CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 805

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: JANUARY 6, 2006

CHANGE REQUEST 4226

SUBJECT: Annual Update to the Therapy Code List

I. SUMMARY OF CHANGES: This change request describes changes to, and billing instructions for, payment policies for rehabilitation therapy services, including physical therapy, occupational therapy and speech-language pathology. This instruction updates the list of codes that sometimes or always describe therapy services and their associated policies.

NEW/REVISED MATERIAL

EFFECTIVE DATE: January 1, 2006

IMPLEMENTATION DATE: February 6, 2006

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:

R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5/20/HCPCS Coding Requirement

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Recurring Update Notification

Manual Instruction

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 805	Date: January 6, 2006	Change Request 4226

SUBJECT: Annual Update to the Therapy Code List

I. GENERAL INFORMATION

A. Background: Section 1834(k)(5) of the Act requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility services be reported using a uniform coding system. The Healthcare Common Procedure Coding System/Current Procedural Terminology, 2006 Edition (HCPCS/CPT-4) is the coding system used for the reporting of these services. This Recurring Update Notification describes changes to, and billing instructions for, payment policies for rehabilitation therapy services, including physical therapy, occupational therapy and speech-language pathology. This instruction updates the list of codes that sometimes or always describe therapy services and their associated policies. The additions, changes, and deletions to the therapy code list reflect those made in the CY 2006 Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4). This notification also reflects policy changes implemented in: (a) the Outpatient Prospective Payment System (OPPS) final rule for CY 2006 and (b) the Medicare Physician Fee Schedule (MPFS) final rule for CY 2006. Other policies contained in this notification correct or clarify our previous policy noted in Transmittal 515, CR 3647, issued April 1, 2005 in Pub. 100-04. The changes noted in this notification are effective for services furnished on or after January 1, 2006.

B. Policy: Some of the policies implemented in this notification were 1) discussed in the CY 2006 OPPS final rule, or 2) discussed in the CY 2006 MPFS final rule or reflected in its Addendum B. Other policies contained in this notification correct or clarify our previous policy noted in Transmittal 515, CR 3647, issued April 1, 2005 in Pub. 100-04. This CR updates the therapy code list and associated policies for CY 2006, as follows:

1) "Orthotic Management and Prosthetic Management" Services.

In order to create a new category under the section for physical medicine and rehabilitation services, HCPCS/CPT modified the descriptor of one of these codes, CPT 97504 (2005), and renumbered it as well as two other HCPCS/CPT codes. The new therapy code list removes the CY 2005 CPT codes, 97504, 97520 and 97703 and replaces them with CPT codes 97760, 97761 and 97762, respectively, for use in CY 2006. See table below for a list of the added CY 2006 CPT codes and the new descriptor for CPT code 97760.

2006 Code	2006 Descriptor	2005 Code
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	97504
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	97520
97762	Checkout for orthotic/prosthetic use, established patient, each 15	97703

	minutes	

2) Active Wound Care Management Services

The therapy code list contains 5 HCPCS/CPT codes that represent active wound care services, including CPT codes 97602, 97605, 97606, 97597 and 97598. Three of these CPT codes for wound care (97602, 97605, and 97606) were previously noted as "bundled" services for payment purposes under the MPFS and represented "always therapy" services. For CY 2006, these three codes were changed to "sometimes therapy" services. While CPT code 97602 remains a bundled service under the MPFS, CPT codes 97605 and 97606, which represent services for negative pressure wound therapy, are now valued and active codes under the MPFS. Except as noted below for hospitals subject to the OPPS, the requirements for other "sometimes therapy codes apply. These requirements are described in more detail in Pub. 100-04, the Medicare Claims Processing Manual, chapter 5, section 20.

This instruction implements new payment policy for hospitals subject to the OPPS, five wound care HCPCS/CPT codes - 97602, 97605, 97606, 97597, and 97598, and adds the indicator "ε", as a note to the code list. This indicator "ε" signifies that these codes represent "sometimes therapy" services and will be paid under the OPPS when (a) the service is not performed by a therapist, and (b) it is inappropriate to bill the service under a therapy plan of care. Wound care provided meeting these two requirements should not be billed with a therapy modifier (e.g., GP, G0, or GN) or a therapy revenue code (e.g., 42X, 43X, or 44X). As for other "sometimes therapy" codes, these services are considered therapy services when rendered by a therapist. They are also considered therapy services when rendered by physicians and nonphysician practitioners who are not therapists in situations where the service provided is integral to an outpatient rehabilitation therapy plan of care. When such services are therapy services as noted above, the appropriate therapy modifier is required.

