MEDICARE PART A BULLETIN

July28, 1998 General Medicare Bulletin G-342

TO: All Medicare Providers

FROM: Program Relations

SUBJECT: **REVISED REPORTING REQUIREMENTS FOR ALL OUTPATIENT REHABILITATION SERVICES, AND ALL CORF SERVICES, USING THE HCFA COMMON PROCEDURE CODING SYSTEM: EFFECTIVE FOR SERVICES RENDERED ON AND AFTER APRIL 1, 1998; MANDATED FOR SERVICES RECEIVED BY THE MEDICARE INTERMEDIARY ON AND AFTER JULY 1, 1998**

ATTENTION MEDICARE BUSINESS OFFICE MANAGER: Please distribute to all appropriate health care facility personnel.

The purpose of this bulletin is to communicate, to all Medicare participating providers, the Health Care Financing Administration's (HCFA's) revised billing requirements for all outpatient rehabilitation services, and all Comprehensive Outpatient Rehabilitation Facility (CORF) services, rendered on and After April 1, 1998. HCFA published these new billing requirements during the later part of July 1998, via an intermediary Program Memorandum (Transmittal No. A-98-24). Therefore, this bulletin **supercedds Medicare Bulletin G-323, dated March 31, 1998.**

Section 4541(a)(2) of the Balanced Budget Act (BBA) (PL 105-33), which added Section (k)(5) to the Social Security Act, requires that claims for outpatient rehabilitation services be reported using a uniform coding system. HCFA has determined that this coding requirement is effective for ***all claims for outpatient rehabilitation services submitted on or after April 1, 1998***. This change in coding/ reporting requirements is effective with claims submitted on or after April 1, 1998. ***All bills received by the intermediary on and after July 1, 1998, that are not billed in compliance with all revised instructions, will be not be accepted for processing.***

This revised billing requirement is needed to ensure proper payment under a new *prospective payment system* (PPS) payment methodology for outpatient rehabilitation services, which will be effective January 1, 1999.

The HCFA Common Procedure Coding System (HCPCS) will be used for the uniform coding system. The HCPCS coding structure consists of three levels of coding, including: CPT codes, Level II HCPCS, and locally assigned Medicare contractor codes. Providers report HCPCS codes via the HCFA-1450 (UB-92) billing format, in form locator (FL) 44, "HCPCS/Rates."

Outpatient rehabilitation services that require HCPCS coding are **outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services.** The following providers must use HCPCS codes (if they do not currently require them) to report outpatient rehabilitation services when provided to their outpatients:

Provider Type	Type of Bill Code(s)
Hospitals	12X and 13X
Skilled Nursing Facilities (SNFs)	22X and 23X
Home Health Agencies (HHAs)	34X
Outpatient Rehabilitation Facilities (ORFs), or Physical Therapy Providers (OPTs)	74X
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	75X
Hospital: Outpatient Ambulatory Surgery Center (ASC)	83X

NOTE: Although some Community Mental Health Centers (CMHCs) provide outpatient Occupational Therapy services, HCFA's revised billing requirements do not yet require HCPCS coding for CMHC bill types (type of bill code 76X).

Hospitals and SNFs providing outpatient rehabilitation services to their inpatients who are entitled to benefits under Part A, but who have exhausted benefits for inpatient services during a spell of illness, or to their inpatients who are not entitled to benefits under Part A, are also required to report HCPCS codes (via type of bill codes 12X and 22X - Inpatient/SNF (Part B) Ancillary Services).

NOTE: For HHAs, HCPCS coding for outpatient rehabilitation services only applies when HHAs provide such services to individuals that are not homebound and; therefore, not under a plan of care.

APPLICABLE BILL TYPES, REVENUE AND HCPCS CODES

The applicable revenue and HCPCS codes for reporting outpatient rehabilitation services are:

Applicable Bill Types

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

The matching of outpatient rehabilitation HCPCS codes to revenue codes has been eliminated because many therapy services, for example, physical therapy modalities or therapy procedures as described by HCPCS codes, are commonly delivered by both physical and occupational therapists. Other services may be delivered by either occupational therapists or speech-language pathologists. Therefore, providers report outpatient rehabilitation HCPCS in conjunction with the appropriate outpatient rehabilitation revenue code based on the type of therapist who delivered the service, or, if the service is not delivered by a therapist, then the type of therapy under the Plan of Care for which the service is delivered.

