CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2868	**Date: February 6, 2014**
	Change Request 8556

SUBJECT: Therapy Modifier Consistency Edits

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to create 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 Pub. 100-04, Chapter 5.

EFFECTIVE DATE: July 1, 2014
IMPLEMENTATION DATE: July 7, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5/Table of Contents
R	5/10.3/Application of Financial Limitations
R	5/20.1/Discipline Specific Outpatient Rehabilitation Modifiers - All Claims
R	5/20.2/Reporting of Service Units With HCPCS
N	5/40.8/Rebilling Therapy Services for Hospital Inpatients

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2868	Date: February 6, 2014	Change Request: 8556

SUBJECT: Therapy Modifier Consistency Edits

EFFECTIVE DATE: July 1, 2014
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I. GENERAL INFORMATION

A. Background: Longstanding Original Medicare billing instructions require reporting of discipline specific outpatient rehabilitation modifiers. All claims for therapy service HCPCS codes must report a modifier that indicates the discipline of the plan of care under which the services are provided. For example, physical therapy services must report modifier GP, which is defined "Services delivered under an outpatient physical therapy plan of care."

Through analysis of Original Medicare claims data, 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 which indicates a 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 this Change Request, create edits to do this, effective for dates of service July 1, 2014 and after.

In addition, this Change Request updates the Medicare Claims Processing Manual, Pub. 100-04, Chapter 5 to reflect recent payment regulations. The fiscal year 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 the chapter.

B. Policy: This Change Request contains no new policy. It updates Medicare systems and manuals to better reflect current published policies.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8556.1	The contractor shall return to the provider (RTP) institutional outpatient claims reporting HCPCS codes 97001 or 97002, if modifier GP is not present.	X				X				
8556.2	The contractor shall return to the provider (RTP) institutional outpatient claims reporting HCPCS codes 97003 or 97004, if modifier GO is not present.	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8556.3	The contractor shall return to the provider (RTP) institutional outpatient claims reporting HCPCS codes 92521, 92522, 92523, or 92524 if modifier GN is not present.	X				X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8556.4	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
8556.1 - 8556.3	Outpatient types of bill are defined in Pub. 100-04, Chapter 1, section 60.4.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services

Table of Contents
(Rev. 2868, 02-05-14)

10.3 - Application of Financial Limitations

(Rev. 2868, Issued: 02-05-14, Effective: 07-01-14, Implementation: 07-07-14)

(Additions, deletions or changes to the therapy code list are updated via a Recurring Update Notification.)

Financial limitations on outpatient therapy services, as described above, began for therapy services rendered on or after on January 1, 2006. References and polices relevant to the exceptions process in this chapter apply only when exceptions to therapy caps are in effect. For dates of service before October 1, 2012, limits apply to outpatient Part B therapy services furnished in all settings except outpatient hospitals, including hospital emergency departments. These excluded hospital services are reported on types of bill 12x or 13x, or 85x. Effective for dates of service on or after October 1, 2012, the limits also apply to outpatient Part B therapy services furnished in outpatient hospitals other than Critical Access Hospitals. During this period, only type of bill 12x claims with a CMS certification number in the Critical Access Hospital range and type of bill 85x claims are excluded. Effective for dates of service on or after January 1, 2014, the limits also apply to Critical Access Hospitals.

Contractors apply the financial limitations to the MPFS amount (or the amount charged if it is smaller) for therapy services for each beneficiary.

As with any Medicare payment, beneficiaries pay the coinsurance (20 percent) and any deductible that may apply. Medicare will pay the remaining 80 percent of the limit after the deductible is met. These amounts will change each calendar year.

Medicare shall apply these financial limitations in order, according to the dates when the claims were received. When limitations apply, the Common Working File (CWF) tracks the limits. Shared system maintainers are not responsible for tracking the dollar amounts of incurred expenses of rehabilitation services for each therapy limit.

In processing claims where Medicare is the secondary payer, the shared system takes the lowest secondary payment amount from MSPPAY and sends this amount on to CWF as the amount applied to therapy limits.

