CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 42 **Date: DECEMBER 8, 2003**

CHANGE REQUEST 3005

I. SUMMARY OF CHANGES: The manual is updated to include new information in Section 10.2 concerning the financial limitation on therapy services. It removes therapy caps on December 8, 2003, the date of enactment of the Medicare Prescription Drug and Modernization Act of 2003 and extends the moratorium through CY 2005. This CR rescinds CR 2973 as it relates to the dates and amounts of therapy caps and it incorporates the sections of CR 2973 required to update the list of therapy services on January 1, 2004.

NEW/REVISED MATERIAL - EFFECTIVE DATE: December 8, 2003 except as noted in the business requirements.

***IMPLEMENTATION DATE: December 8, 2003 except as noted in the business requirements.**

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.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	5/10.2 - The Financial Limitation
R	5/20 - HCPCS Coding Requirement
R	5/20.1 - Discipline Specific Outpatient Rehabilitation Modifiers - All Claims

***III. FUNDING:**

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification

***Medicare contractors only**

Business Requirements

Pub. 100-04	Transmittal: 42	Date: December 8, 2003	Change Request 3005

I. GENERAL INFORMATION

A. Background:

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, which added §1834(k)(5) to the Social Security Act (the Act), required payment under a prospective payment system for outpatient rehabilitation services. Outpatient rehabilitation services include the following services:

- Physical therapy (which includes outpatient speech-language pathology); and
- Occupational therapy.

Section 4541(c) of the BBA required application of a financial limitation to all outpatient rehabilitation services (with the exception of outpatient departments of a hospital). There was an annual per beneficiary limit of $1500 for all outpatient physical therapy services (including speech-language pathology services) and a separate $1500 limit for all occupational therapy services in 1999. The $1500 limit was based on incurred expenses and included an applicable deductible ($100) and coinsurance (20 percent). The annual limitation did not apply to services furnished directly or under arrangement by a hospital to an outpatient, or to a hospital inpatient who was not in a covered Part A stay. The BBA provided that the $1500 limits be indexed by the Medicare Economic Index (MEI) each year beginning in 2002. Legislation extended the moratorium through CY 2002. Limits for 2003 were $1590 for each cap. Limits were in effect from September 1, 2003 until December 7, 2003. Section 624 of the Medicare Prescription Drug and Modernization Act of 2003 imposed another moratorium from the date of enactment, December 8, 2003, through December 31, 2005.

On November 14, 2003, CMS issued Transmittal 30, CR 2973, which updated the list of therapy services and announced the amount that would apply to the cap in 2004. Portions of that transmittal related to the application of financial limitations are changed by this instruction. Other parts, for example, the changes to the list of therapy services, remain in effect.

B. Policy:

From December 8, 2003 through December 31, 2005, there is a moratorium on financial limits for outpatient physical therapy and speech-language pathology. There is no financial limitation on therapy services during that time.

C. Provider Education: Intermediaries and/or carriers shall inform affected providers by posting either a summary or relevant portions of this document on their Web site within two weeks. Also, intermediaries and/or carriers shall publish this same information in their next regularly scheduled bulletin. If they have a listserv that targets affected providers, they shall use it to notify subscribers that information about therapy caps is available on their Web site.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
1	CWF shall bypass all editing regarding the financial limitations for all outpatient therapy services effective calendar date December 8, 2003 for claims received on or after that date and until further notice.	CWF Maintainer
2	Contractors shall change any references in their educational materials to reflect the moratorium on therapy limits for the duration of the moratorium (from the date of the enactment of the Medicare Prescription Drug and Modernization Act of 2003 on December 8, 2003 until Dec 31, 2005) effective within 2 weeks of the date of the issuance of this instruction.	Intermediaries and carriers. DMERC
3	Contractors shall use revised Medicare summary notices 17.13, 17.18 and 17.19, effective December 8, 2003 until system changes can be made to discontinue using these MSN messages.	Intermediaries and carriers, DMERCs, SSMs
4	Contractors shall modify the Medicare summary notice alert to the message in CR3005 effective within 2 weeks of the date of the issuance of this instruction.	Intermediaries and Carriers, DMERCs, SSMs
5	Contractors shall add 97755 and 97602 to the list of applicable therapy codes effective January 1, 2004.	Intermediaries, Carriers, CWF and SSMs
6	Contractors shall use reason code 97 or B15 to identify the reason for claim denials of bundled codes 97010 and 97602 to be effective no later than January 5, 2004.	Intermediaries and Carriers, DMERCs, SSMs
7	Effective Jan 1, 2004, 96110 will be an active code. Carriers shall no longer price this code.	Intermediaries and Carriers
8	Contractors shall add 97010 to the list of applicable therapy codes effective January 1, 2004. It shall be bundled with any therapy code. Regardless of whether it is billed alone or in conjunction with another therapy code, never make payment separately for this code. If billed alone, deny this code using existing EOMB/MSN language. For remittance advice	Intermediaries, Carriers, SSMs

