CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1216	**Date: May 3, 2013**
	Change Request 8278

SUBJECT: Applying Multiple Procedure Payment Reductions to Therapy Cap Amounts for Critical Access Hospital Claims

I. SUMMARY OF CHANGES: This Change Request revises the amount applied toward a beneficiary's therapy cap amounts when therapy services are provided in a Critical Access Hospital. The requirements ensure the multiple procedure payment reduction is applied to these amounts.

EFFECTIVE DATE: January 1, 2013
IMPLEMENTATION DATE: October 7, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1216	Date: May 3, 2013	Change Request: 8278

SUBJECT: Applying Multiple Procedure Payment Reductions to Therapy Cap Amounts for Critical Access Hospital Claims

EFFECTIVE DATE: January 1, 2013
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I. GENERAL INFORMATION

A. Background: Section 603 of the *American Taxpayer Relief Act of 2012* (ATRA) contained a number of Original Medicare provisions affecting the outpatient therapy caps and manual medical review threshold. These provisions became effective on January 1, 2013. One of them required that outpatient therapy services provided in Critical Access Hospital (CAH) settings should be included in the beneficiary's therapy cap and threshold total, using the amount that would be payable if the services were paid under the Medicare Physician Fee Schedule. This change was implemented via Change Request 7881, Transmittal 2537, dated August 31, 2012, and subsequent guidance to Medicare contractors.

Payment for outpatient hospital therapy services includes a multiple procedure payment reduction when more than one unit or procedure is provided to the same patient on the same day by the same provider. Inadvertently, Medicare's initial implementation of this provision updated the therapy cap and threshold total by the full fee schedule amount, without applying the multiple procedure payment reduction. The requirements below correct how CAH claims update the therapy cap and threshold total.

B. Policy: The amounts used to update a beneficiary's therapy cap and threshold total on CAH claims shall apply any applicable multiple procedure payment reduction.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8278.1	Medicare contractors shall reduce the amounts applied to the beneficiary's therapy cap and threshold total on Critical Access Hospital claims by the applicable multiple procedure payment reduction.							X				
8278.1.1	Medicare contractors shall reduce the amount applied to the beneficiary's therapy cap and threshold when the following codes are present: 1. Type of bill 12X with Critical Access Hospital CCNs in the range 1300-1399 or 85X							X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	2. Revenue code 042X, 043X or 044X with matching dates of service 3. HCPCS code with a multiple services indicator of '5' 4. 'Legislation effective' indicator B											
8278.1.2	Medicare contractors shall reduce the amount applied to the beneficiary's therapy cap and threshold when the following codes are present: 1. Type of bill 12X with Critical Access Hospital CCNs in the range 1300-1399 or 85X 2. Revenue code 042X, 043X or 044X 3. HCPCS code with a multiple services indicator of '5' 4. Units greater than one 5. 'Legislation effective' indicator B							X				
8278.1.3	Medicare contractors shall reduce the amount applied to the beneficiary's therapy cap and threshold total using the methodology described in Change Request 8206, Transmittal 1194, dated February 22, 2013.							X				
8278.2	Medicare contractors shall adjust all claims processed before the implementation date of this CR that meet the following criteria: 1. Type of bill 12X with CAH CCNs in the range 1300-1399 or 85X 2. Revenue code 042X, 043X or 044X 3. Dates of service on or after January 1, 2013	X			X							
8278.2.1	Medicare contractors shall ensure that adjustments update the beneficiary's therapy cap and threshold total, but are not reflected on the remittance advice.	X			X							

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8278.3	Medicare contractors shall, upon request, adjust claims from providers other than CAHs if the reduction in the therapy cap total results in previously denied therapy claims becoming payable.	X			X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8278.4	MLN Article: A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information:
8278.1	This requirement has no impact on the payment amount calculated for the CAH therapy service. This change only affects the amount reported to CWF in the "Financial

X-Ref Requirement Number	Recommendations or other supporting information:
	Limitation" field.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
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