A. Exceptions to Therapy Caps - General

The following policies concerning exceptions to caps due to medical necessity apply only when the exceptions process is in effect. *Except for the requirement to* use the KX modifier, the guidance in this section concerning medical necessity applies as well to services provided before caps are reached.

Provider and supplier information concerning exceptions is in this chapter and in Pub. 100-02, chapter 15, section 220.3. Exceptions shall be identified by a modifier on the claim and supported by documentation.

The beneficiary may qualify for use of the cap exceptions *process* at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps. All requests for exception are in the form of a KX modifier added to claim lines. (See subsection D. for use of the KX modifier.)

Use of the exception process does not exempt services from manual or other medical review processes as described in Pub. 100-08. Rather, atypical use of the exception process may invite contractor scrutiny*, for example, when the KX modifier is applied to all services on claims that are below the therapy caps or when the KX modifier is used for all beneficiaries of a therapy provider*. *To substantiate the medical necessity of the therapy services, document in the medical record* (see Pub. 100-02, chapter 15, sections 220.2, 220.3, and 230).

The KX modifier, described in subsection D., is added to claim lines to indicate that the clinician attests that services *at and above the therapy caps* are medically necessary and justification is documented in the medical record.

B. Exceptions Process

An exception may be made when the patient's condition is justified by documentation indicating that the beneficiary requires continued skilled therapy, i.e., therapy beyond the amount payable under the therapy cap, to achieve their prior functional status or maximum expected functional status within a reasonable amount of time.

No special documentation is submitted to the contractor for exceptions. The clinician is responsible for consulting guidance in the Medicare manuals and in the professional literature to determine if the beneficiary may qualify for the exception because documentation justifies medically necessary services above the caps. The clinician's opinion is not binding on the Medicare contractor who makes the final determination concerning whether the claim is payable.

Documentation justifying the services shall be submitted in response to any Additional Documentation Request (ADR) for claims that are selected for medical review. Follow the documentation requirements in Pub. 100-02, chapter 15, section 220.3. If medical records are requested for review, clinicians may include, at their discretion, a summary that specifically addresses the justification for therapy cap exception.

In making a decision about whether to utilize the exception, clinicians shall consider, for example, whether services are appropriate to--

- The patient's condition, including the diagnosis, complexities, and severity;
- The services provided, including their type, frequency, and duration;

- The interaction of current active conditions and complexities that directly and significantly influence the treatment such that it causes services to exceed caps.

In addition, the following should be considered before using the exception process:

1. Exceptions for Evaluation Services

Evaluation. The CMS will except therapy evaluations from caps after the therapy caps are reached when evaluation is necessary, e.g., to determine if the current status of the beneficiary requires therapy services. For example, the following CPT codes for evaluation procedures may be appropriate:

92521, 92522 , 92523, 92524, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004.

These codes will continue to be reported as outpatient therapy procedures as listed in the Annual Therapy Update for the current year at: http://www.cms.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage. They are not diagnostic tests. Definitions of evaluations and documentation are found in Pub. 100-02, sections 220 and 230.

Other Services. There are a number of sources that suggest the amount of certain services that may be typical, either per service, per episode, per condition, or per discipline. For example, see the CSC - Therapy Cap Report, 3/21/2008, and CSC – Therapy Edits Tables 4/14/2008 at www.cms.hhs.gov/TherapyServices (Studies and Reports), or more recent utilization reports. Professional literature and guidelines from professional associations also provide a basis on which to estimate whether the type, frequency, and intensity of services are appropriate to an individual. Clinicians and contractors should utilize available evidence related to the patient's condition to justify provision of medically necessary services to individual beneficiaries, especially when they exceed caps. Contractors shall not limit medically necessary services that are justified by scientific research applicable to the beneficiary. Neither contractors nor clinicians shall utilize professional literature and scientific reports to justify payment for continued services after an individual's goals have been met earlier than is typical. Conversely, professional literature and scientific reports shall not be used as justification to deny payment to patients whose needs are greater than is typical or when the patient's condition is not represented by the literature.

