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

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(Rev. 1472, 03-06-08)

10 - Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General

(Rev. 771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33), which added §1834(k)(5) to the Social Security Act (the Act), required that all claims for outpatient rehabilitation, certain audiology services and comprehensive outpatient rehabilitation facility (CORF) services, be reported using a uniform coding system. The CMS chose HCPCS (Healthcare Common Procedure Coding System) as the coding system to be used for the reporting of these services. This coding requirement is effective for all claims for outpatient rehabilitation services including certain audiology services and CORF services submitted on or after April 1, 1998.

The BBA also required payment under a prospective payment system for outpatient rehabilitation services including audiology and CORF services. Effective for claims with dates of service on or after January 1, 1999, the Medicare Physician Fee Schedule (MPFS) became the method of payment for outpatient physical therapy (which includes outpatient speech-language pathology) services furnished by:

- Comprehensive Outpatient Rehabilitation Facilities (CORFs);
- Outpatient Physical Therapy Providers (OPTs);
- Other Rehabilitation Facilities (ORFs);
- 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); and
- Home Health Agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care (POC)).

The MPFS is used as a method of payment for outpatient rehabilitation services furnished under arrangement with any of these providers.

In addition, the MPFS is used as the payment system for audiology and CORF services identified by the HCPCS codes in §20 Assignment is mandatory.

The Medicare **allowed charge** for the services is the lower of the actual charge or the MPFS amount. The Medicare payment for the services is 80 percent of the allowed charge after the Part B deductible is met. Coinsurance is made at 20 percent of the lower of the actual charge or the MPFS amount. The general coinsurance rule (20 percent of the actual charges) does not apply when making payment under the MPFS. This is a final payment.

The MPFS does **not** apply to outpatient rehabilitation services furnished by critical access hospitals (CAHs). CAHs are to be paid on a reasonable cost basis.

Fiscal Intermediaries (FIs) process outpatient rehabilitation claims from hospitals, including CAHs, SNFs, CORFs, outpatient rehabilitation agencies, and outpatient physical therapy providers for which they have received a tie in notice from the RO. Carriers process claims from physicians, certain nonphysician practitioners (NPPs), and physical and occupational therapists in private practice (PTPPs and OTPPs). A physician-directed clinic that bills for services furnished incident to a physician's service (see Chapter 15 in Pub. 100-02, Medicare Benefit Policy Manual for a definition of "incident to") bills the carrier.

There are different fee rates for nonfacility and facility services. Chapter 23 describes the differences in these two rates. (See fields 28 and 29 of the record therein described). Facility rates apply to professional services performed in a facility other than the professional's office. Nonfacility rates apply when the service is performed in the professional's office. The nonfacility rate (that is paid when the provider performs the services in its own facility) accommodates overhead and indirect expenses the provider incurs by operating its own facility. Thus it is somewhat higher than the facility rate.

FIs pay the nonfacility rate for services performed in the provider's facility. Carriers may pay the facility or nonfacility rate depending upon where the service is performed (place of service on the claim), and the provider specialty.

Carriers pay the codes in §20 under the MPFS regardless of whether they may be considered rehabilitation services. However, FIs must use this list to determine whether to pay under outpatient rehabilitation rules or whether payment rules for other types of service may apply, e.g., OPPS for hospitals, reasonable costs for CAHs.

Note that because a service is considered an outpatient rehabilitation service does not automatically imply payment for that service. Additional criteria, including coverage, plan of care and physician certification must also be met. These criteria are described in Pub. 100-02, Medicare Benefit Policy Manual, Chapters 1 and 15.

Payment for rehabilitation services provided to Part A inpatients of hospitals or SNFs is included in the respective PPS rate. Also, for SNFs (but not hospitals), if the beneficiary has Part B, but not Part A coverage (e.g., Part A benefits are exhausted), the SNF must bill the FI for any rehabilitation service (except audiologic function services). Independent audiologists may bill the carrier directly for services rendered to Part B Medicare entitled beneficiaries residing in a SNF, but not in a SNF Part A covered stay. Payment is made based on the MPFS, whether by the carrier or the FI. For beneficiaries not in a covered Part A SNF stay, who are sometimes referred to as beneficiaries in a Part B SNF stay, audiologic function tests are payable under Part B when billed by the SNF as type of bill 22X, or when billed directly to the carrier by the provider or supplier of the service. For tests that include both a professional component and technical component, the SNF may elect to bill the technical component to the FI, but is not required to bill the

service. (The professional component of a service is the direct patient care provided by the physician or audiologist, e.g., the interpretation of a test.)

Payment for rehabilitation services provided by home health agencies under a home health plan of care is included in the home health PPS rate. HHAs may submit bill type 34X and be paid under the MPFS if there are no home health services billed under a home health plan of care at the same time, and there is a valid rehabilitation POC (e.g., the patient is not homebound).

An institutional employer (other than a SNF) of the PTPPs, OTPPs, or physician performing outpatient services, (e.g., hospital, CORF, etc.), or a clinic billing on behalf of the physician or therapist may bill the carrier on Form CMS-1500.

The MPFS is the basis of payment for outpatient rehabilitation services furnished by PTPPs and OTPPs, physicians, and certain nonphysician practitioners or for diagnostic tests provided incident to the services of such physicians or nonphysician practitioners. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, for a definition of "incident to.") Such services are billed to the Part B carrier. Assignment is mandatory.

The following table identifies the provider types or physician/nonphysician and to which contractor they may submit bills.

"Provider/Service" Type	**Bill to**	**Bill Type**	**Comment**
Inpatient hospital Part A	FI	11X	Included in PPS
Inpatient SNF Part A	FI	21X	Included in PPS
Inpatient hospital Part B	FI	12X	Hospital may obtain services under arrangements and bill, or rendering provider may bill.
Inpatient SNF Part B except for audiology function tests.	FI	22X	SNF must provide and bill, or obtain under arrangements and bill.
Inpatient SNF Part B audiology function tests only.	FI	22X	SNF may bill the FI or provider of service may bill the carrier.
Outpatient hospital	FI	13X	Hospital may provide and bill or obtain under arrangements and bill, or rendering provider may bill
Outpatient SNF	FI	23X	SNF must provide and bill or obtain under arrangements and

"Provider/Service" Type	Bill to	Bill Type	Comment
			bill
HHA billing for services rendered under a Part A or Part B home health plan of care.	FI	32X	Service is included in PPS rate. CMS determines whether payment is from Part A or Part B trust fund.
HHA billing for services not rendered under a Part A or Part B home health plan of care, but rendered under a therapy plan of care.	FI	34X	Service not under home health plan of care.
Other Rehabilitation Facility (ORF)	FI	74X	Paid MPFS for outpatient rehabilitation services effective January 1, 1999, and all other services except drugs effective July 1, 2000. Starting April 1, 2002, drugs are paid 95% of the AWP. For claims with dates of service on or after July 1, 2003, drugs and biologicals do not apply in an OPT setting. Therefore, FIs are to advise their OPTs not to bill for them.
Comprehensive Outpatient Rehabilitation Facility (CORF)	FI	75X	Paid MPFS for outpatient rehabilitation services effective January 1, 1999, and all other services except drugs effective July 1, 2000. Starting April 1, 2002, drugs are paid 95% of the AWP.
Physician, NPPs, PTPPs, OTPPs, and, for diagnostic tests only, audiologists (service in hospital or SNF)	Carrier	See Chapter 26 for place of service, and type of service coding.	Payment may not be made for therapy services to Part A inpatients of hospitals or SNFs, or for Part B SNF residents. Otherwise, carrier billing. Note that physician/ NPP/PTPP/OTPP employee of facility may assign benefits to the facility, enabling the facility to bill for physician/therapist to

"Provider/Service" Type	Bill to	Bill Type	Comment
			carrier
Physician/NPP/PTPP/OTPP office, independent clinic or patient's home	Carrier	See Chapter 26 for place of service, and type of service coding.	Paid via Physician fee schedule.
Practicing audiologist for services defined as diagnostic tests only	Carrier	See Chapter 26 for place of service, and type of service coding.	Some audiologists tests provided in hospitals are considered other diagnostic tests and are subject to HOPPS instead of MPFS for outpatient therapy fee schedule.
Critical Access Hospital - inpatient Part A	FI	85X	Rehabilitation services are paid cost.
Critical Access Hospital - inpatient Part B	FI	85X	Rehabilitation services are paid cost.
Critical Access Hospital – outpatient Part B	FI	85X	Rehabilitation services are paid cost.

Complete Claim form completion requirements are contained in Chapters 25 and 26.

For a list of the outpatient rehabilitation HCPCS codes see §20.

If an FI receives a claim for one of the these HCPCS codes with dates of service on or after July 1, 2003, that does not appear on the supplemental file it currently uses to pay the therapy claims, it contacts its local carrier to obtain the price in order to pay the claim. When requesting the pricing data, it advises the carrier to provide it with the nonfacility fee.

