CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3475	**Date: March 4, 2016**
	Change Request 9424

SUBJECT: Updates to Pub. 100-04, Chapters 4 and 5 to Correct Remittance Advice Messages

I. SUMMARY OF CHANGES: This Change Request revises chapters 4 and 5 of the Medicare Claims Processing Manual to ensure that all remittance advice coding is consistent with nationally standard operating rules. It also provides a format for consistently showing remittance advice coding throughout this manual.

EFFECTIVE DATE: June 6, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 6, 2016

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
N	1/01.1/Remittance Advice Coding Used in this Manual
R	4/240.1/Editing Of Hospital Part B Inpatient Services: Reasonable and Necessary Part A Hospital Inpatient Denials
R	4/240.2/Editing Of Hospital Part B Inpatient Services: Other Circumstances in Which Payment Cannot Be Made under Part A
R	4/250.9.3/Assistant at Surgery Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages
R	4/250.10.3/Co-surgeon Services Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages
R	4/320.2/Medicare Summary Notices (MSN), Reason Codes, and Remark Codes
R	5/10.4/Claims Processing Requirements for Financial Limitations/
R	5/10.7/ Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services
R	5/20.4/Coding Guidance for Certain CPT Codes - All Claims

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 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3475	Date: March 4, 2016	Change Request: 9424

SUBJECT: Updates to Pub. 100-04, Chapters 4 and 5 to Correct Remittance Advice Messages

EFFECTIVE DATE: June 6, 2016
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I. GENERAL INFORMATION

A. Background: Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry's use of electronic data interchange (EDI) transactions. Operating Rule 360: Uniform Use of CARCs and RARCs, regulates the way in which group codes, claims adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) may be used. The rule requires specific codes which are to be used in combination with one another if one of the named business scenarios applies. This rule is authored by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages. This Change Request (CR) establishes a standard format for presenting these code combinations in the Medicare Claims Processing Manual (Pub. 100-04). It also updates chapters 4 and 5 of the manual to reflect the standard format and to correct any non-compliant code combinations. Additional CRs will follow to provide similar revisions to the remaining chapters of Pub. 100-04.

B. Policy: Remittance coding used by Medicare Administrative Contractors shall be compliant with nationally standard CAQH/CORE operating rules.

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	
9424.1	The contractor shall ensure that they apply remittance advice coding as described in instructions in Pub. 100-04, chapter 4 that are reformatted but not changed by this CR. Note: Changes to prior instructions are described in the requirements that follow.	X	X							
9424.2	The contractor shall use CARC 54 without an associated RARC when denying assistant at surgery	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	services.									
9424.3	The contractor shall use CARC 54 without an associated RARC when denying co-surgery services.	X	X							
9424.4	The contractor shall use CARC 16 with RARCs MA66 and N56 when returning as unprocessable claims for OIVIT billed with HCPCS code 99199.		X							
9424.5	The contractor shall use CARC 16 with RARCs MA66 and N56 when returning as unprocessable claims for OIVIT billed with the incorrect diagnosis code.		X							
9424.6	The contractor shall ensure that they apply remittance advice coding as described in instructions in Pub. 100-04, chapter 5 that are reformatted but not changed by this CR.	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9424.7	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 5 business days after receipt of the notification from CMS announcing the availability of the 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	X	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:

Section B: All other recommendations and supporting information:
V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

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.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents
(Rev.3475, Issued: 03-04-16,)

01.1 – Remittance Advice Coding Used in this Manual

(Rev.3475, Issued: 03-04-16, Effective: 06-06-16, Implementation: 06-06-16)

When Medicare denies coverage or adjusts the payment amount for items or services, these actions are documented using codes reported on the provider's remittance advice. Medicare, like all other health insurance payers, uses remittance advice codes in combination to create one message. This combination includes a Claim Adjustment Group Code (Group Code) and a Claim Adjustment Reason Code (CARC). Frequently, payers also use one or more Remittance Advice Remark Codes (RARC) to add additional detail. RARC coding is optional unless the CARC definition requires an accompanying RARC, so RARCs may not appear on all remittance advice messages.

Each of the codes in the message communicates different information:

- *Group Codes assign financial responsibility to the provider or the beneficiary*
- *CARCs communicate the general reason why the payment is different from the billed amount*
- *RARCs, when used in combination with CARCs, provide additional or more specific payment adjustment information*

In certain cases, RARCs may also be used alone to provide information unrelated to the difference between the amount billed and the amount paid. In these cases, the RARC definition always begins with the word "Alert."