3) Carrier Pricing of Unspecified Therapy Codes

Adds Note "◊" to HCPCS/CPT codes 97039 and 97139 to indicate that the MPFS payment has changed to carrier-pricing and they will no longer be paid using the relative values units previously listed in Addendum B. As with other carrier-priced services, where an existing HCPCS/CPT code does not accurately describe the services performed, the provider submits information, for the contractor's review, to describe the "unspecified" modality(s) or therapeutic procedure(s) performed.

In addition to a detailed service description, for CPT code 97039, unlisted modality, information submitted to the contractor must specify the type of modality utilized and, if the modality requires the constant attendance of the therapist, the time spent by the therapist, one-on-one with the beneficiary, must also be noted. For CPT code 97139, unlisted therapeutic procedure, the information supplied to the contractor must specify the procedure furnished and also meet the other requirements for therapeutic procedures, i.e., the process of effecting change, through the application of clinical skills or services that attempt to improve function. CPT codes 97039 and 97139 remain designated as always therapy and require the use of the GP or GO modifier, as appropriate.

4) Creates "Δ" to indicate that the CY 2006 code descriptors were revised for the following CPT codes: 92506 and 92507. CPT code 97760 is also flagged with the "Δ"; although this code number is new, it

reflects a revision to the descriptor of the code it replaces, CPT 97504. The revised 2006 descriptors (except for CPT 97760 discussed above) follow:

2006 Code	2006 Descriptor
92506	Evaluation of speech, language, voice, communication, and/or auditory processing
92507	Treatment of speech, language, voice communication, and/or auditory processing.

5) Removes deleted HCPCS/CPT codes: 96115 and 97020. CPT 96115 was deleted from CPT 2006. CPT code 97020, for the microwave modality, was combined with CPT code 97024 for diathermy. CPT code 97024 is appropriately used to bill for microwave treatment.

6) Adds HCPCS/CPT code 0019T, as a "sometimes" therapy service, to replace HCPCS codes G0279 and G0280 that were both deleted for CY2006. This code is carrier priced.

7) Clarifies, in section ©, that the listed HCPCS/CPT codes 95860, 95861, 95863, 95864, 95867, 95869, 95870, 95900, 95903, 95904 and 95934 represent diagnostic services, under MPFS, and do not represent therapy services.

8) Removes the "□" note for CPT code 96110, because it is no longer applicable. The "□" note indicated that, effective January 1, 2004, CPT 96110 became an active code on the physician fee schedule and that carriers no longer priced this code.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4226.1	Medicare contractors shall change any policies or edits that are not consistent with the policies or list of codes provided in this change request.	X	X	X			X		X	
4226.2	Medicare contractors shall be aware that the new therapy list removes CY2005 HCPCS/CPT codes 97504, 97520, and 97703 and replaces them with HCPCS/CPT codes 97760, 97761,	X	X	X					X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	and 97762 for use in CY2006.									
4226.3	Fiscal Intermediaries shall advise OPPS providers to not report a therapy modifier (GP, GO, or GN) or a therapy revenue code (42X, 43X, or 44X) when wound care HCPCS/CPT codes 97602, 97605, 97606, 97597, and 97598 services are not performed by a therapist and it is inappropriate to bill the service under a therapy plan of care. In this circumstance, claims will be reimbursed under the Outpatient Prospective Payment System (OPPS).	X								
4226.4	Contractors shall continue to require the GP, GN, and GO modifiers on therapy claims adjusting edits as needed according to the annual outpatient rehabilitation HCPCS code update described in Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 20.	X	X	X						
4226. 5	Medicare contractors shall advise therapists, physicians, and nonphysician practitioners who are not therapists that an appropriate therapy modifier is required to be included on therapy claims. They shall advise providers to include a therapy modifier for services which are always considered therapy services as well as for all those considered "sometimes therapy", including HCPCS/CPT codes 97602, 97605, 97606, 97597, and 97598, when the services are deemed therapy services, i.e., a. Rendered by a therapist or b. Rendered by a physician or nonphysician practitioner, including their incident to services, and integral to an outpatient	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	rehabilitation therapy plan of care.									
4226.6	Medicare contractors shall be aware that HCPCS/CPT codes 96115 and 97020 have been deleted from the CY2006 therapy code list.	X	X	X					X	
4226.7	Medicare contractors shall be aware that HCPCS/CPT code 97020 for the microwave modality, has been combined with 97024 for diathermy.	X	X	X						
4226.8	Medicare contractors shall be aware that HCPCS/CPT code 0019T has been added to the CY2006 therapy code list as a "sometimes" therapy service and as such, replaces HCPCS/CPT codes G0279 and G0280 that have been deleted for CY2006.	X	X	X					X	
4226.9	Carriers shall price covered services for HCPCS/CPT codes 0019T, 97039 and 97139. FIs shall consult with carriers as needed to obtain this pricing.	X	X	X						
4226.10	Medicare contractors shall be aware that HCPCS codes 97602, 97605, and 97606 have been changed from "always" therapy to "sometimes" therapy and that a therapy modifier is no longer always required. Medicare contractors shall remove these codes from edits basing the requirement of a therapy modifier upon procedure code alone. Medicare contractors shall edit for the presence of the appropriate therapy modifier to the extent possible as for other "sometimes therapy" codes.	X	X	X						
4226.11	Medicare contractors shall be aware that HCPCS codes 97605 and 97606 are separately payable and are no longer "bundled."	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	
4226.12	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 1 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.	X	X	X						