NOTE: The list of codes in §20 contains commonly utilized codes for outpatient rehabilitation services. FIs may consider other codes for payment under the MPFS as outpatient rehabilitation services to the extent that such codes are determined to be medically reasonable and necessary and those that could be performed within the scope of practice of the therapist providing the service.

10.1 - New Payment Requirement for Intermediaries (FIs)

(Rev. 1, 10-01-03)
A-03-011

Effective with claims with dates of service on or after July 1, 2003, OPTs/Outpatient Rehabilitation Facilities (ORFs), (74X and 75X bill type) are required to report all their services utilizing HCPCS. FIs are required to make payment for these services under the MPFS unless the item or service is currently being paid under the orthotic fee schedule or the item is a drug, biological, supply or vaccine (see below for an explanation of these services).

The CMS currently provides FIs with a CORF supplemental file that contains all physician fee schedule services and their related prices. FIs use this file to price and pay OPT claims. The format of the record layout is provided in Attachment E of PM A-02-090, dated September 27, 2002. This is located at: http://cms.hhs.gov/manuals/pm_trans/A02090.pdf.

Fiscal FIs will be notified in a one-time instruction of updates to this file and when it will be available for retrieval.

If an FI receives a claim for one of the above HCPCS codes with dates of service on or after July 1, 2003, that does not appear on the CORF supplemental file it currently uses to pay the CORF claims, it contacts its local carrier to obtain the price in order to pay the claim. When requesting the pricing data, it advises the carrier to provide it with the nonfacility fee.

10.2 - The Financial Limitation

(Rev. 1414; Issued: 01-17-08; Effective: 01-01-08; Implementation: 01-25-08)

A. Financial Limitation Prior to the Balanced Budget Refinement Act (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 (except those furnished by or under arrangements with a hospital). 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 therapy services the Medicare beneficiary receives, not the type of practitioner who provides the service. 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 and Exceptions for Therapy Claims

Section 221 of the 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 extended through December 31, 2005. Caps were implemented again on January 1, 2006 and policies were modified to allow exceptions as directed by the Deficit Reduction Act of 2005 only for calendar year 2006. The Tax Relief and Health Care Act of 2006 extended the cap exceptions process through calendar year 2007. The Medicare, Medicaid, and SCHIP Extension Act of 2007 extended the cap exceptions process for services furnished through June 30, 2008.

Future exceptions. The cap exception for therapy services billed by outpatient hospitals was part of the original legislation and applies as long as caps are in effect. Exceptions to caps based on the medical necessity of the service are in effect only when Congress legislates the exceptions, as they did for 2007. References to the exceptions process in subsection C of this section apply only when the exceptions are in effect.

C. Application of Financial Limitations

Financial limitations on outpatient therapy services, as described above, began for therapy services rendered on or after on January 1, 2006. See C 1 to C 7 of this section when exceptions to therapy caps apply. The limits were $1740 in 2006 and $1780 in 2007. For 2008, the annual limit on the allowed amount for outpatient physical therapy

and speech-language pathology combined is $1810; the limit for occupational therapy is $1810. 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). These excluded hospital services are reported on types of bill 12x or 13x on intermediary claims.

Contractors apply the financial limitations to the Medicare Physician Fee Schedule (MPFS) amount (or the amount charged if it is smaller) for therapy services for each beneficiary.

As with any Medicare payment, beneficiaries pay the coinsurance (20 percent) and any deductible that may apply. Medicare will pay the remaining 80 percent of the limit after the deductible is met. These amounts will change each calendar year. Medicare Contractors shall publish the financial limitation amount in educational articles. It is also available at 1-800-Medicare.

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.

1. Exceptions to Therapy Caps - General

The Tax Relief and Health Care Act of 2006 directed CMS to extend a process to allow for exceptions to the caps for services received in CY2007 in cases where continued therapy services are medically necessary. The following policies concerning exceptions to caps due to medical necessity apply only when the exceptions process is in effect. With the exception of the use of the KX modifier, the guidance in this section concerning medical necessity applies as well to services provided before caps are reached.

Instructions for contractors to manage automatic process for exceptions will be found in the Program Integrity Manual, chapter 3, section 3.4.1.2. Provider and supplier information concerning exceptions is in this manual and in IOM Pub. 100-02, chapter 15, section 220.3. Exceptions shall be identified by a modifier on the claim and supported by documentation.

Since the providers and suppliers will take an active role in obtaining an exception for a beneficiary, this manual section is written to address them as well as Medicare contractors.

The beneficiary may qualify for use of the cap exceptions at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps.

In 2006, the Exception Processes fell into two categories, Automatic Process Exceptions, and Manual Process Exceptions. Beginning January 1, 2007, there is no manual process for exceptions. All services that require exceptions to caps shall be processed using the automatic process. All requests for exception are in the form of a KX modifier added to claim lines. (See subsection C6 for use of the KX modifier.)

Use of the automatic process for exceptions increases the responsibility of the provider/supplier for determining and documenting that services are appropriate.

Also, use of the automatic process for exception does not exempt services from manual or other medical review processes as described in 100-08, Chapter 3, Section 3.4.1.1.1. Rather, atypical use of the automatic exception process may invite contractor scrutiny. Particular care should be taken to document improvement and avoid billing for services that do not meet the requirements for skilled services, or for services which are maintenance rather than rehabilitative treatment (See Pub. 100-02, chapter 15, sections 220.2, 220.3, and 230).

The KX modifier, described in subsection C6, is added to claim lines to indicate that the clinician attests that services are medically necessary and justification is documented in the medical record.

2. Automatic Process Exceptions

The term "automatic process exceptions" indicates that the claims processing for the exception is automatic, and not that the exception is automatic. An exception may be made when the patient's condition is justified by documentation indicating that the beneficiary requires continued skilled therapy, i.e., therapy beyond the amount payable under the therapy cap, to achieve their prior functional status or maximum expected functional status within a reasonable amount of time.

No special documentation is submitted to the contractor for automatic process exceptions. The clinician is responsible for consulting guidance in the Medicare manuals and in the professional literature to determine if the beneficiary may qualify for the automatic process exception when documentation justifies medically necessary services above the caps. The clinician's opinion is not binding on the Medicare contractor who makes the final determination concerning whether the claim is payable.

Documentation justifying the services shall be submitted in response to any Additional Documentation Request (ADR) for claims that are selected for medical review. Follow the documentation requirements in Pub. 100-02, chapter 15, section 220.3. If medical records are requested for review, clinicians may include, at their discretion, a summary that specifically addresses the justification for therapy cap exception.

In making a decision about whether to utilize the automatic process exception, clinicians shall consider, for example, whether services are appropriate to--

- The patient's condition including the diagnosis, complexities and severity (A list of the excepted evaluation codes are in C.2.a. A list of the ICD-9 codes for conditions and complexities that might qualify a beneficiary for exception to caps is in 10.2 C3. The list is a guideline and neither assures that services on the list will be excepted nor limits provision of covered and medically necessary services for conditions not on the list);

- The services provided including their type, frequency and duration;

- The interaction of current active conditions and complexities that directly and significantly influence the treatment such that it causes services to exceed caps.

In addition, the following should be considered before using the automatic exception process:

a. Exceptions for Services

Evaluation. The CMS will except therapy evaluations from caps after the therapy caps are reached when evaluation is necessary, e.g., to determine if the current status of the beneficiary requires therapy services. For example, the following evaluation procedures may be appropriate:

> 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 97001, 97002, 97003, 97004.

These codes will continue to be reported as outpatient therapy procedures as described in the Claims Processing Manual, Chapter 5, Section 20(B) "Applicable Outpatient Rehabilitation HCPCS Codes." They are not diagnostic tests. Definition of evaluations and documentation is found in Pub 100-02, sections 220 and 230.

Other Services. There are a number of sources that suggest the amount of certain services that may be typical, either per service, per episode, per condition, or per discipline. For example, see the CSC- Utilization and Edit Report, 2006, Appendices at www.cms.hhs.gov/TherapyServices (Studies and Reports). Professional literature and guidelines from professional associations also provide a basis on which to estimate whether the type, frequency and intensity of services are appropriate to an individual. Clinicians and contractors should utilize available evidence related to the patient's condition to justify provision of medically necessary services to individual beneficiaries, especially when they exceed caps. Contractors shall not limit medically necessary services that are justified by scientific research applicable to the beneficiary. Neither contractors nor clinicians shall utilize professional literature and scientific reports to justify payment for continued services after an individual's goals have been met earlier

than is typical. Conversely, professional literature and scientific reports shall not be used as justification to deny payment to patients whose needs are greater than is typical or when the patient's condition is not represented by the literature.

b. Exceptions for Conditions or Complexities Identified by ICD-9 codes.

Clinicians may utilize the automatic process for exception for any diagnosis for which they can justify services exceeding the cap. Based upon analysis of claims data, research and evidence based practice guidelines, CMS has identified conditions and complexities represented by ICD-9 codes that may be more likely than others to require therapy services that exceed therapy caps. This list appears in 10.2 C3. Clinicians may use the automatic process of exception for beneficiaries who do not have a condition or complexity on this list when they justify the provision of therapy services that exceed caps for that patient's condition.

