CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1377	Date: NOVEMBER 23, 2007
	Change Request 5810

SUBJECT: 2008 Annual Update to the Therapy Code List

I. SUMMARY OF CHANGES: This instruction updates the list of codes that sometimes or always describe therapy services.

NEW / REVISED MATERIAL
EFFECTIVE DATE: JANUARY 1, 2008
IMPLEMENTATION DATE: JANUARY 7, 2008

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

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

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Manual Instruction
Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1377	Date: November 23, 2007	Change Request: 5810

SUBJECT: 2008 Annual Update to the Therapy Code List

EFFECTIVE DATE: JANUARY 1, 2008
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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, 2008 Edition (HCPCS/CPT-4) is the coding system used for the reporting of these services.

This instruction updates the list of codes that sometimes or always describe therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the CY 2008 Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4).

B. Policy: This CR updates the therapy code list with one new code update for CY 2008 as follows:

Add: 96125 – Standard cognitive performance testing (eg., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face with the patient and time interpreting test results and preparing the report.

NOTE: This code is considered "always therapy" regardless of who performs the service and will always require a therapy modifier (GN, GO, GP).

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5810.1	Medicare contractors shall change any policies or local edits that are not consistent with the policies or list of codes provided in this change request.	X		X	X	X					
5810.2	Medicare contractors shall be aware that CPT 96125 has been added as "always therapy" to the new 2008 therapy code list.	X		X	X	X	X	X		X	COBC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5810.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.	X		X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	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. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Jason Kerr, Jason.Kerr@cms.hhs.gov (FI Billing), Claudette Sikora, Claudette.Sikora@cms.hhs.gov (Carrier billing) or Pam West, Pamela.West@cms.hhs.gov (Therapy Policy)

Post-Implementation Contact(s): Appropriate Regional Office http://www.cms.hhs.gov/RegionalOffices/01_Overview.asp

VI. FUNDING

A. *For Fiscal Intermediaries and Carriers*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MAC)*:
The Medicare administrative contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

20 - HCPCS Coding Requirement

(Rev. 1377; Issued: 11-23-07; Effective: 01-01-08; Implementation: 01-07-08)

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 current Healthcare Common Procedure Coding System/Current Procedural Terminology is 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 outpatient physical therapy and speech-language pathology services (OPTs), also known as rehabilitation agencies (previously termed outpatient physical therapy facilities in this instruction).

Note 1. The 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, e.g., 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 limitation 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+✓	96125	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+ ع
97598+ ع	97602+ ****ع	97605+ ع	97606+ ع	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 code 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 codes 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 System (OPPS).

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

ع 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 hospitals for outpatient services which are performed by non-therapists as noted in Note "ع" 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 (transcutaneous) 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 codes 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, chapters 12 and 15).

C. Additional HCPCS Codes

Some HCPCS/CPT codes 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 the 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.