	notices, use group code CO and claim adjustment reason code 97 or B15 to deny a procedure code that should have been bundled.	
9	Contractors shall remove 92601, 92602, 92603, 92604, V5362, V5363, and V5364 from the list of applicable therapy codes effective January 1, 2004. These are no longer applicable outpatient rehabilitation therapy codes.	Intermediaries, Carriers, CWF and SSMs

II. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
1a	If Fiscal Intermediaries and Carriers do not have a means of bypassing the therapy limit, they are required to hold all therapy claims beginning December 8, 2003 until the CWF system modifications have been implemented.

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
	NA

C. Interfaces: NA

D. Contractor Financial Reporting /Workload Impact: NA

E. Dependencies: NA

F. Testing Considerations: Unknown

IV. OTHER CHANGES

Citation	Change
	NA

SCHEDULE, CONTACTS, AND FUNDING

Effective Date: December 8, 2003 or as otherwise noted in business requirements. **Implementation Date: December 8, 2003 or as otherwise noted in business requirements.** **Pre-Implementation Contact(s): Dorothy Shannon** **For Therapy policy issues: Dorothy Shannon** **Post-Implementation Contact(s): Same**	**These instructions should be implemented within your current operating budget**

10.2 - The Financial Limitation

(Rev. 42, 12-08-03)

A3-3653, AB-03-018, AB-03-057, AB-03-097, B-03-065

A - Financial Limitation Prior to the BBRA

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, which added §1834(k)(5) to the Act, required payment under a prospective payment system for outpatient rehabilitation services. Outpatient rehabilitation services include the following services:

- Physical therapy (which includes outpatient speech-language pathology); and
- Occupational therapy.

Section 4541(c) of the BBA required application of a financial limitation to all outpatient rehabilitation services (with the exception of outpatient departments of a hospital). In 1999, an annual per beneficiary limit of $1,500 applied to all outpatient physical therapy services (including speech-language pathology services). A separate limit applied to all occupational therapy services. The limit is based on incurred expenses and includes applicable deductible ($100) and coinsurance (20 percent). The BBA provided that the limits be indexed by the Medicare Economic Index (MEI) each year beginning in 2002.

The limitation is based on the services the Medicare beneficiary receives, not the type of practitioner who provides the service. Therefore, physical therapists, speech-language pathologists, occupational therapists as well as physicians and certain non-physicians practitioners could render a therapy service.

As a transitional measure, effective in 1999, providers/suppliers were instructed to keep track of the allowed incurred expenses. This process was put in place to assure providers/suppliers did not bill Medicare for patients who exceeded the annual limitations for physical therapy, and for occupational therapy services rendered by individual providers/suppliers.

B - Moratoria on Therapy Claims

Section 221 of the Balanced Budget Refinement Act *(BBRA)* of 1999 placed a 2-year moratorium on the application of the financial limitation for claims for therapy services with dates of service January 1, 2000, through December 31, 2001.

Section 421 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act *(BIPA)* of 2000, extended the moratorium on application of the financial limitation to claims for outpatient rehabilitation services with dates of service January 1, 2002, through December 31, 2002. Therefore, the moratorium was for a 3-year period and applied to outpatient rehabilitation claims with dates of service January 1, 2000, through December 31, 2002.

