpatient rehabilitation services. Payment rules are the same as those for other services paid on the MPFS.

Assignment is mandatory.

See Chapter 23 for a description of the MPFS.

30.2 - Applicable Carrier CWF Type of Service Codes

(Rev. 1, 10-01-03)

The carrier assigns the type of service code before submitting the claim record to CWF.

U = Occupational therapy

W= Physical therapy

40 - Special Claims Processing Rules for Outpatient Rehabilitation Claims - Form CMS-1450

(Rev. 1, 10-01-03)

40.1 - Determining Payment Amounts - FIs

(Rev. 1, 10-01-03)

PM AB-00-01, SNF-532.F

See §100.2.

40.2 - Applicable Bill Types - FIs

(Rev. 1, 10-01-03)

A3-3653.B

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

40.3 - Applicable Revenue Codes - FIs

(Rev. 1, 10-01-03)

SNF-532.A, PM A-98-63, A3-3653.C

The appropriate revenue codes for reporting outpatient rehabilitation services are

0420 - Physical Therapy Services

0430 - Occupational Therapy Services

0440 - Speech pathology services

0470 - Audiology

The general classification of revenue codes is all that is needed for billing. If, however, providers choose to use more specific revenue code classifications, the FI should accept them. Reporting of services is not limited to specific revenue codes; e.g., services other than therapy may be included on the same claim.

Many therapy services may be provided 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 a therapist does not deliver the service, then on the type of therapy under the plan of care (POC) for which the service is delivered.

40.4 - FI Edit Requirements for Revenue Codes

(Rev. 1, 10-01-03)

A3-3653.H, SNF-532.E

FIs edit to assure the presence of a HCPCS code when revenue codes 0420, 0430, 0440, or 0470 are reported. However, they 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.

40.5 - Line Item Date of Service Reporting on Form CMS-1450

(Rev. 1, 10-01-03)

A3-3653.K, SNF-532.D

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 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 date of service for hardcopy is reported in FL 45 “Service Date” (MMDDYY). For ANSI X12N and the Form CMS-1450 (UB-92) flat file, the date is reported as CCYYMMDD. See example below of reporting line item dates of service. This example is for physical therapy services provided twice during a billing period.

ASC X 12 837

When using the 837 Health Care Claim version 3051 implementations 3A.01 or 1A.C1, or the 837 Health Care Claim HIPAA version (when implemented), the provider reports as follows:

LX*1~

SV2*0420*HC:97001*GP*60.9*UN*1~

DTP*472*D8*20021006~

LX*2~

SV2*0420*HC:97110*GP*44.02*UN*2~

DTP*472*D8*20021029~

Form CMS-1450 (UB-92) flat file

Record Type	Revenue Code	HCPCS	Modifier	Dates of Service	Units	Total Charges
61	0420	97001	GP	20021006	1	$60.90
61	0420	97110	GP	20021029	2	$44.02

Paper CMS-1450

FL 42	FL 44	FL 45	FL 46	FL 47
0420	97001GP	100602	1	$60.90
0420	97110GP	102902	2	$44.02

The FI returns 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 became 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.

50 - CWF and PS&R Requirements - FIs

(Rev. 1, 10-01-03)

A3-3653.P

The FI reports the procedure codes in the financial data section (field 65a-65j) of the PS&R record. It includes 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. The FI reports 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 the PS&R guidelines for specific information.

100 - Special Rules for Comprehensive Outpatient Rehabilitation Facilities (CORFs)

(Rev. 1, 10-01-03)

100.1 - General

(Rev. 1, 10-01-03)

A3-3370.1, B3-9300.1

The Omnibus Reconciliation Act of 1980 (Public Law 96-499, Section 933) defines CORFs (Comprehensive Outpatient Rehabilitation Facilities) as a distinct type of Medicare provider and adds CORF services as a benefit under Medicare Part B. The Balance Budget Act (P.L.105-33) requires payment under a prospective system for all CORF services.

See Chapter 1 for the policy on FI Designations governing CORFs.

See the Medicare Benefit Policy Manual, Chapter 12, for a description of covered CORF services.

Physicians' diagnostic and therapeutic services furnished to a CORF patient are not considered CORF physician's services. The physician must bill the area Part B carrier for these services. If they are covered, the carrier reimburses them via the MPFS.

However, other services are considered CORF services to be billed by the CORF to the FI, and are also considered included in the fee amount under the MPFS. These services include such services as administrative services provided by the physician associated with the CORF, examinations for the purpose of establishing and reviewing the plan of care, consultation with and medical supervision of nonphysician staff, team conferences, case reviews, and other facility staff medical and facility administration activities relating

to the services described in Medicare Benefit Policy Manual, Chapter 12. Related supplies are also included in the MPFS fee amount.

