

Medicare Claims Processing Manual

Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services

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10 - Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General **(Rev. 2044, Issued: 09-03-10, Effective: 09-30-10, Implementation: 09-30-10)**

Language in this section is defined or described in Pub. 100-02, chapter 15, sections 220 and 230.

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33), which added §1834(k)(5) to the Social Security Act (the Act), required that all claims for outpatient rehabilitation services and comprehensive outpatient rehabilitation facility (CORF) services, be reported using a uniform coding system. The CMS chose HCPCS (Healthcare Common Procedure Coding System) as the coding system to be used for the reporting of these services. This coding requirement is effective for all claims for outpatient rehabilitation services and CORF services submitted on or after April 1, 1998.

The BBA also required payment under a prospective payment system for outpatient rehabilitation services including CORF services. Effective for claims with dates of service on or after January 1, 1999, the Medicare Physician Fee Schedule (MPFS) became the method of payment for outpatient therapy services furnished by:

- Comprehensive outpatient rehabilitation facilities (CORFs);
- Outpatient physical therapy providers (OPTs);
- Other rehabilitation facilities (ORFs);
- Hospitals (to outpatients and inpatients who are not in a covered Part A stay);
- Skilled nursing facilities (SNFs) (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF); and
- Home health agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care (POC)).

NOTE: No provider or supplier other than the SNF will be paid for therapy services during the time the beneficiary is in a covered SNF Part A stay. For information regarding SNF consolidated billing see chapter 6, section 10 of this manual.

Similarly, under the HH prospective payment system, HHAs are responsible to provide, either directly or under arrangements, all outpatient rehabilitation therapy services to beneficiaries receiving services under a home health POC. No other provider or supplier will be paid for these services during the time the beneficiary is in a covered Part A stay. For information regarding HH consolidated billing see chapter 10, section 20 of this manual.

Section 143 of the Medicare Improvements for Patients and Provider's Act of 2008 (MIPPA) authorizes the Centers for Medicare & Medicaid Services (CMS) to enroll speech-language pathologists (SLP) as suppliers of Medicare services and for SLPs to begin billing Medicare for outpatient speech-language pathology services furnished in private practice beginning July 1, 2009. Enrollment will allow SLPs in private practice to bill Medicare and receive direct payment for their services. Previously, the Medicare program could only pay SLP services if an institution, physician or nonphysician practitioner billed them.

In Chapter 23, as part of the CY 2009 Medicare Physician Fee Schedule Database, the descriptor for PC/TC indicator "7", as applied to certain HCPCS/CPT codes, is described as specific to the services of privately practicing therapists. Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice.

The MPFS is used as a method of payment for outpatient rehabilitation services furnished under arrangement with any of these providers.

In addition, the MPFS is used as the payment system for CORF services identified by the HCPCS codes in §20. Assignment is mandatory.

The Medicare **allowed charge** for the services is the lower of the actual charge or the MPFS amount. The Medicare payment for the services is 80 percent of the allowed charge after the Part B deductible is met. Coinsurance is made at 20 percent of the lower of the actual charge or the MPFS amount. The general coinsurance rule (20 percent of the actual charges) does not apply when making payment under the MPFS. This is a final payment.

The MPFS does **not** apply to outpatient rehabilitation services furnished by critical access hospitals (CAHs). CAHs are to be paid on a reasonable cost basis.

Contractors process outpatient rehabilitation claims from hospitals, including CAHs, SNFs, HHAs, CORFs, outpatient rehabilitation agencies, and outpatient physical therapy providers for which they have received a tie in notice from the RO. These provider types submit their claims to the contractors using the 837 Institutional electronic claim format or the UB-04 paper form when permissible. Contractors also process claims from physicians, certain nonphysician practitioners (NPPs), therapists in private practices (TPPs), (which are limited to physical and occupational therapists, and speech-language pathologists in private practices), and physician-directed clinics that bill for services furnished incident to a physician's service (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, for a definition of "incident to"). These provider types submit their claims to the contractor using the 837 Professional electronic claim format or the CMS-1500 paper form when permissible.

There are different fee rates for nonfacility and facility services. Chapter 23 describes the differences in these two rates. (See fields 28 and 29 of the record therein described).

