Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal: 1779 **Date: NOVEMBER 1, 2002**

CHANGE REQUEST 2337

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents – Chapter 2	2-1 – 2-2 (2 pp.)	2-1 – 2-2 (2 pp.)
2206.4 – 2210.2	2-91 – 2-92.2 (10 pp.)	2-91 – 2-92.1 (12 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE/IMPLEMENTATION DATE*: *April 1, 2003*

Section 2207, Coding Physician Specialty, has been changed to read "Specialty Codes". Revised to provide more information when receiving a request to expand the specialty code list. Osteopathic Crosswalk, has been **deleted** because the crosswalk has been phased out since 1992. It has been replaced with Primary/Secondary Codes to include language on how to handle a request for a primary or secondary specialty code. The following codes have been added and redefine osteopathic and Group Practice Prepayment Plan (GPPP) codes.

09 – Interventional Pain Management (IPM), allows for differences in treatment approaches, training, utilization patterns and costs between pain management specialists and IPM specialists.

72 – Pain Management, added per Change Request #1872, dated September 21, 2001.

Section 2207.1, Coding Type of Supplier and Non-Physician Practitioners, changed and/or added the following codes.

32 – Anesthesiologist Assistants (AAs), simplifies a planned study by the Agency for Healthcare Research and Quality. AAs previously were grouped with Certified Registered Nurse Anesthetists (43).

43 – Certified Registered Nurse Anesthetist, removed AAs to code "32".

65 – Physical Therapist in Private Practice, removed "independently practicing" and added "Private Practice".

67 – Occupational Therapist in Private Practice, removed "independently practicing" and added "Private Practice".

71 – Registered Dietician/Nutrition Professional, added per Change Request 2142, a PM with a discard date after October 1, 2003.

73 – Mass Immunization Roster Biller, added to make them more identifiable.

74 – Radiation Therapy Centers, added to differentiate them from Independent Diagnostic Testing Facilities (IDTFs).

75 – Slide Preparation Facilities, added to differentiate them from IDTFs.

Section 2207.2, Coding Types of Service for Group Practice Prepayment Plan (GPPP), **is being deleted** because they were phased out in 1992.

Section 2208, Description of Entry Code, is being deleted. This section is no longer needed.

Medicare contractors are to migrate AAs, Radiation Therapy Centers, Slide Preparation Facilities, and Mass Immunization Roster Billers from their current codes to the newly designated ones. All but AAs should have been tracked separately and should be easily identifiable. AAs can be migrated by using their UPINs.

Physicians wishing to choose Interventional Pain Management must send in a Form CMS 855I as a change of information.

The CMS is redefining the osteopathic and GPPP specialty codes with this manual instruction. They have been defunct since 1992. Medicare contractors must search all provider/supplier files and, if there is utilization reported, move the provider/supplier to a more appropriate code.

Also, there is still utilization being reported under specialty code "95", Independent Physiological Laboratory (IPL). Change Request 761, dated December 1998, cited the creation of Independent Diagnostic Testing Facilities (IDTFs) and instructed carriers to review their provider files to identify all IPLs that needed to obtain IDTF status to continue billing for diagnostic tests. These labs were to be moved to specialty code "47". Contractors need to check their files and ensure anything reported under "95" is moved to "47" as "95" will become an unassigned code that will be available for future use.

To educate our physicians and other healthcare providers/suppliers, contractors are to announce these changes and the implementation of the new codes in their next scheduled bulletin or newsletter after these changes become effective. Inform them of their ability to change their specialty code via the appropriate form CMS-855 application. Also, place this information on your web site as well as on any list servers you have created.

