



News Flash – Medicare will cover immunizations for H1N1 influenza also called the "swine flu." There will be no coinsurance or copayment applied to this benefit, and beneficiaries will not have to meet their deductible. H1N1 influenza vaccine is currently under production and will be available in the Fall of 2009. For more information, go to <http://www.cms.gov/About-CMS/Agency-Information/H1N1/index.html> on the CMS website.

MLN Matters® Number: MM6660 **Revised**

Related Change Request (CR) #: 6660

Related CR Release Date: November 23, 2009

Effective Date: January 1, 2010

Related CR Transmittal #: R1860CP

Implementation Date: January 4, 2010

Therapy Cap Values for Calendar Year (CY) 2010

Note: This article was revised on October 19, 2012 to add a reference to MLN Matters® article MM8036, available at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8036.pdf>, to alert 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. All other information remains unchanged.

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), A/B Medicare Administrative Contractors (A/B MACs), and/or DME Medicare Administrative Contractors (DME MACs)) for physical therapy, speech-language pathology, and/or occupational therapy services provided to Medicare beneficiaries.

Provider Action Needed

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.

This article is based on Change Request (CR) 6660 which describes the policy for outpatient therapy caps for 2010 and announces that therapy caps for 2010 will be \$1860. Billing staff should be aware of these revised caps.

Background

The Balanced Budget Act 1997, P.L. 105-33, Section 4541(c) set annual caps for Part B Medicare patients. These limits change annually. The Deficit Reduction Act of 2005 (signed Feb. 8, 2006) directed that a process for exceptions to therapy caps for medically necessary services be implemented. Subsequently, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008, and Section 141 extended the effective date of the exceptions process to the therapy caps to December 31, 2009. The exceptions process will continue unchanged for the time frame directed by Congress.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is \$1860 for calendar year (CY) 2010. For occupational therapy services, the limit is \$1860 for CY 2010. The limit is based on incurred expenses and includes applicable deductible and coinsurance.

CR 6660 revises the Medicare Claims Processing Manual (Pub. 100-04, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Sections 10 (Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General), and Section 20 (HCPCS Coding Requirement) to include the CY 2010 therapy caps, and this revision is included as an attachment to CR 6660.

Additional Information

You can find out more about Medicare therapy services and resources at <http://www.cms.gov/Medicare/Billing/TherapyServices/index.html> on the Centers for Medicare and Medicaid Services (CMS) website.

The official instruction, CR 6660, issued to your carrier, FI, RHHI, A/B MAC, and DME MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1860CP.pdf> on the CMS website.

If you have any questions, please contact your carrier, FI, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring->

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[Programs/provider-compliance-interactive-map/index.html](#) on the CMS website.

You may want to review MM7785 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/NLNMattersArticles/downloads/MM7785.pdf>) for changes in the therapy cap exception process including: (1) extending the therapy caps exception process through December 31, 2012; (2) the therapy caps and related provision will temporarily apply to therapy services furnished in an outpatient hospital between October 1, 2012 and January 1, 2013; (3) requirement that the NPI of the physician certifying the therapy plan of care is on the claim; and (4) adds new thresholds for mandatory medical review.

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