CMS Manual System	Department of Health & Human Services
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services
Transmittal 1851	Date: November 13, 2009
	Change Request 6660

SUBJECT: Therapy Cap Values for Calendar Year (CY) 2010

I. SUMMARY OF CHANGES: Therapy caps for 2010 will be $1860. This information will be public only after publication of the Physician Fee Schedule Final Rule in early November. The exceptions process will continue unchanged for the time frame directed by congress.

NEW / REVISED MATERIAL
EFFECTIVE DATE: JANUARY 1, 2010
IMPLEMENTATION DATE: JANUARY 4, 2010

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5/Table of Contents
R	5/10.2/The Financial Limitation
R	5/20.1/Discipline Specific Outpatient Rehabilitation Modifiers - All Claims
R	5/20.2/Reporting of Service Units With HCPCS
R	5/20.4/Coding Guidance for Certain CPT Codes - All Claims

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: 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 obligated 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:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1851	Date: November 13, 2009	Change Request: 6660

SUBJECT: Therapy Cap Values for Calendar Year (CY) 2010

Effective Date: January 1, 2010
Implementation Date: January 4, 2010

I. GENERAL INFORMATION

This change request describes the policy for outpatient therapy caps for 2010.

A. Background: The Balanced Budget Act of 1997, P.L. 105-33, Section 4541 (c) set annual caps for Part B Medicare patients. These limits change annually. The Deficit Reduction Act of 2005 was signed February 8, 2006. It directed the Secretary to implement a process for exceptions to therapy caps for medically necessary services. The Medicare Improvements for Patients and Providers Act of 2008 (MIIPPA), Section 141, extended exceptions to therapy caps through December 31, 2009.

B. Policy: Therapy caps for 2010 will be $1860. The exceptions process will continue unchanged for the time frame directed by Congress.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6660.1	Within 7 days of receipt of this change request, contractors shall update the Medicare Summary Notice 38.18 to the language stated in these manual instructions.	X	X	X	X						
6660.2	Medicare systems shall update the allowed dollar amount for 2010 outpatient therapy limits, except outpatient hospital services, to $1860 for physical therapy and speech-language pathology combined and $1860 for occupational therapy separately.						X			X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6660.3	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 site 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 your 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	X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
6660.3	The exceptions process for medically necessary services that exceed therapy caps is in effect until December 31, 2009, based on MIPPA. If Congress extends the therapy cap exception process, it will be continued without change for the time required. Contractors will be sent notice of the extension of therapy caps in the form of a change request or Joint Signature Memorandum.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Dorothy Shannon: Dorothy.Shannon@cms.hhs.gov
Post-Implementation Contact(s): Dorothy Shannon: Dorothy.Shannon@cms.hhs.gov

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

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 obligated 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.

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

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(Rev. 1851, 11-13-09)

10.2 - The Financial Limitation

(Rev. 1851, Issued: 11-13-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

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. The Medicare Improvements for Patients and Providers Act of 2008 extended the exceptions process from July 1, 2008 through December 31, 2009.

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 noted above. 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, $1810 for 2008*, and $1840 for 2009*. For 20*10*, the annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is $*1860*; the limit for occupational therapy is $*1860*. Limits apply to outpatient Part B therapy services from all settings except outpatient hospital and hospital emergency room. These excluded hospital services are reported on types of bill 12x or 13x, or 85x.

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 Deficit Reduction Act of 2005 directed CMS to develop exceptions to therapy caps for calendar year 2006 and those exceptions have been extended several times by subsequent legislation. 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 Pub. 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 because 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 <u>might</u> 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 - Therapy Cap Report, 3/21/2008, and CSC – Therapy Edits Tables 4/14/2008 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 More 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. *This list is illustrative and not exclusive.* 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 on 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. 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 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 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 *or A/B Mac*, refer to:

  - 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.

  - 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.

  - For claims paid to carrier *or A/B Mac*, 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

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 Pub. 100-02, chapter 15, section 220.2); and

  - Are justified by appropriate documentation in the medical record, (See 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 $1840 for 2009 *and $1860 for 2010* 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 $1,840 en el 2009 *y a $1860 en el 2010* 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, $1810 in 2008, $1840 in 2009*, and $1860 in 2010*) 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.

Contractors 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 *or A/B Mac* 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. Carrier *or A/B Mac* 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.

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 2009 limit of $1840 for a beneficiary who has paid the deductible and the coinsurance:

Services received to date $1825 ($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 *Contractors* 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 *contractors* 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 me dically 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.

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. Medicare contractors shall advise providers/suppliers to use a form of their own design to inform beneficiaries of the therapy financial limitation and the cap exclusion process.

Prior to March 1, 2009, providers could use the Notice of Exclusion from Medicare Benefits (NEMB Form No. CMS 20007) to inform a beneficiary of financial liability for therapy above the cap, where no exception applies; however, the NEMB form has been discontinued. In its place, providers may now use a form of their own design, or the Advanced Beneficiary Notice of Noncoverage (ABN, Form CMS-R-131) may be used as a voluntary notice. When using the ABN form as a voluntary notice, the form requirements specified for its mandatory use do not apply.

The beneficiary should not be asked to choose an option or sign the form. The provider should include the beneficiary's name on the form and the reason that Medicare may not pay in the space provided within the form's table. Insertion of 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., $*1860* in 20*10*) 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, if appropriate. *A cost estimate for the services may be included but is not required*.

After the cap is exceeded, *voluntary notice via a provider's own form or the ABN is appropriate, even when services are excepted from the cap. The ABN is also used* ***BEFORE*** *the cap is exceeded when notice about noncovered services is mandatory. For example, 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, an ABN must be issued before the beneficiary receives that service. 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 most likely will not provide additional coverage, and issue the ABN prior to delivering any services. The ABN informs the beneficiary of his/her potential financial obligation to the provider and provides guidance regarding appeal rights. When the ABN is used as a mandatory notice, providers must adhere to the form requirements set forth in this manual in chapter 30, section 50.6.3.*

The ABN can be found at: http://www.cms.hhs.gov/BNI/Downloads/ABNFormInstructions.zip

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 carrier *or A/B Mac* 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.

20.1 - Discipline Specific Outpatient Rehabilitation Modifiers - All Claims

(Rev. 1851, Issued: 11-13-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

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, *SLPPs,* 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. 1851, Issued: 11-13-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

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 carrier*s or A/B Macs*.

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. *See examples 2 and 3 below.*

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 *timed* units billed. *See example 1 below.*

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. *See example 5 below.*

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. *See all examples below.*

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, section 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.

20.4 - Coding Guidance for *Certain CPT* Codes - All Claims

(Rev. 1851, Issued: 11-13-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

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.