Medicare Intermediary Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 1872 **Date: JANUARY 24, 2003**

CHANGE REQUEST 2225

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3653 (Cont.) – 3654.2 (Cont.)	6-304.13 – 6-304.16 (4 pp.)	6-304.13 – 6-305 (3pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: January 1, 2003*
IMPLEMENTATION DATE: February 10, 2003

NOTE: This is for notification purposes only and does not contain policy changes

Section 3653, Prospective Payment for Outpatient Rehabilitation Services and the Financial Limitation, is being updated to reiterate our payment policies for group therapy, therapy students, and bad debts.

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

These instructions should be implemented within your current operating budget.

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

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

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

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

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

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

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

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

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

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

- CPT Codes 96105, 97545 and 97546.

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

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

Proper Reporting of Code G0128 by CORFs.

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

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

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

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

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

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

(4) Collecting a laboratory specimen, including phlebotomy.

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

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

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

Administrative tasks or documentation should not be billed under G0128.

T. Group Therapy--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.

U. Therapy Students

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 judgement, 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).

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.

Services Provided Under Part A and Part B—**Note:** The payment methodologies for Part A and B therapy services rendered by a student are different. Under the physician fee schedule (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 determine 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.

V. Bad Debts—There is no payment for bad debts (unrecovered costs attributable to uncollectible deductible and coinsurance arising from covered services to beneficiaries considered in calculating payment to providers reimbursed on the basis of reasonable cost) with respect to services paid under the Medicare physician fee schedule. Under a fee schedule, payment is not based on incurred costs; rather payment is made based on a schedule for the specific service furnished. Whether a fee schedule has its basis in charges or is resource-based, the payment is not related to a specific provider's cost outlay for a service and does not embody the concept of unrecovered cost.

Bad debts are allowable only to an entity to whom payment is made on the basis of reasonable cost.

3654. COORDINATION WITH HEALTH MAINTENANCE ORGANIZATIONS

3654.1 Provider Billing for Services Provided to HMO Beneficiaries.--When a HMO qualifies for participation under the Medicare program, HCFA annotates its records to indicate which Medicare beneficiaries are HMO enrollees.

Depending on the contractual arrangements between the HMO and HCFA, Medicare bills for HMO enrollees may be paid either by an intermediary or HMO. (See §§3555ff. for description of how to determine who processes the bill.) Where these guidelines indicate the HMO has processing jurisdiction, inform the provider to bill the HMO. Process the bill showing HMO payment.

When services are provided to a HMO enrollee for which the HMO has payment jurisdiction it either sends a HCFA-1450 to you via EMC, if possible, for processing as a "paid" HMO bill or arranges for the provider to send a HCFA-1450 directly to you.

Send the UNIBILL to HCFA, showing HMO paid code in field 67 position l840. In field 53 positions l707-1715 show zeros as Medicare Reimbursement Amount, and charges as covered.

Do not make a duplicate payment for the same services the HMO has paid. When you pay a HMO enrollee's bill follow regular bill processing procedures, including proper coding in location l840 of UNIBILL to indicate whether you, or the HMO, paid the bill.

3654.2 Patient is a Member of HMO for Only Part of Billing Period.--Where a patient either enrolls or disenrolls in a HMO during a period of services, two factors determine whether the HMO is liable for the payment.

- o Whether the facility is included in PPS, and
- o The date of enrollment.

If the patient changes HMO status during an inpatient hospitalization in a PPS hospital, his status at admission determines liability. If he was enrolled in the HMO before admission, the HMO is responsible regardless of whether the patient disenrolled before discharge. If the patient was not a HMO enrollee upon admission, later enrolls before discharge, the HMO is not responsible for payment.

Where the facility is a non-PPS hospital or unit, SNFs, HHAs, etc., the HMO is responsible for payment for services on and after the day of enrollment up through the day disenrollment is effective.