Remittance advice codes are identified in standard code sets that are used by all payers, as required by HIPAA. Since the definitions of the codes are an industry standard, the instructions in this manual refer only to the code values. Providers and contractors can access the definitions of the codes at: www.wpc-edi.com/reference/.

Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry's use of electronic data interchange (EDI) transactions. Operating Rule 360: Uniform Use of CARCs and RARCs, regulates the way in which group codes, CARCs and RARCs may be used. The rule requires specific codes which are to be used in combination with one another if one of the named business scenarios applies. This rule is authored by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages. Providers and contractors can access the business scenarios and code combinations at: caqh.org/CORECodeCombinations.php. When remittance advice messages are used to explain payments to providers, Medicare Summary Notice (MSN) messages are used to explain payments to beneficiaries.

In order to provide remittance advice codes and MSN messages consistently throughout the Medicare Claims Processing Manual, the one of the following standard language statements will be included as necessary.

- *If the CARC/RARC being reported is included in the CAQH CORE list of valid combinations:*

  "The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario [Insert Business Scenario number].

Group Code: [Insert Group Code]
CARC: [Insert CARC number or N/A if the RARC is an Alert message]
RARC: [Insert RARC number(s) or N/A if a RARC is not needed]
MSN: [Insert MSN message number(s)]"

- *If the CARC is not included in the CAQH CORE publication and therefore, standard business scenarios do not apply:*

  "The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. The CARC below is not included in the CAQH CORE Business Scenarios.

  Group Code: [Insert Group Code]
  CARC: [Insert CARC number or N/A if the RARC is an Alert message]
  RARC: [Insert RARC number(s) or N/A if a RARC is not needed]
  MSN: [Insert MSN message number(s)]"

240.1 – Editing Of Hospital Part B Inpatient Services: Reasonable and Necessary Part A Hospital Inpatient Denials

(Rev.3475, Issued: 03-04-16, Effective: 06-06-16, Implementation: 06-06-16)

When inpatient services are denied as not medically necessary or a provider submitted medical necessity denial utilizing occurrence span code "M1", and the services are furnished by a participating hospital, Medicare pays under Part B for physician services and the non-physician medical and other health services provided in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, §10.1, "Reasonable and Necessary Part A Hospital Inpatient Claim Denials." The claims processing system shall set edits to prevent payment on Type of Bill 12x for claims containing the revenue codes listed in the table below.

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	024x	029x
0390	0399	045x	050x	051x	052x	054x	055x
056x	057x	058x	059x	060x	0630	0631	0632
0633	0637	064x	065x	066x	067x	068x	072x
0762	082x	083x	084x	085x	088x	089x	0905
0906	0907	0912	0913	093x	0941	0943	0944
0945	0946	0947	0948	095x	0960	0961	0962
0963	0964*	0969	097x	098x	099x	100x	210x
310x							

* In the case of Revenue Code 0964, this is used by hospitals that have a CRNA exception.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR
CARC: 96
RARC: M28
MSN: 21.21

CWF shall edit to ensure that DSMT services are not billed on a 12x claim.

Hospitals are required to report HCPCS codes that identify the services rendered.

240.2 – Editing Of Hospital Part B Inpatient Services: Other Circumstances in Which Payment Cannot Be Made under Part A

(Rev.3475, Issued: 03-04-16, Effective: 06-06-16, Implementation: 06-06-16)

When Medicare pays under Part B for the limited set of non-physician medical and other health services provided in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, §10.2 (that is, when furnished by a participating hospital to an inpatient of the hospital who is not entitled to benefits under Part A, has exhausted his or her Part A benefits, or receives services not covered under Part A), the contractor shall set revenue code edits to prevent payment on Type of Bill 12x for claims containing the revenue codes listed in the table below.

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	024x	0250
0251	0252	0253	0256	0257	0258	0259	0261
0269	0270	0273	0277	0279	029x	0339	0360

0370	0374	038x	039x	041x	045x	0472	0479
049x	050x	051x	052x	053x	0541	0542	0543
0544	0546	0547	0548	0549	055x	057x	058x
059x	060x	0630	0631	0632	0633	0637	064x
065x	066x	067x	068x	072x	0762	078x	079X
082x	083x	084x	085x	088x	0905	0906	0907
0912	0913	093x	0940	0941	0943	0944	0945
0946	0947	0948	0949	095x	0960	0961	0962
0964*	0969	097x	098x	099x	100x	210x	310x

* In the case of Revenue Code 0964, this is used by hospitals that have a CRNA exception.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR
CARC: 96
RARC: M28
MSN: 21.21

Hospitals are required to report HCPCS codes that identify the services rendered.