In 2003, there was not a moratorium on therapy caps. Implementation was delayed until September 1, 2003. Therapy caps were in effect for services rendered on September 1, 2003 through December 7, 2003.

Congress re-enacted a moratorium on financial limitations on outpatient therapy services on December 8, 2003 that extends through December 31, 2005.

C - Application of Financial Limitation (FIs and Carriers) ***September 1, 2003 through December 7, 2003.***

Financial limitations on outpatient therapy services began for services *rendered* on or after September 1, 2003 *and continued through December 7, 2003. Limits will not apply to claims received on or after December 8, 2003, through December 31, 2005, regardless of the date services were rendered.*

For *claims received during the dates when limitations were in effect in* the calendar year 2003, the limit for outpatient physical therapy and speech-language pathology combined *wa*s $1590; the limit for occupational therapy *wa*s $1590. Contractors apply the financial limitation for occupational therapy and physical therapy (including speech-language pathology) service to claims *received* on and after September 1, 2003 through *December 7, 2003.* The full $1590 amount for each limit applies to that time period in 2003.

When the therapy limitations were in effect in 2003, the Common Working File (CWF) track*ed* the physical therapy (which includes speech-language pathology services) and the occupational therapy financial limitation for outpatient rehabilitation services.

NOTE: Shared System Maintainers are not responsible for tracking the dollar amounts of incurred expenses of rehabilitation services for each therapy limitation.

This financial limitation *wa*s an annual per beneficiary limitation. The limitation *wa*s on the allowed incurred expenses, which *we*re defined as the Medicare Physician Fee Schedule (MPFS) amount prior to any application of deductible ($100) and coinsurance (20 percent). If the beneficiary ha*d* already satisfied the Medicare Part B deductible, the maximum amount payable by the Medicare program *wa*s 80 percent of each annual limit. The beneficiary *wa*s responsible for paying the remaining 20 percent co-insurance.

See the following examples, which are based on the 2003 limits of $1590:

EXAMPLE I - Part B Deductible Previously Met:

$1,590 (2003 MPFS total allowed amount) x 80 percent = $1,272 (Medicare reimbursement).

The amount applied to the limitation in this example is $1,590. The Medicare program pays $1,272 and the beneficiary is responsible for $318 co-insurance.

EXAMPLE II - Part B Deductible Not Met:

$1,590 (2003 MPFS total allowed amount) - $100 (Part B deductible) = $1,490

$1,490 x 80 percent = $1,192 (Medicare reimbursement)

The amount applied to the limitation in this example is $1,590. The Medicare program pays $1,192 and the beneficiary is responsible for $398 ($100 Part B deductible and $298 co-insurance).

EXAMPLE III - Part B Deductible Previously Met:

$800 (MPFS allowed amount) x 80 percent = $640 (Medicare reimbursement).

The amount applied to the limitation in this example is $800. The Medicare program pays $640 and the beneficiary is responsible for $160 coinsurance.

EXAMPLE IV - Part B Deductible Not Met:

$800 (MPFS allowed amount) - $100 (Part B deductible) = $700

$700 x 80 percent = $560 (Medicare reimbursement).

The amount applied to the limitation in this example is $800. The Medicare program pays $560 and the beneficiary is responsible for $240, ($100 Part B Deductible and $140 coinsurance.)

NOTE: In the above examples the MPFS allowed amount is the lower of charges or the MPFS rate times the unit.

D - MSN Messages

Contractors shall provide the following "therapy caps alert" on all MSNs. The MSN change is required as soon as possible, *but within two weeks of issuance of CR 3005.* Contractors shall print the message in bold, to the extent that it is feasible without shared systems changes.

ALERT: Starting with services received on September 1, 2003, through *December 7, 2003,* coverage by Medicare *was* limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services. *When limits were in effect*, the limits *we*re $1,590 for PT and SLP combined and $1,590 for OT. Medicare pays up to 80 percent of the limits. These limits don't apply to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility.

From December 8, 2003 through December 31, 200*5*, *outpatient therapy services (PT, OT,* and SLP) are not limited by *a dollar amount*. If you have questions, please call 1-800-MEDICARE.