The above specialty codes will be updated into the Unique Physician Identification Number Registry process. For further instructions see the MCM Part 4, Professional Relations §1000.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

CHAPTER II
COVERAGE AND LIMITATIONS

Covered Medical and Other Health Services

CHAPTER II

pathologist's or physical therapist's plan must be established (that is, reduced to writing by that pathologist or physical therapist or by the provider itself when it makes a written record of the pathologist's or physical therapist's oral orders) before treatment is begun. Such plans should be promptly signed by the pathologist or physical therapist providing such services and incorporated into the provider's permanent record for the patient. Plans of treatment for outpatient speech pathology or OPT services established by the speech pathologist or physical therapist providing such services must also relate the type, amount, frequency, and duration of the speech pathology or PT services that are to be furnished the patient and indicate the diagnosis and anticipated goals. Any changes to a plan established by the speech pathologist or physical therapist must be made in writing and signed by that pathologist or physical therapist or by the attending physician. Changes to such plans may be made pursuant to the oral orders given by the attending physician, as stated above, or by the pathologist to another qualified speech pathologist or by the physical therapist to another qualified physical therapist or a registered professional nurse on the staff of the provider. Such changes must be immediately recorded in the patient's records and signed by the individual receiving the orders. While the physician may change a plan of treatment established by the speech pathologist or physical therapist providing such services, the speech pathologist or physical therapist may not alter a plan of treatment established by a physician.

The plan must be reviewed by the attending physician, in consultation with the physical therapist(s) or speech pathologist(s), as appropriate, of the clinic at such intervals as the severity of the patient's condition requires, but at least every 30 days. Each review of the plan should contain the initials of the physician and the date performed. The patient's plan normally need not be forwarded to the carrier for review but will be retained in the clinic's file. The clinic must certify on the billing form that the plan is on file.

2206.4 Requirement That Services Be Furnished on an Outpatient Basis.--OPT and speech pathology services are payable when furnished by a provider to its outpatients, i.e., to patients in their homes, to patients who come to the facility's outpatient department, or to inpatients of other institutions. In addition, coverage includes PT and speech pathology services furnished by participating hospitals and SNFs to those of their inpatients who have exhausted their Part A inpatient benefits or who are otherwise not eligible for Part A benefits. Providers of OPT and speech pathology services that have inpatient facilities, other than participating hospitals and SNFs, may not furnish covered OPT or speech pathology services to their own inpatients. However, since the inpatients of one institution may be considered the outpatients of another institution, all providers of OPT and speech pathology services may furnish such services to inpatients of another health facility.

While OPT and speech pathology are payable when furnished in the home, when added expense is caused by a visit to the home, a question must be raised as to whether the rendition of the service in the home is reasonable and necessary. Where the patient is not confined to his home, such added expense cannot be considered as reasonable and necessary for the treatment of an illness or injury since the home visit is substantially more costly than the medically appropriate and realistically feasible alternative pattern of care; e.g., in the facility's outpatient department. Consequently, these additional expenses incurred by providers due to travel to a person who is not homebound will not be covered.

2207. CODING SPECIALTY CODES

A. General Requirements.--Specialty codes are self-designated and describe the kind of medicine physicians, non-physician practitioners or other healthcare providers/suppliers practice. Appropriate use of specialty codes helps reduce inappropriate suspensions and improves the quality of utilization data.

A physician, non-physician practitioner or other healthcare provider or supplier will submit a specialty code change via the Form CMS-855 application. Update the specialty code that is submitted to CWF on the Part B Claim Record and the one used for prepayment and post payment medical review. This should also be consistent with your UPIN files and provider files. Follow the most cost-effective method for updating specialty codes.

Do not add any specialty codes to the list. Send all requests for expansion of the list to your regional office (RO). Your RO will forward the list to central office (CO). CO will consider whether the requestor has the authority to bill independently; the reason or purpose for the code expansion and if a current code would suffice; the requester is/are recognized by another organization, such as the American Board of Medical Specialties; and whether the specialty treats a significant volume of the Medicare population.

All physicians that have an UPIN must have a specialty code other than 70 multi-specialty "Clinic" or "Group Practice". Contact physicians who are listed as specialty 70 and obtain a valid specialty. Osteopathic codes and health care prepayment plans codes have been phased-out and been replaced with new codes.