250.9.3 – Assistant at Surgery Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages

(Rev.3475, Issued: 03-04-16, Effective: 06-06-16, Implementation: 06-06-16)

Contractors shall deny medically unnecessary assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of '0' or '2' when an Advance Beneficiary Notice (ABN) was issued.
The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR
CARC: 54
RARC: N/A
MSN: 36.1

Contractors shall deny medically unnecessary assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of '0' or '2' when an ABN was **not** issued.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 54
RARC: N/A
MSN: 36.2

Contractors shall deny assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of '1'.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 54
RARC: N/A
MSN: 15.11

250.10.3 – Co-surgeon Services Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages

(Rev.3475, Issued: 03-04-16, Effective: 06-06-16, Implementation: 06-06-16)

Contractors shall deny co-surgeon services for HCPCS/CPT codes with a payment policy indicator of '0'.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 54
RARC: N/A
MSN: 15.12

Contractors shall deny medically unnecessary co-surgeon services for HCPCS/CPT codes with a payment policy indicator of '1' when an Advance Beneficiary Notice (ABN) was issued.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR
CARC: 54
RARC: N/A
MSN: 36.1

Contractors shall deny medically unnecessary co-surgeon services for HCPCS/CPT codes with a payment policy indicator of '1' when an Advance Beneficiary Notice (ABN) was **not** issued.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 54
RARC: N/A
MSN: 36.2

Contractors shall deny co-surgeon services for HCPCS/CPT codes with a payment policy indicator of '2' when the co-surgeons each have the same specialty.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 54
RARC: N/A
MSN: 21.21
Contractors shall deny line items for co-surgeon services without the 62 modifier on claims with the same surgical procedure code and line item date of service on more than one line when only one line has the 62 modifier.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 4
RARC: N/A
MSN: 16.10

320.2 – Medicare Summary Notices (MSN), Reason Codes, and Remark Codes

(Rev.3475, Issued: 03-04-16, Effective: 06-06-16, Implementation: 06-06-16)

Contractors shall return non-covered OIVIT claims billed with HCPCS 99199 to provider/return as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: MA66, N56
MSN: N/A

Contractors shall return non-covered OIVIT claims billed with HCPCS 94681 with or without diabetes-related conditions 250-00-250.93 to provider/return as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 16
RARC: MA66, N56
MSN: N/A

Contractors shall deny claims for non-covered OIVIT and any services comprising an OIVIT regimen billed with HCPCS code G9147.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 96
RARC: N386
MSN: 16.10

10.4 - Claims Processing Requirements for Financial Limitations

(Rev.3475, Issued: 03-04-16, Effective: 06-06-16, Implementation: 06-06-16)

A. Requirements – Institutional Claims

Regardless of financial limits on therapy services, CMS requires modifiers (See section 20.1 of this chapter) on specific codes for the purpose of data analysis. Beneficiaries may not be simultaneously covered by Medicare as an outpatient of a hospital and as a patient in another facility. When outpatient hospital therapy services are excluded from the limitation, the beneficiary must be discharged from the other setting and registered as a hospital outpatient in order to receive payment for outpatient rehabilitation services in a hospital outpatient setting after the limitation has been reached.

A hospital may bill for services of a facility as hospital outpatient services if that facility meets the requirements of a department of the provider (hospital) under 42 CFR 413.65. Facilities that do not meet those requirements are not considered to be part of the hospital and may not bill under the hospital's provider number, even if they are owned by the hospital. For example, services of a Comprehensive Outpatient Rehabilitation Facility (CORF) must be billed as CORF services and not as hospital outpatient services, even if the CORF is owned by the hospital.

The CWF applies the financial limitation to the following bill types 22X, 23X, 34X, 74X and 75X using the MPFS allowed amount (before adjustment for beneficiary liability).

For SNFs, the financial limitation does apply to rehabilitation services furnished to those SNF residents in noncovered stays (bill type 22X) who are in a Medicare-certified section of the facility, i.e., one that is either certified by Medicare alone, or is dually certified by Medicare as a SNF and by Medicaid as a nursing facility (NF). For SNF residents, consolidated billing requires all outpatient rehabilitation services be billed to Part B by the SNF. If a resident has reached the financial limitation, and remains in the Medicare-certified section of the SNF, no further payment will be made to the SNF or any other entity. Therefore, SNF residents who are subject to consolidated billing may not obtain services from an outpatient hospital after the cap has been exceeded.

