

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



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- [“Quick Reference Information: Medicare Immunization Billing”](#) Educational Tool, ICN 006799, downloadable

MLN Matters® Number: MM8556

Related Change Request (CR) #: CR 8556

Related CR Release Date: February 6, 2014

Effective Date: July 1, 2014

Related CR Transmittal #: R2868CP

Implementation Date: July 7, 2014

Therapy Modifier Consistency Edits

What You Should Know

This MLN Matters® Article is intended for physicians, providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8556, which creates edits in Original Medicare claims processing systems to ensure that certain 'always therapy' evaluation and reevaluation codes are reported with the correct modifier. It also makes several clarifications of details in the "Medicare Claims Processing Manual," Chapter 5 - Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services.

CR8556 contains no new policy. It updates Medicare systems and manuals to better reflect current published policies. Make sure that your billing staffs are aware of these updates.

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Background

Longstanding Original Medicare billing instructions require reporting of discipline specific outpatient rehabilitation modifiers. All claims for therapy service Healthcare Common Procedure Coding System (HCPCS) codes must report a modifier that indicates the discipline of the plan of care under which the services are provided.

Through analysis of Original Medicare claims data, the Centers for Medicare & Medicaid Services (CMS) has identified cases where claims for discipline specific evaluation codes have reported the modifier corresponding to another discipline. For example, occupational therapy evaluations have been billed and paid while reporting a GP modifier (Services delivered under an outpatient physical therapy plan of care.). When information on a claim is clearly self-contradictory, as in this example, the claim should be returned to the provider for correction. The business requirements in CR8556 create edits to do this, effective for dates of service July 1, 2014, and after.

In addition, CR8556 updates "Medicare Claims Processing Manual," Chapter 5 - Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services to reflect recent payment regulations. The Fiscal Year (FY) 2014 inpatient hospital final rule contained a policy regarding rebilling of Part B services when an inpatient stay is denied as not reasonable and necessary. This policy is now included in Section 40.8 of Chapter 5 of the "Medicare Claims Processing Manual.". Specifically, it states that if a beneficiary receives therapy services during an inpatient hospital stay which was denied because the stay was not medically necessary, the therapy services may be rebilled under Medicare Part B coverage. If the therapy would have been reasonable and necessary as hospital outpatient services, and provided the beneficiary has Part B entitlement, the services can be billed using Type of Bill 012x. All payment and billing requirements for outpatient therapy (including therapy caps, functional reporting and other instructions in this chapter) apply to these claims.

Additional Information

The official instruction, CR8556, issued to your MAC regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2868CP.pdf> on the CMS website.

If you have any questions, please contact your 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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