

CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 759

Department of Health &
Human Services (DHHS)

Center for Medicare &
Medicaid Services (CMS)

Date: NOVEMBER 18, 2005
CHANGE REQUEST 4115

NOTE: This instruction was previously communicated as sensitive and controversial. This instruction is no longer sensitive and may be posted to your web site as early as today, November 25, 2005.

SUBJECT: Therapy Caps to be Effective January 1, 2006

I. SUMMARY OF CHANGES: Financial Limitation of therapy services (therapy caps) are scheduled to be implemented on January 1, 2006 in the same manner that they were implemented in September 1, 2003, except the dollar amount.

NEW/REVISED MATERIAL

EFFECTIVE DATE: January 1, 2006

IMPLEMENTATION DATE: January 3, 2006

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	5/10.2/The Financial Limitation
R	5/20.1/Discipline Specific Outpatient Rehabilitation Modifiers - All Claims

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 759	Date: November 18, 2005	Change Request 4115
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SUBJECT: Therapy Caps to be Effective January 1, 2006

I. GENERAL INFORMATION

A. Background: Financial limitations of therapy services (therapy caps) were initiated by the Balanced Budget Act of 1997 and were implemented in 1999 and for a short time in 2003. Congress placed moratoria on the limits for 2004 and 2005. Caps are scheduled to be implemented on January 1, 2006. This change request includes the dollar amount for the 2006 caps. For more information, refer to Medicare Pub. 100-04, the Medicare Claims Processing Manual, chapter 5, section 10.2. The business requirements below reflect only instructions not previously communicated to contractors via other change requests and not previously in the manual section cited above.

B. Policy: Financial limitations on therapy services will be implemented according to statute on January 1, 2006.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
4115.1	CWF shall change the dollar amount for the limitation on physical therapy and speech-language pathology services combined to \$1740 for dates of service from January 1, 2006 through December 31, 2006.			X		X			X	
4115.2	CWF shall change the dollar amount for the limitation on occupational therapy services combined to \$1740 for dates of service from January 1, 2006 through December 31, 2006.			X		X			X	

4115.3	<p>CWF shall apply the financial limitation described in 4115.1 and 4115.2 in the order of date received for claims having the following conditions:</p> <ol style="list-style-type: none"> 1. Dates of service from January 1, 2006 through December 31, 2006. 2. Modifier of GN, GO, or GP 3. Place of service code (where applicable) not equal to 22 (outpatient hospital) or 23 (emergency room-hospital) 								X	
4115.4	<p>CWF shall exclude from the financial limitation described in 4115.1 and 4115.2 claims having the following conditions:</p> <ol style="list-style-type: none"> 1. Dates of service from January 1, 2006 through December 31, 2006. 2. Modifier of GN, GO, or GP 3. Place of service code equals 22 (outpatient hospital) or 23 (emergency room-hospital) 								X	
4115.5	<p>Contractors shall deny claims for outpatient therapy services exceeding the financial limit described in 4115.1 and 4115.2 as indicated by CWF and as appropriate according to Medicare policy.</p>	X	X	X						
4115.6	<p>Contractors shall modify Medicare Summary Notices (MSNs) 17.13, 17.18, and 17.19 such that when the calendar year is 2006, the (\$) limit is \$1740, effective January 1, 2006.</p>	X	X	X						
4115.7	<p>Contractors shall modify and print in the General Information section of all Medicare Summary Notices (MSNs) the Therapy ALERT message. It should be printed as follows:</p> <p>ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2006. The limits are \$1,740 for PT and SLP combined and \$1,740 for OT. Medicare pays up to 80</p>	X	X	X						

