DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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MLN Matters® Number: MM7785 Revised	**Related Change Request (CR) #: CR 7785**
Related CR Release Date: December 14, 2012	**Effective Date: October 1, 2012**
Related CR Transmittal #: R2615CP	**Implementation Date: October 1, 2012**

Revisions of the Financial Limitation for Outpatient Therapy Services – Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012

Note: This article was revised on December 15, 2015, to add a reference to MLN Matters® Article MM9223 which revises Original Medicare Systems to ensure therapy services provided in Maryland hospitals are subject to the outpatient therapy per beneficiary caps. All other information remains the same.

Provider Types Affected

This MLN Matters® article is intended for physicians, other suppliers and providers who submit claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for therapy services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 7785, which extends the therapy cap exceptions process through December 31, 2012, adds therapy services provided in outpatient hospital settings other than Critical Access Hospitals (CAHs) to the therapy cap effective October 1, 2012, requires the National Provider Identifier (NPI) of the physician certifying therapy plan of care on the claim, and addresses new thresholds for mandatory medical review.

CAUTION – What You Need to Know

The therapy cap amounts for 2012 are $1880 for occupational therapy services, and $1880 for the combined services for physical therapy and speech-language pathology. Suppliers and providers will continue to use the KX modifier to request an exception to the therapy caps on claims that are over these amounts. The use of the KX modifier indicates that the services are reasonable and necessary, and there is documentation of medical necessity in the patient's medical record. For services provided on or after October 1, 2012 and before January 1, 2013, there will be two new therapy services thresholds of $3700 per year: one annual threshold each for 1) Occupational Therapy (OT) services, and 2) Physical Therapy (PT) services and Speech-Language Pathology (SLP) services combined. Per-beneficiary services above these thresholds will require mandatory medical review .

GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Balanced Budget Act of 1997 (see **http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf** on the Internet) enacted financial limitations on outpatient PT, OT, and SLP services in all settings except outpatient hospital. Exceptions to the limits were enacted by the Deficit Reduction Act (see **http://www.gpo.gov/fdsys/pkg/PLAW-109publ171/pdf/PLAW-109publ171.pdf** on the Internet), and have been extended by legislation several times.

The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA, Section 3005; see **http://www.gpo.gov/fdsys/pkg/BILLS-112hr3630enr/pdf/BILLS-112hr3630enr.pdf** on the Internet) extended the therapy caps exceptions process through December 31, 2012, and made several changes affecting the processing of claims for therapy services.

The therapy cap amounts for 2012 are:

- $1880 for OT services, and
- $1880 for the combined services for PT and SL P.

Change Request (CR) 7785 instructs Medicare suppliers and providers to continue to use the KX modifier to request an exception to the therapy cap on claims that are over these amounts. Note that use of the KX modifier is an attestation from the provider or supplier that:

1. The services are reasonable and necessary, and
2. There is documentation of medical necessity in the patient's medical record.

Therapy services furnished in an outpatient hospital setting have been exempt from the application of the therapy caps. However, MCTRJCA requires Original Medicare to temporarily apply the therapy caps (and related provisions) to the therapy services furnished in an outpatient hospital between October 1, 2012, and December 31, 2012.

Although the therapy caps are only applicable to hospitals for services provided on or after October 1, 2012, in applying the caps after October 1, 2012, claims paid for outpatient therapy services since January 1, 2012, will be included in the caps accrual totals.

In addition, MCTRJCA contains two requirements that become effective on October 1, 2012.

- The first of these requires that suppliers and providers report on the beneficiary's claim for therapy services the National Provider Identifier (NPI) of the physician (or Non-Physician Practitioner (NPP) where applicable) who is responsible for reviewing the therapy plan of care. For implementation purposes, the physician (or NPP as applicable) certifying the therapy plan of care is reported. NPPs who can certify the therapy plan of care include nurse practitioners, physician assistants and clinical nurse specialists.
- The second requires a manual medical review process for those exceptions where the beneficiary therapy services for the year reach a threshold of $3,700. The two separate thresholds triggering manual medical reviews build upon the separate therapy caps as follows:
    - One for OT services, and
    - One for PT and SLP services combined.

    Although PT and SLP services are combined for triggering the threshold, medical review is conducted separately by discipline.

Claims with the KX modifier requesting exceptions for services above either threshold are subject to a manual medical review process. The count of services to which these thresholds

apply begins on January 1, 2012. Absent Congressional action, manual medical review expires when the exceptions process expires on December 31, 2012.

Claims for services at or above the therapy caps or thresholds for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable. Although Medicare suppliers and providers are not required to issue an Advance Beneficiary Notice (ABN) for these benefit category denials, *they are encouraged to issue the voluntary ABN as a courtesy to their patients requiring services over the therapy cap amounts ($1,880 for each cap in CY 2012) to alert them of their possible financial liability.*

Key Billing Points

Remember the caps will apply to outpatient hospitals as detected via:

- Types of Bill (TOB) 12X (excluding CAHs with CMS Certification Numbers (CCNs) in the range of 1300-1399) or 13X;
- A revenue code of 042X, 043X, or 044X;
- Modifier GN, GO, or GP; and
- Date of service on or after October 1, 2012.

Other important points are as follows:

- The new thresholds will accrue for claims with dates of service from January 1, 2012, through December 31, 2012. Medicare will display the total amount applied toward the therapy caps and thresholds on all applicable inquiry screens and mechanisms.
- Providers should report the NPI of the physician/NPP certifying the therapy plan of care in the Attending Physician field on institutional claims for outpatient therapy services, for dates of service on or after October 1, 2012.
- In cases where different physicians/NPPs certify the OT, PT, or SLP plan of care, report the additional NPI in the Referring Physician field (loop 2310F) on institutional claims for outpatient therapy services for dates of service on or after October 1, 2012.
- On professional claims, providers are to report the physician/NPP certifying the therapy plan of care, including his/her NPI, for outpatient therapy services on or after October 1, 2012.
- For claims processing purposes, the certifying physician/NPP is considered a referring provider and such providers must follow the instructions in Chapter 15, Section 220.1.1 of the "Medicare Benefit Policy Manual" (**http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf**) for reporting the referring provider on a claim.

- On electronic professional claims, report the referring provider, including NPI, per the instructions in the appropriate ASC X12 837 Technical Report 3 (TR3).
- For paper claims, report the referring provider, including NPI, per the instructions in Chapter 26, Section 10 of the "Medicare Claims Processing Manual" at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf** on the Centers for Medicare & Medicaid services (CMS) website.

Claims without at least one referring provider, including his/her NPI, will be returned as unprocessable with the following codes:

- Claim Adjustment Reason Code 165 (Referral absent or exceeded).
- Remittance Advice Remark Code of N285 (Missing/incomplete/invalid referring provider name) and/or N286 (Missing/incomplete/invalid referring provider number).

Additional Information

The official instruction, CR7785, issued to your carriers, FIs, A/B MACs, and RHHIs regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2615CP.pdf** on the CMS website.

If you have any questions, please contact your carriers, FIs, A/B MACs, or RHHIs 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.

Document History

Date of Change	Description
December 15, 2015	This article was revised, to add a reference to MLN Matters® Article **MM9223** which revises Original Medicare Systems to ensure therapy services provided in Maryland hospitals are subject to the outpatient therapy per beneficiary caps.
December 18 2012	The article was changed to reflect a revised CR7785 issued on December 14, 2012. In this article, the CR release date, transmittal number and the Web address for accessing CR7785 have been revised.