CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1019	Date: AUGUST 3, 2006
	Change Request 5253

NOTE: Transmittal 1016, dated July 28, 2006 is rescinded and replaced with Transmittal 1019, dated August 3, 2006. This instruction is being re-issued to correct the Business Requirements that were originally issued. In BR5253.4, Medicare Summary Notice was incorrectly referred to 16.26, and corrected to 16.25. Also, BR5253.45 was listed incorrectly and corrected to BR5253.5. The Business Requirement has been revised. All other information remains the same.

SUBJECT: Outpatient Therapy - Additional DRA Mandated Service Edits

I. SUMMARY OF CHANGES: This instruction provides additional limitations on outpatient therapy services, consistent with the provisions of the Deficit Reduction Act of 2005. Certain services are limited to certain numbers of units per day for physical therapy , occupational therapy and speech-language pathology, separately to control inappropriate billing.

NEW / REVISED MATERIAL
EFFECTIVE DATE: JANUARY 1, 2007
IMPLEMENTATION DATE: JANUARY 2, 2007

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	5/20.2/Reporting of Service Units With HCPCS

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Manual Instruction
Business Requirements

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1019	Date: August 3, 2006	Change Request 5253

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SUBJECT: Outpatient Therapy - Additional DRA Mandated Service Edits

I. GENERAL INFORMATION

A. Background: Deficit Reduction Act of 2005 Section 5107 requires limitations on outpatient therapy services, for the purpose of identifying and eliminating improper payments.

B. Policy: Certain services are limited to certain numbers of units per day for physical therapy, occupational therapy and speech-language pathology, separately to control inappropriate billing**.**

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	
5253.1	Contractors shall pay for outpatient therapy services, when covered, as described in the Claims Processing Manual chapter 5, section 20.2, allowing units per beneficiary, per HCPC, per day, per therapy discipline (PT, OT, SLP, physician/NPP) up to and including the number of units indicated.	X	X	X		X	X			
5253.2	Contractors shall line item deny as medically unnecessary any units on each claim line greater than the number of units designated in the Claims Processing Manual, chapter 5, section 20.2.	X	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	
5253.2.1	Contractors shall pay as appropriate for the number of allowed units on each claim line per the Claims Processing Manual, chapter 5, section 20.2	X	X	X		X	X			
5253.3	Contractors shall use adjustment reason code B5 when denying units of therapy services greater than the number of units designated in the Claims Processing Manual.	X	X	X		X	X			
5253.4	When denying units of therapy services greater than the number of units designated in the Claims Processing Manual, contractors shall use Medicare Summary Notice 16.25 – Medicare does not pay for this much equipment, or this many services or supplies.	X	X	X		X	X			
5253.5	If local coverage determinations (LCDs) do not agree with the units allowed in this manual section for covered services, contractors shall modify their LCDs to conform to this instruction.	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	
5253.6	Contractors shall post the entire IOM instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire IOM instruction must be included in your next regularly scheduled bulletin and incorporated into any educational events on this	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	
	topic. Business requirements and transmittal forms are for contractors and shall not be posted for providers and suppliers									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
5253.2	Appeals are allowed according to the policies for medical necessity denials. Issuance of an ABN is appropriate for such denials.
5253.3	Adjustment reason code B5 is defined " Payment adjusted because coverage/program guidelines were not met or were exceeded.

B. Design Considerations: NA

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: NA

D. Contractor Financial Reporting /Workload Impact: NA

E. Dependencies: NA

F. Testing Considerations: NA

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2007 **Implementation Date:** January 2, 2007 **Pre-Implementation Contact(s):** Dorothy Shannon 63396 for therapy policy, Wil Gehne 66148 for FI	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.**

payment issues, Claudette Sikora 65618 for carrier payment issues **Post-Implementation Contact(s):** Pam West 62302 for code questions, Dorothy Shannon 63396 for therapy policy, Wil Gehne 66148 for FI payment issues, Claudette Sikora 65618 for carrier payment issues.	

