

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



**News Flash** – Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the Affordable Care Act further expands Section 1862 (a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means. As part of Medicare’s revalidation efforts, all suppliers and providers who are not currently receiving EFT payments will be identified, and required to submit the CMS 588 EFT form with the Provider Enrollment Revalidation application. For more information about provider enrollment revalidation, review the Medicare Learning Network’s [Special Edition Article #SE1126](#), titled “Further Details on the Revalidation of Provider Enrollment Information.”

MLN Matters® Number: MM7529 **Revised**

Related Change Request (CR) #: 7529

Related CR Release Date: November 18, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2351CP

Implementation Date: January 3, 2012

### Therapy Cap Values for Calendar Year (CY) 2012

**Note:** This article was revised on October 19, 2012 to add a reference to MLN Matters® article MM8036, available at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8036.pdf>, to alert providers that all requests for therapy services above \$3,700 provided by speech language therapists, physical therapists, occupational therapists, and physicians must be approved in advance. This applies to: Part B Skilled Nursing Facilities (SNFs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), rehabilitation agencies (Outpatient Rehabilitation Facilities (ORFs), private practices, home health agencies (TOB 34X), and hospital outpatient departments. All other information remains unchanged.

### Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Medicare Administrative

#### Disclaimer

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Contractors (MACs), Fiscal Intermediaries (FIs), and/or Regional Home Health Intermediaries (RHHIs)) for therapy services provided to Medicare beneficiaries.

## Provider Action Needed

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This article is based on Change Request (CR) 7529, which describes the Centers for Medicare & Medicaid Services (CMS) policy for outpatient therapy caps for Calendar Year (CY) 2012. Therapy caps for 2012 will be \$1880.00. Be sure your billing staff is aware of the update.

## Background

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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 directed the Secretary to implement a process for exceptions to therapy caps for medically necessary services. The Affordable Care Act extended the exceptions to therapy caps through December 31, 2010; and, the Medicare and Medicaid Extenders Act (MMEA) of 2010 extended the therapy caps exceptions through CY 2011. If Congress extends the therapy cap exceptions process, CMS will provide an update to inform providers of the details of such extension.

Note that the therapy caps apply to outpatient services and do not apply to Skilled Nursing Facility (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 prospective payment system (PPS) for the covered stay. Also, therapy caps do not apply to any therapy services billed under the home Health PPS, inpatient hospitals, or the outpatient department of hospitals, including critical access hospitals.

## Additional Information

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**Note:** This article was also revised on December 7, 2011, to provide a statement in the Background section, which indicated further changes may be needed if Congress extends the therapy cap exceptions process.

The official instruction, CR7529 issued to your carrier, FI, RHHI and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2351CP.pdf> on the CMS website.

If you have any questions, please contact your carrier, FI, RHHI or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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You may also want to review MM7785 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7785.pdf>) that alerts providers to changes in the therapy cap exception process including: (1) extending the therapy cap exception process through December 31, 2012; (2) the therapy caps and related provisions will temporarily apply to therapy services furnished in an outpatient hospital between October 1, 2012 and January 1, 2013; (3) requirement that the NPI of the physician certifying the therapy plan of care is on the claim; and (4) adds new thresholds for mandatory medical review.

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