	<p>percent of the limits after the deductible has been met. 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. If you have questions, please call 1-800-MEDICARE.</p> <p><u>Spanish Translation</u></p> <p>ALERTA: La cobertura de Medicare estará limitada para los servicios de terapia física ambulatoria (PT, por sus siglas en inglés), terapia de patología del habla (SLP, por sus siglas en inglés), y terapia ocupacional (OT) si son recibidos entre el 1 de enero de 2006 y el 31 de diciembre de 2006. Estos límites son \$1,740 para PT y SLP combinados y \$1,740 para OT. Medicare paga hasta 80 por ciento de los límites después que se haya pagado el deducible. Estos límites no se aplican a la terapia que usted obtenga en los departamentos de hospital para paciente ambulatorio, a menos que usted sea un residente y ocupe una cama certificada por Medicare en un centro de enfermería especializada. Si tiene preguntas, por favor llame GRATIS al 1-800-MEDICARE.</p>								
4115.8	Contractors shall change any references in their educational materials to reflect therapy limits for CY 2006 as \$1740 for physical therapy and speech language pathology combined and \$1740 for occupational therapy.	X	X	X					
4115.9	The CWF shall display the therapy cap amount applied per beneficiary on all CWF inquiry screens (HIMR, HIQA, HUQA, HIQH, ELGA, ELGB, and ELGH).							X	
4115.10	In processing claims where Medicare is the secondary payer, the shared system takes the lowest secondary payment amount from MSPPAY and sends this amount to CWF as the amount applied to therapy limits.				X	X			

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)
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		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
4115.11	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X						

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: January 1, 2006 Implementation Date: January 3, 2006</p> <p>Pre-Implementation Contact(s): Claudette Sikora, 410-786-5618 (carrier billing), Yvonne Young, 410-786-1886 (FI Billing); Dorothy Shannon, 410-786-3396 (cap policy);</p> <p>Post-Implementation Contact(s): Regional office</p>	<p>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.</p>
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10.2 - The Financial Limitation

(Rev.759, Issued: 11-18-05, Effective: 01-01-06, Implementation: 01-03-06)

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 *(except those furnished by or under arrangements with 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 and coinsurance. 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 nonphysician 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. In 2003 and later, the limitation was applied through CMS systems.

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. Caps will be implemented again on January 1, 2006 unless there is legislation to change them before that time.

C. Application of Financial Limitation (FIs and Carriers) January 1, 2006 through December 31, 2006

Financial limitations on outpatient therapy services begins for therapy services rendered on or after on January 1, 2006, and continues through December 31, 2006. The annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is \$1740; the limit for occupational therapy is \$1740. Limits apply to outpatient Part B therapy services from all settings except outpatient hospital (place of service code 22 on carrier claims) and hospital emergency room (place of service code 23 on carrier claims).

Contractors apply the financial limitations to the allowed amount for therapy services for each beneficiary. The allowed amount is the amount in the Medicare Physician Fee Schedule (or the amount charged if it is smaller) less the coinsurance (20 percent) and any deductible that may apply. If the deductible has been met prior to submission of a therapy claim for \$1740 of services, Medicare will pay 80 percent of the allowed amount (\$1392) and the beneficiary will pay the 20 percent coinsurance (\$348). If the deductible has not been met, the beneficiary will also pay the deductible amount of \$124 for 2006. For claims with dates of service from January 1, 2006, through December 31, 2006, Medicare shall apply these financial limitations in order, according to the dates when the claims were received. When limitations apply, the Common Working File (CWF) tracks the limits. Shared System Maintainers are not responsible for tracking the dollar amounts of incurred expenses of rehabilitation services for each therapy limit.

In processing claims where Medicare is the secondary payer, the shared system takes the lowest secondary payment amount from MSPPAY and sends this amount on to CWF as the amount applied to therapy limits.

D. MSN Messages

Existing MSN message 38.18 shall continue to appear on all Medicare MSN forms. It has been updated to the following:

- *ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2006. The limits are \$1,740 for PT and SLP combined and \$1,740 for OT. Medicare pays up to 80*

percent of the limits after the deductible has been met. 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. If you have questions, please call 1-800-MEDICARE.