2. Exceptions for Medically Necessary Services

Clinicians may utilize the process for exception for any diagnosis or condition for which they can justify services exceeding the cap. Regardless of the diagnosis or condition, the patient must also meet other requirements for coverage.

Bill the most relevant diagnosis. As always, when billing for therapy services, the ICD-9 code that best relates to the reason for the treatment shall be on the claim, unless there is a compelling reason to report another diagnosis code. For example, when a patient with diabetes is being treated with therapy for gait training due to amputation, the preferred diagnosis is abnormality of gait (which characterizes the treatment). Where it is possible in accordance with State and local laws and the contractors' local coverage determinations, avoid using vague or general diagnoses. When a claim includes several types of services, or where the physician/NPP must supply the diagnosis, it may not be possible to use the most relevant therapy diagnosis code in the primary position. In that case, the relevant diagnosis code should, if possible, be on the claim in another position.

Codes representing the medical condition that caused the treatment are used when there is no code representing the treatment. Complicating conditions are preferably used in non-primary positions on the claim and are billed in the primary position only in the rare circumstance that there is no more relevant code.

The condition or complexity that caused treatment to exceed caps must be related to the therapy goals and must either be the condition that is being treated or a complexity that directly and significantly impacts the rate of recovery of the condition being treated such that it is appropriate to exceed the caps. Documentation for an exception should indicate how the complexity (or combination of complexities) directly and significantly affects treatment for a therapy condition.

If the contractor has determined that certain codes do not characterize patients who require medically necessary services, providers/suppliers may not use those codes, but must utilize a billable diagnosis code allowed by their contractor to describe the patient's condition. Contractors shall not apply therapy caps to services based on the patient's condition, but only on the medical necessity of the service for the condition. If a service would be payable before the cap is reached and is still medically necessary after the cap is reached, that service is excepted.

Contact your contractor for interpretation if you are not sure that a service is applicable for exception.

It is very important to recognize that most conditions would not ordinarily result in services exceeding the cap. Use the KX modifier only in cases where the condition of the individual patient is such that services are APPROPRIATELY provided in an episode that exceeds the cap. Routine use of the KX modifier for all patients with these conditions will likely show up on data analysis as aberrant and invite inquiry. Be sure that documentation is sufficiently detailed to support the use of the modifier.

In justifying exceptions for therapy caps, clinicians and contractors should not only consider the medical diagnoses and medical complications that might directly and significantly influence the amount of treatment required. Other variables (such as the availability of a caregiver at home) that affect appropriate treatment shall also be considered. Factors that influence the need for treatment should be supportable by

published research, clinical guidelines from professional sources, and/or clinical or common sense. See Pub. 100-02, chapter 15, section 220.3 for information related to documentation of the evaluation, and section 220.2 on medical necessity for some factors that complicate treatment.

NOTE: The patient's lack of access to outpatient hospital therapy services alone, when outpatient hospital therapy services are excluded from the limitation, does not justify excepted services. Residents of skilled nursing facilities prevented by consolidated billing from accessing hospital services, debilitated patients for whom transportation to the hospital is a physical hardship, or lack of therapy services at hospitals in the beneficiary's county may or may not qualify as justification for continued services above the caps. The patient's condition and complexities might justify extended services, but their location does not. For dates of service on or after October 1, 2012, therapy services furnished in an outpatient hospital are not excluded from the limitation.

C. Appeals Related to Disapproval of Cap Exceptions

Disapproval of Exception from Caps. When a service beyond the cap is determined to be medically necessary, it is covered and payable. But, when a service provided beyond the cap (outside the benefit) is determined to be NOT medically necessary, it is denied as a benefit category denial. Contractors may review claims with KX modifiers to determine whether the services are medically necessary, or for other reasons. Services that exceed therapy caps but do not meet Medicare criteria for medically necessary services are not payable even when clinicians recommend and furnish these services.

Services without a Medicare benefit may be billed to Medicare with a GY modifier for the purpose of obtaining a denial that can be used with other insurers. See Pub. 100-04, chapter 1, section 60.4 for appropriate use of modifiers.

