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Related CR Transmittal #: R805CP **Implementation Date: February 6, 2006**

Annual Update to the Therapy Code List

Note: This article was updated on June 5, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Private practicing therapists, physicians, suppliers, and providers of therapy services billing Medicare carriers and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs) for rehabilitation therapy services.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4226, which implements policy changes discussed in the Outpatient Prospective Payment System (OPPS) final rule for Calendar Year (CY) 2006 and the Medicare physician fee schedule (MPFS) final rule for CY2006.

CAUTION – What You Need to Know

CR4226 describes changes to, and billing instructions for, payment policies for rehabilitation therapy services, including physical therapy, occupational therapy and speech-language pathology. It also updates the list of codes that sometimes or always describe therapy services and their associated policies.

GO – What You Need to Do

See the *Background* section of this article for further details regarding these changes.

Background

The Social Security Act (Section 1834(k)(5)) 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 - Fourth Edition (HCPCS/CPT-4), is the coding system used for the reporting of these services.

The uniform coding requirement in the Social Security Act is specific to payment for all CORF services and outpatient rehabilitation therapy services that are provided and billed to carriers and fiscal intermediaries (FIs) including:

- Physical therapy;
- Occupational therapy; and
- Speech-language pathology.

Section 1834(k)(5) of the Social Security Act can be found at *http://www.ssa.gov/OP_Home/ssact/title18/1834.htmon* the Internet.

The Medicare Physician Fee Schedule (MPFS) is used to make payment for these therapy services at the nonfacility rate. The following "providers of therapy services" must bill the FI/RHHI 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 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 rehabilitation facilities).

[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.

[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.

CR4226 Requirements

Change Request (CR) 4226:

- Describes changes to, and billing instructions for, payment policies for rehabilitation therapy services, including physical therapy, occupational therapy and speech-language pathology;
- Updates the list of codes that sometimes or always describe therapy services and their associated policies; and
- 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 CR4226 correct or clarify the previous policy noted in CR3647 (Transmittal 515 dated April 1, 2005).

The therapy code list and associated policies for CY 2006 is updated by CR4226 as described below.

CR3647 can be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R515CP.pdf on the CMS website. The MLN Matters article that corresponds to CR3647 can be reviewed at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3647.pdf on the CMS website.

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 descriptors 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. The following table contains a list of the added CY 2006 CPT codes and the new short descriptor for CPT code 97760:

2006 Code	2006 Short Descriptor	2005 Code
97760	Orthotic management and training	97504
97761	Prosthetic training	97520
97762	C/o for orthotic/prosth use	97703

Active Wound Care Management Services

The therapy code list contains five (5) HCPCS/CPT codes that represent active wound care services: 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 Outpatient Prospective Payment System (OPPS), the requirements for "sometimes therapy" apply. These requirements are described in more detail in Publication 100-04, Chapter 5, Section 20, of the *Medicare Claims Processing Manual.* That manual is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html* on the CMS website.

A new payment policy for hospitals paid under the OPPS is being implemented for these five wound care HCPCS/CPT codes – 97602, 97605, 97606, 97597, and 97598, and the indicator **"ع"** is being added as a note to the code list. The indicator **"ع"** 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 (i.e., under the therapy benefit); and (b) it is inappropriate to bill the service under a therapy plan of care.

Wound care provided, which meets 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 (i.e.; under the therapy benefit) 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.

2006 Status	HCPCS/ CPT Code	Short Descriptor	2005 Status
Bundled service for payment purposes under the MPFS; sometimes therapy service.	97602	Wound (s) care, non-selective	Bundled service for payment purposes under the MPFS; always therapy service.
Valued and active code under the MPFS; sometimes therapy service.	97605	Neg press wound tx,< 50 cm	Bundled service for payment purposes under the MPFS; always therapy service.
Valued and active code under the MPFS; sometimes therapy service.	97606	Neg press wound tx, > 50 cm	Bundled service for payment purposes under the MPFS; always therapy service.
Sometimes therapy service.	97597	Active wound care/20 cm or <	Sometimes therapy service.
Sometimes therapy service.	97598	Active wound care > 20 cm	Sometimes therapy service.

Carrier Pricing of Unspecified Therapy Codes

The 2006 policy adds Note **"◊"** to HCPCS/CPT codes 97039 and 97139 to indicate that the MPFS payment has changed to carrier-pricing and these two codes will no longer be paid using the relative values units previously listed in Addendum B of the 2006 MPFS final rule.

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, 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, the information supplied to the carrier 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.

HCPCS/CPT Code	Short Descriptor
97039	Physical therapy treatment
97139	Physical medicine procedure

Speech, Language, Voice, Communication and/or Auditory Processing

The 2006 policy creates a **"Δ"** indicator 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 for 95206 and 95207 are the following:

2006 Code	2006 Short Descriptor
92506	Speech/hearing evaluation
92507	Speech/hearing therapy

Microwave Modality

The 2006 policy removes deleted HCPCS/CPT codes 96115 and 97020. CPT 96115 was deleted for CY 2006. CPT code 97020, for the microwave modality, was combined with CPT code 97024 for diathermy.

2006 Code	2006 Short Descriptor
97024	Diathermy e.g., microwave

Code 0019T

The 2006 policy 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.

2006 Code	2006 Short Descriptor	2006 Status
0019T	Extracorp shock wv tx, ms nos	Sometimes therapy

Diagnostic Services

The 2006 policy clarifies in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 5, Section 20, Subsection C (Additional HCPCS Codes)), 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 and cannot be billed as such. Those codes and their short descriptors are in the following table:

HCPCS/CPT Code	Short Descriptor	Status under MPFS
95860	Muscle trest, one limb	Diagnostic Service
95861	Muscle test, 2 limbs	Diagnostic Service
95863	Muscle test, 3 limbs	Diagnostic Service
95864	Muscle tesl, 4 limbs	Diagnostic Service
95867	Muscle test cran nerv unilat	Diagnostic Service
95868	Muscle test cran nerve bilat	Diagnostic Service
95869	Muscle test, thor paraspinal	Diagnostic Service
95870	Muscle test, nonparaspinal	Diagnostic Service
95900	Motor nerve conduction test	Diagnostic Service
95903	Motor nerve conduction test	Diagnostic Service
95904	Sense nerve conduction test	Diagnostic Service
95934	H-reflex test	Diagnostic Service

Code 96110

The 2006 policy 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.

HCPCS/CPT Code	Short Descriptor
96110	Developmental test, lim

Summary

In summary, CR4226 instructs your carrier and/or FI/RHHI to change any policies or edits that are not consistent with the policies or list of codes provided in CR 4226.

The changes noted in CR4226 are effective for services furnished on or after January 1, 2006. The additions, changes, and deletions to the therapy code list reflect those made in the CY 2006 HCPCS/CPT-4.

Additional Information

For complete details, please see the official instruction issued to your carrier/FI/RHHI regarding this change. That instruction may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R805CP.pdf* on the CMS website.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.