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

Medicare Claims Processing Manual
Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services

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(Rev.1019, 08-03-06)

20.2 - *Reporting of Service Units With HCPCS*

(Rev.1019, Issued: 08-03-06, Effective: 01-01-07, Implementation: 01-02-07)

A. General

Effective with claims submitted on or after April 1, 1998, providers billing on Form CMS-1450 *were* required to report the number of units for outpatient rehabilitation 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*, and* CORFs *were required to* report their full range of CORF services on the Form CMS-*1450*. *These unit-reporting requirements continue with the standards required for electronically submitting health care claims under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) - the currently adopted version of the ASC X12 837 transaction standards and implementation guides. The Administrative Simplification Compliance Act mandates that claims be sent to Medicare electronically unless certain exceptions are met.*

B. Timed and Untimed Codes

When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe ("untimed" HCPCS), the provider enters "1" in *the field labeled* units. *For untimed codes, units are reported based on the number of times the procedure is performed, as described in the HCPCS code definition (often once per day).*

EXAMPLE: *A beneficiary received a speech-language pathology evaluation represented by HCPCS "untimed" code 92506. Regardless of the number of minutes spent providing this service only one unit of service is appropriately billed on the same day.*

Providers billing *to FIs and RHHIs* should report Value Code 50, 51, or 52, the total number of physical therapy, occupational therapy, or speech–language pathology visits provided from start of care through the billing period. This item is visits, not service units. *Value codes do not apply to claims sent to carriers.*

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 *single* calendar day** using CPT codes and the appropriate number of *15 minute* units of service.

EXAMPLE: *A beneficiary received occupational therapy (HCPCS "timed" code 97530 which is defined in 15 minute units) for a total of 60 minutes. The provider would then report revenue code 043X and 4 units.*

C. Counting Minutes for Timed Codes in 15 Minute Units

*When only one service is provided in a day, p*roviders should not bill for services performed for less than 8 minutes. For any single *timed* CPT code *in the same day measured in 15 minute units*, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes *through and including 22* minutes. If the duration of a single modality or procedure *in a day* is greater than or equal to 23 minutes t*hrough and including* 3*7* minutes, then 2 units should be billed. Time intervals for *1 through 8* units are as follows:

Units	**Number of Minutes**
1 unit:	*≥ 8 minutes through 22 minutes*
2 units:	*≥ 23 minutes through 37 minutes*
3 units*:*	≥ 38 minutes t*hrough* 5*2* minutes
4 units*:*	≥ 53 minutes t*hrough* 6*7* minutes
5 units*:*	≥ 68 minutes t*hrough* 8*2* minutes
6 units*:*	≥ 83 minutes t*hrough* 9*7* minutes
7 units*:*	≥ 98 minutes t*hrough* 11*2* minutes
8 units*:*	≥ 113 minutes t*hrough* 12*7* minutes

The pattern remains the same for treatment times in excess of 2 hours.

If a service represented by a 15 minute timed code is performed in a single day for at least 15 minutes, that service shall be billed for at least one unit. If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc. It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes.

When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service (as noted on the chart above) determines the number of units billed.

If any 15 minute timed service that is performed for 7 minutes or less than 7 minutes on the same day as another 15 minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater than 8 minutes, then bill one unit for the service performed for the most minutes . This is correct because the total time is greater than the minimum time for one unit. The same logic is applied when three or more different services are provided for 7 minutes or less than 7 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.

If more than one *15 minute timed* CPT code is billed during a *single* calendar day, then the total number of *timed* units that can be billed is constrained by the total treatment *minutes for that day*.

Pub. 100-02, chapter 15, section 230.3B Treatment Notes indicates that the amount of time for each specific intervention/modality provided to the patient is not required to be documented in the Treatment Note. However, the total number of timed minutes must be documented. These examples indicate how to count the appropriate number of units for the total therapy minutes provided.

Example 1 -

24 minutes of neuromuscular reeducation, code 97112,
23 minutes of therapeutic exercise, code 97110,
Total timed code treatment time was 47 minutes.

See the chart above. The 47 minutes falls within the range for 3 units = 38 to 52 minutes.

Appropriate billing for 47 minutes is only 3 *timed* units. *Each of the codes is performed for more than 15 minutes, so each shall be billed for at least 1 unit.* The correct coding is 2 units of code 97112 and one unit of code 97110, assigning more *timed* units to the service that took the most time.

Example 2 -

20 minutes of neuromuscular reeducation (97112)
20 minutes therapeutic exercise (97110),
40 Total timed code minutes.

Appropriate billing for 40 minutes is 3 units. Each service was done at least 15 minutes and should be billed for at least one unit, but the total allows 3 units. Since the time for each service is the same, choose either code for 2 units and bill the other for 1 unit. Do not bill 3 units for either one of the codes.

Example 3

33 minutes of therapeutic exercise (97110),
7 minutes of manual therapy (97140),
40 Total timed minutes

Appropriate billing for 40 minutes is for 3 units. Bill 2 units of 97110 and 1 unit of 97140. Count the first 30 minutes of 97110 as two full units. Compare the remaining time for 97110 (33-30 = 3 minutes) to the time spent on 97140 (7 minutes) and bill the larger, which is 97140.