NOT ALL patients who have a condition or complexity on the list are "automatically" excepted from therapy caps. See Pub. 100-02, chapter 15, section 230.3 for documenting the patient's condition and complexities. Contractors may scrutinize claims from providers whose services exceed caps more frequently than is typical.

Regardless of the condition, the patient must also meet other requirements for coverage. For example, the patient must require skilled treatment for a covered, medically necessary service; the services must be appropriate in type, frequency and duration for the patient's condition and service must be documented appropriately. Guidelines for utilization of therapy services may be found in Medicare manuals, Local Coverage Determinations of Medicare contractors, and professional guidelines issued by associations and states.

Bill the most relevant diagnosis. As always, when billing for therapy services, the ICD-9 code that best relates to the reason for the treatment shall be on the claim, unless there is a compelling reason. For example, when a patient with diabetes is being treated for gait training due to amputation, the preferred diagnosis is abnormality of gait (which characterizes the treatment). Where it is possible in accordance with State and local laws and the contractors Local Coverage Determinations, avoid using vague or general diagnoses. When a claim includes several types of services, or where the physician/NPP must supply the diagnosis, it may not be possible to use the most relevant therapy code in the primary position. In that case, the relevant code should, if possible, be on the claim in another position.

Codes representing the medical condition that caused the treatment are used when there is no code representing the treatment. Complicating conditions are preferably used in non-primary positions on the claim and are billed in the primary position only in the rare circumstance that there is no more relevant code.

The condition or complexity that caused treatment to exceed caps must be related to the therapy goals and must either be the condition that is being treated or a complexity that

directly and significantly impacts the rate of recovery of the condition being treated such that it is appropriate to exceed the caps. Codes marked as complexities represented by ICD-9 codes on the list below are unlikely to require therapy services that would exceed the caps unless they occur in a patient who also has another condition (either listed or not listed). Therefore, documentation for an exception should indicate how the complexity (or combination of complexities) directly and significantly affects treatment for a therapy condition. For example, if the condition underlying the reason for therapy is V43.64, hip replacement, the treatment may have a goal to ambulate 60' with stand-by assistance and a KX modifier may be appropriate for gait training (assuming the severity of the patient is such that the services exceed the cap). Alternatively, it would not be appropriate to use the KX modifier for a patient who recovered from hip replacement last year and is being treated this year for a sprain of a severity which does not justify extensive therapy exceeding caps.

3. ICD-9 Codes That are Likely to Qualify for the Automatic Process Therapy Cap Exception Based Upon Clinical Condition or Complexity

When using this table, refer to the ICD-9 code book for coding instructions. Some contractors' Local Coverage Determinations do not allow the use of some of the codes on this list in the primary diagnosis position on a claim. If the contractor has determined that these codes do not characterize patients who require medically necessary services, providers/suppliers may not use these codes, but must utilize a billable diagnosis code allowed by their contractor to describe the patient's condition. Contractors shall not apply therapy caps to services based on the patient's condition, but only on the medical necessity of the service for the condition. If a service would be payable before the cap is reached and is still medically necessary after the cap is reached, that service is excepted. Providers/suppliers may use the automatic process for exception for medically necessary services when the patient has a billable condition that is not on the list below. The diagnosis on the list below may be put in a secondary position on the claim and/or in the medical records, as the contractor directs.

When two codes are listed in the left cell in a row, all the codes between them are also eligible for exception. If one code is in the cell, only that one code is likely to qualify for exception. The descriptions in the table are not always identical to those in the ICD-9 code book, but may be summaries. Contact your contractor for interpretation if you are not sure that a condition or complexity is applicable for automatic process exception.

It is very important to recognize that most of the conditions on this list would not ordinarily result in services exceeding the cap. Use the KX modifier only in cases where the condition of the individual patient is such that services are APPROPRIATELY provided in an episode that exceeds the cap. In most cases, the severity of the condition, comorbidities, or complexities will contribute to the necessity of services exceeding the cap, and these should be documented. Routine use of the KX modifier for all patients with these conditions will likely show up on data analysis as aberrant and invite inquiry. Be sure that documentation is sufficiently detailed to support the use of the modifier.

The following ICD-9 codes describe the conditions (etiology or underlying medical conditions) that may result in excepted conditions (marked X) and complexities (marked *) that MIGHT cause medically necessary therapy services to qualify for the automatic process exception for each discipline separately. When the field corresponding to the therapy discipline treating and the diagnosis code is marked with a dash (–) services by that discipline are not appropriate for that diagnosis and, therefore, services do not qualify for exception to caps.

These codes are grouped only to facilitate reference to them. The codes may be used only when the code is applicable to the condition being actively treated. For example, an exception should not be claimed for a diagnosis of hip replacement when the service provided is for an unrelated dysphagia.

Key	
Automatic (only ICD-9 needed on claim)	X
Complexity (requires another ICD-9 on claim)	*
Does not serve as qualifying ICD-9 on claim	--

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
V43.61-V43.69	Joint Replacement	X	X	--
V45.4	Arthrodesis Status	*	*	--
V45.81-V45.82 and V45.89	Other Postprocedural Status	*	*	--
V49-61-V49.67	Upper Limb Amputation Status	X	X	--
V49.71-V49.77	Lower Limb Amputation Status	X	X	--
V54.10-V54.29	Aftercare for Healing Traumatic or Pathologic Fracture	X	X	--
V58.71-V58.78	Aftercare Following Surgery to Specified Body Systems, Not Elsewhere Classified	*	*	*
244.0-244.9	Acquired Hypothyroidism	*	*	*
250.00-251.9	Diabetes Mellitus and Other Disorders of Pancreatic Internal Secretion	*	*	*
276.0-276.9	Disorders of Fluid, Electrolyte, and Acid-Base Balance	*	*	*
278.00-278.01	Obesity and Morbid Obesity	*	*	*
280.0-289.9	Diseases of the blood and blood-forming organs	*	*	*
290.0-290.43	Dementias	*	*	*
294.0-294.9	Persistent Mental Disorders due to Conditions Classified Elsewhere	*	*	*
295.00-299.91	Other Psychoses	*	*	*
300.00-300.9	Anxiety, Disassociative and Somatoform Disorders	*	*	*
310.0-310.9	Specific Nonpsychotic Mental Disorders due to Brain Damage	*	*	*
311	Depressive Disorder, Not Elsewhere Classified	*	*	*

315.00-315.9	Specific delays in Development	*	*	*
317	Mild Mental Retardation	*	*	*
320.0-326	Inflammatory Diseases of the Central Nervous System	*	*	*
330.0-337.9	Hereditary and Degenerative Diseases of the Central Nervous System	X	X	X
340-345.91 and 348.0-349.9	Other Disorders of the Central Nervous System	X	X	X
353.0-359.9	Disorders of the Peripheral Nervous system	X	X	--
365.00-365.9	Glaucoma	*	*	*
369.00-369.9	Blindness and Low Vision	*	*	*
386.00-386.9	Vertiginous Syndromes and Other Disorders of Vestibular System	*	*	*
389.00-389.9	Hearing Loss	*	*	*
401.0-405.99	Hypertensive Disease	*	*	*
410.00-414.9	Ischemic Heart Disease	*	*	*
415.0-417.9	Diseases of Pulmonary Circulation	*	*	*
420.0-429.9	Other Forms of Heart Disease	*	*	*
430-438.9	Cerebrovascular Disease	X	X	X
440.0-448.9	Diseases of Arteries, Arterioles, and Capillaries	*	*	*

Key	
Automatic (only ICD-9 needed on claim)	X
Complexity (requires another ICD-9 on claim)	*
Does not serve as qualifying ICD-9 on claim	--

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
451.0-453.9 and 456.0-459.9	Diseases of Veins and Lymphatics, and Other Diseases of Circulatory System	*	*	*
465.0-466.19	Acute Respiratory Infections	*	*	*
478.30-478.5	Paralysis, Polyps, or Other Diseases of Vocal Cords	*	*	*
480.0-486	Pneumonia	*	*	*
490-496	Chronic Obstructive Pulmonary Disease and Allied Conditions	*	*	*
507.0-507.8	Pneumonitis due to solids and liquids	*	*	*
510.0-519.9	Other Diseases of Respiratory System	*	*	*
560.0-560.9	Intestinal Obstruction Without Mention of Hernia	*	*	*
578.0-578.9	Gastrointestinal Hemorrhage	*	*	*
584.5-586	Renal Failure and Chronic Kidney Disease	*	*	*
590.00-599.9	Other Diseases of Urinary System	*	*	*
682.0-682.8	Other Cellulitis and Abscess	*	*	--
707.00-707.9	Chronic Ulcer of Skin	*	*	--
710.0-710.9	Diffuse Diseases of Connective Tissue	*	*	*
711.00-711.99	Arthropathy Associated with Infections	*	*	--
712.10-713.8	Crystal Arthropathies and Arthropathy	*	*	--