Applicable Revenue Codes

The applicable revenue codes for reporting outpatient rehabilitation services are 420, 430, and 440.

Applicable HCPCS Codes

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

11040*	29405*	92598	97020	97250
11041*	29445*	95831	97022	97260
11042*	29505*	95832	97024	97261
11043*	29515*	95833	97026	97265
11044*	29520*	95834	97028	97504**
29065*	29530*	95851	97032	97520
29075*	29540*	95852	97033	97530
29085*	29550*	96105	97034	97535
29105*	29580*	96110	97035	97537
29125*	29590*	96111	97036	97542
29126*	64550	96115	97039	97545
29130*	90901	97001	97110	97546
29131	90911	97002	97112	97703
29200*	92506	97003	97113	97750
29220	92507	97004		97770***
29240	92508	97010	97116	
29260	92510	97012	97122	97799
29280	92525	97014	97124	V5362
29345*	92526	97016	97139	V5363
29365*	92597	97018	97150	V5364

***These codes were previously listed as only being reported by CORFs. They now apply in all settings except hospital outpatient departments. (See the following NOTE for additional information regarding hospital outpatient departments.)**

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

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

The above list of codes contain commonly utilized codes for outpatient rehabilitation services. You may consider other codes for payment 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 and, therefore, will not be subject to the outpatient rehabilitation prospective payment system.

In addition, the following HCPCS codes are to be reported when billing for audiological services:

Revenue Code	Description	HCPCS Codes
470	Audiologic function test	92551, 92552, 92553, 92555, 92556, 92557, 92559, 92560, 92561, 92562, 92563, 92564, 92565, 92567, 92568, 92569, 92571, 92572, 92573, 92575, 92576, 92577, 92579, 92582, 92583, 92584, 92587, 92588, 92589, 92590, 92591, 92593, 92594, 92595, 92596, V5299

The above codes listed under revenue code 470 will be subject to the prospective payment system for outpatient rehabilitation services. However, they will not be applied to the financial limitation.

NOTE: The HCPCS codes listed under revenue code 470 with the exception of 92551, 92559, 92560, 92590, 92591, 92593, 92594, 92595 and V5299 should not be billed under revenue code 470 by hospital outpatient departments. These codes are currently subject to the blended payment methodology and are reported under revenue code 471 with bill type 13X, 14X, or 83X as appropriate when provided to outpatients of a hospital. For more detailed information see section 3631.C1.b of the Medicare Part A Intermediary Manual.

NOTE: The HCPCS codes listed above, associated with revenue code 470, are considered part of a therapeutic plan of care or treatment and, therefore, meet the definition of outpatient rehabilitation services.

REPORTING OF SERVICE UNITS

Providers are required to report the number of units for outpatient rehabilitation services via the HCFA-1450 (UB-92) billing format, in form locator (FL) 46, "Units of Service," based on the procedure or service (e.g., based on the HCPCS codes reported) instead of the revenue code.

CORFs will also report **their full range of CORF services** in the same manner. Units are to be 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 time frame report "1" (one) in FL 46.

For providers that currently report visits, they should no longer be reported as units for these services.

Since providers may perform a number of procedures or services in a single visit, the number of units may exceed the number of visits. This change in reporting service units is effective with claims submitted on or after April 1, 1998. Providers should make all necessary changes and begin utilizing HCFA's revised instructions as soon as possible. All bills received by the intermediary on and after July 1, 1998, that are not billed in compliance with all revised instructions will be not be accepted for processing.

EXAMPLE: A beneficiary received occupational therapy (HCPCS code 97530 that is defined in 15-minute intervals) for a total of 60 minutes. The provider would report revenue code 430 in FL 42, HCPCS code 97530 in FL 44, four (4) units in FL 46 and one (1) visit in value code 51 (FL's 39-41).

This change to the reporting of units for outpatient rehabilitation services supersedes the current instructions contained in Sections 3604, 3627.9, and 3661 of the Part A Medicare Intermediary Manual, Part 3, as well as individual provider billing instructions in the Medicare Manuals (e.g. HCFA-Publication 10, Hospital Manual; HCFA-Publication 9, OPT Manual; HCFA-Publication 12, SNF Manual). HCFA will release revised transmittals for each specific manual in the near future.