Example 4 –

18 minutes of therapeutic exercise (97110),
13 minutes of manual therapy (97140),
10 minutes of gait training (97116),
8 minutes of ultrasound (97035),
49 Total timed minutes

Appropriate billing is for 3 units. Bill the procedures you spent the most time providing. Bill 1 unit each of 97110, 97116, and 97140. You are unable to bill for the ultrasound because the total time of timed units that can be billed is constrained by the total timed code treatment minutes (i.e., you may not bill 4 units for less than 53 minutes regardless of how many services were performed). You would still document the ultrasound in the treatment notes.

Example 5 –

7 minutes of neuromuscular reeducation (97112)
7 minutes therapeutic exercise (97110)
7 minutes manual therapy (97140)
21 Total timed minutes

Appropriate billing is for one unit. The qualified professional (See definition in Pub 100-02/15, sec. 220) shall select one *appropriate CPT code* (97112, 97110, 97140) *to bill since each unit was performed for the same amount of time* and only one unit is allowed.

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 *total minutes of* active treatment counted *for all 15 minute timed codes* includes all direct treatment time *for the timed codes*. *Total treatment minutes-- including minutes spent providing services represented by untimed codes— are also documented. For documentation in the medical record of the services provided see Pub. 100-02, chapter 15, section 230.3: Documentation, Treatment Notes.*

D. Specific Limits for HCPCS

The Deficit Reduction Act of 2005, section 5107 requires the implementation of clinically appropriate code edits to eliminate improper payments for outpatient therapy services. The following codes may be billed, when covered, only at or below the number of units indicated on the chart per treatment day. When higher amounts of units are billed than those indicated in the table below, the units on the claim line that exceed the limit shall be denied as medically unnecessary (according to 1862(a)(1)(A)). Denied claims may be appealed and an ABN is appropriate to notify the beneficiary of liability.

This chart does not include all of the codes identified as therapy codes; refer to section 20 of this chapter for further detail on these and other therapy codes. For example, therapy codes called "always therapy" must always be accompanied by therapy modifiers identifying the type of therapy plan of care under which the service is provided.

Use the chart in the following manner:

- *The codes that are allowed one unit for "Allowed Units" in the chart below may be billed no more than once per provider, per discipline, per date of service, per patient.*

- *The codes allowed 0 units in the column for "Allowed Units", may not be billed under a plan of care indicated by the discipline in that column. Some codes may be billed by one discipline (e.g., PT) and not by others (e.g., OT or SLP).*

- *When physicians/NPPs bill "always therapy" codes they must follow the policies of the type of therapy they are providing e.g., utilize a plan of care, bill with the appropriate therapy modifier (GP, GO, GN), bill the allowed units on the chart below for PT, OT or SLP depending on the plan. A physician/NPP shall not bill an "always therapy" code unless the service is provided under a therapy plan of care. Therefore, NA stands for "Not Applicable" in the chart below.*

- *When a "sometimes therapy" code is billed by a physician/NPP, but as a medical service, and not under a therapy plan of care, the therapy modifier shall not be used, but the number of units billed must not exceed the number of units indicated in the chart below per patient, per provider/supplier, per day.*

HCPCS	Code Description and Claim Line Outlier/Edit Details	Timed or Untimed	PT Allowed units	OT Allowed units	SLP Allowed units	Physician/NP NOT under Therapy POC
92506	Speech/hearing evaluation	Untimed	0	0	1	NA
92597	Oral speech device eval	Untimed	0	1	1	NA
92607	Ex for speech device rx, 1hr	Timed	0	1	1	NA
92611	Motion fluroscopy/swallow	Untimed	0	1	1	1
92612	Endoscope swallow test (fees)	Untimed	0	1	1	1
92614	Laryngoscopic sensory test	Untimed	0	1	1	1
92616	Fees w/laryngeal sense test	Untimed	0	1	1	1
95833	Limb muscle testing, manual	Untimed	1	1	0	1
95834	Limb muscle testing, manual	Untimed	1	1	0	1
96110	Developmental test, lim	Untimed	1	1	1	1
96111	Developmental test, extend	Untimed	1	1	1	1
97001	PT evaluation	Untimed	1	0	0	NA
97002	PT re-evaluation	Untimed	1	0	0	NA
97003	OT evaluation	Untimed	0	1	0	NA
97004	OT re-evaluation	Untimed	0	1	0	NA