	Associated with Other Disorders Classified Elsewhere			
714.0-714.9	Rheumatoid Arthritis and Other Inflammatory Polyarthropathies	*	*	--
715.00-715.98	Osteoarthrosis and Allied Disorders (Complexity except as listed below)	*	*	--
715.09	Osteoarthritis and allied disorders, multiple sites	X	X	--
715.11	Osteoarthritis, localized, primary, shoulder region	X	X	--
715.15	Osteoarthritis, localized, primary, pelvic region and thigh	X	X	--
715.16	Osteoarthritis, localized, primary, lower leg	X	X	--
715.91	Osteoarthritis, unspecified id gen. or local, shoulder	X	X	--
715.96	Osteoarthritis, unspecified if gen. or local, lower leg	X	X	--
716.00-716.99	Other and Unspecified Arthropathies	*	*	--
717.0-717.9	Internal Derangement of Knee	*	*	--
718.00-718.99	Other Derangement of Joint (Complexity except as listed below)	*	*	--
718.49	Contracture of Joint, Multiple Sites	X	X	--
719.00-719.99	Other and Unspecified Disorders of Joint (Complexity except as listed below)	*	*	--
719.7	Difficulty Walking	X	X	--
720.0-724.9	Dorsopathies	*	*	--

Key	
Automatic (only ICD-9 needed on claim)	X
Complexity (requires another ICD-9 on claim)	*
Does not serve as qualifying ICD-9 on claim	--

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
725-729.9	Rheumatism, Excluding Back (Complexity except as listed below)	*	*	--
726.10-726.19	Rotator Cuff Disorder and Allied Syndromes	X	X	--
727.61-727.62	Rupture of Tendon, Nontraumatic	X	X	--
730.00-739.9	Osteopathies, Chondropathies, and Acquired Musculoskeletal Deformities (Complexity except as listed below)	*	*	--
733.00	Osteoporosis	X	X	--
741.00-742.9 and 745.0-748.9 and 754.0-756.9	Congenital Anomalies	*	*	*
780.31-780.39	Convulsions	*	*	*
780.71-780.79	Malaise and Fatigue	*	*	*
780.93	Memory Loss	*	*	*
781.0-781.99	Symptoms Involving Nervous and	*	*	*

	Musculoskeletal System (Complexity except as listed below)			
781.2	Abnormality of Gait	X	X	--
781.3	Lack of Coordination	X	X	--
783.0-783.9	Symptoms Concerning Nutrition, Metabolism, and Development	*	*	*
784.3-784.69	Aphasia, Voice and Other Speech Disturbance, Other Symbolic Dysfunction	*	*	X
785.4	Gangrene	*	*	--
786.00-786.9	Symptoms involving Respiratory System and Other Chest Symptoms	*	*	*
787.2	Dysphagia	*	*	X
800.00-828.1	Fractures (Complexity except as listed below)	*	*	--
806.00-806.9	Fracture of Vertebral Column With Spinal Cord Injury	X	X	--
810.11-810.13	Fracture of Clavicle	X	X	--
811.00-811.19	Fracture of Scapula	X	X	--
812.00-812.59	Fracture of Humerus	X	X	--
813.00-813.93	Fracture of Radius and Ulna	X	X	--
820.00-820.9	Fracture of Neck of Femur	X	X	--
821.00-821.39	Fracture of Other and Unspecified Parts of Femur	X	X	--
828.0-828.1	Multiple Fractures Involving Both Lower Limbs, Lower with Upper Limb, and Lower Limb(s) with Rib(s) and Sternum	X	X	--
830.0-839.9	Dislocations	X	X	--
840.0-848.8	Sprains and Strains of Joints and Adjacent Muscles	*	*	--
851.00-854.19	Intracranial Injury, excluding those With Skull Fracture	X	X	X

Key	
Automatic (only ICD-9 needed on claim)	X
Complexity (requires another ICD-9 on claim)	*
Does not serve as qualifying ICD-9 on claim	--

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
880.00-884.2	Open Wound of Upper Limb	*	*	--
885.0-887.7	Traumatic Amputation, Thumb(s), Finger(s), Arm and Hand (complete)(partial)	X	X	--
890.0-894.2	Open Wound Lower Limb	*	*	--
895.0-897.7	Traumatic Amputation, Toe(s), Foot/Feet, Leg(s) (complete)(partial)	X	X	--
905.0-905.9	Late Effects of Musculoskeletal and Connective Tissue Injuries	*	*	*
907.0-907.9	Late Effects of Injuries to the Nervous System	*	*	*

941.00-949.5	Burns	*	*	*
952.00-952.9	Spinal Cord Injury Without Evidence of Spinal Bone Injury	X	X	X
953.0-953.8	Injury to Nerve Roots and Spinal Plexus	X	X	*
959.01	Head Injury, Unspecified	X	X	X

4. Additional Considerations for Exceptions

In justifying exceptions for therapy caps, clinicians and contractors should not only consider the medical diagnoses and medical complications that might directly and significantly influence the amount of treatment required. Other variables (such as the availability of a caregiver at home) that affect appropriate treatment shall also be considered. Factors that influence the need for treatment should be supportable by published research, clinical guidelines from professional sources, and/or clinical/common sense. See Pub. 100-02, chapter 15, section 230.3 subsections related to documentation of the evaluation, and section 220.2 medical necessity for some factors that complicate treatment.

Note that the patient's lack of access to outpatient hospital therapy services alone does not justify excepted services. Residents of skilled nursing facilities prevented by consolidated billing from accessing hospital services, debilitated patients for whom transportation to the hospital is a physical hardship or lack of therapy services at hospitals in the beneficiary's county may or may not qualify for continued services above the caps. The patient's condition and complexities might justify extended services, but their location does not.

5. Appeals Related to Disapproval of Cap Exceptions

Disapproval of Exception from Caps. The DRA allows that certain services that would not be covered due to caps, but are medically necessary, may be covered if they meet certain criteria. Therefore, when a service beyond the cap is determined to be medically necessary, it is covered and payable. But, when a service provided beyond the cap (outside the benefit) is determined to be NOT medically necessary, it is denied as a benefit category denial. Contractors may review claims with KX modifiers to determine whether the services are medically necessary, or for other reasons. Services that exceed therapy caps but do not meet Medicare criteria for medically necessary services are not payable even when clinicians recommend and furnish and these services.

Services without a Medicare benefit may be billed to Medicare with a GY modifier for the purpose of obtaining a denial that can be used with other insurers. See CMS IOM Pub. 100-04 Chapter 1, Section 60 for appropriate use of modifiers.

APPEALS –If a beneficiary whose excepted services do not meet the Medicare criteria for medical necessity elects to receive such services and a claim is submitted for such services, the resulting determination would be subject to the administrative appeals process. Further details concerning appeals are found in CMS IOM Pub. 100-04, chapter 29.

6. Use of the KX Modifier for Therapy Cap Exceptions

When exceptions are in effect and when the beneficiary qualifies for a therapy cap exception, the provider shall add a KX modifier to the therapy HCPCS subject to the cap limits The KX modifier shall not be added to any line of service that is not a medically necessary service; this applies to services that, according to a Local Coverage Determination by the contractor, are not medically necessary services.

The codes subject to the therapy cap tracking requirements are listed in a table in the Claims Processing Manual, Pub. 100-04, chapter 5, section 20(B), "Applicable Outpatient Rehabilitation HCPCS Codes."

The GN, GO, or GP therapy modifiers are currently required. In addition to the KX modifier, the GN, GP and GO modifiers shall continue to be used. Providers may report the modifiers on claims in any order. If there is insufficient room on a claim line for multiple modifiers, additional modifiers may be reported in the remarks field. Follow the routine procedure for placing HCPCS modifiers on a claim as described below.

- For professional claims, sent to the carrier, refer to:

o Pub.100-04 Medicare Claims Processing Manual, Chapter 26, for more detail regarding completing the CMS- Form 1500 claim form, including the placement of HCPCS modifiers. Note that the CMS-Form1500 claim form currently has space for providing two modifiers in block 24D, but, if you have more than two to report, you can do so by placing the -99 modifier (which indicates multiple modifiers) in block 24D and placing the additional modifiers in block 19.

You may access the Medicare Claims Processing Manual at this web address http://www.cms.hhs.gov/Manuals/

From this site, click the links to Internet-Only Manuals (IOMs), then Pub. 100-04 to reach the Medicare Claims Processing Manual.

o The ASC X12N 837 Health Care Claim: Professional Implementation Guide, Version 4010A1, for more detail regarding how to electronically submit a health care claim transaction, including the placement of HCPCS modifiers. The ASC X12N 837 implementation guides are the standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for submitting health care claims electronically. The 837 professional transaction currently permits the placement of up to four modifiers, in the 2400 loop, SV1 segment, data elements SV101-3, SV101-4, SV101-5, and SV101-6. You may obtain copies of the ASC X12N 837 implementation guides from the Washington Publishing Company.

o For claims paid to carriers, it is only appropriate to use a KX for a service that reasonably may exceed the cap. Use of the KX modifier when there is no indication

that the cap is likely to be exceeded is abusive. For example, use of the KX modifier for low cost services early in an episode when there is no evidence of a previous episode that might have exceeded the cap is inappropriate.

