Program Memorandum
Intermediaries/Carriers

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal AB-00-14 **Date: MARCH 2000**

CHANGE REQUEST 842

SUBJECT: **Questions and Answers Regarding the Prospective Payment System (PPS) for Outpatient Rehabilitation Services and Physical Medicine Current Procedural Terminology (CPT) Coding Guidance**

This Program Memorandum (PM) is being issued in the form of questions and answers to respond to numerous inquiries relating to PM AB-00-01, dated January 2000 (formerly PM AB-98-63 dated October 1998). It also provides coding guidance on physical medicine CPT codes. It does not provide clarification regarding the financial limitation as this limitation has been suspended for 2 years based on the Balanced Budget Refinement Act of 1999. Guidance regarding the suspension of the financial limitation will be issued in a separate PM.

Coding--Intermediaries

Q1. Is it HCFA's intent that HCPCS codes 11040, 11041, 11042, 11043, and 11044 be billable on all bill types listed except 13X and 83X and paid on the Medicare Physician Fee Schedule (MPFS)?

A. Yes, except for hospital outpatient departments, codes 11042, 11043, and 11044 are paid under the MPFS. (Refer to Q&A #9 under the heading "Coding--Intermediaries and Carriers" which will be a more appropriate way to code these services.)

Q2. Codes 11042, 11043, and 11044 when billed on a 13X bill are changed by the Outpatient Code Editor (OCE) to 83X and paid under the ambulatory surgical center (ASC) pricer. What do we do about billing for these codes?

A. Until systems changes are completed to edit for the reporting of therapy modifiers appended to codes 11042, 11043, and 11044 to clearly distinguish when these debridement procedures are being billed in the hospital outpatient setting as surgical procedures versus therapy modalities, it is appropriate for 13X bills to be processed in this manner. Currently, these codes on a hospital outpatient bill are treated as surgical procedures subject to the ASC payment blend.

Q3. The OCE rejects as noncovered, HCPCS codes 92551, 92559, 92560, 92590, 92593, 92594, and 92595 when billed by any provider other than a home health agency (HHA). You cannot get past the OCE edit unless you manually override it. What do we do in this situation?

A. These codes are noncovered for all providers including HHAs. They were deleted from the list of audiology codes in PM AB-00-01. However, they were not deleted from the note on page 5 of the PM due to an oversight. Please disregard these codes.

Q4. If hospitals are exempt from the payment caps, why is it necessary for them to report modifiers?

A. HCFA has identified certain codes as therapy codes, e.g., the debridement codes cited in questions 1 and 2 above, which the American Medical Association (AMA) classifies as surgical procedures and are routinely performed as surgery in the hospital outpatient setting. By law, these procedures must be paid under the MPFS when furnished as an outpatient therapy service in the hospital outpatient setting and on the ASC blended payment method when provided as an outpatient surgical procedure. When the new hospital outpatient PPS is implemented in 2000, these procedures would be paid under the hospital outpatient PPS. Therefore, when systems renovations are completed, use of the therapy discipline-specific modifiers would facilitate appropriate payment for these procedures. In the meantime, hospitals would become accustomed to properly billing therapy procedures.

Additionally, the Balanced Budget Act (BBA) of 1997 requires HCFA to submit a report to Congress by January 1, 2001, which recommends establishing coverage policy for beneficiaries based on diagnostic categories and prior use of services in both inpatient and outpatient settings rather than on the current dollar limitations. Use of the discipline-specific modifiers by hospitals would greatly enhance HCFA's collection of data for the study it must develop as required by Congress.

Q5. If services are performed by audiologists, are they required to report one of the modifiers? For example, if the HCPCS code is 92552 and the revenue code is 470, is modifier GN, GO, or GP required?

A. If an audiology procedure (HCPCS code, for example 92552) is performed by an audiologist, a modifier is not required.

Q6. Is a therapy modifier, GN, GO, or GP, required if the claim is for partial hospitalization services which are billed with condition code 41?

A. No. These modifiers are not required on partial hospitalization claims.

Q7. Some intermediaries have indicated that they would not pay for the three V codes listed in PM AB-00-01. These codes are for speech, language, and dysphagia screening and are priced by the carriers. In addition, some intermediaries have indicated that they will not pay for some codes, including certain codes within the 97000 series and the debridement codes (11040-43). With respect to codes specifically listed in PM AB-00-01, do intermediaries have the discretion to universally deny use of these codes? Can the intermediaries universally prohibit the reporting of a code (or codes)?

