PROGRAM MEMORANDUM INTERMEDIARIES/CARRIERS

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. AB-00-01 **Date JANUARY 2000**

This Program Memorandum re-issues Program Memorandum AB-98-63, Change Request 483 dated October 1998. The only change is the discard date; all other material remains the same.

Change Request #483

SUBJECT: Prospective Payment System for Outpatient Rehabilitation Services and Application of Financial Limitation

Background Regarding Prospective Payment System

Section 4541 (a) (2) of the Balanced Budget Act (BBA) (P.L. 105-33) which added §1834 (k) to the Social Security Act requires 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.

This payment system also applies to certain audiology and Comprehensive Outpatient Rehabilitation Facility (CORF) services. Audiology and CORF services are identified by HCPCS codes below. The Medicare Physician Fee Schedule (MPFS) will be used as the prospective payment system for these services.

Carriers

The MPFS is currently the basis of payment for outpatient rehabilitation services furnished by physical therapists in independent practice (PTIPs) and occupational therapists in independent practice (OTIPs), physicians, and certain nonphysician practitioners or incident to the services of such physicians or nonphysician practitioners. Such services are billed to the Part B carrier. Assignment is mandatory. The MPFS has been the method of payment for outpatient rehabilitation therapy services provided by these suppliers for several years and will continue to be so.

Intermediaries

Effective for claims with dates of service on or after January 1, 1999, the MPFS will be the method of payment when outpatient physical therapy (which includes outpatient speech-language pathology) and occupational therapy services are furnished by rehabilitation agencies, (outpatient physical therapy providers and CORFs), hospitals (to outpatients and inpatients who are not in a covered Part A stay), SNFs (to residents not in a covered Part A stay and to non-residents who receive outpatient rehabilitation services from the SNF), and HHAs (to individuals who are not homebound or otherwise are not receiving services under a home health plan of treatment). The MPFS will be used as a method of payment for outpatient rehabilitation services furnished under arrangement with any of these providers. In addition, the MPFS will also be used as the payment system for audiology and CORF services identified by the HCPCS codes below unless otherwise noted. Such services are billed to the intermediary. Assignment is mandatory. The Medicare allowed charge for the services is the lower of the actual charge or the fee schedule amount. The Medicare payment for the services is 80 percent of the allowed charge after the Part B deductible is met. 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.

Implementation of MPFS (Intermediaries)

HCFA will provide you with a physician fee schedule abstract file which will contain non-facility fee schedule payment amounts for the outpatient rehabilitation (including audiology) and CORF HCPCS codes listed in this PM. These codes are identified in the abstract file by a value of "R" in the fee indicator field. See attachment for the record layout of this file. The file will include fee schedule payment amounts by locality and will be available via the HCFA Mainframe Telecommunications System (formerly referred to as the Network Data Mover). You will be responsible for retrieving this file upon notification by HCFA and making payment based on 80 percent of the lower of the actual charge or fee schedule amount indicated on the file after the Part B deductible has been met. HCFA will notify you of updates to the MPFS and when the updated files will be available for retrieval.

To assist you in implementing these instructions, HCFA will be releasing a physician fee schedule abstract test file. This test file will be available for retrieval on or after October 1, 1998. The file name for retrieving this file is:

MU00.@BF12390.MFS1999.ABSTR.VTEST.FI

A final physician fee schedule abstract file will be available on November 4, 1998. The file name for retrieval of this file is:

MU00.@BF12390.MFS1999.ABSTR.V1104.FI

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

NOTE: Outpatient occupational therapy (OT) services defined in §1861(g) should not be confused with the "OT" included in the definition of partial hospitalization services by §1861(ff)(2)(B). Partial hospitalization services, including any OT furnished in that setting, are not payable under the MPFS. Therefore, if a hospital outpatient claim for OT services contains a condition code 41 designating partial hospitalization services, make payment on a reasonable cost basis. Your system must be able to determine the appropriate payment methodology for OT services based on the presence/non-presence of condition code 41.

Application of the Outpatient Mental Health Treatment Limitation (Intermediaries)

In accordance with §1833 of the Social Security Act (the Act) payment is made at 62 ½ percent of the approved amount for outpatient mental health treatment services. This provision will continue to be implemented in accordance with the Act when these services are furnished to beneficiaries by CORFs. Therefore, make payment at 62 ½ percent of 80 percent of the approved amount (or in effect 50 percent) for outpatient mental health treatment services.