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
4226.1	Change Request 4084 supplies the instructions on downloading the appropriate coding abstract files.

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

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** February 6, 2006 **Pre-Implementation Contact(s):** Yvonne Young, (410) 786-1886, Yvonne.Young@cms.hhs.gov (FI Billing), Wil Gehne, (410) 786-6148, Wilfried.Gehne@cms.hhs.gov (FI Billing), Pam West (410) 786-2302, Pamela.West@cms.hhs.gov (Policy), Claudette Sikora, (410) 786-5618, Claudette.Sikora@cms.hhs.gov (Carrier Billing) **Post-Implementation Contact(s):** Regional office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

20 - HCPCS Coding Requirement

(Rev.805, Issued: 01-06-06, Effective: 01-01-06, Implementation: 02-06-06)

A. Uniform Coding

Section 1834(k)(5) of the Act requires that all claims for outpatient rehabilitation *therapy services* and *all comprehensive outpatient rehabilitation facility (*CORF*)* services be reported using a uniform coding system. The *Healthcare Common Procedure Coding System/Current Procedural Terminology, 2006 Edition (HCPCS/CPT-4)* is the coding system used for the reporting of these services. *The uniform coding requirement in the Act is specific to payment for all CORF services and outpatient rehabilitation therapy services - including physical therapy, occupational therapy, and speech-language pathology - that is provided and billed to carriers and fiscal intermediaries (FIs). The Medicare physician fee schedule (MPFS) is used to make payment for these therapy services at the nonfacility rate.*

Effective for claims submitted on or after April 1, 1998, providers that had not previously reported *HCPCS/CPT* for outpatient rehabilitation and CORF services began using HCPCS to report these services. This requirement does not apply to outpatient rehabilitation 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[1] stay);
- Skilled nursing facilities (SNFs) (to residents not in a covered Part A[1] 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[2] (POC);
- Comprehensive outpatient rehabilitation *facilities* (CORFs); and
- *Providers of o*utpatient physical therapy *and speech-language pathology services* (OPTs), *also known as rehabilitation agencies (previously termed* outpatient physical therapy facilities *in this instruction)*.

Note *1. T*he requirements for hospitals and SNFs apply to inpatient Part B and outpatient services only. Inpatient Part A *services are bundled into* the respective *prospective payment system payment; no* separate *payment is made*.

Note 2. For HHAs, HCPCS/CPT 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.

The following practitioners must bill the carriers for outpatient rehabilitation therapy services using HCPCS/CPT codes:

- *Physical therapists in private practice (PTPPs),*
- *Occupational therapists in private practice (OTPPs),*
- *Physicians, including MDs, DOs, podiatrists and optometrists, and*
- *Certain nonphysician practitioners (NPPs), acting within their State scope of practice, eg., nurse practitioners and clinical nurse specialists.*

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

The CMS identifies the following codes as therapy services*, regardless of the presence of a financial limitation.* 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.

When in effect, any financial limit*ation will also* 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 *or applicable to all provider settings*.

64550+	90901+	92506Δ	92507Δ	92508	92526
92597	92605****	92606****	92607	92608	92609

92610+	92611+	92612+	92614+	92616+	95831+
95832+	95833+	95834+	95851+	95852+	96105+
96110+✓	96111+✓	97001	97002	97003	97004
97010****	97012	97016	97018	97022	97024
97026	97028	97032	97033	97034	97035
97036	97039*◊	97110	97112	97113	97116
97124	97139*◊	97140	97150	97530	97532+
97533	97535	97537	97542	97597+Ɛ	97598+Ɛ
97602+ ****Ɛ	97605+Ɛ	97606+Ɛ	97750	97755	97760**Δ
97761	97762	97799*	G0281	G0283	G0329
0019T+***	0029T+***				

* The physician fee schedule abstract file does not contain a price for *CPT* codes *97039, 97139,* 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, 2006, these codes will no longer be valued under the MPFS. They will be priced by the carriers.*

Δ Effective January 1, 2006, the code descriptors for these services have been changed.

