

MLN Matters Number: MM4014

Related Change Request (CR) #: 4014

Related CR Release Date: June 14, 2006

Effective Date: October 1, 2006

Related CR Transmittal #: R980CP and R55NCD

Implementation Date: October 2, 2006

Changes Conforming to Change Request 3648 (CR3648) for Therapy Services

Note: This article was updated on October 23, 2012, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for therapy services

Provider Action Needed



STOP – Impact to You

This article is based on Change Request (CR) 4014, which updates language in the *Medicare National Coverage Determinations Manual* (Publication 100-03) and the *Medicare Claims Processing Manual* (Publication 100-04) by changing the term “speech therapy” to “speech-language pathology.”



CAUTION – What You Need to Know

To conform to changes in CR3648, CR4014 removes from the *Medicare Claims Processing Manual* (Publication 100-04) the requirement to include the date last seen by a physician for outpatient services provided by a physical or occupational therapist or speech-language pathologist. Requirements for therapy services incident to a physician have not been changed.



GO – What You Need to Do

See the *Background* section of this article for further details regarding these changes.

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.

Background

The Centers for Medicare & Medicaid Services (CMS) is updating language in the *Medicare National Coverage Determinations (NCD) Manual* (Publication 100-03) and the *Medicare Claims Processing Manual* (Publication 100-04) as follows: The term “speech therapy” is being changed to “speech-language pathology.”

In addition, CMS is changing requirements in Chapter 1 of the *Medicare Claims Processing Manual* where therapists are to provide information on CMS-1500 (Health Insurance Claim Form) and the UB-92 claim form concerning the date last seen by the physician to conform with instructions in CR3648, Transmittal 36, dated June 24, 2005; subject: Publication 100-02, Chapter 15, Sections 220 and 230 Therapy Services. CR3648 can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R36BP.pdf> on the CMS website.

Health Insurance Portability and Accountability Act (HIPAA) guidelines require the following information only when it impacts the payer’s adjudication process:

- Date last seen; and
- The Unique Provider Identification Number (UPIN) of the physician.

Medicare payment is not impacted by this information except when the service is provided “incident to” the services of a physician’s or non-physician practitioner’s (NPP), in which case it is required. CR4014 updates instructions in CR3648 (related to claims for services “incident to” a physician’s/NPP’s service) by acknowledging that:

- The “incident to” service can be identified only on prepay or postpay review;
- Manual review of all therapy claims is not required; and
- “Incident to” policies have not changed and still apply to therapy services.

CR4014 also clarifies selected business requirements in CR3648 to indicate that some contractor actions:

- Will occur on prepay or postpay review. For example, compare the following:
 - Business Rule (BR) 3648.8 – Contractors shall pay for therapy services only when the service qualifies as a therapy service and the service is furnished by qualified professionals, or qualified personnel as defined in the manuals; with
 - BR 4014.8 – On prepay or post pay review of outpatient therapy claims for services provided on or after July 25, 2005, contractors shall pay for physical therapy and occupational therapy services only when the service is furnished by qualified professionals, or qualified personnel as defined in the appropriate Medicare manuals.

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.

- Should not be applied to services “incident to.” (e.g., BR 3648.3 - Medicare contractors shall not deny therapy claims based on missing documentation of a visit to the physician on prepay or postpay review).

CR3648 omitted the requirement for a physician visit when therapy services are billed. This change omits the requirement that the physician visit be documented on the claim.

This change does not affect the requirements for services billed “incident to” a physician.

Therefore, when a therapy service is billed “incident to,” the following requirements remain in effect because they are required by “incident to” policies:

- An initial physician visit (date last seen); and
- Identification of the ordering (and supervising) physicians/NPPs.

Implementation

The implementation date for this instruction is October 2, 2006.

Additional Information

CR3648 (Transmittal 36 dated June 24, 2005, subject Pub. 100-02, Chapter 15, Sections 220 and 230 Therapy Services) can be reviewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R36BP.pdf> on the CMS website.

The MLN Matters article, MM3648 can be viewed at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3648.pdf> on the CMS website.

For complete details, please see the official instructions (CR4014) issued to your carrier/intermediary regarding this change. There are two transmittals for CR4014, the NCD, transmittal 55 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R55NCD.pdf> on the CMS website.

Transmittal 941 is the Medicare Claims Processing Manual update, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R980CP.pdf> on the CMS site.

If you have any questions, please contact your carrier/intermediary 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.

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.