Providers continue to report Value Code 50, 51, or 52 as appropriate (in FL's 39-41), the total number of physical therapy, occupational therapy, or speech therapy visits **provided during the billing period.**

LINE ITEM DATE OF SERVICE REPORTING

Providers are required to report line item dates of service per revenue code line for outpatient rehabilitation services. HCFA has instructed intermediaries to reject bills that **span two or more dates if a line item date of service is not entered for each HCPCS reported. Line item date of service reporting is effective for claims with dates of service on or after October 1, 1998**.

In addition, CORFs are required to report their full range of CORF services by line item date of service. **This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence.** Line item dates of service are reported in FL 45 "Service Date" (MMDDYY). See example below of reporting line item dates of service. **This example is for physical therapy services provided twice during a billing period.**

For electronic billing via the HCFA-1450 (UB-92) flat file, report as follows:

Record Type	Revenue Code	HCPCS	Service Date	Units	Total Charges
61	420	97001	050598	1	$ 60.90
61	420	97110	052998	2	$ 44.02

For the hardcopy/paper HCFA-1450 (UB-92), report as follows:

FL 42	FL 44	FL 45	FL 46	FL 47
420	97001	050598	1	$ 60.90
420	97110	052998	2	$ 44.02

ADDITIONAL HCPCS CODING REQUIREMENTS FOR CORFS

In addition to the above HCPCS coding requirement for outpatient rehabilitation services, CORFs are required to use HCPCS code for their full range of services. This HCPCS coding requirement is also effective for services submitted on or after April 1, 1998, and **must be adhered to no later than July 1, 1998.**

Such CPT codes are used by physicians to report physician services and do not necessarily reflect the "**technical component**" of a service furnished by the CORF. **CORFs should *ignore any wording* in the CPT codes that indicates that *the service must be performed by a physician***.

In cases where there are separate codes for the technical component, professional component, and/or complete procedure, CORFs must use the code that represents the technical component. If there is not a technical component code for the service, CORFs are to use the code that represents the complete procedure.

The following codes are required to be reported when the identified CORF services are provided. **Where CPT codes are not appropriate, the required Level II HCPCS codes are provided**.

Revenue Code	Description	HCPCS Codes
410	Respiratory therapy	94664, 94665, 94667, 94668
55X	Nursing services	* G0128 (see definition provided)
636	Immunizations	90724, 90732; 90744-90747
771	Vaccine administration	G0008, G0009, G0010
91X	Psychiatric therapeutic Procedures	90804

*G0128 = Direct face-to-face with patient. Skilled nursing services of a registered nurse provided in a comprehensive outpatient rehabilitation facility, each 10 minutes beyond the first 5 minutes.

NOTE: CORFs continue to bill for orthotic/prosthetic devices and surgical dressings utilizing existing HCPCS codes provided to them by their intermediary. Payment will continue for these items under the orthotic/prosthetic and surgical dressing fee schedules.

ADDITIONAL HCPCS CODING REQUIREMENTS FOR SNFS

As a result of Section 4432(b)(3) of the BBA, SNFs are also required to use HCPCS codes for there **full range of Part B services effective on or after July 1, 1998**. Effective for services provided on or after April 1, 1998, SNFs are required to report HCPCS codes for outpatient rehabilitation services. Effective for services provided on or after July 1, 1998, SNFs are also required to report HCPCS codes for their remaining Part B services (those other than rehabilitation services). Separate instructions will be issued, by HCFA, addressing the HCPCS coding requirement for services other than SNF outpatient rehabilitation services.

TIME FRAME FOR NEW CODING/REPORTING REQUIREMENTS

Since most providers will not be not capable of these coding/reporting requirements by the effective date (i.e., April 1, 1998), the Medicare intermediary will not reject your claims for failure to report in accordance with these requirements. The Medicare intermediary's processing system will allow your continued billing under the current reporting method, to allow a reasonable amount of "lead time" for implementation purposes.

With the exception of line item date of service reporting, **claims must be completed in accordance with these instructions no later than July 1, 1998.** Therefore, claims received by the intermediary on and after July 1, 1998, must be completed in accordance with HCFA's revised reporting requirements.

However, line item date of service reporting is effective for claims with dates of service on or after October 1, 1998.

Questions regarding this bulletin may be addressed to the Medicare Part A Customer Service Department by calling (904) 355-8899.