APPEALS –If a beneficiary whose excepted services do not meet the Medicare criteria for medical necessity elects to receive such services and a claim is submitted for such services, the resulting determination would be subject to the administrative appeals process. Further details concerning appeals are found in Pub. 100-04, chapter 29.

D. Use of the KX Modifier for Therapy Cap Exceptions

When exceptions are in effect and the beneficiary qualifies for a therapy cap exception, the provider shall add a KX modifier to the therapy HCPCS code subject to the cap limits. The KX modifier shall not be added to any line of service that is not a medically necessary service; this applies to services that, according to a local coverage determination by the contractor, are not medically necessary services.

The codes subject to the therapy cap tracking requirements for a given calendar year are listed at:
http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage.

The GN, GO, or GP therapy modifiers are currently required to be appended to therapy services. In addition to the KX modifier, the GN, GP and GO modifiers shall continue to be used. Providers may report the modifiers on claims in any order. If there is insufficient room on a claim line for multiple modifiers, additional modifiers may be reported in the remarks field. Follow the routine procedure for placing HCPCS modifiers on a claim as described below.

- For professional claims, sent to the carrier or A/B MAC, refer to:
    - Pub.100-04, Medicare Claims Processing Manual, chapter 26, for more detail regarding completing the CMS-Form 1500 claim form, including the placement of HCPCS modifiers. **NOTE**: The CMS-Form 1500 currently has space for providing two modifiers in block 24D, but, if the provider has more than two to report, he/she can do so by placing the -99 modifier (which indicates multiple modifiers) in block 24D and placing the additional modifiers in block 19.
    - The ASC X12N 837 Health Care Claim: Professional Implementation Guide for more detail regarding how to electronically submit a health care claim transaction, including the placement of HCPCS modifiers. The ASC X12N 837 implementation guides are the standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for submitting health care claims electronically. The 837 professional transaction currently permits the placement of up to four modifiers, in the 2400 loop, SV1 segment, and data elements SV101-3, SV101-4, SV101-5, and SV101-6. Copies of the ASC X12N 837 implementation guides may be obtained from the Washington Publishing Company.
    - For claims paid by a carrier or A/B MAC, it is only appropriate to append the KX modifier to a service that reasonably may exceed the cap. Use of the KX modifier when there is no indication that the cap is likely to be exceeded is abusive. For example, use of the KX modifier for low cost services early in an episode when there is no evidence of a previous episode that might have exceeded the cap is inappropriate.
- For institutional claims, sent to the FI or A/B MAC:
    - When the cap is exceeded by at least one line on the claim, use the KX modifier on all of the lines on that institutional claim that refer to the same therapy cap (PT/SLP or OT), regardless of whether the other services exceed the cap. For example, if one PT service line exceeds the cap, use the KX modifier on all the PT and SLP service lines (also identified with the GP or GN modifier) for that claim. When the PT/SLP cap is exceeded by PT services, the SLP lines on the claim may meet the requirements for an exception due to the complexity of two episodes of service.

- Use the KX modifier on either all or none of the SLP lines on the claim, as appropriate. In contrast, if all the OT lines on the claim are below the cap, do not use the KX modifier on any of the OT lines, even when the KX modifier is appropriately used on all of the PT lines. Refer to Pub.100-04, Medicare Claims Processing Manual, chapter 25, for more detail.

By appending the KX modifier, the provider is attesting that the services billed:

- Are reasonable and necessary services that require the skills of a therapist; (See Pub. 100-02, chapter 15, section 220.2); and

- Are justified by appropriate documentation in the medical record, (See Pub. 100-02, chapter 15, section 220.3); and

- Qualify for an exception using the automatic process exception.

If this attestation is determined to be inaccurate, the provider/supplier is subject to sanctions resulting from providing inaccurate information on a claim.

When the KX modifier is appended to a therapy HCPCS code, the contractor will override the CWF system reject for services that exceed the caps and pay the claim if it is otherwise payable.

Providers and suppliers shall continue to append correct coding initiative (CCI) HCPCS modifiers under current instructions.

