# CMS Manual System

## Pub 100-04 Medicare Claims Processing

**Transmittal 515**

**Department of Health & Human Services**

**Center for Medicare and & Medicaid Services**

**Date: APRIL 1, 2005**

**Change Request 3647**

**NOTE: Transmittal 463, dated February 4, 2005, is rescinded and replaced with transmittal 515 dated April 1, 2005**

**SUBJECT: Update to 100-04 and Therapy Code Lists**

**I. SUMMARY OF CHANGES:**This Manual change updates the list of HCPCS codes that sometimes or always describe therapy services (physical therapy, occupational therapy or speech-language pathology. It adds instructions for billing therapy services to intermediaries and clarifies the term "always therapy" codes. Since the code list was moved from section 10.2 to section 20, references were updated for the rest of the chapter.

**NEW/REVISED MATERIAL :**
**EFFECTIVE DATE : January 03, 2005**
**IMPLEMENTATION DATE : July 05, 2005**

***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
**R = REVISED, N = NEW, D = DELETED –** ***Only One Per Row.***

| R/N/D | Chapter / Section / SubSection / Title |
|---|---|
| **R** | 5/20 - HCPCS Coding Requirement |
| **R** | 5/10 - Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General |
| **R** | 5/20.1 - Discipline Specific Outpatient Rehabilitation Modifiers - All Claims |
| **R** | 5/10.2 - The Financial Limitation |
| **R** | 5/20.2 - Reporting of Service Units With HCPCS - Form |

| | |
|---|---|
| | CMS-1500 and Form CMS-1450 |
| **R** | 5/Exhibit 1 - Physician Fee Schedule Abstract File |

**III. FUNDING:**

**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.**

**IV. ATTACHMENTS:**

**Business Requirements**

**Manual Instruction**

***Unless otherwise specified, the effective date is the date of service.***

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 515 | Date: April 1, 2005 | Change Request 3647 |
|---|---|---|---|

**NOTE: Transmittal 463, dated February 4, 2005, is rescinded and replaced with transmittal 515 dated April 1, 2005**

**SUBJECT: Update to 100-04 and Therapy Code Lists**

## I. GENERAL INFORMATION

**A. Background:** Limitations on therapy services were mandated by the Balanced Budget Act. In order to limit the services, a list of the services to which limits would apply was developed and published as AB-03-018 in February 7, 2003. This was manualized when the Internet Only Manuals were implemented in October, 2003. This list has changed due to new codes and new information about the codes listed. Therefore, it is being updated.

Also, as a result of implementation of the electronic claim form, instructions for therapy billing services to intermediaries have been added to this section.

**B. Policy:** CMS contractors shall implement policies in the manuals.

**C. Provider Education:** A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

## II. BUSINESS REQUIREMENTS

*"Shall" denotes a mandatory requirement*
*"Should" denotes an optional requirement*

| Requirement Number | Requirements | Responsibility (place an "X" in the columns that apply) | | | | | |
|---|---|---|---|---|---|---|---|
| | | FI | RH | Car | DM | Shared System Maintainers | Other |

| | | | | | | FISS | MCS | VMS | CWF | |
|---|---|---|---|---|---|---|---|---|---|---|
| 3647.1 | Medicare contractors shall change any policies or edits that are not consistent with the policies or list of codes provided in this manual change. | X | X | X | | X | | | | |

## III. PROVIDER EDUCATION

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| 3647.2 | A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. | | | | | | | | | |

## IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

### A. Other Instructions: N/A

| X-Ref Requirement # | Instructions |
|---|---|
| | |

**B. Design Considerations: N/A**

| X-Ref Requirement # | Recommendation for Medicare System Requirements |
|---|---|
| | |

**C. Interfaces: N/A**

**D. Contractor Financial Reporting /Workload Impact: N/A**

**E. Dependencies: N/A**

**F. Testing Considerations: N/A**

## IV. SCHEDULE, CONTACTS, AND FUNDING

| | |
|---|---|
| **Effective Date*:** January 3, 2005<br><br>**Implementation Date:** July 5, 2005<br><br>**Pre-Implementation Contact(s):** Dorothy Shannon 410-786-3396<br><br>**Post-Implementation Contact(s):** Pam West 410-786-2302 | **Medicare Contractors shall implement these instructions within their current operating budgets.** |

***Unless otherwise specified, the effective date is the date of service.**

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

***(Rev. 515, Issued: 04-01-05, Effective: 01-03-05, Implementation: 07-05-05)***

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 *§20* 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 *§20* 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 *audiologist*, e.g., the interpretation of a test.)

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 |
| 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. |

| "Provider/Service" Type | Bill to | Bill Type | Comment |
|---|---|---|---|
| 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.<br>Otherwise, carrier billing.<br>Note that physician/ NPP/PTPP/OTPP employee of 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 | Some audiologists tests provided in hospitals are considered other diagnostic tests and are subject to HOPPS instead of MPFS for outpatient |

| "Provider/Service" Type | Bill to | Bill Type | Comment |
|---|---|---|---|
| | | coding. | 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 *§20*

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 *§20* 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 *providing the service*.

## *10.2 - The Financial Limitation*

***(Rev. 515, Issued: 04-01-05, Effective: 01-03-05, Implementation: 07-05-05)***

**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. *Caps will be implemented again on January 1, 2006 unless there is legislation to change them before that time.*

## 20 - HCPCS Coding Requirement

***(Rev. 515, Issued: 04-01-05, Effective: 01-03-05, Implementation: 07-05-05)***

**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 requirement 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.