Facility rates apply to professional services performed in a facility other than the professional's office. Nonfacility rates apply when the service is performed in the professional's office. The nonfacility rate (that is paid when the provider performs the services in its own facility) accommodates overhead and indirect expenses the provider incurs by operating its own facility. Thus it is somewhat higher than the facility rate.

Contractors pay the nonfacility rate on institutional claims for services performed in the provider's facility. Contractors may pay professional claims using the facility or nonfacility rate depending upon where the service is performed (place of service on the claim), and the provider specialty.

Contractors pay the codes in §20 under the MPFS on professional claims regardless of whether they may be considered rehabilitation services. However, contractors must use this list for institutional claims to determine whether to pay under outpatient rehabilitation rules or whether payment rules for other types of service may apply, e.g., OPSS for hospitals, reasonable costs for CAHs.

Note that because a service is considered an outpatient rehabilitation service does not automatically imply payment for that service. Additional criteria, including coverage, plan of care and physician certification must also be met. These criteria are described in Pub. 100-02, Medicare Benefit Policy Manual, chapters 1 and 15.

Payment for rehabilitation services provided to Part A inpatients of hospitals or SNFs is included in the respective PPS rate. Also, for SNFs (but not hospitals), if the beneficiary has Part B, but not Part A coverage (e.g., Part A benefits are exhausted), the SNF must bill for any rehabilitation service.

Payment for rehabilitation therapy services provided by home health agencies under a home health plan of care is included in the home health PPS rate. HHAs may submit bill type 34X and be paid under the MPFS if there are no home health services billed under a home health plan of care at the same time, and there is a valid rehabilitation POC (e.g., the patient is not homebound).

An institutional employer (other than a SNF) of the TPPs, or physician performing outpatient services, (e.g., hospital, CORF, etc.), or a clinic billing on behalf of the physician or therapist may bill the contractor on a professional claim.

The MPFS is the basis of payment for outpatient rehabilitation services furnished by TPPs, physicians, and certain nonphysician practitioners or for diagnostic tests provided incident to the services of such physicians or nonphysician practitioners. (See Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, for a definition of "incident to, therapist, therapy and related instructions.") Such services are billed to the contractor on the professional claim format. Assignment is mandatory.

The following table identifies the provider and supplier types, and identifies which claim format they may use to submit bills to the contractor.

“Provider/Supplier Service” Type	Format	Bill Type	Comment
Inpatient hospital Part A	Institutional	11X	Included in PPS
Inpatient SNF Part A	Institutional	21X	Included in PPS
Inpatient hospital Part B	Institutional	12X	Hospital may obtain services under arrangements and bill, or rendering provider may bill.
Inpatient SNF Part B (audiology tests are not included)	Institutional	22X	SNF must provide and bill, or obtain under arrangements and bill.
Outpatient hospital	Institutional	13X	Hospital may provide and bill or obtain under arrangements and bill, or rendering provider may bill.
Outpatient SNF	Institutional	23X	SNF must provide and bill or obtain under arrangements and bill.
HHA billing for services rendered under a Part A or Part B home health plan of care.	Institutional	32X	Service is included in PPS rate. CMS determines whether payment is from Part A or Part B trust fund.
HHA billing for services not rendered under a Part A or Part B home health plan of care, but rendered under a therapy plan of care.	Institutional	34X	Service not under home health plan of care.
Other Rehabilitation Facility (ORF)	Institutional	74X	Paid MPFS for outpatient rehabilitation services effective January 1, 1999, and all other services except drugs effective July 1, 2000. Starting April 1, 2002, drugs are paid 95% of the AWP. For claims with dates of service on or after July 1, 2003, drugs and biologicals do not apply in an OPT setting. Therefore, FIs are to advise their OPTs not to bill for them.
Comprehensive Outpatient Rehabilitation Facility (CORF)	Institutional	75X	Paid MPFS for outpatient rehabilitation services effective January 1, 1999, and all other services except drugs effective July 1, 2000. Starting April 1, 2002, drugs are paid 95% of the AWP.