B. Primary/Secondary Codes.--Physicians are allowed to choose a primary and a secondary specialty code. If your provider file can accommodate only one specialty code, then assign the code that corresponds to the greater amount of allowed charges. For example, if the practice is 50 percent ophthalmology and 50 percent otolaryngology, compare the total allowed charges for the previous year for ophthalmology and otolaryngology services. Assign the code that corresponds to the greater amount of the allowed charges.

C. Physician Specialty Codes.—

Code	Physician Specialty
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
09	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Therapy
13	Neurology
14	Neurosurgery
15	Unassigned
16	Obstetrics/Gynecology
17	Unassigned
18	Ophthalmology
19	Oral Surgery (dentists only)
20	Orthopedic Surgery
21	Unassigned
22	Pathology
23	Unassigned
24	Plastic and Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Unassigned

28	Colorectal Surgery (formerly proctology)
29	Pulmonary Disease
30	Diagnostic Radiology
31	Unassigned
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometry
44	Infectious Disease
46	Endocrinology
48	Podiatry
66	Rheumatology
70	Multispecialty Clinic or Group Practice
72	Pain Management
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
81	Critical Care (Intensivists)
82	Hematology
83	Hematology/Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
90	Medical Oncology
91	Surgical Oncology

92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
98	Gynecological/Oncology
99	Unknown Physician Specialty

2207.1 Coding Type of Supplier and Non-physician Practitioner.--These codes represent requests for payment involving services by suppliers/providers other than physicians.

Use the following 2-digit codes:

Code	Type of Supplier/Provider
32	Anesthesiologist Assistant
42	Certified Nurse Midwife (effective July 1, 1988)
43	Certified Registered Nurse Anesthetist (CRNA)
45	Mammography Screening Center
47	Independent Diagnostic Testing Facility (IDTF)
49	Ambulatory Surgical Center
50	Nurse Practitioner

51 Medical supply company with orthotic personnel certified by an accrediting organization

52 Medical supply company with prosthetic personnel certified by an accrediting organization

53 Medical supply company with prosthetic/orthotic personnel certified by an accrediting organization

54 Medical supply company not included in 51, 52, or 53

55 Individual orthotic personnel certified by an accrediting organization

56 Individual prosthetic personnel certified by an accrediting organization

57 Individual prosthetic/orthotic personnel certified by an accrediting organization

58 Medical Supply Company with registered pharmacist

59 Ambulance Service Supplier (e.g., private ambulance companies, funeral homes)

60 Public Health or Welfare Agencies (Federal, State, and local)

61 Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)

62 Psychologist (Billing Independently)

63 Portable X-Ray Supplier (Billing Independently)

64 Audiologist (Billing Independently)

65 Physical Therapist in Private Practice

67 Occupational Therapist in Private Practice

68 Clinical Psychologist

69 Clinical Laboratory (Billing Independently)

71 Registered Dietician/Nutrition Professional

73 Mass Immunization Roster Billers (Mass Immunizers have to roster bill assigned claims and can only bill for immunizations)

74 Radiation Therapy Centers

75 Slide Preparation Facilities

80 Clinical Social Worker

87 All other suppliers, e.g., Drug Stores

88 Unknown Supplier/Provider

89 Clinical Nurse Specialist

95 Unassigned

96 Optician

97 Physician Assistant

A0 Hospital

A1 Skilled Nursing Facility

A2 Intermediate Care Nursing Facility

A3 Nursing Facility, Other

A4 Home Health Agency

A5 Pharmacy

A6 Medical Supply Company with Respiratory Therapist

A7 Department Store

A8 Grocery Store

2210. PAYABLE PHYSICAL THERAPY (PT)

A. General.--To be covered PT services, the services must relate directly and specifically to an active written treatment regimen established by the physician after any needed consultation with the qualified physical therapist and must be reasonable and necessary to the treatment of the individual's illness or injury. Effective July 18, 1984, a plan of treatment for OPT services may be established by either the physician or the qualified physical therapist providing such services. Services related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute PT services for Medicare purposes.