A. Yes, intermediaries have the discretion to universally deny certain codes but they do not have the discretion to prohibit reporting of them. The listing of codes in PMs A-99-35 dated August 1999 (formerly PM A-98-24 dated July 1998) and AB-00-01 dated January 2000 is not related to coverage as indicated in the note on page 2 of PM A-99-35. Intermediaries should determine whether any of the reported codes are covered and medically necessary.

<u>Coding--Intermediaries and Carriers</u>

Q1. Payment cannot be made for code 97010 when billed alone. Should this code be bundled and if so with which codes?

A. Yes, 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, payment is never made.

Q2. Should contractors edit when codes 97504 and 97116 are both reported in appropriate clinical

situations?

A. In general, codes 97504 and 97116 should not be billed together. However, if code 97504 was performed on an upper extremity and code 97116 (gait training) was also performed, both codes may be billed with a modifier to denote a separate anatomic site.

Q3. Is modifier 59 the correct modifier to use when 97504 and 97116 are both billed?

A. Yes, 59 is the correct modifier to use.

Q4. Explain the difference between HCPCS codes 97139 and 97799.

A. Code 97139 is an unlisted therapeutic procedure, which the CPT defines as "a manner of effecting change through the application of clinical skills and/or services that attempt to improve function" in one or more areas, each 15 minutes. Performance of this code requires that a physician or therapist have direct (one-to-one) patient contact.

Code 97799 denotes an unlisted physical medicine/rehabilitation service or procedure, including tests and measurements.

Q5. Does Medicare allow re-evaluation for speech therapy? There are physical and occupational therapy HCPCS codes for re-evaluation. If speech re-evaluation is allowed, what is the appropriate HCPCS code to report?

A. Yes, Medicare does make payment for speech re-evaluation services when medically necessary and appropriate. The appropriate code to report in billing such services is 92506.

Q6. Is HCPCS code 92525 valid for speech therapy when billing a patient for a modified barium swallowing to evaluate swallowing ability?

A. Yes.

Q7. Is there a specific HCPCS code or range of HCPCS codes to report for cognitive speech therapy training?

A. For cognitive speech therapy, a speech and language pathologist could use either code 92507 or 97770 but not both for the same treatment.

Q8. What resources are available for providers who have specific questions about coding?

A. Specific coding questions should be directed to the AMA or to a therapy association.

Q9. We understand there is a new HCPCS code G0169. Can you describe when this code should be reported?

A. G0169, a new HCPCS Level II code was created for use starting January 1, 2000. It is defined to describe the type of active debridement performed by therapists. (A more complete description can be found in the ***Federal Register***, November 2, 1999, p. 59426.) This code can be used to describe active debridement, whether performed with a scissor, scalpel, or waterjet regardless of the depth of tissue involved. There is no global period on this code. Dressings placed on the wound after debridement are included in this code. We expect therapists to start using this code instead of 10040-4 and 97799 as soon as is feasible.

<u>Billing -- Intermediaries</u>

Q1. If a splint (HCPCS code 97504) is provided by an occupational therapist, what revenue code should be reported?

A. Revenue code 430.

Q2. Was it HCFA's intent that providers change their charge masters mid-cost report year to accommodate the change from visit to modality?

A. It was not HCFA's intent to require providers to change their charge masters. However, in order to be paid appropriately, providers will need to make changes to their charge masters. Our intent was to implement §4541 of the BBA in a timely fashion and allow as much lead time as possible for providers to make necessary changes to their internal systems.

Q3. Will HHA type of bills eventually be included in OCE edits?

A. There are no plans to include the HHA type of bills in the OCE.

Q4. When reporting line item dates of service, in what order should revenue codes be reported?

A. Revenue codes should be reported in revenue code order by date of service.

Q5. If you have more than one HCPCS code for the same revenue code during a single visit, how is that illustrated on the UB-92?

A. Each HCPCS code should be reported with the appropriate revenue code on a separate line item.

Q6. When billing for services not subject to line item date of service reporting, does it matter where on the claim these services are reported?

A. Services that do not require line item date of service reporting may be reported before or after line item services at either the top or the bottom of the claim.

<u>Billing--Carriers</u>

Q1. When outpatient rehabilitation services are billed to the Part B carrier, is assignment mandatory?

A. The mandatory assignment provision does not apply to therapy services furnished by a physician, a physical therapist in a private practice, an occupational therapist in private practice, or by a nonphysician practitioner. In addition, the mandatory assignment provision does not apply to therapy services furnished incident to the services of such physicians, therapists, or nonphysician practitioners.

