



News Flash – In October 2008, the Centers for Medicare & Medicaid Services (CMS) and 34 partner organizations hosted a meeting about the mechanics of implementing an e-prescribing program in a practice. **Audiotapes and slides are now archived online for continuing education credit.** The Massachusetts Medical Society and the American Pharmacist Association are pleased to provide Continuing Medical Education (a maximum of 22.5 *AMA PRA Category 1 Credits™*, (risk management study for MA Physicians) and Continuing Education for pharmacists (up to 13.25 hours of continuing education credit (1.325 CEUs)). Simply go to <http://www.massmed.org/Content/NavigationMenu2/ContinuingEducationEvents/NewCourses/NationalEprescribingConferenceOnline/EprescribingConferen.htm> to view the presentations and hear the audiotapes of the program. There are no registration or certificate fees.

MLN Matters Number: MM6321 **Revised**

Related Change Request (CR) #: 6321

Related CR Release Date: February 13, 2008

Effective Date: January 1, 2009

Related CR Transmittal #: R1678CP

Implementation Date: April 6, 2009

Outpatient Therapy Caps with Exceptions in Calendar Year (CY) 2009

Note: This article was updated on December 17, 2012, to reflect current Web addresses. This article was previously revised on October 19, 2012, to add a reference to MM7881 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7881.pdf>) to alert providers that Medicare now has a mechanism that MACs can use to extend the effective dates of certain policies, which will be first used to set the expiration dates of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) outpatient therapy provisions. All other information remains unchanged.

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Medicare Administrative Contractors (MACs), Fiscal Intermediaries (FIs), and/or Regional Home Health Intermediaries (RHHIs)) for therapy services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6321 which describes the Centers for Medicare & Medicaid Services (CMS) policy for outpatient therapy cap exceptions for 2009 and updates the dollar amount of the therapy caps for 2009. Be sure billing staff is aware of the updates.

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 Balanced Budget Act of 1997 established limits on outpatient therapy services. These limits change annually. The Deficit Reduction Act of 2005 allowed CMS to establish an exceptions process, which began January 1, 2006 and was extended by later legislation. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) **extended the exceptions process for therapy caps through December 31, 2009. CR 6321 makes no change to the exceptions process.**

CR 6321 revises the Medicare Claims Processing Manual Chapter 5, Section 10.2 (The Financial Limitation) to include the outpatient therapy cap exceptions for 2009. The revised manual chapter is included as attachment to CR6321, and the following is extracted from that attachment:

Financial limitations on outpatient therapy services, as described in the Medicare Claims Processing Manual (Chapter 5, Section 10.2 (The Financial Limitation)) were \$1740 in 2006, \$1780 in 2007, and \$1810 for 2008.

For 2009,

- **The annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is \$1840; and**
- **The separate limit for occupational therapy is \$1840.**

An **Advance Beneficiary Notice of Noncoverage (ABN)** is required to be given to a beneficiary whenever the treating clinician determines that the services being provided are no longer expected to be covered because they do not satisfy Medicare's medical necessity requirements before the cap is reached. The ABN informs the beneficiary of their potential financial obligation to the provider and provides guidance regarding appeal rights. **Since therapy that exceeds the cap is statutorily excluded from Medicare coverage, the ABN is not required.** However, the ABN may be used on a voluntary basis to inform the beneficiary of potential liability for therapy that exceeds the cap.

Note: The ABN-G is no longer effective as of March 1, 2009. The revised ABN (CMS-R-131) must now be used and the revised ABN is available for download at <http://www.massmed.org/Content/NavigationMenu2/ContinuingEducationEvents/NewCourses/NationalEprescribingConferenceOnline/EprescribingConference.htm> on the CMS website.

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Additional Information

The official instruction, CR 6321, issued to your carrier, FI, MAC, and RHHI regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1678CP.pdf> on the CMS website.

If you have any questions, please contact your carrier, FI, MAC, or RHHI 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.

This article was also revised on March 10, 2009, to clarify the Advance Beneficiary Notice (ABN) language on page 2. All other information remains the same.

News Flash - It's Not Too Late to Give and Get the Flu Shot! In the United States, the peak of flu season typically occurs anywhere from late December through March; however, flu season can last as late as May. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a one time pneumococcal vaccination. Protect yourself, your patients, and your family and friends by getting and giving the flu shot. **Don't Get the Flu. Don't Give the Flu.** Remember - Influenza and pneumococcal vaccinations plus their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. Health care professionals and their staff can learn more about Medicare's Part B coverage of adult immunizations and related provider education resources, by reviewing Special Edition *MLN Matters* article SE0838 <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0838.pdf> on the CMS website.

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