“Provider/Supplier Service” Type	Format	Bill Type	Comment
Physician, NPPs, TPPs, (service in hospital or SNF)	Professional	See Chapter 26 for place of service, and type of service coding.	Payment may not be made for therapy services to Part A inpatients of hospitals or SNFs, or for Part B SNF residents. Otherwise, suppliers bill to the contractor using the professional claim format. Note that services of a physician/ NPP/TPP employee of a facility may be billed by the facility to a contractor.
Physician/NPP/TPPs office, independent clinic or patient’s home	Professional	See Chapter 26 for place of service, and type of service coding.	Paid via Physician fee schedule.
Critical Access Hospital - inpatient Part A	Institutional	11X	Rehabilitation services are paid at cost.
Critical Access Hospital - inpatient Part B	Institutional	85X	Rehabilitation services are paid at cost.
Critical Access Hospital – outpatient Part B	Institutional	85X	Rehabilitation services are paid at cost.

Complete Claim form completion requirements are contained in chapters 25 and 26.

For a list of the outpatient rehabilitation HCPCS codes see §20.

If a contractor receives an institutional claim for one of these HCPCS codes with dates of service on or after July 1, 2003, that does not appear on the supplemental file it currently uses to pay the therapy claims, it contacts its professional claims area to obtain the non-facility price in order to pay the claim.

NOTE: The list of codes in §20 contains commonly utilized codes for outpatient rehabilitation services. Contractors may consider other codes on institutional claims for payment under the MPFS as outpatient rehabilitation services to the extent that such codes are determined to be medically reasonable and necessary and could be performed within the scope of practice of the therapist providing the service.

10.1 - New Payment Requirement for Intermediaries (FIs)

(Rev. 1, 10-01-03)

A-03-011

Effective with claims with dates of service on or after July 1, 2003, OPTs/outpatient rehabilitation facilities (ORFs), (74X and 75X bill type) are required to report all their services utilizing HCPCS. FIs are required to make payment for these services under the MPFS unless the item or service is currently being paid under the orthotic fee schedule or the item is a drug, biological, supply or vaccine (see below for an explanation of these services).

The CMS currently provides FIs with a CORF supplemental file that contains all physician fee schedule services and their related prices. FIs use this file to price and pay OPT claims. The format of the record layout is provided in Attachment E of PM A-02-090, dated September 27, 2002. This is located at:
http://cms.hhs.gov/manuals/pm_trans/A02090.pdf.

Fiscal FIs will be notified in a one-time instruction of updates to this file and when it will be available for retrieval.

If an FI receives a claim for one of the above HCPCS codes with dates of service on or after July 1, 2003, that does not appear on the CORF supplemental file it currently uses to pay the CORF claims, it contacts its local carrier to obtain the price in order to pay the claim. When requesting the pricing data, it advises the carrier to provide it with the nonfacility fee.

10.2 - The Financial Limitation Legislation

(Rev. 2073, Issued:10-22-10, Effective: 01-01-11, Implementation: 01-03-11)

A. Legislation on Limitations

The dollar amount of the limitations (caps) on outpatient therapy services is established by statute. The updated amount of the caps is released annually via Recurring Update Notifications and posted on the CMS Website www.cms.gov/TherapyServices, on contractor Websites, and on each beneficiary's Medicare Summary Notice. Medicare contractors shall publish the financial limitation amount in educational articles. It is also available at 1-800-Medicare.

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, which added §1834(k)(5) to the Act, required payment under a prospective payment system (PPS) for outpatient rehabilitation services (except those furnished by or under arrangements with a hospital). Outpatient rehabilitation services include the following services:

- Physical therapy
- Speech-language pathology; and
- Occupational therapy.

Section 4541(c) of the BBA required application of financial limitations to all outpatient rehabilitation services (except those furnished by or under arrangements with a hospital).

In 1999, an annual per beneficiary limit of \$1,500 was applied, including all outpatient physical therapy services and speech-language pathology services. A separate limit applied to all occupational therapy services. The limits were based on incurred expenses and included applicable deductible and coinsurance. The BBA provided that the limits be indexed by the Medicare Economic Index (MEI) each year beginning in 2002.

Since the limitations apply to outpatient services, they do not apply to skilled nursing facility (SNF) residents in a covered Part A stay, including patients occupying swing beds. Rehabilitation services are included within the global Part A per diem payment that the SNF receives under the prospective payment system (PPS) for the covered stay. Also, limitations do not apply to any therapy services covered under prospective payment systems for home health or inpatient hospitals, including critical access hospitals.

The limitation is based on therapy services the Medicare beneficiary receives, not the type of practitioner who provides the service. Physical therapists, speech-language pathologists, and occupational therapists, as well as physicians and certain nonphysician practitioners, could render a therapy service.