Once the financial limitation has been reached, services furnished to SNF residents who are in a non-Medicare certified section of the facility, i.e., one that is certified only by Medicaid as a NF or that is not certified at all by either program, use bill type 23X. For SNF residents in non-Medicare certified portions of the facility and SNF nonresidents who go to the SNF for outpatient treatment (bill type 23X), medically necessary outpatient therapy may be covered at an outpatient hospital facility after the financial limitation has been exceeded when outpatient hospital therapy services are excluded from the limitation.

B. Requirements - Professional Claims

Claims containing any of the "always therapy" codes should have one of the therapy modifiers appended (GN, GO, GP). When any code on the list of therapy codes is submitted with specialty codes "65" (physical therapist in private practice), "67" (occupational therapist in private practice), or "15" (speech-language pathologist in private practice) they always represent therapy services, because they are provided by therapists. Contractors shall return claims for these services when they do not contain therapy modifiers for the applicable HCPCS codes.

The CMS identifies certain codes listed at: http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage as "sometimes therapy" services, regardless of the presence of a financial limitation. Claims from physicians (all specialty codes) and nonphysician practitioners, including specialty codes "50" (Nurse Practitioner), "89," (Clinical Nurse Specialist), and "97," (Physician Assistant) may be processed without therapy modifiers when they are not therapy services. On review of these claims, "sometimes therapy" services that are not accompanied by a therapy modifier must be documented, reasonable and necessary, and payable as physician or nonphysician practitioner services, and not services that the contractor interprets as therapy services.

The CWF will capture the amount and apply it to the limitation whenever a service is billed using the GN, GO, or GP modifier.

C. Contractor Action Based on CWF Trailer

Upon receipt of the CWF error code/trailer, contractors are responsible for assuring that payment does not exceed the financial limitations, when the limits are in effect, except as noted below.

In cases where a claim line partially exceeds the limit, the contractor must adjust the line based on information contained in the CWF trailer. For example, where the MPFS allowed amount is greater than the financial limitation available, always report the MPFS allowed amount in the "Financial Limitation" field of the CWF record and include the CWF override code. See example below for situations where the claim contains multiple lines that exceed the limit.

EXAMPLE:

Services received to date are $15 under the limit. There is a $15 allowed amount remaining that Medicare will cover before the cap is reached.

Incoming claim: Line 1 MPFS allowed amount is $50.
Line 2 MPFS allowed amount is $25.
Line 3, MPFS allowed amount is $30.

Based on this example, lines 1 and 3 are denied and line 2 is paid. The contractor reports in the "Financial Limitation" field of the CWF record "$25.00 along with the CWF override code. The contractor always applies the amount that would least exceed the limit. Since institutional claims systems cannot split the payment on a line, CWF will allow payment on the line that least exceeds the limit and deny other lines.

D. Additional Information for Contractors During the Time Financial Limits Are in Effect With or Without Exceptions

Once the limit is reached, if a claim is submitted, CWF returns an error code stating the financial limitation has been met. Over applied lines will be identified at the line level. The outpatient rehabilitation therapy services that exceed the limit should be denied.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO or PR (as defined by section 10.5)
CARC: 119
RARC: N/A
MSN: 20.5

In situations where a beneficiary is close to reaching the financial limitation and a particular claim might exceed the limitation, the provider/supplier should bill the usual and customary charges for the services furnished even though such charges might exceed the limit. The CWF will return an error code/trailer that will identify the line that exceeds the limitation.

Because CWF applies the financial limitation according to the date when the claim was received (when the date of service is within the effective date range for the limitation), it is possible that the financial limitation will have been met before the date of service of a given claim. Such claims will prompt the CWF error code and subsequent contractor denial.

When the provider/supplier knows that the limit has been reached, and exceptions are either not appropriate or not available, further billing should not occur. The provider/supplier should inform the beneficiary of the limit and their option of receiving further covered services from an outpatient hospital when outpatient hospital therapy services are excluded from the limitation (unless consolidated billing rules prevent the use of the outpatient hospital setting). If the beneficiary chooses to continue treatment at a setting other than the outpatient hospital where medically necessary services may be covered, the services may be billed at the rate the provider/supplier determines. Services provided in a capped setting after the limitation has been reached are not Medicare benefits and are not governed by Medicare policies.

If a beneficiary elects to receive services that exceed the cap limitation and a claim is submitted for such services, the resulting determination is subject to the administrative appeals process as described in subsection C. of section 10.3 and Pub. 100-04, Chapter 29.