Spanish Translation:

ALERTA: La cobertura de Medicare estará limitada para los servicios de terapia física ambulatoria (PT, por sus siglas en inglés), terapia de patología del habla (SLP, por sus siglas en inglés), y terapia ocupacional (OT) si son recibidos entre el 1 de enero de 2006 y el 31 de diciembre de 2006. Estos límites son \$1,740 para PT y SLP combinados y \$1,740 para OT. Medicare paga hasta 80 por ciento de los límites después que se haya pagado el deducible. Estos límites no se aplican a la terapia que usted obtenga en los departamentos de hospital para paciente ambulatorio, a menos que usted sea un residente y ocupe una cama certificada por Medicare en un centro de enfermería especializada. Si tiene preguntas, por favor llame GRATIS al 1-800-MEDICARE.

Existing MSN messages 17.13, 17.18 and 17.19 shall be issued on all claims containing outpatient rehabilitation services as noted in this PM. Add applied amount for individual beneficiaries and the generic limit amount (e.g., \$1740 in 2006) to all MSN that require them.

- 17.13 - Medicare approves a limited dollar amount each year for physical therapy and speech-language pathology services and a separate limit each year for occupational therapy services when billed by providers, physical and occupational therapists, physicians, and other non-physician practitioners. Medically necessary therapy over these limits is covered when received at a hospital outpatient department.*

Spanish Translation

17.13 - Cada año, Medicare aprueba una cantidad límite por servicios de terapia física y patología del lenguaje. Anualmente también aprueba otra cantidad límite por servicios de terapia ocupacional cuando son facturados por proveedores, terapeutas físicos y ocupacionales, médicos y otros practicantes no médicos. La terapia que es médicamente necesaria y que sobrepasa estas cantidades límites está cubierta cuando se recibe en una unidad de hospital ambulatorio.

- 17.18 (\$) has been applied during this calendar year (CCYY) towards the (\$) limit on outpatient physical therapy and speech-language pathology benefits.*

Spanish Translation

17.18 - En este año (CCYY), (\$) han sido deducidos de la cantidad límite de (\$) por los beneficios de terapia física ambulatoria y de patología del lenguaje hablado.

- *17.19 (\$) has been applied during this calendar year (CCYY) towards the (\$) limit on outpatient occupational therapy benefits.*

Spanish Translation

17.19 - En este año (CCYY), (\$) han sido deducidos de la cantidad límite de (\$) por los beneficios de terapia ocupacional ambulatoria.

Carriers and intermediaries shall use the existing Medicare Summary Notice message 17.6 to inform the beneficiaries that they have reached the financial limitation. 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 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, GP, or GO 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 42CFR 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 a 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).

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. 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. Also, 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

Claims containing any of the “Applicable Outpatient Rehabilitation HCPCS Codes” in section 20 below marked “always therapy” (underlined) codes should contain one of the therapy modifiers (GN, GO, GP). All claims submitted for codes underlined but without a therapy modifier shall be returned as unprocessable.

When any code on the list of “Applicable Outpatient Rehabilitation HCPCS Codes” codes are submitted with specialty codes “65” (physical therapist in private practice), and “67” (occupational therapist in private practice), they always represent therapy services, because they are provided by therapists. Carriers shall return claims for these services when they do not contain therapy modifiers for the applicable HCPCS codes.

The “Applicable Outpatient Rehabilitation HCPCS Codes in section 20 of this chapter that are marked (+) are sometimes therapy codes. Claims from physicians (all specialty codes) and nonphysician practitioners, including specialty codes “50,” “89,” and “97” may be processed without therapy modifiers. On review of these claims, services that are not accompanied by a therapy modifier must be documented, reasonable and necessary, and payable as physician or nonphysician practitioner services, and not services that the contractor interprets as therapy services.