CORFs bill Medicare with the Form CMS-1450 using HCPCS codes and revenue codes. Usually the zero level revenue code is used. Payment is based on the HCPCS code and related MPFS amount.

Requirements in §§10 - 50 apply to CORF billing. In addition the following requirements apply.

100.2 - Obtaining Fee Schedule Amounts

(Rev. 1, 10-01-03)

PM AB-00-01, SNF-532.F

The CMS furnishes FIs with an annual therapy abstract file and a CORF supplemental file through the Medicare Telecommunications System. The CMS notifies FIs when new files are available. FIs are responsible for informing CORFs of new fee schedule amounts.

Payment is calculated at 80 percent of the allowed charge after deductible is met. The allowed charge is the lower of billed charges or the fee schedule amount. Unmet deductible is subtracted from the allowed charge, and payment is calculated at 80 percent of the result.

EXAMPLE

$120 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 (MPFS) X 80 percent.)

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

These codes are updated as needed by CMS.

If the FI receives a claim for a Medicare covered CORF service with dates of service on or after July 1, 2000, that does not appear on its fee schedule abstract file, it has two options for obtaining pricing information:

- It is provided with a therapy abstract file or CORF supplemental file that contains all therapy services and their related prices. This supplemental file contains approximately a million records, and may be used as a resource to extract pricing data as needed. The data in the supplemental file is in the same format as the

MPFS abstract file in exhibit 1, but the fields defining the fee and outpatient hospital indicators are not populated, instead they are space-filled.

The FI can contact the local carrier to obtain the price. When requesting the pricing data, it advises the carrier to provide the nonfacility fee from the MPFS. The MPFS supplemental file of physician fee schedule services is available for retrieval through CMS' Mainframe Telecommunications System. The FI is notified yearly of the file retrieval names and dates by a program memorandum or other communication.

100.3 - Proper Reporting of Code G0128 by CORFs - FIs

(Rev. 1, 10-01-03)

A3-3653

Code G0128 was created for use by CORFs to report nursing services provided to beneficiaries as part of their plan of care 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:

- 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, code G0128 is used to bill for services that are specified in the beneficiary's plan of care that are not part of other services. Examples of services that cannot be billed under code 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 codes 11040 - 11044) or whirlpool treatment (HCPCS code 97601) 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 code G0128.

4. Collecting a laboratory specimen, including phlebotomy.

Co-treatment by a nurse with a physical or occupational therapist or speech and language pathologist is not generally separately reimbursed unless a separate nursing service is clearly identifiable in the plan of care 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 technique for in-and-out urethral catheterization, skin care for decubitus ulcer, and care/teaching of a colostomy.

Administrative tasks or documentation should not be billed under code G0128.

100.4 - Application of the Outpatient Mental Health Treatment Limitation to CORF Claims

(Rev. 1, 10-01-03)

A3-3653

Section §1833 of the Act payment requires that payment be made at 62.5 percent of the allowed amount for CORF mental health treatment services. The allowed amount is the lower of the MPFS amount or billed charges. Therefore, the FI makes payment at 62.5 percent of 80 percent of the allowed 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. The FI reports 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.

Unmet deductible must be subtracted from the allowed amount met before applying the 62.5 percent.

100.5 - Off-Site CORF Services

(Rev. 1, 10-01-03)

CORF-403.D

CORFs may provide physical, speech and occupational therapy off the CORF's premises in addition to the home evaluation. Services provided offsite are billed separately and identified as "offsite" on the Form CMS-1450 (UB-92), in FL 84, Remarks. The charges for offsite visits include any additional charge for providing the services at a place other than the CORF premises. There is no change in the payment method for offsite services.

100.6 - Notifying Patient of Service Denial

(Rev. 1, 10-01-03)

CORF-410, PM A-01-77

Services may be noncovered because they are statutorily excluded from coverage under Medicare, or because they are not medically reasonable and necessary.

If a service is excluded by statute, the CORF may submit a claim for them to Medicare to obtain a denial prior to billing another insurance carrier. It shows the charges as noncovered (FL 48 on the Form CMS-1450 (UB-92)), and includes Condition Code 21 in FL 24-30). It may bill the beneficiary for the excluded services, and need not issue an advance beneficiary notice (ABN). However, when providing therapy services under the financial limitations, the CORF should provide the beneficiary with the Notice of Exclusion of Medicare Benefits (NEMB). The Medicare Claims Processing Manual, Chapter 30, "Limitation on Liability," discusses ABNs for FI processed claims for Part B services.

