



Removal of the Provider Reporting Requirement for Total Number of Therapy Visits using Value Codes 50-53 – JA6899

Related CR Release Date: April 27, 2010

Date Job Aid Revised: May 3, 2010

Effective Date: October 1, 2010

Implementation Date: October 4, 2010

Key Words MM6899, CR6899, R1951CP, Provider, Reporting, Therapy, Visits

Contractors Affected

- Fiscal Intermediaries (FIs)
- Part A/B Medicare Administrative Contractors (A/B MACs)
- Regional Home Health Intermediaries (RHHIs)

Provider Types Affected Provider types affected are hospitals, Home Health Agencies, Comprehensive Outpatient Rehabilitation Facilities, Skilled Nursing Facilities, and other providers submitting claims to Medicare FIs, A/B MACs and RHHIs for services provided to Medicare beneficiaries.



Change Request (CR) 6899 advises providers that the requirement to report the total number of therapy visits using value codes 50 (physical therapy), 51 (occupational therapy), 52 (speech therapy), and 53 (cardiac rehab) has been removed.

Provider Needs to Know...

- Effective October 1, 2010, providers are **no longer required** to submit any of the these value codes (50, 51, 52, and 53) when billing for therapy services.
- The *Medicare Claims Processing Manual* has been updated to remove this requirement.

Background N/A

Operational
Impact

The related MLN Matters® article can be found at
<http://www.cms.gov/MLN MattersArticles/downloads/MM6899.pdf> on the CMS website.

Reference
Materials

The official instruction (CR6899) issued regarding this change may be found at
<http://www.cms.gov/Transmittals/downloads/R1951CP.pdf> on the CMS website.