The CWF will capture the amount and apply it to the limitation whenever a service is billed using the GN, GO, or GP modifier, except when the place of service code is 22 (outpatient hospital) or 23 (emergency room-hospital). The CWF has disabled the edit involving specialty codes “65” and “67” and Type of Service W or U.

G. FI Action Based on CWF Trailer During the Time Therapy Limits are in Effect

Upon receipt of the CWF error code/trailer, FIs 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 the 2006 limit of \$1740 for a beneficiary who has paid the deductible and the coinsurance:*

*Services received to date \$1725 (\$15 under the limit)
Incoming claim: Line 1 MPFS allowed amount is \$50.
Line 2 MPFS allowed amount is \$25.
Line 3, MPFS allowed amount is \$30.*

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 the 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.

H. Additional Information for Carriers and FIs During the Time Financial Limits are in Effect

Once the limit 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 that exceed the limit should be denied. The FIs and carriers 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/supplier should advise the beneficiary that a claim for services that exceeds the limitation is being denied pursuant to §1833(g) of the Act (42U.C.S. §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/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 exceed the financial limit 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/supplier should bill the usual and customary charges for the services furnished even though such charges might exceed the limit. The CWF will return an error code/trailer that will identify the line that exceeds the limitation.

Because CWF applies the financial limitation according to the date when the claim was received (when the date of service is within the effective date range for the limitation), it is possible that the financial limitation will have been met before the date of service of a given claim. Such claims will prompt the CWF error code and subsequent contractor denial.

When the provider/supplier knows that the limit has been reached, further billing should not occur. The provider/supplier should inform the beneficiary of the limit and their option of receiving further covered services from an outpatient hospital (unless consolidated billing rules prevent the use of the outpatient hospital setting). If the beneficiary chooses to continue treatment at a setting other than the outpatient hospital where medically necessary services may be 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 limits. The beneficiary is to be advised of his or her appeal rights set forth in 42CFR Part 405, Subpart G. Physicians, nonphysician practitioners, therapists and other suppliers who accept assignment may also appeal denials. Physicians, nonphysician practitioners, therapists and other suppliers who do not accept assignment and institutional providers do not have the right to appeal.

I. Provider Notification for Beneficiaries Exceeding Therapy Limits

Contractors will advise providers/suppliers to notify beneficiaries of the therapy financial limitations at their first therapy encounter with the beneficiary. 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 arrangements by a hospital. Patients who are residents in a Medicare certified part of a SNF may not utilize outpatient hospital services for therapy services over the financial limits, because consolidated billing rules require all services to be billed by the SNF.

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 limits can be obtained at a hospital outpatient therapy department. Advise providers/suppliers to use the Notice of Exclusion from Medicare Benefits (NEMB Form No. CMS 20007 & Formulario No. CMS 20007) form, or a similar form of their own design to inform beneficiaries of the therapy financial limitation.

NOTE: *ABNs cannot be used because of the statutory nature of the financial limitations.*

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, e.g., \$1740 in 2006)." Providers are to supply this same information 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/medicare/bni/>

All providers/suppliers and contractors may access the accrued amount of therapy services from the ELGA and ELGB screen inquiries into CWF or the HIPAA 270/271 eligibility inquiry transaction. 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 these inquiries may call the contractor to obtain the amount accrued.

20.1 - Discipline Specific Outpatient Rehabilitation Modifiers - All Claims

(Rev.759, Issued: 11-18-05, Effective: 01-01-06, Implementation: 01-03-06)

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 §20 of this chapter. *Consult §20 for the list of codes to which modifiers must be applied.* These modifiers do not allow a provider to deliver services that they are not qualified and recognized by Medicare to perform.

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, nonphysician practitioners (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 §20 of this chapter.

Modifiers GN, GO, and GP refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services. They should never be used with codes that are not on the list of applicable therapy services. For example, respiratory therapy services, or nutrition therapy services shall not be represented by the *rapy* codes which require GN, GO, and GP modifiers.