Spanish Translation

Alerta: La cubierta de Medicare para servicios ambulatorios de terapia física, patología del habla y terapia ocupacional recibidos entre el 1 de septiembre del 2003 hasta el 7 de diciembre del 2003 era limitada. Durante el período en que los límites estaban en vigencia, el límite combinado para las terapias físicas y del habla era de $1,590. Además, había un límite separado de $1,590 para las terapias ocupacionales. De estos límites, Medicare paga hasta el 80%. Estos límites no se aplican a la terapia que usted recibe como servicio ambulatorio en un hospital, a menos que usted resida en un centro de enfermería especializada y que ocupe una cama certificada por Medicare.

Desde el 8 de diciembre del 2003 hasta el 31 de diciembre del 2005, no se le aplicaran límites a los servicios ambulatorios de las terapias físicas, ocupacionales y del habla. Si tiene preguntas, for favor llame al 1-800-MEDICARE.

Existing MSN messages 17.13, and the new MSN messages 17.18 and 17.*19 have been revised to indicate therapy caps were removed. They* shall be issued on all claims *services received between December 8, 2003 and the earliest date contractors can modify systems to appropriately remove them.*

MSN *messages have* been revised to read:

English 17.13

17.13 - *During the period September 1, 2003 through December 7, 2003, Medicare approved a limited dollar amount each year for physical therapy, speech-language pathology services and occupational therapy services. Therapy services are not limited by dollar amount from December 8, 2003 through December 31, 2005.*

Spanish Translation *17.13*
17.13 - *Medicare había aprobado un límite de dinero para cada año por servicios de terapias físicas, del habla y ocupacionales (en el 2003, el período de la cubierta limitada fue entre el 1 de septiembre del 2003 hasta el 7 de diciembre del 2003). No habrá un límite de dinero para las terapias recibidas entre el 8 de diciembre del 2003 hasta el 31 de diciembre del 2005.*

English 17.18
17.18 - *Physical therapy and speech-language pathology services were limited during part of 2003, but those limits no longer apply. Services will not be denied because of therapy caps.*

Spanish Translation *17.18*
17.18 - *La cobertura de las terapias física y del habla estaba limitada durante parte del año 2003, pero esa limitación ya no es vigente. La cobertura por servicios de terapias no será negada por motivo de los límites del 2003.*

English 17.19
17.19 - *Occupational therapy services were limited during part of 2003, but those limits no longer apply. Services will not be denied because of therapy caps.*

Spanish Translation *17.19*

17.19 - *La cobertura de las terapias ocupacionales estaba limitada durante parte del año 2003, pero esa limitación ya no es vigente. La cobertura por servicios de terapias no será negada por motivo de los límites del 2003.*

Contractors shall use the existing Medicare Summary Notice message 17.6 to inform the beneficiaries that they have reached the financial limitation *in cases where it applies on or prior to December 7, 2003.* Contractors apply this message at the line level:

> 17.6 - Full payment was not made for this service because the yearly limit has been met.

Spanish translation

> 17.6 - Debido a que usted alcanzó su límite anual por este servicio, no se hará un pago completo.

E - FI Requirements

1. General Requirements

Regardless of financial limits on therapy services, CMS requires modifiers (See Sec. 20.1 of this chapter) on specific codes for the purpose of data analysis. Edit to ensure that the therapy modifiers (See Sec. 20.1 of this chapter) are present on a claim based on the presence of revenue codes 042X, 043X, or 044X. Claims containing revenue codes 042X, 043X, or 044X without a therapy modifier GN, GO, or GP should be returned to the provider.

Beneficiaries may not be simultaneously covered by Medicare as an outpatient of a hospital and as a patient in another facility. They must be discharged from the other setting and registered as a hospital outpatient in order to receive payment for outpatient rehabilitation services in a hospital outpatient setting after the limitation has been reached.