- For institutional claims, sent to the FI:

    - When the cap is exceeded by at least one line on the claim, use the KX modifier on all of the lines on that institutional claim that refer to the same therapy cap (PT/SLP or, OT,) regardless of whether the other services exceed the cap. For example, if one PT service line exceeds the cap, use the KX on all the PT and SLP service lines (also identified with the GP or GN modifier) for that claim. (When the PT/SLP cap is exceeded by PT services, the SLP lines on the claim may meet the requirements for an exception due to the complexity of two episodes of service. Use the KX on either all or none of the SLP lines on the claim, as appropriate.) In contrast, if all the OT lines on the claim are below the cap, do not use the KX modifier on any of the OT lines, even when the KX is appropriately used on all of the PT lines.

    - Refer to Pub.100-04 Medicare Claims Processing Manual, Chapter 25, for more detail regarding completing the CMS- Form 1450 claim form, including the placement of HCPCS modifiers.

You may access the Medicare Claims Processing Manual at this web address http://www.cms.hhs.gov/Manuals/. From this site, click the links to Internet-Only Manuals (IOMs), then Pub. 100-04 to reach the Medicare Claims Processing Manual.

- By attaching the KX modifier, the provider is attesting that the services billed:

    - Are reasonable and necessary services that require the skills of a therapist; (See CMS Pub. 100-02, chapter 15, section 220.2 B); and

    - Are justified by appropriate documentation in the medical record, (See CMS Pub. 100-02, chapter 15, section 220.3); and

    - Qualify for an exception using the automatic process exception.

If this attestation is determined to be inaccurate, the provider/supplier is subject to sanctions resulting from providing inaccurate information on a claim.

- When the KX modifier is attached to a therapy HCPCS, the contractor will override the CWF system reject for services that exceed the caps and pay the claim if it is otherwise payable.

- Providers and suppliers shall continue to attach correct coding initiative (CCI) HCPCS modifiers under current instructions.

- If a claim is submitted without KX modifiers and the cap is exceeded, those services will be denied. In cases where the KX would have been appropriate, contractors may reopen and/or adjust the claim, if it is brought to their attention.

- Services billed after the cap has been exceeded which are not eligible for exceptions may be billed for the purpose of obtaining a denial using condition code 21.

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 is limited to $1,780 in 2007 and $1,810 in 2008 for outpatient physical therapy and speech-language pathology combined. Occupational therapy services have the same limits. Medicare pays up to 80 percent of the limits after the deductible has been met. Exceptions to these limits apply to therapy billed by hospital outpatient departments and may also apply to medically necessary services.

- Spanish Translation: ALERTA: La cobertura de Medicare se limita a $1,780 en el 2007 y a $1,810 en el 2008 para los servicios combinados de terapia física ambulatoria y terapia de patología del habla. Los servicios de terapia ocupacional tienen los mismos límites. Medicare paga hasta 80 por ciento de los límites después de que se haya pagado el deducible. Estos límites no se aplican a terapia que usted obtenga en los departamentos de hospital para paciente ambulatorio, y pueden también aplicarse a los servicios médicamente necesarios.

Existing MSN messages 17.13, 17.18 and 17.19 shall be issued on all claims containing outpatient rehabilitation services as noted in this manual. Add applied amount for individual beneficiaries and the generic limit amount (e.g., $1740 in 2006, $1780 in 2007, and $1810 in 2008) 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 or when approved by Medicare.

  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, terapistas 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 o cuando está aprobada por Medicare.

- 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 lenguage 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 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 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 2007 limit of $1780 for a beneficiary who has paid the deductible and the coinsurance:

Services received to date $1765 ($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 With or Without Exceptions

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 or occurrence has been reached- in the provider remittance advice to establish the reason for denial.

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.

If a beneficiary elects to receive services that exceed the cap limitation and a claim is submitted for such services, the resulting determination is subject to the administrative appeals process as described in subsection C.6 of this section and Pub. 100-04, chapter 29.

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. However, when therapy cap exceptions apply, SNF residents may qualify for exceptions that allow billing within the consolidated billing rules.

NEMB 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. Although use of the NEMB form is not a Medicare requirement, Medicare contractors shall 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 and the cap exclusion process.

The NEMB form can be found at: http://www.cms.hhs.gov/medicare/bni/

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. The following reason is suggested: "Services do not qualify for exception to therapy caps. 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., $1810 in 2008) unless the beneficiary qualifies for a cap exception." Providers are to supply this same information for occupational therapy services over the limit for the same time period, as appropriate.

ABN An Advance Beneficiary Notice (ABN) is required to be given to a beneficiary whenever the treating clinician determines that the services being provided are no longer expected to be covered because they do not satisfy Medicare's medical necessity requirements. The ABN informs the beneficiary of their potential financial obligation to the provider and provides guidance regarding appeal rights. ABN applies to services that are provided BEFORE the cap is exceeded.

After the cap is exceeded, only the NEMB is appropriate, regardless of whether the services were excepted from the cap. For example, if services are provided over the cap for an excepted condition, when the therapist determines that the services no longer meet the criteria for reasonable and necessary services, an NEMB and not an ABN is provided to the patient.

At the time the clinician determines that skilled services are not necessary, the clinical goals have been met, or that there is no longer potential for the rehabilitation of health and/or function in a reasonable time, the beneficiary should be informed. If the beneficiary requests further services, inform the beneficiary that Medicare will not likely provide additional coverage. Use the ABN form for this purpose if the services are within the cap, and use the NEMB for services after the cap is exceeded.

Access to Accrued Amount All providers and contractors may access the accrued amount of therapy services from the ELGA screen inquiries into CWF. Provider/suppliers may access remaining therapy services limitation dollar amount through the 270/271 eligibility inquiry and response transaction. Providers who bill to FIs will also find the amount a beneficiary has accrued toward the financial limitations on the HIQA. Some suppliers and providers billing to carriers may, in addition, have access the accrued amount of therapy services from the ELGB screen inquiries into CWF. Suppliers who do not have access to these inquiries may call the contractor to obtain the amount accrued.

20 - HCPCS Coding Requirement

(Rev. 1377; Issued: 11-23-07; Effective: 01-01-08; Implementation: 01-07-08)

A. Uniform Coding

Section 1834(k)(5) of the Act 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 current Healthcare Common Procedure Coding System/Current Procedural Terminology is used for the reporting of these services. The uniform coding requirement in the Act is specific to payment for all CORF services and outpatient rehabilitation therapy services - including physical therapy, occupational therapy, and speech-language pathology - that is provided and billed to carriers and fiscal intermediaries (FIs). The Medicare physician fee schedule (MPFS) is used to make payment for these therapy services at the nonfacility rate.

Effective for claims submitted on or after April 1, 1998, providers that had not previously reported HCPCS/CPT for outpatient rehabilitation and CORF services began using HCPCS to report these services. This requirement does not apply to outpatient rehabilitation 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[1] stay);
- Skilled nursing facilities (SNFs) (to residents not in a covered Part A[1] 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 physical therapy facilities in this instruction).

Note 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.
Note 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.

Providers billing to intermediaries shall report:

- The date the therapy plan of care was either established or last reviewed (see §220.1.3B) in Occurrence Code 17, 29, or 30.

- The first day of treatment in Occurrence Code 35, 44, or 45.

B. Applicable Outpatient Rehabilitation HCPCS Codes

The CMS identifies the following codes as therapy services, regardless of the presence of a financial limitation. Therapy services include only physical therapy, occupational therapy and speech-language pathology services. Therapist means only a physical therapist, occupational therapist or speech-language pathologist. Therapy modifiers are GP for physical therapy, GO for occupational therapy, and GN for speech-language pathology. Check the notes below the chart for details about each code.

When in effect, any financial limitation will also 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 or applicable to all provider settings.

64550+	90901+	92506Δ	92507Δ	92508	92526
92597	92605****	92606****	92607	92608	92609
92610+	92611+	92612+	92614+	92616+	95831+
95832+	95833+	95834+	95851+	95852+	96105+
96110+✓	96111+✓	96125	97001	97002	97003
97004	97010****	97012	97016	97018	97022
97024	97026	97028	97032	97033	97034
97035	97036	97039*◊	97110	97112	97113
97116	97124	97139*◊	97140	97150	97530
97532+	97533	97535	97537	97542	97597+ \ع
97598+\ع	97602+****ع	97605+\ع	97606+ \ع	97750	97755
97760**Δ	97761	97762	97799*	G0281	G0283
G0329	0019T+***	0029T+***			

* The physician fee schedule abstract file does not contain a price for CPT codes 97039, 97139, or 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, 2006, these codes will no longer be valued under the MPFS. They will be priced by the carriers.

Δ Effective January 1, 2006, the code descriptors for these services have been changed.

** CPT code 97760 should not be reported with CPT code 97116 for the same extremity.

*** The physician fee schedule abstract file does not contain a price for CPT codes 0019T or 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.