If a claim is submitted without KX modifiers and the cap is exceeded, those services will be denied. In cases where appending the KX modifier would have been appropriate, contractors may reopen and/or adjust the claim, if it is brought to their attention.

Services billed after the cap has been exceeded which are not eligible for exceptions may be billed for the purpose of obtaining a denial using condition code 21.

E. Therapy Cap Manual Review Threshold

For calendar year 2012, there shall be two total therapy service thresholds of $3700 per year: one annual threshold each for

(1) Occupational therapy services.

(2) Physical therapy services and speech-language pathology services combined.

Services shall accrue toward the thresholds beginning with claims with dates of service on and after January 1, 2012. The thresholds shall apply to both services showing the KX modifier and those without the modifier. Beginning with claims with dates of service on and after October 1, 2012, contractors shall apply the thresholds to claims exceeding it by

suspending the claim for manual review. Instructions regarding the manual review process may be found in the Program Integrity Manual.

F. Identifying the Certifying Physician

Therapy plans of care must be certified by a physician or non-physician practitioner (NPP), per the requirements in the Medicare Benefit Policy Manual, Pub.100-02, chapter 15, section 220.1.3. Further, the National Provider Identifier (NPI) of the certifying physician/NPP identified for a therapy plan of care must be included on the therapy claim.

For the purposes of processing professional claims, the certifying physician/NPP is considered a referring provider. At the time the certifying physician/NPP is identified for a therapy plan of care, private practice therapists (PPTs), physicians or NPPs, as appropriate, submitting therapy claims, are to treat it as if a referral has occurred for purposes of completing the claim and to follow the instructions in the appropriate ASC X12 837 Professional Health Care Claim Technical Report 3 (TR3) for reporting a referring provider (for paper claims, they are to follow the instructions for identifying referring providers per chapter 26 of this IOM). These instructions include requirements for reporting NPIs.

Currently, in the 5010 version of the ASC X12 837 Professional Health Care Claim TR3, referring providers are first reported at the claim level; additional referring providers are reported at the line level only when they are different from that identified at the claim level. Therefore, there will be at least one referring provider identified at the claim level on the ASC X12 837 Professional claim for therapy services. However, because of the hierarchical nature of the ASC X12 837 health care claim transaction, and the possibility of other types of referrals applying to the claim, the number of referring providers identified on a professional claim may vary. For example, on a claim where one physician/NPP has certified all the therapy plans of care, and there are no other referrals, there would be only one referring provider identified at the claim level and none at the line levels. Conversely, on a claim also containing a non-therapy referral made by a different physician/NPP than the one certifying the therapy plan of care, the billing provider may elect to identify either the nontherapy or the therapy referral at the claim level, with the other referral(s) at the line levels. Similarly, on a claim having different certifying physician/NPPs for different therapy plans of care, only one of these physician/NPPs will be identified at the claim level, with the remainder identified at the line levels. These scenarios are only examples: there may be other patterns of representing referring providers at the claim and line levels depending upon the circumstances of the care and the manner in which the provider applies the requirements of the ASC X12 837 Professional Health Care Claim TR3.

For situations where the physician/NPP is both the certifier of the plan of care and furnishes the therapy service, he/she supplies his/her own information, including the NPI, in the appropriate referring provider loop (or, appropriate block on the 1500 form). This is applicable to those therapy services that are personally furnished by the physician/NPP

as well as to those services that are furnished incident to their own and delivered by "qualified personnel" (see section 230.5 of this manual for qualifications for incident to personnel).

Contractors shall edit to ensure that there is at least one claim-level referring provider identified on professional therapy claims, and shall use the presence of the therapy modifiers (GN, GP, GO) to identify those claims subject to this requirement.

For the purposes of processing institutional claims, the certifying physician/NPP and their NPI are reported in the Attending Provider fields on institutional claim formats. Since the physician/NPP is certifying the therapy plan of care for the services on the claim, this is consistent with the National Uniform Billing Committee definition of the Attending Provider as "the individual who has overall responsibility for the patient's medical care and treatment" that is reported on the claim. In cases where a patient is receiving care under more than one therapy plan of care (OT, PT, or SLP) with different certifying physicians/NPPs, the second certifying physicians/NPP and their NPI are reported in the Referring Physician fields on institutional claim formats.