B. Moratoria and Exceptions for Therapy Claims

Since the creation of therapy caps, Congress has enacted several moratoria. The Deficit Reduction Act of 2005 directed CMS to develop exceptions to therapy caps for calendar year 2006 and the exceptions have been extended periodically. The cap exception for therapy services billed by outpatient hospitals was part of the original legislation and applies as long as caps are in effect. Exceptions to caps based on the medical necessity of the service are in effect only when Congress legislates the exceptions.

10.3 - Application of Financial Limitations

(Rev. 2073, Issued:10-22-10, Effective: 01-01-11, Implementation: 01-03-11)

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. 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 bill types 12x or 13x, or 85x.

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. With the exception of the use of the KX modifier, the guidance in this section concerning medical necessity applies as well to services provided before caps are reached.

Instructions for contractors to manage automatic process for exceptions will be found in the Program Integrity Manual, chapter 3, section 3.4.1.1.1. 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 at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps.

In 2006, the Exception Processes fell into two categories, Automatic Process Exceptions, and Manual Process Exceptions. Beginning January 1, 2007, there is no manual process for exceptions. All services that require exceptions to caps shall be processed using the automatic process. 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 automatic process for exception does not exempt services from manual or other medical review processes as described in Pub. 100-08, chapter 3, section 3.4.1.1.1. Rather, atypical use of the automatic exception process may invite contractor scrutiny. Particular care should be taken to document improvement and avoid billing for services that do not meet the requirements for skilled services, or for services which are maintenance rather than rehabilitative treatment (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 are medically necessary and justification is documented in the medical record.

B. Automatic Process Exceptions

The term “automatic process exceptions” indicates that the claims processing for the exception is automatic, and not that the exception is automatic. 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 automatic process 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 automatic process 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 automatic process 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 automatic 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:

92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 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 automatic 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 automatic process 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 that the patient's lack of access to outpatient hospital therapy services alone 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.

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 that 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. 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

10.4 - Claims Processing Requirements for Financial Limitations (Rev. 2073, Issued:10-22-10, Effective: 01-01-11, Implementation: 01-03-11)

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. They 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. Only services billed by the hospital on bill types 12X or 13X are exempt from limitations on therapy services.

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, 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—FIs or A/B MACs 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.

B. Requirements - Carrier or A/B Mac 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. Carriers or A/B MACs 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. FI or A/B MAC Action Based on CWF Trailer

Upon receipt of the CWF error code/trailer, FIs or A/B MACs 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 FI or A/B MAC 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 FI or A/B MAC reports in the "Financial Limitation" field of the CWF record "\$25.00 along with the CWF override code. The FI or A/B MAC always applies the amount that would least exceed the limit. Since the FI 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 contractors use group code PR and claim adjustment reason code 119 - Benefit maximum for this time period or occurrence has been reached- in the provider remittance advice to establish the reason for denial.

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 (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.

10.5 - Notification for Beneficiaries Exceeding Financial Limitations (Rev. 2073, Issued:10-22-10, Effective: 01-01-11, Implementation: 01-03-11)

A. Notice to Beneficiaries

Contractors will advise providers/suppliers to notify beneficiaries of the therapy financial limitations at their first therapy encounter with the beneficiary. Providers/suppliers should inform beneficiaries that beneficiaries are responsible for 100 percent of the costs of therapy services above each respective therapy limit, unless this outpatient care is furnished directly or under arrangements by a hospital. Patients who are residents in a Medicare-certified part of a SNF may not utilize outpatient hospital services for therapy services over the financial limits, because consolidated billing rules require all services to be billed by the SNF. However, when therapy cap exceptions apply, SNF residents may qualify for exceptions that allow billing within the consolidated billing rules.

It is the provider's responsibility to present each beneficiary with accurate information about the therapy limits, and indicate that, where necessary, appropriate care above the limits can be obtained at a hospital outpatient therapy department.