**** These HCPCS/CPT codes are bundled under the MPFS. They are bundled with any therapy codes. Regardless of whether they are billed alone or in conjunction with another therapy code, never make payment separately for these codes. If billed alone, HCPCS/CPT codes marked as "****" shall be denied using the existing 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.

✓ If billed by an outpatient hospital department, these HCPCS codes are paid using the Outpatient Prospective Payment System (OPPS).

Underlined codes are "always therapy" services, regardless of who performs them. These codes always require therapy modifiers (GP, GO, GN).

\ع\ If billed by a hospital subject to OPPS for an outpatient service, these HCPCS codes –also indicated as "sometimes therapy" services - will be paid under the OPPS when the service is not performed by a qualified therapist and it is inappropriate to bill the service under a therapy plan of care. The requirements for other "sometimes therapy" codes, described below, apply.

+ These HCPCS/CPT codes sometimes represent therapy services. However, these codes always represent therapy services and require the use of a therapy modifier when performed by therapists.

There are some circumstances when these 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 when:

- It is not appropriate to bill the service under a therapy plan of care, and

- They are billed by practitioners/providers of services who are not therapists, i.e., physicians, clinical nurse specialists, nurse practitioners and psychologists; or they are billed to fiscal intermediaries by hospitals for outpatient services which are performed by non-therapists as noted in Note \"ع" above.

While the "+" designates that a particular HCPCS/CPT code will not of itself always indicate that a therapy service was rendered, these codes always represent therapy services when rendered by therapists or by practitioners who are not therapists in situations where the service provided is integral to an outpatient rehabilitation therapy plan of care. For these situations, these codes must always have a therapy modifier. For example, when the service is rendered by either a doctor of medicine or a nurse practitioner (acting within the scope of his or her license when performing such service), with the goal of rehabilitation, a modifier is required. When there is doubt about whether a service should be part of a therapy plan of care, the contractor shall make that determination.

"Outpatient rehabilitation therapy" refers to skilled therapy services, requiring the skills of qualified therapists, performed for restorative purposes and generally involving ongoing treatments as part of a therapy plan of care. In contrast, a non-therapy service is a service performed by non-therapist practitioners, without an appropriate rehabilitative plan or goals, e.g., application of a surface (transcutaneous) neurostimulator – CPT code 64550, and biofeedback training by any modality – CPT code 90901. When performed by therapists, these are "always" therapy services. Contractors have discretion to determine whether circumstances describe a therapy service or require a rehabilitation plan of care.

The underlined HCPCS codes on the above list do not have a + sign because they 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, chapters 12 and 15).

C. Additional HCPCS Codes

Some HCPCS/CPT codes that are not on the list of therapy services should not be billed with a modifier. For example, outpatient non-rehabilitation HCPCS codes G0237, G0238, and G0239 should be billed without therapy modifiers. These HCPCS codes describe services for the improvement of respiratory function and may represent either "incident to" services or respiratory therapy services that may be appropriately billed in the CORF setting. When the services described by these G-codes are provided by physical therapists (PTs) or occupational therapists (OTs) treating respiratory conditions, they are considered therapy services and must meet the other conditions for physical and occupational therapy. The PT or OT would use the appropriate HCPCS/CPT code(s) in the 97000 – 97799 series and the corresponding therapy modifier, GP or GO, must be used.

Another example of codes that are not on the list of therapy services and should not be billed with a therapy modifier includes the following HCPCS codes: 95860, 95861, 95863, 95864, 95867, 95869, 95870, 95900, 95903, 95904, and 95934. These services represent diagnostic services - not therapy services; they must be appropriately billed and shall not include therapy modifiers.

Other codes not on the above list, and not paid under another fee schedule, are appropriately billed with therapy modifiers when the services are furnished by therapists or provided under a therapy plan of care and where the services are covered and appropriately delivered (e.g., the therapist is qualified to provide the service). One example of non-listed codes where a therapy modifier is indicated, regards the provision of services described in the CPT code series, 29000 through 29590, for the application of casts and strapping. Some of these codes previously appeared on the above list, but were deleted because we determined that they represented services that are most often performed outside a therapy plan of care. However, when these services are provided by

therapists or as an integral part of a therapy plan of care, the CPT code must be accompanied with the appropriate therapy modifier.

NOTE: The above lists of HCPCS/CPT codes are intended to facilitate the contractor's ability to pay claims under the MPFS. It is not intended to be an exhaustive list of covered services, imply applicability to provider settings, and does not assure coverage of these services.

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 therapy codes which require GN, GO, and GP modifiers.

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, providers 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 through and

including 37 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 through 52 minutes
4 units:	≥ 53 minutes through 67 minutes
5 units:	≥ 68 minutes through 82 minutes
6 units:	≥ 83 minutes through 97 minutes
7 units:	≥ 98 minutes through 112 minutes
8 units:	≥ 113 minutes through 127 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/ NPP 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

20.3 - Determining What Time Counts Towards 15-Minute Timed Codes - All Claims

(Rev. 1, 10-01-03)
A3-3653, SNF-532.C, AB-00-39

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as "intra-service care" begins when the therapist or physician (or an assistant

under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment.

The time counted is the time the patient is treated. For example, if gait training in a patient with a recent stroke requires both a therapist and an assistant, or even two therapists, to manage in the parallel bars, each 15 minutes the patient is being treated can count as only one unit of code 97116. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.

20.4 - Coding Guidance for Certain Physical Medicine CPT Codes - All Claims

(Rev. 1183, Issued: 02-09-07, Effective: 10-24-06, Implementation: 01-16-07)

The following provides guidance about the use of codes 96105, 97026, 97150, 97545, 97546, and G0128.

- CPT Codes 96105, 97545, and 97546.

Providers report code 96105, assessment of aphasia with interpretation and report in 1-hour units. This code represents formal evaluation of aphasia with an instrument such as the Boston Diagnostic Aphasia Examination. If this formal assessment is performed during treatment, it is typically performed only once during treatment and its medical necessity should be documented. If the test is repeated during treatment, the medical necessity of the repeat administration of the test must also be documented. It is common practice for regular assessment of a patient's progress in therapy to be documented in the chart, and this may be done using test items taken from the formal examinations. This is considered to be part of the treatment and should not be billed as 96105 unless a full, formal assessment is completed.

Other timed physical medicine codes are 97545 and 97546. The interval for code 97545 is 2 hours and for code 97546, 1 hour. These are specialized codes to be used in the context of rehabilitating a worker to return to a job. The expectation is that the **entire** time period specified in the codes 97545 or 97546 would be the treatment period, since a shorter period of treatment could be coded with another code such as codes 97110, 97112, or 97537. (Codes 97545 and 97546 were developed for reporting services to persons in the Worker's Compensation program, thus we do not expect to see them reported for Medicare patients except under very unusual circumstances. Further, we would not expect to see code 97546 without also seeing code 97545 on the same claim. Code 97546, when used, is used in conjunction with 97545.)

- CPT Code 97026

Effective for services performed on or after October 24, 2006, the Centers for Medicare & Medicaid Services announce a NCD stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), is non-covered for the treatment, including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries. Further coverage guidelines can be found in the National Coverage Determination Manual (Publication 100-03), section 270.6.

Contractors shall deny claims with CPT 97026 (infrared therapy incident to or as a PT/OT benefit) and HCPCS E0221 or A4639, if the claim contains any of the following ICD-9 codes:

250.60-250.63

354.4, 354.5, 354.9

355.1-355.4

355.6-355.9

356.0, 356.2-356.4, 356.8-356.9

357.0-357.7

674.10, 674.12, 674.14, 674.20, 674.22, 674.24

707.00-707.07, 707.09-707.15, 707.19

870.0-879.9

880.00-887.7

890.0-897.7

998.31-998.32

Contractors can use the following messages when denying the service:

- Medicare Summary Notice # 21.11 "This service was not covered by Medicare at the time you received it."

- Reason Claim Adjustment Code #50 "These are noncovered services because this is not deemed a medical necessity by the payer."

Advanced Beneficiary Notice (ABN):

Physicians, physical therapists, occupational therapists, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHA), and hospital outpatient departments are liable if the service is performed, unless the beneficiary signs an ABN.

Similarly, DME suppliers and HHA are liable for the devices when they are supplied, unless the beneficiary signs an ABN.

20.5 – CORF/OPT Edit for Billing Inappropriate Supplies
(Rev. 319, Issued: 10-22-04, Effective: 07-01-01, Implementation: 04-04-05)

Supplies furnished by CORFs/OPTs are considered part of the practice expense. Under the Medicare Physician Fee Schedule (MPFS) these expenses are already taken into account in the practice expense relative values. Therefore, CORFs/OPTs should not bill for the supplies they furnish except for the splint and cast, level II HCPCS Q codes associated with the level I HCPCS in the 29000 series.

The shared system maintainer will return to CORFs/OPTs any claims that they receive that contain a supply revenue code 270 without the splint and cast Level II HCPCS Q codes and the related Level I applicable HCPCS codes in the 29000 series.