If, after reviewing the plan of care, the CORF determines that the services to be furnished to the patient are not medically reasonable or necessary, it immediately provides the beneficiary with an ABN. If the patient signs an ABN, the Form CMS-1450 includes occurrence code 32 "Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)" (FL 32-36) along with the date the ABN was signed.

If the beneficiary insists that a claim be submitted for payment, the CORF must indicate on the bill (billed separately from bills with covered charges) that it is being submitted at the beneficiary's request. This is done by using condition code 20.

If during the course of the patient's treatment the FI advises the CORF that covered care has ceased, the CORF must notify the beneficiary (or the beneficiary's representative) immediately.

100.7 - Payment of Drugs, Biologicals, and Supplies in a CORF

(Rev. 1, 10-01-03)

A3-3653

Drugs

Drugs and biologicals do not apply in an OPT setting. Therefore, FIs are to advise their OPTs not to bill for them.

Supplies

OPTs should not bill for the supplies they furnish. Since supplies are part of the practice expense, under the MPFS these expenses are already taken into account in the practice expense relative values.

Vaccines

OPTs should not be providing influenza, pneumococcal pneumonia, and Hepatitis B vaccines and their administration.

100.8 - Billing for DME, Prosthetic and Orthotic Devices, and Surgical Dressings

(Rev. 1, 10-01-03)

CORF-412

CORFs bill DME on Form CMS-1500 to the DMERC except for claims for implanted DME, which are billed on Form CMS-1500 to the local carrier. If the CORF does not have a supplier billing number from the National Supplier Clearinghouse (NSC), it may contact the NSC to secure one. If the local carrier has issued the CORF a provider number for billing physician services, the CORF may not use the same number when billing for DME.

CORFs bill the FI for prosthetic/orthotic devices and surgical dressings on Form CMS-1450. Form completion requirements are contained in Chapter 25100.9 - Surgical Dressings

If the CORF supplies the surgical dressings for its patients, it bills using revenue code 0623 "Surgical Dressings." The appropriate HCPCS code for the dressing is reported.

The FI makes payment based on the surgical dressing fee schedule.

100.10 - Group Therapy Services (Code 97150)

(Rev. 1, 10-01-03)

CR 2225, A3-1872 Dated 1-24-03, A3-3653, B3-15302-15304

Carriers pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services. The individuals can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.

100.10.1 - Therapy Students

(Rev. 1, 10-01-03)

A - General

Only the services of the therapist can be billed and paid under Medicare Part B. The services performed by a student are not reimbursed even if provided under "line of sight" supervision of the therapist; however, the presence of the student "in the room" does not make the service unbillable. Pay for the direct (one-to-one) patient contact services of the physician or therapist provided to Medicare Part B patients. Group therapy services performed by a therapist or physician may be billed when a student is also present "in the room".

EXAMPLES

Therapists may bill and be paid for the provision of services in the following scenarios:

- The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.

- The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient of doing other tasks at the same time.

- The qualified practitioner is responsible for the services and as such, signs all documentation. (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician's service, not for the student's services).

B - Therapy Assistants as Clinical Instructors

Physical therapist assistants and occupational therapy assistants are not precluded from serving as clinical instructors (CIs) for therapy students, while providing services within their scope of work and performed under the direction and supervision of a licensed physical or occupational therapist to a Medicare beneficiary.

C - Services Provided Under Part A and Part B

The payment methodologies for Part A and B therapy services rendered by a student are different. Under the MPFS (Medicare Part B), Medicare pays for services provided by physicians and practitioners that are specifically authorized by statute. Students do not meet the definition of practitioners under Medicare Part B. Under SNF PPS, payments are based upon the case mix or RUG category that describes the patient. In the rehabilitation groups, the number of therapy minutes delivered to the patient determines the RUG category. Payment levels for each category are based upon the costs of caring

for patients in each group rather than providing specific payment for each therapy service as is done in Medicare Part B

Exhibit 1 - Physician Fee Schedule Abstract File

(Rev. 1, 10-01-03)

This file contains nonfacility fee schedule payment amounts for the outpatient rehabilitation, audiology and CORF HCPCS codes listed in §10.2.G. These codes are identified in the abstract file by a value of "R" in the fee indicator field. The file includes fee schedule payment amounts by locality and is available via the CMS Mainframe Telecommunications System (formerly referred to as the Network Data Mover).

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

Data Element Name	COBOL Location	Picture	Value
12 -- Filler	43-60	X(18)	

Upon CMS notification, the contractor is responsible for retrieving this file 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. The CMS will notify contractors of updates to the MPFS, file names and when the updated files will be available for retrieval. Upon retrieval, contractors disseminate the fee schedules to their providers. The file is also available on the CMS Web site in the Public Use Files (PUF) area.