** *CPT c*ode *97760* should not be reported with *CPT* code 97116 *for the same extremity*.

*** The physician fee schedule abstract file does not contain a price for *CPT* codes *0019T* 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.

**** *These HCPCS/CPT c*odes are bundled *under the MPFS*. 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, *HCPCS/CPT* codes marked *as* "****" *shall* be denied using the existing 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 *HCPCS codes* are paid using the Outpatient Prospective Payment *S*ystem (OPPS).

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

ℰ If billed by a hospital subject to OPPS for an outpatient service, these HCPCS codes – also indicated as "sometimes therapy" services - will be paid under the OPPS when the service is not performed by a qualified therapist and it is inappropriate to bill the service under a therapy plan of care. The requirements for other "sometimes therapy" codes, described below, apply.

+ These HCPCS/CPT codes sometimes represent therapy services. However, these codes always represent therapy services and require the use of a therapy modifier 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 *practitioners/*providers of services who are not therapists, i.e., physicians, clinical nurse specialists, nurse practitioners and psychologists*; or they are billed to fiscal intermediaries by hospital*s for outpatient services which are *performed by non-therapists as noted in Note "ℰ" above.*

While the "+" designates that a particular HCPCS/CPT code will not of itself always indicate that a therapy service was rendered, these codes always represent therapy services when rendered by therapists or by practitioners who are not therapists in situations where the service provided is integral to an outpatient rehabilitation therapy plan of care. For these situations, these codes must always have a therapy modifier. For example, when the service is rendered by either a doctor of medicine or a nurse practitioner (acting within the scope of his or her license when performing such service), with the goal of rehabilitation, 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 *as part of a therapy plan of care*. In contrast, a non-therapy service is a service performed by non-therapist practitioners, without *an appropriate* rehabilitative plan or goals, e.g., application of a surface (*t*ranscutaneous) neurostimulator – *CPT code* 64550, and biofeedback training by any modality – *CPT code* 90901. When performed by therapists, these are *"always"* therapy services. Contractors have discretion to determine whether circumstances *describe a therapy service or* require a *rehabilitation* plan *of care.*

*The underlined HCPCS c*odes on the above list do not have a + sign *because they* 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*s 12 and* 15).

C. Additional HCPCS Codes

*Some HCPCS/CPT c*odes that are not on the list of therapy services should not be billed with a modifier. For example, *outpatient non-rehabilitation HCPCS codes G0237, G0238, and G0239 should be billed without therapy modifiers. These HCPCS codes describe services for the improvement of respiratory function and may represent either "incident to" services or respiratory therapy services that may be appropriately billed in the CORF setting. When the services described by these G-codes are provided by physical therapists (PTs) or occupational therapists (OTs) treating respiratory conditions, they are considered therapy services and must meet the other conditions for physical and occupational therapy. The PT or OT would use the appropriate HCPCS/CPT code(s) in the 97000 – 97799 series and the corresponding therapy modifier, GP or GO, must be used.*

Another example of codes that are not on the list of therapy services and should not be billed with a therapy modifier includes the following HCPCS codes: 95860, 95861, 95863, 95864, 95867, 95869, 95870, 95900, 95903, 95904, *and* 95934. *These services represent diagnostic services - not therapy services; they must be appropriately billed and shall not include therapy modifiers.*

Other codes not on the above list, and not paid under another fee schedule, are appropriately billed with therapy modifiers when the services are furnished by therapists or provided under a therapy plan of care and where the services are covered and appropriately delivered (e.g., the therapist is qualified to provide the service). One example of non-listed codes where a therapy modifier is indicated, regards the provision of services described in the CPT code series, 29000 through 29590, for the application of casts and strapping. Some of these codes previously *appeared* on th*e above* list*, but were deleted because we determined that they represented services that are most often performed outside a therapy plan of care. However, when these services are provided by therapists or as an integral part of a therapy plan of care, the CPT code must be accompanied with the appropriate therapy modifier.*

NOTE: The above lists of *HCPCS/CPT* codes are intended to facilitate the contractor's ability to pay claims under the MPFS. It is not intended to be *an exhaustive list of covered services, imply applicability to provider settings,* and does not assure coverage of these services.