Services furnished beneficiaries must constitute PT where entitlement to benefits is at issue. Since the OPT benefit under Part B provides coverage only of PT services, payment can be made only for those services which constitute PT.

B. Reasonable and Necessary.--To be considered reasonable and necessary the following conditions must be met:

o The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition.

o The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under his supervision. Services which do not require the performance or supervision of a physical therapist are not considered reasonable or necessary PT services, even if they are performed or supervised by a physical therapist. (When you determine the services furnished were of a type that could have been safely and effectively performed only by a qualified physical therapist or under his supervision, presume that such services were properly supervised. However, this assumption is rebuttable, and, if in the course of processing claims you find that PT services are not being furnished under proper supervision, deny the claim and bring this matter to the attention of the Division of Survey and Certification of the RO.)

o The development, implementation, management, and evaluation of a patient care plan constitute skilled physical therapy services when, because of the beneficiary's condition, those activities require the skills of a physical therapist to meet the beneficiary's needs, promote recovery, and ensure medical safety. Where the skills of a physical therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program because of an identified danger to the patient, those reasonable and necessary management and evaluation services could be covered, even if the skills of a therapist are not needed to carry out the activities performed as part of the maintenance program.

o While a beneficiary's particular medical condition is a valid factor in deciding if skilled physical therapy services are needed, a beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a physical therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel.

o A service that ordinarily would be performed by nonskilled personnel could be considered a skilled physical therapy service in cases in which there is clear documentation that, because of special medical complications, a skilled physical therapist is required to perform or supervise

the service. However, the importance of a particular service to a beneficiary or the frequency with which it must be performed does not, by itself, make a nonskilled service into a skilled service.

o There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state.

o The amount, frequency, and duration of the services must be reasonable.

NOTE: Claims for PT services denied because they are not considered reasonable and necessary are excluded by §1862(a)(1) of the Act and are thus subject to consideration under the waiver of liability provision in §1879 of the Act. (See §7300.10.)

2210.1 Restorative Therapy.--To constitute physical therapy a service must, among other things, be reasonable and necessary to the treatment of the individual's illness. If an individual's expected restoration potential would be insignificant in relation to the extent and duration of physical therapy services required to achieve such potential, the physical therapy would not be considered reasonable and necessary. In addition, there must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time. However, if at any point in the treatment of an illness it is determined that the expectations will not materialize the services will no longer be considered reasonable and necessary; and they, therefore, should be excluded from coverage under §l862(a)(l) of the Act.

Skilled physical therapy may be needed, and improvement in a patient's condition may occur, even where a patient's full or partial recovery is not possible. For example, a terminally ill patient may begin to exhibit self care, mobility, and/or safety dependence requiring skilled physical therapy services. The fact that full or partial recovery is not possible does not necessarily mean that skilled physical therapy is not needed to improve the patient's condition. The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a physical therapist, or whether they can be safely and effectively carried out by nonskilled personnel without physical therapy supervision.

2210.2 Maintenance Programs.--The repetitive services required to maintain function generally do not involve complex and sophisticated physical therapy procedures, and, consequently, the judgment and skill of a qualified physical therapist are not required for safety and effectiveness.

However, in certain instances, the specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program intended to prevent or minimize deterioration caused by a medical condition, if the program is to be safely carried out and the treatment aims of the physician achieved. Establishing such a program is a skilled service. For example, a Parkinson patient who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises will contribute the most to maintain the patient's present functional level. In such situations, the initial evaluation of the patient's needs, the designing by the qualified physical therapist of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or family members in carrying out the program, and such infrequent reevaluations as may be required would constitute physical therapy.