*Providers billing to intermediaries shall report:*

- *The date the therapy plan of care was either established or last reviewed (see* ***§220.1.3B****) in Occurrence Code 17, 29, or 30.*
- *The first day of treatment in Occurrence Code 35, 44, or 45.*

**B - Applicable Outpatient Rehabilitation HCPCS Codes**

Regardless of *the presence of a* financial limitation, CMS identifies the following codes as therapy services. *Therapy services include only physical therapy, occupational therapy and speech-language pathology services. Therapist means only a physical therapist, occupational therapist or speech-language pathologist. Therapy modifiers are GP for physical therapy, GO for occupational therapy, and GN for speech-language pathology. Check the notes below the chart for details about each code.*

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.)

| | | | | | |
|---|---|---|---|---|---|
| 64550+ | 90901+ | *92506* | *92507* | *92508* | *92526* |
| *92597* | *92605***** | *92606***** | *92607* | *92608* | *92609* |
| 92610+ | 92611+ | 92612+ | 92614+ | 92616+ | 95831+ |
| 95832+ | 95833+ | 95834+ | 95851+ | 95852+ | 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* | *97597+* | *97598+* | *97602***** | *97605***** |
| *97606***** | *97703* | *97750* | *97755* | *97799** | G0279+*** |
| G0280+*** | *G0281* | *G0283* | *G0329* | 0029T+*** | |

* The physician fee schedule abstract file does not contain a price for codes 96110, or 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, *or* 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.

****Codes are bundled. They are bundled with any therapy codes. Regardless of whether they are billed alone or in conjunction with another therapy code, never make payment separately for these codes. If billed alone, code*s marked ***** 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.

✓ *If billed by an outpatient hospital department, these are paid using the Outpatient Prospective Payment system (OPPS).*

*Underlined codes are always therapy services, regardless of who performs them. These codes always require therapy modifiers (GP, GO, GN).*

+ Codes 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 these 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 when:

- It is not appropriate to bill the service under a therapy plan of care, and
- They are billed by providers of services who are not therapists, i.e., physicians, clinical nurse specialists, nurse practitioners and psychologists.

The Codes marked + on the above list may not be used by *therapists, or by* practitioners *who are not therapists* without a therapy modifier in situations where the service provided is integral to an outpatient rehabilitation therapy service. *For example, when the service is rendered with the goal of rehabilitation and the service is within the scope of practice of a therapist as defined by State or local law, a modifier is required. When there is doubt about whether a service should be part of a therapy plan of care, the contractor shall make that determination.*

"Outpatient rehabilitation therapy" refers to skilled *therapy* services, requiring the skills of qualified therapists, 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 surface (Transcutaneous) neurostimulator – 64550, and biofeedback training by any modality – 90901 may be non-therapy services when not done by therapists. When performed by therapists, these are therapy services.* Contractors have discretion to determine whether circumstances require a plan or describe a therapy service.

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**

*Codes that are not on the list of therapy services should not be billed with a modifier. For example,* the following outpatient non-rehabilitation HCPCS codes *should be billed without modifiers:* 95860, 95861, 95863, 95864, 95867, 95869, 95870, 95900, 95903, 95904, 95934, G0237, G0238, and G0239.

*Some codes that were previously on this list have been removed (e.g., cast and splint services). We have determined that these services are most often performed outside a therapy plan of care and have removed them from the list. Codes that are not on the list may be billed when the services are furnished by therapists if the services are covered and appropriately delivered (e.g., the therapist is qualified to provide the service).*

NOTE: The above lists of codes are intended to facilitate the *contractor's*'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. 515, Issued: 04-01-05, Effective: 01-03-05, Implementation: 07-05-05)***

*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 §20 of this chapter. These modifiers do not allow a provider to deliver services that they are not qualified and recognized by Medicare to perform.*

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 §20 of this chapter.*

*Modifiers GN, GO, and GP refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services. They should never be used with codes that are not on the list of applicable therapy 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. 515, Issued: 04-01-05, Effective: 01-03-05, Implementation: 07-05-05)***

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 *("untimed" HCPCS),* 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 > 38 minutes to < 53 minutes

4 units > 53 minutes to < 68 minutes

5 units > 68 minutes to < 83 minutes

6 units > 83 minutes to < 98 minutes

7 units > 98 minutes to < 113 minutes

8 units > 113 minutes to < 128 minutes

The pattern remains the same for treatment times in excess of 2 hours. Providers should not bill for services performed for 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.

## Exhibit 1 - Physician Fee Schedule Abstract File

***(Rev. 515, Issued: 04-01-05, Effective: 01-03-05, Implementation: 07-05-05)***

This file contains nonfacility fee schedule payment amounts for the outpatient rehabilitation, and CORF HCPCS codes listed in *§20.* 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 |

| | COBOL | | |
|---|---|---|---|
| **Data Element Name** | **Location** | **Picture** | **Value** |
| 1 – HCPCS | 1-5 | X(05) | |
| 2 – Modifier | 6-7 | X(02) | |

| | COBOL | | |
|---|---|---|---|
| **Data Element Name** | **Location** | **Picture** | **Value** |
| 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<br>"1" - Fee not applicable in hospital outpatient setting |
| 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.