A hospital may bill for services of a facility as hospital outpatient services if that facility meets the requirements of a department of the provider (hospital) under 42 CFR 413.65. Facilities that do not meet those requirements are not considered to be part of the hospital and may not bill under the hospital's provider number, even if they are owned by the hospital. For example, services of a Comprehensive Outpatient Rehabilitation Facility (CORF) must be billed as CORF services and not as hospital outpatient services, even if the CORF is owned by the hospital. Only services billed by the hospital as bill type 12X or 13X are exempt from limitations on therapy services.

2. When financial limits are in effect.

The CWF applies the financial limitation to the following bill types 22X, 23X, 34X, 74X, and 75X, using the MPFS allowed amount (before adjustment for beneficiary liability). The reimbursement field portion of the CWF record is not used by the CWF to track the financial limitation. The CWF creates a new "line-level" field entitled "Financial Limitation" to be used by Shared Systems to transmit to CWF the amount to be applied to the limitation. The CWF also creates a new line level override code value to be reported in situations where the MPFS allowed amount exceeds the limitation available. This override code can also be used for appeals. (See "FI Action Based on CWF Trailer" below for additional information.)

For SNFs, *the financial* limitation does apply to rehabilitation services furnished to those SNF residents in noncovered stays (bill type 22X) who are in a Medicare-certified section of the facility--i.e., one that is either certified by Medicare alone, or is dually certified (by Medicare as a SNF and by Medicaid as a nursing facility (NF)). For SNF residents, consolidated billing requires all outpatient rehabilitation services be billed to Part B by the SNF. If a resident has reached the financial limitation, and remains in the Medicare-certified section of the SNF, no further payment will be made to the SNF or any other entity. Therefore, SNF residents who are subject to consolidated billing may not obtain services from an outpatient hospital after the cap has been exceeded.

Once the financial limitation has been reached, SNF residents who are in a **non-Medicare certified** section of the facility--i.e., one that is certified only by Medicaid as a NF, or that is not certified at all by either program--FIs use bill type 23X (see CR 2674). For SNF residents in non-Medicare certified portions of the facility and SNF nonresidents who go to the SNF for outpatient treatment (bill type 23X), medically necessary outpatient therapy may be covered at an outpatient hospital facility after the financial limitation has been exceeded.

Limitations do not apply for SNF residents in a covered Part A stay, including swing beds. Rehabilitation services are included within the global Part A per diem payment that the SNF receives under the PPS for the covered stay. Similarly, limitations do not apply to any therapy services billed under PPS Home Health, or inpatient hospitals including critical access hospitals.

F - Carrier Requirements when Financial Limits are in Effect

All claims containing any of the following list of "Applicable Outpatient Rehabilitation HCPCS Codes" should contain one of the therapy modifiers (GN, GO, GP) except as follows: Claims from physicians (all specialty codes) and nonphysician practitioners, including specialty codes "50," "89," and "97" do not have to contain modifiers for the HCPCS codes for casts and splints as noted with a "+" sign below.

For all other claims submitted by physicians or nonphysician practitioners (as noted above) containing these applicable HCPCS codes without therapy modifiers, return the claim as unprocessable.

If specialty codes "65" and "67" are present on the claim and an applicable HCPCS code is without one of the therapy modifiers (GN, GO, or GP) the carrier returns the claim as unprocessable.

The CWF will capture the amount and apply it to the limitation whenever a service is billed using the GN, GO, or GP modifier. The CWF must also disable the edit involving specialty codes "65" and "67" and Type of Service W or U.

Once the financial limitation has been reached, beneficiaries may receive outpatient rehabilitation services furnished directly by or under arrangement with a hospital.

G* - Additional Information for Carriers and FIs *during the time financial limits are in effect.

Once the limitation is reached, if a claim is submitted, CWF returns an error code stating the financial limitation has been met. Over applied lines will be identified at the line level. The outpatient rehabilitation therapy services should be denied. The FIs use group code PR and claim adjustment reason code 119, benefit maximum for this time period has been reached, in the provider remittance advice to establish the reason for denial. The provider/physician/supplier should advise the beneficiary that a claim for services that exceeds the limitation is being denied pursuant to §1833(g) of the Act (42 U.S.C. §1395(g)). The providers/suppliers should inform the beneficiary that any additional outpatient rehabilitation services in this setting would result in the beneficiary exceeding the financial limitation, but medically necessary services above the limit may be obtained at an outpatient hospital. Such notification will allow the beneficiary to make an informed choice about continuing to receive services from the provider/physician/supplier or to change to a hospital outpatient department. This is advised because the beneficiary is responsible for payment of all outpatient rehabilitation services that exceeded the financial limitation on an annual basis.