Prior to March 1, 2009, providers could use the Notice of Exclusion from Medicare Benefits (NEMB Form No. CMS 20007) to inform a beneficiary of financial liability for therapy above the cap, where no exception applied; however, the NEMB form has been discontinued. In its place, providers may now use a form of their own design, or the Advanced Beneficiary Notice of Noncoverage (ABN, Form CMS-R-131) may be used as a voluntary notice. When using the ABN form as a voluntary notice, the form requirements specified for its mandatory use do not apply. The beneficiary should not be asked to choose an option or sign the form. The provider should include the beneficiary's name on the form and the reason that Medicare may not pay in the space provided within the form's table. Insertion of the following reason is suggested: "Services do not qualify for exception to therapy caps. Medicare will not pay for physical therapy and speech-language pathology services over (add the dollar amount of the cap) in (add the year or the dates of service to which it applies) unless the beneficiary qualifies for a cap exception." Providers are to supply this same information for occupational therapy services over the limit for the same time period, if appropriate. A cost estimate for the services may be included but is not required.

After the cap is exceeded, voluntary notice via a provider's own form or the ABN is appropriate, even when services are excepted from the cap. The ABN is also used **BEFORE** the cap is exceeded when notice about noncovered services is mandatory. For example, 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, an ABN must be issued before the beneficiary receives that service. At the time the clinician determines that skilled services are not necessary, the clinical goals have been met, or there is no longer potential for the rehabilitation of health and/or function in a reasonable time, the beneficiary should be informed. If the beneficiary requests further services, beneficiaries should be informed that Medicare most likely will not provide additional coverage, and the ABN should be issued prior to delivering any services. The ABN informs the beneficiary of his/her potential financial obligation to the provider and provides guidance regarding appeal rights. When the ABN is used as a mandatory notice, providers must adhere to the form requirements set forth in this manual in chapter 30, section 50.6.3.

The ABN can be found at:

<http://www.cms.hhs.gov/BNI/Downloads/ABNFormInstructions.zip>

B. Access to Accrued Amount

All providers and contractors may access the accrued amount of therapy services from the ELGA screen inquiries into CWF. Provider/suppliers may access remaining therapy services limitation dollar amount through the 270/271 eligibility inquiry and response transaction. Providers who bill to FIs or A/B MACs will also find the amount a beneficiary has accrued toward the financial limitations on the HIQA. Some suppliers and providers billing to carriers or A/B MACs may, in addition, have access to the accrued amount of therapy services from the ELGB screen inquiries into CWF. Suppliers who do not have access to these inquiries may call the contractor to obtain the amount accrued.

Beneficiaries are provided with the most current amount accrued toward their caps on each MSN.

10.6 - Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services

(Rev. 2328, Issued: 10-27-11, Effective:01-01-11, Implementation: 04-02-12)

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 carrier-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services.

Medicare applies a 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, 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 837 Professional electronic format or the CMS-1500 paper claim form) and 75 percent payment is made for the PE for services submitted on institutional claims (any claim submitted using the 837 Institutional electronic format or the UB-04 paper claim form).

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 full fee schedule payments and the MPPR payments are summarized below in the following example for services on in an institutional claim (Note: on professional claims, the reduction percentage is 20 percent).

	Procedure 1 Unit 1	Procedure 1 Unit 2	Procedure 2	Full MPFS Payment	MPPR Total Payment	Proposed Payment Calculation
<i>Work</i>	\$7.00	\$7.00	\$11.00	\$25.00	\$25.00	<i>no reduction</i>
<i>PE</i>	\$10.00	\$10.00	\$8.00	\$28.00	\$23.50	$\$10 + (.75 \times \$10) + (.5 \times \$8)$
<i>Malpractice</i>	\$1.00	\$1.00	\$1.00	\$3.00	\$3.00	<i>no reduction</i>
<i>Total</i>	\$18.00	\$18.00	\$20.00	\$56.00	\$51.50	$\$18 + (\$18 - \$10) + (.75 \times \$10) + (\$20 - \$8) + (.75 \times \$8)$

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.

Contractors indicate services have been subject to the MPPR using the following coding on the provider's remittance advice:

- *Group code CO and*
- *Claim adjustment reason code 59 - Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)*

Contractors shall use the following message on Medicare Summary Notices for claims subject to the MPPR:

- *30.1 The approved amount is based on a special payment method, or*
- *30.1 La cantidad aprobada está basada en un método especial de pago.*

20 - HCPCS Coding Requirement

(Rev. 1850, Issued: 11-13-09, Effective: 01-01-10, Implementation: 01-04-10)

A. Uniform Coding

Section 1834(k)(5) of the Act requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility (CORF) services be reported using a uniform coding system. The current Healthcare Common Procedure Coding System/Current Procedural Terminology is used for the reporting of these services. The uniform coding requirement in the Act is specific to payment for all CORF services and outpatient rehabilitation therapy services - including physical therapy, occupational therapy, and speech-language pathology - that is provided and billed to Medicare contractors. The Medicare physician fee schedule (MPFS) is used to make payment for these therapy services at the non facility rate.