Q2. HCPCS codes that are considered to be outpatient rehabilitation services when submitted by physicians or nonphysician practitioners are listed in 42CFR Parts 405, Addendum D, dated June 5, 1998 of the proposed notice. The outpatient rehabilitation codes listed in PM AB-00-01 include several codes that are not listed in Addendum D. Which of these codes are always considered rehabilitation services and should always be subject to the financial limitation?

A. The codes identified in Addendum D of the June 5, 1998 MPFS proposed rule should always be considered therapy services when submitted by physicians or nonphysician practitioners.

<u>Billing--Intermediaries and Carriers</u>

Q1. Do providers have to bill other payers by modalities?

A. Our understanding is that some providers bill other payers by modalities; however, it depends on the payer.

Q2. If a patient has therapy (any type) for 3 minutes, would a provider charge for 15 minutes?

A. No, this would not constitute a therapy session. (See the section on CPT coding below.)

Q3. If a patient has therapy (any type) for 20 minutes, would a provider charge for 15 minutes?

A. Yes. (See the section on CPT coding below.)

Q4. Are unused minutes in excess of 15 or 30 minutes charged for future visits?

A. No. (See the section on CPT coding below.)

Q5. How should code 97010 be processed when billed alone? We suggest returning the claim to the provider or subjecting it to line item denial.

A. The code should be denied and existing Explanation of Medicare Benefits/Medicare Summary Notice (EOMB/MSN) language used.

Q6. In regards to bundled services, does the time for the bundled service get counted in the time for the primary service? This comes up especially with hot/cold packs, 97010. For example, if a patient has a 25 minute visit with a hot pack for 10 minutes and therapeutic exercises for 15 minutes, does this get billed as 2 units of 97110? Or is the hot pack time not counted and only one unit of 97110 billed?

A. The scenario described is one unit of therapeutic exercise, 97110. The time of the hot and cold pack is not skilled and thus does not count in the total time.

<u>Payment--Intermediary</u>

Q1. The MPFS abstract file contains a technical component price, a professional component price, and a global price for codes 92587 and 92588. Which price should intermediaries apply in making payment for these services?

A. Intermediaries should pay for these services based on the technical component relative value unit indicated in the file.

Q2. How will drugs be paid for in Comprehensive Outpatient Rehabilitation Facilities (CORFs)?

A. Some medications are included in the practice expenses, (e.g., local anesthetics) and other medications have Level II HCPCS codes. Because of Y2K issues, we were unable to make the systems modifications necessary for the payment of drugs and biologicals. Payment for drugs and biologicals furnished in a CORF, therefore, will continue to be paid on a cost basis until the Y2K issues are resolved.

Q3. What is the payment for outpatient rehabilitation services furnished on or after January 1, 1999?

A. Generally, for outpatient rehabilitation services furnished on or after January 1, 1999, Medicare payment is equal to 80 percent of the lesser of (1) the actual charges for the service or (2) the

physician fee schedule amount after the Part B deductible is met. The only exception to this method of payment is for those services specifically cited in PM AB-00-01 as being paid for on a cost basis in hospital outpatient departments.

Q4. How is payment determined for a CORF that performs rehabilitation services; for example, if the bill type is 75X, the revenue code is 41X, and the HCPCS code is 97110?

A. Payment is based on HCPCS code, not the revenue code. Payment for CORF services under the MPFS is limited to the procedures identified by HCPCS codes in PM AB-00- 01. All other CORF services at this time should be paid on a reasonable cost basis until our Y2K changes are completed. Since code 97110 is listed as a rehabilitation service in the PM, it should be paid under the MPFS, regardless of the revenue code with which it is billed.

Payment--Intermediaries and Carriers

Q1. How do intermediaries obtain prices for therapy services that are not priced on the MPFS abstract file?

A. A service with a code that is not priced on the MPFS indicates it is carrier priced. Intermediaries should request all required documentation from the provider and forward a copy of the claim with all supporting documentation to the carrier for pricing. To establish documentation requirements, contact the appropriate local carrier for the jurisdiction that is being billed. Each carrier will have discretion as to what documentation is needed to price a particular service. There are certain services that carry a restricted status on the MPFS database. If the carrier reviews the necessary documentation and determines that the service is noncovered, you will be instructed to deny the claim.

Miscellaneous--Intermediaries

Q1. How can providers that bill the intermediary obtain the MPFS amounts?

