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Medicare
Part B

August 25, 2005

Sharmila Sandhu, Esq.
Regulatory Counsel
Reimbursement and Regulatory Policy Department
American Occupational Therapy Association
4720 Montgomery Lane
P. O. Box 31220
Bethesda, Maryland 20814-1220

Re: CPT Code 97755

Dear Ms. Sandhu:

Thank you for your July 22, 2005, email to Heather Bennett, RN, and Laura Minter of my staff regarding the eligibility of occupational therapists (OT's) to be reimbursed under traditional Medicare for CPT code 97755.

97755 Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes

On July 5, 2005, I responded by letter in a timely manner to a Local Coverage Determination (LCD) Reconsideration Request pertaining to LCD Y-2, "Occupational Therapy." This LCD Request requested that HGSAdministrators add CPT code 97755 to LCD Y-2. The following was my response:

"Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of LCD Y-2N, it advises that the policy addresses only evaluation and re-evaluation services:

'This policy addresses evaluation and re-evaluation services provided by a licensed occupational therapist, a physician or non-physician practitioner or incident to a physician's service. Although there may be an overlap in services provided by an occupational and a physical therapist, this policy only addresses evaluation and re-evaluation services provided by an occupational therapist.'

In addition, Article A20087, the billing and coding article on "Occupational Therapy Services," provides the following instruction in the "Other Comments" section;

'Refer to LCD Y-1 for detailed information and coverage guidelines for physical therapy services that can also be provided by occupational therapists.'

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Therefore, the scope of LCD Y-2 does not include CPT 97755. In addition, HGSA has provided instructions in LCD Y-2's companion billing and coding article that directs individuals to LCD Y-1 for information and guidelines on services other than evaluation and re-evaluation when rendered by an occupational therapist.

It is our determination that it is inappropriate to add CPT code 97755 to LCD Y-2. And more importantly, the guidelines for CPT 97755 when rendered by occupational therapists are currently available in LCD Y-1."

LCD Y-2 does not list the services that an OT may render under traditional Medicare in Pennsylvania. Rather, the policy provides the required qualifications of OT's and OT assistants, and describes covered occupational therapy services and the occupation therapy plan of care. In fact, the policy does not list covered services; rather, it provides a listing of the services that are ineligible when provided by an OT. And, as described above, the related article refers one to LCD Y-1, "Physical Therapy and Rehabilitation Services," for more detailed information on services that are eligible when rendered by either a physical therapist, *or an OT*.

However, as a result of your inquiry, we have located and corrected a processing system problem that prevented OT's from being reimbursed for 97755. This correction was made to our processing system on August 24, 2005. Claims that have denied incorrectly may be appealed, or resubmitted when the time frame for an appeal has expired. These guidelines are provided in this letter for your convenience. As stated, the problem identified was a system processing problem, not a policy issue.

The guidelines in LCD Y-1 and LCD Y-2 are accurate. However, we plan on clarifying the language in these policies relating to occupational therapy, per your suggestions. We will make the appropriate verbiage changes in the policy(ies) and/or the associated article(s) when we update our polices with the new HCPCS code changes for 2006. Please watch our website for notification of these changes.

Filing a Request for a Redetermination

Regulations at 42 CFR 405.807 provide that a party to an initial determination that is dissatisfied with such initial determination may request that the carrier make a redetermination. *The request for a redetermination must be filed within 120 days after the date of the notice of the initial determination.* To determine the date of your initial determination, please refer to the "date paid" on your reconciliation or Standard Paper Remittance (SPR) to determine the date the claim processed.

All redetermination requests must contain the following information:

- Beneficiary name
- Medicare health insurance claim (HIC) number
- Name and address of provider/supplier of service
- Date of initial determination
- Date(s) of service for which the initial determination was issued (dates must be reported in a manner that comports with the Medicare claims filing instructions; ranges of dates are acceptable only if a range of dates is properly reportable to the Medicare claim form); and
- Which service(s) is at issue in the redetermination

If you submit a redetermination in writing, all forms must be signed. Send the request to:

HGSAdministrators Redeterminations
P. O. Box 890413
Camp Hill, Pa 17089-0413

However, you may request a redetermination by telephone. A telephone redetermination can be requested if the issue is not complex. We now offer toll-free service for our telephone redetermination lines. The telephone number is 1-866-488-0551.

The *Medicare Part B Reference Manual*, Chapter 18, provides additional information regarding the Redetermination and Hearing process. This manual can be found on our web page at www.hgsa.com.

If I can be of any further assistance, please feel free to contact me at (717) 302-4198.

Sincerely,



Andrew Bloschichak, M.D., MBA
VP and Contractor Medical Director
HGSAdministrators

AB/agr