The appropriate Level II HCPCS "Q" codes to be used are Q4001 thru Q4049.

The appropriate Level I HCPCS codes associated with the Level II HCPCS "Q" codes are 29000 thru 29085; 29105 thru 29131; and 29305 thru 29515.

30 - Special Claims Processing Rules for Outpatient Rehabilitation Claims - Form CMS-1500
(Rev. 1, 10-01-03)

Rules for completing a Form CMS-1500 and electronic formats are in Chapter 26. Instructions in §§10.1, 20.1, 20.2, 20.3 and 20.4 above also apply.

30.1 - Determining Payment Amounts
(Rev. 1, 10-01-03)

Carriers use the MPFS to determine payment for outpatient rehabilitation services. Payment rules are the same as those for other services paid on the MPFS.

Assignment is mandatory.

See chapter 23, for a description of the MPFS.

30.2 - Applicable Carrier CWF Type of Service Codes
(Rev. 1, 10-01-03)

The carrier assigns the type of service code before submitting the claim record to CWF.

U = Occupational therapy
W= Physical therapy

40 - Special Claims Processing Rules for Outpatient Rehabilitation Claims - Form CMS-1450

(Rev. 1, 10-01-03)

40.1 - Determining Payment Amounts - FIs

(Rev. 1, 10-01-03)
PM AB-00-01, SNF-532.F

See §100.2.

40.2 - Applicable Bill Types - FIs

(Rev. 1, 10-01-03)
A3-3653.B

The appropriate bill types requiring HCPCS coding under this payment system are: 12X, 13X, 22X, 23X, 34X, 74X, 75X, and 83X.

40.3 - Applicable Revenue Codes - FIs

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

The appropriate revenue codes for reporting outpatient rehabilitation services are

0420 - Physical Therapy Services
0430 - Occupational Therapy Services
0440 – Speech-language pathology services
0470 – Audiology

The general classification of revenue codes is all that is needed for billing. If, however, providers choose to use more specific revenue code classifications, the FI should accept them. Reporting of services is not limited to specific revenue codes; e.g., services other than therapy may be included on the same claim.

Many therapy services may be provided by both physical and occupational therapists. Other services may be delivered by either occupational therapists or speech-language pathologists. Therefore, providers report outpatient rehabilitation HCPCS codes in conjunction with the appropriate outpatient rehabilitation revenue code based on the type of therapist who delivered the service, or, if a therapist does not deliver the service, then on the type of therapy under the plan of care (POC) for which the service is delivered.

40.4 - FI Edit Requirements for Revenue Codes
(Rev. 1, 10-01-03)
A3-3653.H, SNF-532.E

The FIs edit to assure the presence of a HCPCS code when revenue codes 0420, 0430, 0440, or 0470 are reported. However, they do not edit the matching of revenue code to HCPCS codes or edit to limit provider reporting to only those HCPCS listed in this instruction.

40.5 - Line Item Date of Service Reporting on Form CMS-1450
(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Providers are required to report line item dates of service per revenue code line for outpatient rehabilitation services and audiology services. CORFs are also required to report their full range of CORF services by line item date of service. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item date of service for hardcopy is reported in *the* "Service Date" (MMDDYY) *form locator*. See example below of reporting line item dates of service and *reference Chapter 25 for electronic claim mappings*. This example is for physical therapy services provided twice during a billing period.

Paper CMS-1450

Revenue Code	HCPCS/Modifier	Service	Units	Total Charges
0420	97001GP	100602	1	$60.90
0420	97110GP	102902	2	$44.02

The FI returns bills that span two or more dates if a line item date of service is not entered for each HCPCS reported. Line item date of service reporting became effective for claims with dates of service on or after October 1, 1998.

Providers report line item dates of service in revenue code order by date of service. Services that do not require line item date of service reporting may be reported before or after those services that require line item reporting.

50 - CWF and PS&R Requirements - FIs
(Rev. 1, 10-01-03)
A3-3653.P

The FI reports the procedure codes in the financial data section (field 65a-65j) of the PS&R record. It includes revenue code, HCPCS, units, and covered charges in the

record. Where more than one HCPCS procedure is applicable to a single revenue code, the provider reports each HCPCS and related charge on a separate line. The FI reports the payment amount before adjustment for beneficiary liability in field 65g "Rate" and the actual charge in field 65h "Covered Charges." The PS&R system includes outpatient rehabilitation, audiology and CORF services listed in subsections E and F on a separate report from cost based payments. See the PS&R guidelines for specific information.

100 - Special Rules for Comprehensive Outpatient Rehabilitation Facilities (CORFs)

(Rev. 1, 10-01-03)

100.1 - General

(Rev. 1, 10-01-03)
A3-3370.1, B3-9300.1

The Omnibus Reconciliation Act of 1980 (Public Law 96-499, Section 933) defines CORFs (Comprehensive Outpatient Rehabilitation Facilities) as a distinct type of Medicare provider and adds CORF services as a benefit under Medicare Part B. The Balance Budget Act (P.L.105-33) requires payment under a prospective system for all CORF services.

See chapter 1, for the policy on FI Designations governing CORFs.

See the Medicare Benefit Policy Manual, Chapter 12, for a description of covered CORF services.

Physicians' diagnostic and therapeutic services furnished to a CORF patient are not considered CORF physician's services. The physician must bill the area Part B carrier for these services. If they are covered, the carrier reimburses them via the MPFS.

However, other services are considered CORF services to be billed by the CORF to the FI, and are also considered included in the fee amount under the MPFS. These services include such services as administrative services provided by the physician associated with the CORF, examinations for the purpose of establishing and reviewing the plan of care, consultation with and medical supervision of nonphysician staff, team conferences, case reviews, and other facility staff medical and facility administration activities relating to the services described in Medicare Benefit Policy Manual, Chapter 12. Related supplies are also included in the MPFS fee amount.

CORFs bill Medicare with the Form CMS-1450 using HCPCS codes and revenue codes. Usually the zero level revenue code is used. Payment is based on the HCPCS code and related MPFS amount.

Requirements in §§10 - 50 apply to CORF billing. In addition the following requirements apply.

100.1.1 - Allowable Revenue Codes on CORF 75X Bill Types

100.2 - Obtaining Fee Schedule Amounts

(Rev. 1, 10-01-03)
PM AB-00-01, SNF-532.F

The CMS furnishes FIs with an annual therapy abstract file and a CORF supplemental file through the Medicare Telecommunications System. The CMS notifies FIs when new files are available. FIs are responsible for informing CORFs of new fee schedule amounts.

Payment is calculated at 80 percent of the allowed charge after deductible is met. The allowed charge is the lower of billed charges or the fee schedule amount. Unmet deductible is subtracted from the allowed charge, and payment is calculated at 80 percent of the result.

EXAMPLE:

> $120 Provider charge;
> $100 MPFS amount.
> Payment is 80 percent of the lower of the actual charge or fee schedule amount, which in this case is $80.00. ($100.00 (MPFS) X 80 percent.)
>
> The remaining 20 percent or $20 is the patient s coinsurance liability.

These codes are updated as needed by CMS.

If the FI receives a claim for a Medicare covered CORF service with dates of service on or after July 1, 2000, that does not appear on its fee schedule abstract file, it has two options for obtaining pricing information:

- It is provided with a therapy abstract file or CORF supplemental file that contains all therapy services and their related prices. This supplemental file contains approximately a million records, and may be used as a resource to extract pricing data as needed. The data in the supplemental file is in the same format as the MPFS abstract file in exhibit 1, but the fields defining the fee and outpatient hospital indicators are not populated, instead they are space-filled.

The FI can contact the local carrier to obtain the price. When requesting the pricing data, it advises the carrier to provide the nonfacility fee from the MPFS. The MPFS supplemental file of physician fee schedule services is available for retrieval through CMS' Mainframe Telecommunications System. The FI is notified yearly of the file retrieval names and dates by a program memorandum or other communication.

100.3 - Proper Reporting of Code G0128 by CORFs - FIs

(Rev. 1, 10-01-03)

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

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).

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.

100.4 - Application of the Outpatient Mental Health Treatment Limitation to CORF Claims

(Rev. 1, 10-01-03)
A3-3653

Section §1833 of the Act payment requires that payment be made at 62.5 percent of the allowed amount for CORF mental health treatment services. The allowed amount is the lower of the MPFS amount or billed charges. Therefore, the FI makes payment at 62.5 percent of 80 percent of the allowed amount (or in effect 50 percent) for outpatient mental health treatment services. Hence, if the MPFS amount for a mental health treatment service provided in a CORF is $100, this amount is multiplied by 62.5 percent (the mental health treatment limitation). The resulting amount of $62.50 is then multiplied by 80 percent, which yields the Medicare payment of $50. The remaining 20 percent or the balance of $12.50, is the coinsurance responsibility of the beneficiary. The FI reports the amount in excess of the mental health limitation amount, $37.50, in the provider remittance advice with group code PR and claim adjustment reason code 122, Psychiatric reduction. This limitation may not be included in the coinsurance amount.