Effective for claims submitted on or after April 1, 1998, providers that had not previously reported HCPCS/CPT for outpatient rehabilitation and CORF services began using HCPCS to report these services. This requirement does not apply to outpatient rehabilitation services provided by:

- Critical access hospitals, which are paid on a cost basis, not MPFS;
- RHCs, and FQHCs for which therapy is included in the all-inclusive rate; or
- Providers that do not furnish therapy services.

The following "providers of services" must bill the FI for outpatient rehabilitation services using HCPCS codes:

- Hospitals (to outpatients and inpatients who are not in a covered Part A¹ stay);
- Skilled nursing facilities (SNFs) (to residents not in a covered Part A¹ stay and to nonresidents who receive outpatient rehabilitation services from the SNF);
 - Home health agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care² (POC). (See 60.4.1, Definition of Homebound Patient Under the Medicare Home Health (HH) Benefit.)
- Comprehensive outpatient rehabilitation facilities (CORFs); and
- Providers of outpatient physical therapy and speech-language pathology services (OPTs), also known as rehabilitation agencies (previously termed outpatient physical therapy facilities in this instruction).

Note 1. The requirements for hospitals and SNFs apply to inpatient Part B and outpatient services only. Inpatient Part A services are bundled into the respective prospective payment system payment; no separate payment is made.

Note 2. For HHAs, HCPCS/CPT coding for outpatient rehabilitation services is required only when the HHA provides such service to individuals that are not homebound and, therefore, not under a home health plan of care.

The following practitioners must bill the carrier for outpatient rehabilitation therapy services using HCPCS/CPT codes:

- Physical therapists in private practice (PTPPs),
- Occupational therapists in private practice (OTPPs),
- Speech-language pathologists in private practice (SLPPs),
- Physicians, including MDs, DOs, podiatrists and optometrists, and
- Certain nonphysician practitioners (NPPs), acting within their State scope of practice, e.g., nurse practitioners and clinical nurse specialists.

Providers billing to intermediaries shall report:

- The date the therapy plan of care was either established or last reviewed (see §220.1.3B) in Occurrence Code 17, 29, or 30.
- The first day of treatment in Occurrence Code 35, 44, or 45.

B. Applicable Outpatient Rehabilitation HCPCS Codes

The CMS identifies the codes listed at:

http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage as therapy services, regardless of the presence of a financial limitation. Therapy services include only physical therapy, occupational therapy and speech-language pathology services. Therapist means only a physical therapist, occupational therapist or speech-language pathologist. Therapy modifiers are GP for physical therapy, GO for occupational therapy, and GN for speech-language pathology.

When in effect, any financial limitation will also apply to services represented unless otherwise noted on the therapy page on the CMS Web site.

C. Additional HCPCS Codes

Some HCPCS/CPT codes that are not on the list of therapy services should not be billed with a modifier. For example, outpatient non-rehabilitation HCPCS codes G0237, G0238, and G0239 should be billed without therapy modifiers. These HCPCS codes describe services for the improvement of respiratory function and may represent either “incident to” services or respiratory therapy services that may be appropriately billed in the CORF setting. When the services described by these G-codes are provided by physical therapists (PTs) or occupational therapists (OTs) treating respiratory conditions, they are considered therapy services and must meet the other conditions for physical and occupational therapy. The PT or OT would use the appropriate HCPCS/CPT code(s) in the 97000 – 97799 series and the corresponding therapy modifier, GP or GO, must be used.

Another example of codes that are not on the list of therapy services and should not be billed with a therapy modifier includes the following HCPCS codes: 95860, 95861, 95863, 95864, 95867, 95869, 95870, 95900, 95903, 95904, and 95934. These services represent diagnostic services - not therapy services; they must be appropriately billed and shall not include therapy modifiers.

