

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



Are you billing correctly for ordered/referred services? Will you be impacted when the Centers for Medicare & Medicaid Services (CMS) turns on the edits for these services? See the revised MLN Matters® articles [SE1221](#), [SE1011](#), and MLN fact sheets “[Medicare Enrollment Guidelines for Ordering/Referring Providers](#)” and “[The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement](#)” to learn what you need to do.

MLN Matters® Number: MM7881

Related Change Request (CR) #: CR 7881

Related CR Release Date: August 31, 2012

Effective Date: January 1, 2013

Related CR Transmittal #: R2537CP

Implementation Date: January 7, 2013

## Expiration of 2012 Therapy Cap Revisions and User-Controlled Mechanism to Identify Legislative Effective Dates

Note: This article was revised on April 1, 2014, to add a reference to MLN Matters® article MM8426 (<http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8426.pdf>) that informs providers that outpatient therapy services furnished by a CAH are subject to the therapy cap and related policies, and the exceptions process, including the KX modifier and the manual medical review of claims in excess of \$3,700, applies to services furnished by a CAH in CY2014. All other information remains the same.

### Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers 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.

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2011 American Medical Association.

## Provider Action Needed

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This article is informational in nature and is based on Change Request (CR) 7881 which implements the statutory expiration date of certain provisions affecting claims for therapy services, to which the therapy caps apply.

Provisions relating to therapy caps are among a number of legislative changes that may be extended from year to year or for portions of a year. These changes may currently require a non-recurring CR to change hard coded edits in Medicare systems. Frequently, these CRs cannot be implemented quickly enough to meet the changing effective dates. Therefore, CR7881 creates a mechanism that MACs can use to extend the effective dates of certain policies in urgent situations.

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

## Background

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The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA, Section 3005; see <http://www.gpo.gov/fdsys/pkg/PLAW-112publ96/pdf/PLAW-112publ96.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. Previously, therapy services furnished in an outpatient hospital setting had been exempt from the application of the therapy caps.

However, MCTRJCA required Original Medicare to apply the therapy caps temporarily to the therapy services furnished in an outpatient hospital on/after October 1, 2012, and on/before December 31, 2012. Although claims processing requirements associated with the cap are only applicable to hospitals on/after October 1, 2012, claims paid for hospital outpatient therapy services since January 1, 2012, are included in calculating the cap beginning October 1, 2012.

MCTRJCA also required a manual review process for those exceptions where the beneficiary therapy services for the year reach a threshold of \$3,700. The separate thresholds triggering manual medical reviews build upon the separate therapy caps - one for Physical Therapy (PT) and Speech-Language Pathology (SLP) services combined and one for Occupational Therapy (OT) services. The count of services to which these thresholds apply began on January 1, 2012.

Unless Congressional action is taken, all of these provisions expire for dates of service after December 31, 2012. Provisions relating to the therapy caps are among a number of legislative changes that may be extended from year to year, or for portions of a year.

Medicare systems currently lack the flexibility to apply policies to claims based on frequently changing effective dates. These changes may currently require a non-recurring

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Change Request (CR) to change hard coded edits in Medicare systems, and often, these CRs cannot be implemented quickly enough to meet the changing effective dates.

Therefore, CR7881 creates a mechanism that MACs can use to extend the effective dates of certain policies based in urgent situations. This mechanism will be first used to set the expiration dates of the MCTRJCA (Section 3005) therapy provisions.

## Additional Information

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The official instruction, CR7881 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/R2537CP.pdf> on the CMS website.

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

You may want to review MM8036, available at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8036.pdf> which alerts 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

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