Unmet deductible must be subtracted from the allowed amount met before applying the 62.5 percent.

100.5 - Off-Site CORF Services

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

CORFs may provide physical therapy, speech-language pathology and occupational therapy off the CORF's premises in addition to the home evaluation. Services provided offsite are billed separately and identified as "offsite" on the Form CMS-1450 (UB-*04*), in the "Remarks" form locator. The charges for offsite visits include any additional charge for providing the services at a place other than the CORF premises. There is no change in the payment method for offsite services.

100.6 - Notifying Patient of Service Denial

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Services may be noncovered because they are statutorily excluded from coverage under Medicare, or because they are not medically reasonable and necessary.

If a service is excluded by statute, the CORF may submit a claim for them to Medicare to obtain a denial prior to billing another insurance carrier. It shows the charges as noncovered, and includes Condition Code 21. It may bill the beneficiary for the excluded services, and need not issue an advance beneficiary notice (ABN). However, when providing therapy services under the financial limitations, the CORF should provide the beneficiary with the Notice of Exclusion of Medicare Benefits (NEMB). The Medicare Claims Processing Manual, Chapter 30, "Limitation on Liability," discusses ABNs for FI processed claims for Part B services.

If, after reviewing the plan of care, the CORF determines that the services to be furnished to the patient are not medically reasonable or necessary, it immediately provides the beneficiary with an ABN. If the patient signs an ABN, the Form CMS-1450 includes occurrence code 32 "Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)" along with the date the ABN was signed.

If the beneficiary insists that a claim be submitted for payment, the CORF must indicate on the bill (billed separately from bills with covered charges) that it is being submitted at the beneficiary's request. This is done by using condition code 20.

If during the course of the patient's treatment the FI advises the CORF that covered care has ceased, the CORF must notify the beneficiary (or the beneficiary's representative) immediately.

NOTE: *Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.*

100.7 - Payment of Drugs, Biologicals, and Supplies in a CORF

(Rev. 1, 10-01-03)
A3-3653

Drugs

Drugs and biologicals do not apply in an OPT setting. Therefore, FIs are to advise their OPTs not to bill for them.

Supplies

OPTs should not bill for the supplies they furnish. Since supplies are part of the practice expense, under the MPFS these expenses are already taken into account in the practice expense relative values.

Vaccines

OPTs should not be providing influenza, pneumococcal pneumonia, and Hepatitis B vaccines and their administration.

100.8 - Billing for DME, Prosthetic and Orthotic Devices, and Surgical Dressings

(Rev. 1, 10-01-03)
CORF-412

The CORFs bill DME on Form CMS-1500 to the DMERC except for claims for implanted DME, which are billed on Form CMS-1500 to the local carrier. If the CORF does not have a supplier billing number from the National Supplier Clearinghouse (NSC), it may contact the NSC to secure one. If the local carrier has issued the CORF a provider number for billing physician services, the CORF may not use the same number when billing for DME.

The CORFs bill the FI for prosthetic/orthotic devices and surgical dressings on Form CMS-1450. Form completion requirements are contained in Chapter 25100.9 - Surgical Dressings

If the CORF supplies the surgical dressings for its patients, it bills using revenue code 0623 “Surgical Dressings.” The appropriate HCPCS code for the dressing is reported.

The FI makes payment based on the surgical dressing fee schedule.

100.10 - Group Therapy Services (Code 97150)

(Rev. 1145, Issued: 12-29-06, Effective: 01-01-07, Implementation: on or before 01-29-07)

Policies for group therapy services for CORF are the same as group therapy services for other Part B outpatient services**.** See Pub 100-02, chapter 15, section 230.

100.10.1 - Therapy Students

(Rev. 1145, Issued: 12-29-06, Effective: 01-01-07, Implementation: on or before 01-29-07)

Policies for therapy students for CORF are the same as policies for therapy students for other Part B outpatient services. See Pub. 100-02, chapter 15, section 230.

100.11 - Billing for Social Work and Psychological Services in a CORF

100.12 - Billing for Respiratory Therapy Services in a CORF

Exhibit 1 - Physician Fee Schedule Abstract File
(Rev. 515, Issued: 04-01-05, Effective: 01-03-05, Implementation: 07-05-05)

This file contains nonfacility fee schedule payment amounts for the outpatient rehabilitation, and CORF HCPCS codes listed in §20. These codes are identified in the abstract file by a value of "R" in the fee indicator field. The file includes fee schedule payment amounts by locality and is available via the CMS Mainframe Telecommunications System (formerly referred to as the Network Data Mover).

Record Length: 60
Record Format: FB
Block size: 6000
Character Code: EBCDIC
Sort Sequence: Carrier, Locality HCPCS Code, Modifier

Data Element Name	COBOL Location	Picture	Value
1 – HCPCS	1-5	X(05)	
2 – Modifier	6-7	X(02)	
3 – Filler	8-9	X(02)	
4 -- Non-Facility Fee	10-16	9(05)V99	
5 – Filler	17-23	X(07)	
6 – Filler	24-30	X(07)	
7 -- Carrier Number	31-35	X(05)	
8 – Locality	36-37	X(02)	Identical to the radiology/diagnostic fees
9 – Filler	38-40	X(03)	
10 -- Fee Indicator	41-41	X(1)	"R" - Rehab/Audiology/CORF services
11 -- Outpatient Hospital indicator	42-42	X(1)	"0" - Fee applicable in hospital outpatient setting "1" - Fee not applicable in hospital outpatient setting
12 – Filler	43-60	X(18)	

Upon CMS notification, the contractor is responsible for retrieving this file and making payment based on 80 percent of the lower of the actual charge or fee schedule amount indicated on the file after the Part B deductible has been met. The CMS will notify contractors of updates to the MPFS, file names and when the updated files will be available for retrieval. Upon retrieval, contractors disseminate the fee schedules to their providers. The file is also available on the CMS Web site in the Public Use Files (PUF) area.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R1472CP	03/06/2008	Update of Institutional Claims References	04/07/2008	5893
R1421CP	01/25/2008	Update of Institutional Claims References - Rescinded and Replaced by Transmittal 1472	04/07/2008	5893
R1414CP	01/17/2008	Outpatient Therapy Caps Without KX Modifier Exceptions Start January 1, 2008	01/07/2008	5871
R1407CP	01/10/2008	Outpatient Therapy Caps Without KX Modifier Exceptions Start January 1, 2008 – Replaced by Transmittal 1414	01/07/2008	5871
R1377CP	11/23/2007	2008 Annual Update to the Therapy Code List	01/07/2008	5810
R1183CP	02/09/2007	Infrared Therapy Devices	01/16/2007	5421
R1145CP	12/29/2006	Outpatient Therapy Cap Exceptions Process for Calendar Year (CY) 2007	01/29/2007	5478
R1127CP	12/15/2006	Infrared Therapy Devices – Replaced by Transmittal 1183	01/16/2007	5421
R1106CP	11/09/2006	Outpatient Therapy Cap Clarifications	12/09/2006	5271
R1019CP	08/03/2006	Outpatient Therapy - Additional DRA Mandated Service Edits	01/02/2007	5253
R1016CP	07/28/2006	Outpatient Therapy - Additional DRA Mandated Service Edit	01/02/2007	5253
R1000CP	07/19/2006	Common Working File (CWF) to the Medicare Beneficiary Database (MBD) Data Exchange Changes	10/02/2006	4300
R980CP	06/14/2006	Changes Conforming to CR 3648 Instructions for Therapy Services - Replaces Rev. 941	10/02/2006	4014

Rev #	Issue Date	Subject	Impl Date	CR#
R941CP	05/05/2006	Changes Conforming to CR 3648 Instructions for Therapy Services	10/02/2006	4014
R908CP	04/21/2006	Common Working File (CWF) to the Medicare Beneficiary Database (MBD) Data Exchange Changes	10/02/2006	4300
R855CP	02/15/2006	Therapy Caps Exception Process	3/13/2006	4364
R853CP	02/13/2006	Therapy Caps Exception Process	3/13/2006	4364
R805CP	01/06/2006	Annual Update to the Therapy Code List	02/06/2006	4226
R771CP	12/02/2005	Revisions to Pub.100-04, Medicare Claims Processing Manual in Preparation for the National Provider Identifier	01/03/2006	4181
R759CP	11/18/2005	Therapy Caps to be Effective January 1, 2006	01/03/2006	4115
R515CP	04/01/2005	Update to 100-04 and Therapy Code Lists	07/05/2005	3647
R463CP	02/04/2005	Update to 100-04 and Therapy Code Lists	07/05/2005	3647
R319CP	10/22/2004	CORF/OPT Edit for Billing Inappropriate Supplies	04/04/2005	3468
R042CP	12/08/2003	The Financial Limitation on Therapy Services	12/08/2003	3005
R030CP	11/14/2003	The Financial Limitation on Therapy Services	01/05/2004	2973
R001CP	10/01/2003	Initial Publication of Manual	NA	NA