In situations where a beneficiary is close to reaching the financial limitation and a particular claim might exceed the limitation, the provider should bill the usual and customary charge for the service furnished even though such charge might exceed the limit. For example, using the 2003 limit of $1590, a beneficiary to date received services for which the total amount of payment and the beneficiary co-insurance total $1,575**.** The beneficiary then received 3 services - 1 at $50; 1 at $25; and 1 at $30. The CWF will return an error code/trailer that will identify the line that exceeds the limitation.

When the financial limitation has been exceeded and the beneficiary chooses to continue treatment at a setting other than the outpatient hospital where medically necessary services are covered, the services may be billed at the rate the provider/supplier determines. Services provided in a capped setting after the limitation has been reached are not Medicare benefits and are not governed by Medicare policies.

Beneficiaries may appeal claims denied due to exceeding therapy caps. The beneficiary is to be advised of his or her appeal rights set forth in 42 CFR Part 405, Subpart G. Physicians, therapists, and other suppliers who accept assignment may also appeal denials. Physicians, therapists, and other suppliers who do not accept assignment and institutional providers do not have the right to appeal.

H **- FI Action Based on CWF Trailer** ***during the time therapy limits are in effect.***

Upon receipt of the CWF error code/trailer, FI are responsible for assuring that payment does not exceed the financial limitations*, when the limits are in effect,* (except as noted below).

In cases where a claim line partially exceeds the limit, the FI must adjust the line based on information contained in the CWF trailer. For example, where the MPFS allowed amount is greater than the financial limitation available, always report the MPFS allowed amount in the "Financial Limitation" field of the CWF record and include the CWF override code. See example below for situations where the claim contains multiple lines that exceed the limit.

EXAMPLE (based on 2003 limit of $1590):

Services received to date: $1,575

Incoming claim: Line 1 MPFS allowed amount of $50.00

Line 2 MPFS allowed amount of $25.00

Line 3 MPFS allowed amount of $30.00

Based on this example, lines 1 and 3 are denied and line 2 is paid. The FI reports in the "Financial Limitation" field of the CWF record $25.00 along with CWF override code. The FI always applies the amount that would least exceed the limit. Since the FI systems cannot split the payment on a line, CWF will allow payment on the line that least exceeds the limit and deny other lines.

I* - Provider Notification *for Beneficiaries Exceeding therapy limits September 1, 2003 through claims received on December 7, 2003.

Contractors will advise providers/suppliers that they may use the Notice of Exclusions from Medicare Benefits (NEMB Form No. CMS-20007 & Formulario No. CMS-20007) or a similar form of their own design to notify beneficiaries of the therapy financial limitations and that these limits are applied in all settings except hospital outpatient departments. ABNs cannot be used because of the statutory nature of the financial limitations. Therefore, providers/suppliers should inform beneficiaries that beneficiaries are responsible for 100 percent of the costs of therapy services above each respective therapy limit, unless this outpatient care is furnished directly or under arrangement by a hospital. It is the provider's responsibility to present each beneficiary with accurate information about the therapy limits and that, where necessary, appropriate care above the limit*s* can be obtained at a hospital outpatient therapy department. Advise providers/suppliers to use the Notice of Exclusion from Medicare Benefits (NEMB) form to inform beneficiaries of the therapy financial limitation at their first therapy encounter with the beneficiary. When using the NEMB form, the practitioner checks box number 1 and writes the reason for denial in the space provided at the top of the form. Provide the following reason: "Medicare will not pay for physical therapy and speech-language pathology services over (add the dollar amount of the cap and the year or the dates of service to which it applies)." This same information is provided for occupational therapy services over the limit for the same time period, as appropriate.