CWF and PS&R Requirements (Intermediaries)

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

Background Regarding Financial Limitation (Intermediaries and Carriers)

Section 4541(c) of the BBA also requires application of a financial limitation to all rehabilitation services. An annual per beneficiary limit of $1500 will apply to all outpatient physical therapy services (including speech-language pathology services). A separate $1500 limit will also apply to all occupational therapy services. The annual limitations do not apply to services furnished directly or under arrangements by a hospital to an outpatient or to an inpatient who is not in a covered Part A stay. This limitation applies to expenses incurred on or after January 1, 1999. Beginning 2002, these limits will be increased by the percentage increase in the Medicare Economic Index. By 2001, a report must be submitted to Congress recommending a revised coverage policy for outpatient rehabilitation services in place of the $1500 limitation.

Application of Financial Limitation (Intermediaries)

CWF will not be tracking the financial limitation at this time for intermediary processed claims. As a transitional measure, effective for claims with dates of service on or after January 1, 1999, non-hospital providers will be held accountable for tracking incurred expenses for each beneficiary to assure they do not bill Medicare for patients who have met the annual $1500 limitation at their facility for each separate limitation. **For SNFs, this means that the SNF itself is responsible for the billing of all outpatient rehabilitation services and the tracking of incurred expenses for those services when furnished to a SNF resident not in a covered Part A stay and SNF non-resident receiving outpatient rehabilitation services at the SNF regardless of whether the services are furnished by the SNF itself or by an outside therapist**. However, even though the non-hospital provider realizes services are not covered by Medicare, a bill may be submitted for purposes of receiving a denial notice from Medicare in order to bill Medicaid or other insurers. In this situation, the non-hospital provider reports condition code 21 in Form Locator 24-30 of the HCFA-1450.

Application of Financial Limitation (Carriers)

Effective for claims with dates of service on or after January 1, 1999, CWF will increase the current dollar limit, which applies to PTIPs and OTIPs who bill the Part B Carrier from $900 to $1500. This will be based on type of service as follows:

- Type of service “U” for occupational therapy; and
- Type of service “W” for physical therapy.

Use existing EOMB/MSN messages.

In addition, as a transitional measure, effective for claims with dates of service on or after January 1, 1999, physicians and other practitioners who are not currently subject to the financial limitation imposed by CWF will also be held accountable for tracking incurred expenses for each beneficiary. They must assure they do not bill Medicare for patients who have met the annual $1500 limitation at their facility for each separate limitation. Addendum D of the June 5, 1998, proposed notice (page 31008) lists the HCPCS codes that are considered to be outpatient rehabilitation services when submitted by physicians or non-physician practitioners. Once the $1500 limitation has been met, the provider should bill using HCPCS code A9270 for the purposes of receiving a denial notice from Medicare in order to bill other insurers. EOMB message 16.17 and MSN message 16.10 should be used. The following message will be generated: “Medicare does not pay for this item or service.”

Outpatient Rehabilitation HCPCS Codes (Intermediaries and Carriers)

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

11040	29405	92598	97020	97504**
11041	29445	95831	97022	97520
11042	29505	95832	97024	97530
11043	29515	95833	97026	97535
11044	29520	95834	97028	97537
29065	29530	95851	97032	97542
29075	29540	95852	97033	97545****

29085	29550	96105	97034	97546****
29105	29580	96110****	97035	97703
29125	29590	96111	97036	97750
29126	64550	96115	97039	97770*
29130	90901	97001	97110	97799****
29131	90911	97002	97112	V5362****
29200	92506	97003	97113	V5363****
29220	92507	97004	97116	V5364****
29240	92508	97010***	97124	
29260	92510	97012	97139	
29280	92525	97014	97140	
29345	92526	97016	97150	
29365	92597	97018	97250	

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

**Code 97504 should not be reported with code 97116.

***The physician fee schedule abstract file will not contain a price for this code since it is a bundled procedure. Therefore, payment cannot be made for 97010 when billed alone.