G. MSN Messages

Existing MSN messages 38.18, 17.13, 17.18 and 17.19 shall be issued on all claims containing outpatient rehabilitation services as noted in this manual. Contractors add the applied amount for individual beneficiaries and the generic limit amount to all MSNs that require them. For details of these MSNs, see:
http://www.cms.gov/MSN/02_MSN%20Messages.asp

20.1 - Discipline Specific Outpatient Rehabilitation Modifiers - All Claims

(Rev. 2868, Issued: 02-05-14, Effective: 07-01-14, Implementation: 07-07-14)

Modifiers are used to identify therapy services whether or not financial limitations are in effect. When limitations are in effect, the CWF tracks the financial limitation based on the presence of therapy modifiers. Providers/suppliers must continue to report one of these modifiers for any therapy code on the list of applicable therapy codes except as noted in §20 of this chapter. Consult §20 for the list of codes to which modifiers must be applied. These modifiers do not allow a provider to deliver services that they are not qualified and recognized by Medicare to perform.

The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered:

- GN Services delivered under an outpatient speech-language pathology plan of care;

- GO Services delivered under an outpatient occupational therapy plan of care; or,

- GP Services delivered under an outpatient physical therapy plan of care.

This is applicable to all claims from physicians, nonphysician practitioners (NPPs), PTPPs, OTPPs, SLPPs, CORFs, OPTs, hospitals, SNFs, and any others billing for physical therapy, speech-language pathology or occupational therapy services as noted on the applicable code list in §20 of this chapter.

Modifiers GN, GO, and GP refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services. They should never be used with codes that are not on the list of applicable therapy services. For example, respiratory therapy services, or nutrition therapy services shall not be represented by therapy codes which require GN, GO, and GP modifiers.

Contractors edit *institutional claims to ensure the following:*

- that *a GN, GO or GP modifier is* present *for all lines reporting* revenue codes 042X, 043X, or 044X.

- that *no* more than one GN, GO or GP modifier *is* reported on the same service line.

- that revenue codes and modifiers are reported only in the following combinations:

    - Revenue code 42x (physical therapy) lines may only contain modifier GP
    - Revenue code 43x (occupational therapy) lines may only contain modifier GO
    - Revenue code 44x (speech-language pathology) lines may only contain modifier GN.

- *that discipline-specific evaluation and re-evaluation HCPCS codes are always reported with the modifier for the associated discipline (e.g. modifier GP with a HCPCS code for a physical therapy evaluation).*

Contractors return to the provider institutional claims that do not meet one or more of these conditions.

20.2 - Reporting of Service Units With HCPCS

(Rev. 2868, Issued: 02-05-14, Effective: 07-01-14, Implementation: 07-07-14)

A. General

Effective with claims submitted on or after April 1, 1998, providers billing on Form CMS-1450 were required to report the number of units for outpatient rehabilitation services based on the procedure or service, e.g., based on the HCPCS code reported instead of the revenue code. This was already in effect for billing on the Form CMS-1500, and CORFs were required to report their full range of CORF services on the Form

CMS-1450. These unit-reporting requirements continue with the standards required for electronically submitting health care claims under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) - the currently adopted version of the ASC X12 837 transaction standards and implementation guides. The Administrative Simplification Compliance Act mandates that claims be sent to Medicare electronically unless certain exceptions are met.

B. Timed and Untimed Codes

When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe ("untimed" HCPCS), the provider enters "1" in the field labeled units. For untimed codes, units are reported based on the number of times the procedure is performed, as described in the HCPCS code definition (often once per day).

EXAMPLE: A beneficiary received a speech-language pathology evaluation represented by HCPCS "untimed" code *92521*. Regardless of the number of minutes spent providing this service only one unit of service is appropriately billed on the same day.

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any single calendar day** using CPT codes and the appropriate number of 15 minute units of service.

EXAMPLE: A beneficiary received occupational therapy (HCPCS "timed" code 97530 which is defined in 15 minute units) for a total of 60 minutes. The provider would then report revenue code 043X and 4 units.