The NEMB form can be found at: http://www.cms.hhs.gov/medlearn/refabn.asp

All providers/suppliers and contractors may access the accrued amount of therapy services from the ELGA and ELGB screens in the HIPAA system. Providers who bill to FIs will also find the amount a beneficiary has accrued toward the financial limitations on the HIQA. Suppliers who do not have access to the HIPAA system may call the contractor to obtain the amount accrued.

20 - HCPCS Coding Requirement

(Rev. 42, 12-08-03)

A3-3653, SNF-532, AB-00-39

A. Uniform Coding

Section 1834(k)(5) of the Act requires that all claims for outpatient rehabilitation, certain audiology services and CORF services be reported using a uniform coding system. The HCPCS is the coding system used for the reporting of these services.

Effective for claims submitted on or after April 1, 1998, providers that had not previously reported HCPCS for outpatient rehabilitation and CORF services began using HCPCS to report these services and certain audiology services. This requirements does not apply to outpatient rehabilitation and audiology services provided by:

- Critical Access Hospitals, which are paid on a cost basis, not MPFS;
- RHCs, and FQHCs for which therapy is included in the all-inclusive rate; or
- Providers that do not furnish therapy services.

The following "providers of services" must bill the FI for outpatient rehabilitation services using HCPCS codes:

- Hospitals (to outpatients and inpatients who are not in a covered Part A 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 (POC));
- Comprehensive outpatient rehabilitation agencies (CORFs); and
- Outpatient physical therapy providers (OPTs), i.e., outpatient physical therapy facilities.

Note that the requirements for hospitals and SNFs apply to inpatient Part B and outpatient services only. Inpatient Part A is included in the respective PPS rate and not billed separately.

For HHAs, HCPCS 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.

B **- Applicable Outpatient Rehabilitation HCPCS Codes**

Regardless of financial limitation, CMS identifies the following codes as therapy services. *Codes* without + signs always require *t*herapy modifiers. Codes with + signs need modifiers when the*y* represent therapy services.

The financial *limits (when in effect) apply to services represented by the* following codes, except as noted below. (NOTE: Listing of the following codes does not imply that services are covered.)

29065+	29075+	29085+	29086+	29105+	29125+
29126+	29130+	29131+	29200+	29220+	29240+
29260+	29280+	29345+	29355+	29365+	29405+

29425+	29445+	29505+	29515+	29520+	29530+
29540+	29550+	29580+	29590+	64550+	90901+
90911+	92506	92507	92508	92526	92597
92607	92608	92609	92610+	92611+	92612+
92614+	92616+	95831+	95832+	95833+	95834+
95851+	95852+	96000+	96001+	96002+	96003+
96105+	96110+◆	96111+	96115+	97001	97002
97003	97004	97010****	97012	97016	97018
97020	97022	97024	97026	97028	97032
97033	97034	97035	97036	97039	97110
97112	97113	97116	97124	97139	97140
97150	97504**	97520	97530	97532	97533
97535	97537	97542	97601+	*97602****	97703
97750	97755	97799*	G0279+***	G0280+***	G0281
G0283	0020T+***	0029T+***			

* The physician fee schedule abstract file does not contain a price for codes 96110, 97799, since the carrier prices them. Therefore, the FI must contact the carrier to obtain the appropriate fee schedule amount in order to make proper payment for these codes.

◆ Effective January 1, 2004, 96110 will be an active code on the physician fee schedule. Carriers shall no longer price this code.

** Code 97504 should not be reported with code 97116. However, if code 97504 was performed on an upper extremity and code 97116 (gait training) was also performed, both codes may be billed with modifier 59 to denote a separate anatomic site.

*** The physician fee schedule abstract file does not contain a price for codes G0279, G0280, 0020T, 0029T since they are priced by the carrier. In addition, the carrier determines coverage for these codes. Therefore, the FI contacts the carrier to obtain the appropriate fee schedule amount.