10.7 - Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services

(Rev.3475, Issued: 03-04-16, Effective: 06-06-16, Implementation: 06-06-16)

Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services (see section 20), excluding A/B MAC (B)-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services.

Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.

Full payment is made for the unit or procedure with the highest PE payment.

For subsequent units and procedures with dates of service prior to April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment is made for the PE for services submitted on professional claims (any claim submitted using the ASC X12 837 professional claim format or the CMS-1500 paper claim form) and 75 percent payment is made for the PE for services submitted on institutional claims (ASC X12 837 institutional claim format or Form CMS-1450).

For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.

To determine which services will receive the MPPR, contractors shall rank services according to the applicable PE relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services. When the highest PE RVU applies to more than one of the identified services, contractors shall additionally sort and rank these services according to highest total fee schedule amount, and price the service with the highest total fee schedule amount at 100% and apply the appropriate MPPR to the remaining services.

The therapy payment amount that has been reduced by the MPPR is applied toward the therapy caps described in section 10.2. As a result, the MPPR may increase the amount of medically necessary therapy services a beneficiary may receive before exceeding the caps. The reduced amount is also used to calculate the beneficiary's coinsurance and deductible amounts.

The contractor shall use the following remittance advice messages and associated codes when adjusting payment under this policy. The CARC below is not included in the CAQH CORE Business Scenarios.

Group Code: CO
CARC: 59
RARC: N/A
MSN: 30.1

20.4 - Coding Guidance for Certain CPT Codes - All Claims

(Rev.3475, Issued: 03-04-16, Effective: 06-06-16, Implementation: 06-06-16)

The following provides guidance about the use of codes 96105, 97026, 97150, 97545, 97546, and G0128.

- CPT Codes 96105, 97545, and 97546.

Providers report code 96105, assessment of aphasia with interpretation and report in 1-hour units. This code represents formal evaluation of aphasia with an instrument such as the Boston Diagnostic Aphasia Examination. If this formal assessment is performed during treatment, it is typically performed only once during treatment and its medical necessity should be documented. If the test is repeated during treatment, the medical necessity of the repeat administration of the test must also be documented. It is common practice for regular assessment of a patient's progress in therapy to be documented in the chart, and this may be done using test items taken from the formal examinations. This is considered to be part of the treatment and should not be billed as 96105 unless a full, formal assessment is completed.

Other timed physical medicine codes are 97545 and 97546. The interval for code 97545 is 2 hours and for code 97546, 1 hour. These are specialized codes to be used in the context of rehabilitating a worker to return to a job. The expectation is that the **entire** time period specified in the codes 97545 or 97546 would be the treatment period, since a shorter period of treatment could be coded with another code such as codes 97110, 97112, or 97537. (Codes 97545 and 97546 were developed for reporting services to persons in the worker's compensation program, thus CMS does not expect to see them reported for Medicare patients except under very unusual circumstances. Further, CMS would not expect to see code 97546 without also seeing code 97545 on the same claim. Code 97546, when used, is used in conjunction with 97545.)

- CPT Code 97026

Effective for services performed on or after October 24, 2006, the Centers for Medicare & Medicaid Services announce a NCD stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), is non-covered for the treatment, including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries. Further coverage guidelines can be found in the National Coverage Determination Manual (Pub. 100-03), section 270.6.

Contractors shall deny claims with CPT 97026 (infrared therapy incident to or as a PT/OT benefit) and HCPCS E0221 or A4639, if the claim contains any of the following diagnosis codes:

ICD-9-CM

250.60 - 250.63

354.4, 354.5, 354.9

355.1 - 355.4

355.6 - 355.9

356.0, 356.2-356.4, 356.8-356.9

357.0 - 357.7

674.10, 674.12, 674.14, 674.20, 674.22, 674.24

707.00 -707.07, 707.09-707.15, 707.19

870.0 - 879.9

880.00 - 887.7

890.0 - 897.7

998.31 - 998.32

ICD-10-CM

See Addendum A Chapter 5, Section 20.4 (at end of this chapter) for the list of ICD 10-CM diagnosis codes that require denial with the above HCPCD codes.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 50
RARC: N/A
MSN: 21.11

Advanced Beneficiary Notice (ABN):

Physicians, physical therapists, occupational therapists, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHA), and hospital outpatient departments are liable if the service is performed, unless the beneficiary signs an ABN.

Similarly, DME suppliers and HHA are liable for the devices when they are supplied, unless the beneficiary signs an ABN.