****The physician fee schedule abstract file will not contain a price for these codes since they are carrier priced codes. Therefore, intermediaries must contact their carrier to obtain the appropriate fee schedule amount in order to make proper payment.

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

NOTE: HCPCS codes 11040, 11041, 11042, 11043, 11044, 29065, 29075, 29085, 29105, 29125, 29126, 29130, 29200, 29220, 29240, 29345, 29365, 29405, 29445, 29505, 29515, 29520, 29530, 29540, 29550, 29580 and 29590 when delivered in an outpatient hospital setting are not considered outpatient rehabilitation services if they are performed on beneficiaries who are not receiving services under the outpatient rehabilitation benefit in accordance with an established Plan of Treatment. Therefore, they will not be subject to payment under the MPFS. Hospitals will continue to be paid under current payment methodologies for these services. These services are identified by a value of “1" in the outpatient hospital value field of the abstract file.

In addition, the following audiology services will also be subject to payment under the MPFS. However, they are not subject to the financial limitation.

Audiology HCPCS Codes (Intermediaries and Carriers)

The applicable HCPCS codes for reporting audiology services are as follows:

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

For intermediaries, the above audiology codes are paid under the MPFS when performed by an entity primarily engaged in the delivery of outpatient rehabilitation services.

*The physician fee schedule abstract file will not contain a price for this code since it is a carrier priced code. Therefore, intermediaries must contact their carrier to obtain the appropriate fee schedule amount in order to make proper payment.

NOTE: The HCPCS codes listed above with the exception of 92551, 92559, 92560, 92590, 92591, 92593, 92594, 92595 and V5299 should not be paid under the MPFS when furnished by hospital outpatient departments. These audiology codes are currently subject to the blended payment methodology when provided to outpatients of a hospital. For more detailed information see §3631.C1.b of the Medicare Part A Intermediary Manual. These services are identified by a value of "1" in the outpatient hospital value field of the abstract file.

CORF HCPCS Codes (Intermediaries)

In addition to the outpatient rehabilitation HCPCS codes listed above, the other HCPCS codes for reporting CORF services are as follows:

90657*	90732*	90748*	G0008*
90658*	90744*	94664	G0009*
90659*	90745*	94665	G0010*
90660*	90746*	94667	G0128
90669*	90747*	94668	

*These codes are not subject to payment under the MPFS. Therefore, continue to pay on a reasonable cost basis.

Revenue Codes (Intermediaries)

The applicable revenue codes for reporting outpatient rehabilitation services are 420, 430, and 440. The applicable revenue code for reporting audiology services is 470. Reporting of CORF services is not limited to specific revenue codes.

Bill Types (Intermediaries)

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

Discipline Specific Outpatient Rehabilitation Modifiers (Intermediaries and Carriers)

Providers are required to report one of the following modifiers to distinguish the type of therapist who performed the outpatient rehabilitation service (not the payment designation) or, if the service was not delivered by a therapist, then the discipline of the Plan of Treatment/Care under which the service is delivered should be reported:

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

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

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

As a transitional measure, reporting of the above modifiers is for data collection purposes and for

provider tracking of the financial limitation.

Additional Reporting Requirements (Intermediaries)

Your providers are required to report HCPCS for outpatient rehabilitation, certain audiology and all CORF services as well as unit and line item date of service reporting as outlined in Program Memorandum AB 98-24 dated July 1998.

These instructions should be implemented within your current operating budget.

Contact persons for coverage, payment, and financial limitation issues in this Program Memorandum are Roberta Epps on (410) 786-4503, Gail Addis on (410) 786-4522 or Terri Harris on (410) 786-6830. For HCPCS/CPT-4 issues in this Program Memorandum, contact Laurie Feinberg, M.D. on (410) 786-7069. Intermediary operational issues in this Program Memorandum should be addressed to Faith Ashby on (410) 786-6145 or Linda Gregory on (410) 786-6138 and Carrier operational issues should be addressed to Joan Proctor-Young on (410) 786-0949.

| **This Program Memorandum may be discarded January 31, 2001.**

Attachment

Attachment

RECORD LENGTH: 60
RECORD FORMAT: FB
BLOCK SIZE: 6000
CHARACTER CODE: EBCDIC
SORT SEQUENCE: Carrier, Locality HCPCS Code, Modifier

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