Other codes not on the therapy code list, and not paid under another fee schedule, are appropriately billed with therapy modifiers when the services are furnished by therapists or provided under a therapy plan of care and where the services are covered and appropriately delivered (e.g., the therapist is qualified to provide the service). One example of non-listed codes where a therapy modifier is indicated regards the provision of services described in the CPT code series, 29000 through 29590, for the application of casts and strapping. Some of these codes previously appeared on the therapy code list, but were deleted because we determined that they represented services that are most often performed outside a therapy plan of care. However, when these services are provided by therapists or as an integral part of a therapy plan of care, the CPT code must be accompanied with the appropriate therapy modifier.

NOTE: The above lists of HCPCS/CPT codes are intended to facilitate the contractor’s ability to pay claims under the MPFS. It is not intended to be an exhaustive list of

covered services, imply applicability to provider settings, and does not assure coverage of these services.

20.1 - Discipline Specific Outpatient Rehabilitation Modifiers - All Claims

(Rev. 2091, Issued: 11-12-10; Effective Date: 04-01-11; Implementation Date: 04-04-11)

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 to ensure that more than one GN, GO or GP are not reported on the same service line on all institutional claims. Contractors will return to the provider any claim that reports more than one of these modifiers on the same line.

Contractors also edit to ensure that the therapy modifiers are present based on revenue codes 042X, 043X, or 044X. Claims containing revenue codes 042X, 043X, or 044X without a therapy modifier GN, GP, or GO are returned to the provider. Additionally, contractors ensure that revenue codes and modifiers are reported 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.

Contractors return to the provider institutional claims that contain lines with any other combinations of these revenue codes and modifiers.

20.2 - Reporting of Service Units With HCPCS

(Rev. 2160, Issued: 02-18-11, Effective: 05-19-11, Implementation: 05-19-11)

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 92506. 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 and Claim Line Outlier/Edit Details	Timed or Untimed	PT Allowed units	OT Allowed units	SLP Allowed units	Physician/NPP NOT under Therapy POC
92506	Speech/hearing evaluation	Untimed	0	0	1	NA
92597	Oral speech device eval	Untimed	0	1	1	NA

HCPCS	Code Description and Claim Line Outlier/Edit Details	Timed or Untimed	PT Allowed units	OT Allowed units	SLP Allowed units	Physician/NPP NOT under Therapy POC
92607	Ex for speech device rx, 1hr	Timed	0	1	1	NA
92611	Motion fluroscopy/swallow	Untimed	0	1	1	1
92612	Endoscope swallow test (fees)	Untimed	0	1	1	1
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

20.3 - Determining What Time Counts Towards 15-Minute Timed Codes - All Claims

(Rev. 1, 10-01-03)

A3-3653, SNF-532.C, AB-00-39

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as “intra-service care” begins when the therapist or physician (or an assistant under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment.

The time counted is the time the patient is treated. For example, if gait training in a patient with a recent stroke requires both a therapist and an assistant, or even two therapists, to manage in the parallel bars, each 15 minutes the patient is being treated can count as only one unit of code 97116. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.

20.4 - Coding Guidance for Certain CPT Codes - All Claims (Rev. 1860; Issued: 11-23-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

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 we do not expect to see them reported for Medicare patients except under very unusual circumstances. Further, we 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 (Publication 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 ICD-9 codes:

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

Contractors can use the following messages when denying the service:

- Medicare Summary Notice # 21.11 “This service was not covered by Medicare at the time you received it.”

- Reason Claim Adjustment Code #50 "These are noncovered services because this is not deemed a medical necessity by the payer."

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.

20.5 – CORF/OPT Edit for Billing Inappropriate Supplies (Rev. 319, Issued: 10-22-04, Effective: 07-01-01, Implementation: 04-04-05)

Supplies furnished by CORFs/OPTs are considered part of the practice expense. Under the Medicare Physician Fee Schedule (MPFS) these expenses are already taken into account in the practice expense relative values. Therefore, CORFs/OPTs should not bill for the supplies they furnish except for the splint and cast, level II HCPCS Q codes associated with the level I HCPCS in the 29000 series.

The shared system maintainer will return to CORFs/OPTs any claims that they receive that contain a supply revenue code 270 without the splint and cast Level II HCPCS Q codes and the related Level I applicable HCPCS codes in the 29000 series.

The appropriate Level II HCPCS "Q" codes to be used are Q4001 thru Q4049.

The appropriate Level I HCPCS codes associated with the Level II HCPCS "Q" codes are 29000 thru 29085; 29105 thru 29131; and 29305 thru 29515.