****Code*s* 97010 *and 97602 are* bundled. *They are* bundled with any therapy code*s*. Regardless of whether *they are* billed alone or in conjunction with another therapy code, never make payment separately for th*ese codes*. If billed alone, *either code* should be denied using the existing EOMB/MSN language. For remittance advice notices, use group code CO and claim adjustment reason code 97 that says: "Payment is included in the allowance for another service/procedure." Use reason code 97 to deny a procedure code that should have been bundled. *Alternatively, reason code B15, which has the same intent, may also be used.*

+ *Codes marked + sometimes represent therapy services. These codes and all codes on the above list always represent therapy services when performed by therapists.*

*There are some circumstances when t*hese codes will not *be considered representative of therapy services and therapy limits (when they are in effect) will not apply. Codes marked + are not therapy services w*hen they are not done under a therapy plan of care *and* they are billed by providers of services who *are not therapists. That is, they* are represented by any specialty codes except 65 and 67 (PT in Private Practice, OT in Private Practice), 73 and 74. *Specialty codes 73 and 74* were incorrectly noted in AB-03-018 and have since been reassigned to specialties that are not therapy services. Since removal requires system changes, they will be removed in a future (non-emergency) instruction.

The Codes marked + on the above list may not be used by non-therapist practitioners without a therapy modifier in situations where the service provided is integral to an outpatient rehabilitation therapy service.

"Outpatient rehabilitation therapy" refers to skilled PT, OT and SLP services, requiring the skills of qualified professional personnel such as physical therapists, occupational therapists or speech-language pathologists, performed for restorative purposes and generally involving ongoing treatments. In contrast, a non-therapy service (usually a one-time service) is a service performed by non-therapist practitioners, without rehabilitative plan or goals, e.g., application of a cast to stabilize and protect a fracture. Contractors have discretion to determine whether circumstances *require a plan or* describe a therapy service.

Physicians and non-physician practitioners who can appropriately provide the services represented by the codes marked + on the above list should only use therapy modifiers (GP, GN, GO) with the above codes when the services are outpatient rehabilitation therapy services provided under a therapy plan of care.

Codes on the above list that do not have a + sign are considered "always therapy" codes and always require a therapy modifier. Therapy services, whether represented by "always therapy" codes, or + codes in the above list performed as outpatient rehabilitation therapy services, must follow all the policies for therapy services (e.g., Pub. 100-04, Chapter 5; Pub. 100-02, Chapter 15).

C - Additional HCPCS Codes

OPTs may also bill for the following outpatient non-rehabilitation HCPCS codes:

95860, 95861, 95863, 95864, 95867, 95869, 95870, 95900, 95903, 95904, 95934, G0237, G0238*, G0239*

*The physician fee schedule abstract file described below does not contain a price for codes G0238 and G0239, since the carrier prices them. Therefore, the FI contacts its carrier to obtain the appropriate fee schedule amount in order to make proper payment for these codes.

NOTE: The above list of codes is intended to facilitate the FI's ability to pay claims under the MPFS. It is not intended to be a list of all covered OPT services and does not assure coverage of these services.

20.1 - Discipline Specific Outpatient Rehabilitation Modifiers - All Claims

(Rev. 42, 12-08-03)

A3-3653, AB-00-01, SNF-532.G, AB-03-057

Modifiers are used to identify therapy services whether or not financial limitations are in effect. When limitations are in effect, the CWF tracks the financial limitation based on the presence of therapy modifiers. Providers/suppliers must continue to report one of these modifiers for any therapy code on the list of applicable therapy codes except as noted in §10.2 of this chapter. These modifiers do not allow a provider to deliver services that they are not qualified and recognized by Medicare to perform. Therapy modifiers should never be used with codes that are not on the list of applicable therapy codes.

The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered:

GN Services delivered under an outpatient speech-language pathology plan of care;

GO Services delivered under an outpatient occupational therapy plan of care; or,

GP Services delivered under an outpatient physical therapy plan of care.

This is applicable to all claims from physicians, NPPs, PTPPs, OTPPs, CORFs, OPTs, hospitals, SNFs, and any others billing for physical therapy, *speech-language pathology or occupational therapy services as noted on the applicable code list in §10.2 of this chapter.*

Modifiers refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services. For example, respiratory therapy services, or nutrition therapy services shall not be represented by the codes, which require GN, GO, and GP modifiers.