C. Counting Minutes for Timed Codes in 15 Minute Units

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:

Units	**Number of Minutes**
1 unit:	≥ 8 minutes through 22 minutes
2 units:	≥ 23 minutes through 37 minutes
3 units:	≥ 38 minutes through 52 minutes

4 units: ≥ 53 minutes through 67 minutes

5 units: ≥ 68 minutes through 82 minutes

6 units: ≥ 83 minutes through 97 minutes

7 units: ≥ 98 minutes through 112 minutes

8 units: ≥ 113 minutes through 127 minutes

The pattern remains the same for treatment times in excess of 2 hours.

If a service represented by a 15 minute timed code is performed in a single day for at least 15 minutes that service shall be billed for at least one unit. If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc. It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes. See examples 2 and 3 below.

When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service (as noted on the chart above) determines the number of timed units billed. See example 1 below.

If any 15 minute timed service that is performed for 7 minutes or less than 7 minutes on the same day as another 15 minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater than 8 minutes, then bill one unit for the service performed for the most minutes. This is correct because the total time is greater than the minimum time for one unit. The same logic is applied when three or more different services are provided for 7 minutes or less than 7 minutes. See example 5 below.

The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

If more than one 15 minute timed CPT code is billed during a single calendar day, then the total number of timed units that can be billed is constrained by the total treatment minutes for that day. See all examples below.

Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.3B, Documentation Requirements for Therapy Services, indicates that the amount of time for each specific intervention/modality provided to the patient is not required to be documented in the Treatment Note. However, the total number of timed minutes must be documented. These examples indicate how to count the appropriate number of units for the total therapy minutes provided.

Example 1 –

24 minutes of neuromuscular reeducation, code 97112,
23 minutes of therapeutic exercise, code 97110,
Total timed code treatment time was 47 minutes.

See the chart above. The 47 minutes falls within the range for 3 units = 38 to 52 minutes.

Appropriate billing for 47 minutes is only 3 timed units. Each of the codes is performed for more than 15 minutes, so each shall be billed for at least 1 unit. The correct coding is 2 units of code 97112 and one unit of code 97110, assigning more timed units to the service that took the most time.

Example 2 –

20 minutes of neuromuscular reeducation (97112)
20 minutes therapeutic exercise (97110),
40 Total timed code minutes.

Appropriate billing for 40 minutes is 3 units. Each service was done at least 15 minutes and should be billed for at least one unit, but the total allows 3 units. Since the time for each service is the same, choose either code for 2 units and bill the other for 1 unit. Do not bill 3 units for either one of the codes.

Example 3 –

33 minutes of therapeutic exercise (97110),
7 minutes of manual therapy (97140),
40 Total timed minutes

Appropriate billing for 40 minutes is for 3 units. Bill 2 units of 97110 and 1 unit of 97140. Count the first 30 minutes of 97110 as two full units. Compare the remaining time for 97110 (33-30 = 3 minutes) to the time spent on 97140 (7 minutes) and bill the larger, which is 97140.

Example 4 –

18 minutes of therapeutic exercise (97110),
13 minutes of manual therapy (97140),
10 minutes of gait training (97116),
8 minutes of ultrasound (97035),
49 Total timed minutes

Appropriate billing is for 3 units. Bill the procedures you spent the most time providing. Bill 1 unit each of 97110, 97116, and 97140. You are unable to bill for the ultrasound because the total time of timed units that can be billed is constrained by the total timed

code treatment minutes (i.e., you may not bill 4 units for less than 53 minutes regardless of how many services were performed). You would still document the ultrasound in the treatment notes.

Example 5 –

7 minutes of neuromuscular reeducation (97112)
7 minutes therapeutic exercise (97110)
7 minutes manual therapy (97140)
21 Total timed minutes

Appropriate billing is for one unit. The qualified professional (See definition in Pub. 100-02, chapter 15, section 220) shall select one appropriate CPT code (97112, 97110, 97140) to bill since each unit was performed for the same amount of time and only one unit is allowed.