A. Intermediaries should forward their providers the abstract file they retrieved from HCFA. Providers requesting the entire MPFS should be advised of its availability via HCFA's website at www.hcfa.gov/stats/pufiles.htm, then scroll down to National Physician Fee Schedule Relative Value File.

Q2. How is coinsurance calculated for providers?

A. Medicare payment is made at 80 percent of the lower of the actual charge or the MPFS amount. The remaining 20 percent is the beneficiary's coinsurance obligation.

Q3. Are rehabilitation agencies and CORFs required to continue submitting cost reports? If so, will provider cost reports be revised to reflect (1) the movement from a cost based payment methodology to the MPFS and/or (2) imposition of the $1500 limitation?

A. Yes, providers (including rehabilitation agencies and CORFs) are required to file cost reports, notwithstanding the fact that therapy services are paid under the MPFS. A revised cost report will reflect the movement from cost based payment to MPFS payment.

Q4. Does the 62.5 percent limit on mental health services apply to services paid to a CORF under the MPFS? If so, how does the limit apply?

A. Yes, the outpatient mental health treatment limitation applies to mental health services delivered

in a CORF and paid under the MPFS. 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.

Miscellaneous--Intermediaries and Carriers

Q1. Can occupational therapist and physical therapist dressing changes for wounds be charged?

A. No. Dressing changes are bundled into the MPFS payment for the service.

Q2. Can a facility charge for home exercise programs or any education program unattended when the patient is exercising at home?

A. No. No charge can be made for a home therapy program (or for an unsupervised program conducted in another part of the facility). Payment is made only for the face-to-face time involved in teaching the exercise.

Q3. Are providers and practitioners required to charge Medicare and non-Medicare patients the same amounts for outpatient rehabilitation services?

A. No. Providers and practitioners may charge different amounts for outpatient rehabilitation services furnished to Medicare and non-Medicare patients. However, §1128(b)(6) of the Social Security Act provides that the Secretary may exclude from participation in the Medicare program and from participation in any State health care program, individuals and entities that charge substantially in excess of their usual charges for furnished services. The determination of whether a charge substantially exceeds a usual charge is made by the Office of the Inspector General.

Physical Medicine CPT Codes
Coding Guidance

The following provides guidance regarding the use of codes 97032-97036, 97110-97124, 97140, 97504-97542, and 97703-97770.

Determining What Time Counts Towards 15 Minute Timed Codes

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post- delivery services are not to be counted in determining the treatment service time. In other words, the time counted as "intraservice care" begins when the therapist or physician or an assistant under the supervision of a physician or therapist is 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 for a patient with a recent stroke requires both a therapist and an assistant, or even two therapists to manage the patient or 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.

Determining How to Bill Units for 15 Minute Timed Codes

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	$\geq$ 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 < 8 minutes. The expectation (based on the work values for these codes) is that a provider's 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 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 8th should be excluded from the total count as the timing of active treatment counted includes all time.

It is advisable that the beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. **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**, see examples below.

Example 1: If 24 minutes of 97112 and 23 minutes of 97110 were furnished, then the total treatment time was 47 minutes, so only 3 units can be billed for the treatment. The correct coding is 2 units of 97112 and one unit of 97110, assigning more units to the service that took more time.

Example 2: If a therapist delivers 5 minutes of 97035 (ultrasound), 6 minutes of 97140 (manual techniques), and 10 minutes of 97110 (therapeutic exercise), then the total minutes are 21 and only one unit can be paid. Bill one unit of 97110 (the service with the longest time) and the clinical record will serve as documentation that the other two services were also performed.

Other Timed Physical Medicine Codes

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 on 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 96545 or 97546 would be the treatment period, since a shorter period could be coded with another code such as 97110, 97112, 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.)

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 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; and

4. Collecting a laboratory specimen, including phlebotomy.

Co-treatment by a nurse with a physical or occupational therapist or speech and language pathologist, generally will 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 would 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 of a colostomy.

Administrative tasks or documentation should not be billed under G0128.

Advise your providers in your next scheduled bulletin of this information.

The *effective date* of this PM: N/A

The *implementation date* of this PM: N/A

These instructions should be implemented within your current operating budget.

Contact persons for coverage, payment, and financial limitation issues in this PM are Roberta Epps on (410)786-4503, Gail Addis on (410)786-4522, or Terri Harris on (410)786-6830; HCPCS/CPT-4 issues and the 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; and carrier billing issues, contact Joan Proctor-Young on (410)786-0949.

This PM may be discarded March 31, 2001.