NOTE: The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the eighth should be excluded from the total count. The total minutes of active treatment counted for all 15 minute timed codes includes all direct treatment time for the timed codes. Total treatment minutes-- including minutes spent providing services represented by untimed codes-- are also documented. For documentation in the medical record of the services provided see Pub. 100-02, chapter 15, section 220.3.

D. Specific Limits for HCPCS

The Deficit Reduction Act of 2005, section 5107 requires the implementation of clinically appropriate code edits to eliminate improper payments for outpatient therapy services. The following codes may be billed, when covered, only at or below the number of units indicated on the chart per treatment day. When higher amounts of units are billed than those indicated in the table below, the units on the claim line that exceed the limit shall be denied as medically unnecessary (according to 1862(a)(1)(A)). Denied claims may be appealed and an ABN is appropriate to notify the beneficiary of liability.

This chart does not include all of the codes identified as therapy codes; refer to section 20 of this chapter for further detail on these and other therapy codes. For example, therapy codes called “always therapy” must always be accompanied by therapy modifiers identifying the type of therapy plan of care under which the service is provided.

Use the chart in the following manner:

The codes that are allowed one unit for “Allowed Units” in the chart below may be billed no more than once per provider, per discipline, per date of service, per patient.

The codes allowed 0 units in the column for "Allowed Units", may not be billed under a plan of care indicated by the discipline in that column. Some codes may be billed by one discipline (e.g., PT) and not by others (e.g., OT or SLP).

When physicians/NPPs bill "always therapy" codes they must follow the policies of the type of therapy they are providing e.g., utilize a plan of care, bill with the appropriate therapy modifier (GP, GO, GN), bill the allowed units on the chart below for PT, OT or SLP depending on the plan. A physician/NPP shall not bill an "always therapy" code unless the service is provided under a therapy plan of care. Therefore, NA stands for "Not Applicable" in the chart below.

When a "sometimes therapy" code is billed by a physician/NPP, but as a medical service, and not under a therapy plan of care, the therapy modifier shall not be used, but the number of units billed must not exceed the number of units indicated in the chart below per patient, per provider/supplier, per day.

HCPCS	**Code Description**	**Timed or Untimed**	**PT Allowed units**	**OT Allowed units**	**SLP Allowed units**	**Physician/ NPP NOT under Therapy POC**
92521	*Evaluation of speech fluency*	*Untimed*	*0*	*0*	*1*	*NA*
92522	*Evaluation of speech sound production*	*Untimed*	*0*	*0*	*1*	*NA*
92523	*Evaluation of language comprehension and expression*	*Untimed*	*0*	*0*	*1*	*NA*
92524	*Behavioral and qualitative analysis of voice and resonance*	*Untimed*	*0*	*0*	*1*	*NA*
92597	Oral speech device eval	Untimed	0	1	1	NA
92607	Ex for speech device rx, 1hr	Timed	0	1	1	NA
92611	Motion fluroscopy/swallow	Untimed	0	1	1	1
92612	Endoscope	Untimed	0	1	1	1

HCPCS	Code Description	Timed or Untimed	PT Allowed units	OT Allowed units	SLP Allowed units	Physician/ NPP NOT under Therapy POC
	swallow test (fees)					
92614	Laryngoscopic sensory test	Untimed	0	1	1	1
92616	Fees w/laryngeal sense test	Untimed	0	1	1	1
95833	Limb muscle testing, manual	Untimed	1	1	0	1
95834	Limb muscle testing, manual	Untimed	1	1	0	1
96110	Developmental test, lim	Untimed	1	1	1	1
96111	Developmental test, extend	Untimed	1	1	1	1
97001	PT evaluation	Untimed	1	0	0	NA
97002	PT re-evaluation	Untimed	1	0	0	NA
97003	OT evaluation	Untimed	0	1	0	NA
97004	OT re-evaluation	Untimed	0	1	0	NA

40.8 – Rebilling Therapy Services for Hospital Inpatients

(Rev. 2868, Issued: 02-05-14, Effective: 07-01-14, Implementation: 07-07-14)

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.