30 - Special Claims Processing Rules for Outpatient Rehabilitation Claims - Form CMS-1500

(Rev. 1, 10-01-03)

Rules for completing a Form CMS-1500 and electronic formats are in Chapter 26. Instructions in §§[10.1](#), [20.1](#), [20.2](#), [20.3](#) and [20.4](#) above also apply.

30.1 - Determining Payment Amounts

(Rev. 1, 10-01-03)

Carriers use the MPFS to determine payment for outpatient rehabilitation services. Payment rules are the same as those for other services paid on the MPFS.

Assignment is mandatory.

See chapter 23, for a description of the MPFS.

30.2 - Applicable Carrier CWF Type of Service Codes

(Rev. 1, 10-01-03)

The carrier assigns the type of service code before submitting the claim record to CWF.

U = Occupational therapy

W = Physical therapy

40 - Special Claims Processing Rules for Institutional Outpatient Rehabilitation Claims

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

40.1 - Determining Payment Amounts - FIs

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Institutional outpatient rehabilitation claims are paid under the Medicare Physician Fee Schedule (MPFS). Medicare contractors should see [§100.2](#) for details on obtaining the correct fee amounts.

40.2 - Applicable Types of Bill

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

The appropriate types of bill for submitting outpatient rehabilitation services, and requiring HCPCS coding to ensure payment under the MPFS are: 12X, 13X, 22X, 23X, 34X, 74X, 75X, and 83X.

40.3 - Applicable Revenue Codes

(Rev. 2044, Issued: 09-03-10, Effective: 09-30-10, Implementation: 09-30-10)

The appropriate revenue codes for reporting outpatient rehabilitation services are

0420 - Physical Therapy Services

0430 - Occupational Therapy Services

0440 – Speech-language pathology services

The general classification of revenue codes is all that is needed for billing. If, however, providers choose to use more specific revenue code classifications, the FI should accept them. Reporting of services is not limited to specific revenue codes; e.g., services other than therapy may be included on the same claim.

Many therapy services may be provided by both physical and occupational therapists. Other services may be delivered by either occupational therapists or speech-language pathologists. Therefore, providers report outpatient rehabilitation HCPCS codes in conjunction with the appropriate outpatient rehabilitation revenue code based on the type of therapist who delivered the service, or, if a therapist does not deliver the service, then on the type of therapy under the plan of care (POC) for which the service is delivered.

40.4 - Edit Requirements for Revenue Codes

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Medicare contractors edit to assure the presence of a HCPCS code when revenue codes 0420, 0430, 0440, or 0470 are reported. However, Medicare contractors do not edit the matching of revenue code to certain HCPCS codes or edit to limit provider reporting to only those HCPCS listed in section 20.

40.5 - Line Item Date of Service Reporting

(Rev. 2044, Issued: 09-03-10, Effective: 09-30-10, Implementation: 09-30-10)

Providers are required to report line item dates of service per revenue code line for outpatient rehabilitation services. CORFs are also required to report their full range of CORF services by line item date of service. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence.

Contractors will return claims that span two or more dates if a line item date of service is not entered for each HCPCS reported. Line item date of service reporting became effective for claims with dates of service on or after October 1, 1998.

Services that do not require line item date of service reporting may be reported before or after those services that require line item reporting.

40.6 – Non-covered Charge Reporting

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Institutional outpatient therapy claims may report non-covered charges when appropriate according to the instructions provided in of this manual. Outpatient therapies billed as non-covered charges are not counted toward the financial limitation described above, when that limitation is in effect, unless the charges are subject to review after they are submitted and found to be covered by Medicare. Modifiers associated with non-covered charges that are presented in Chapter 1, section 60 can be used on claim lines for therapy services, in addition to the use of modifiers –GN, –GO and –GP.

50 - CWF and PS&R Requirements - FIs

(Rev. 2044, Issued: 09-03-10, Effective: 09-30-10, Implementation: 09-30-10)

The FI reports the procedure codes in the financial data section (field 65a-65j) of the PS&R record. It includes revenue code, HCPCS, units, and covered charges in the record. Where more than one HCPCS procedure is applicable to a single revenue code, the provider reports each HCPCS and related charge on a separate line. The FI reports the payment amount before adjustment for beneficiary liability in field 65g "Rate" and the actual charge in field 65h "Covered Charges." The PS&R system includes outpatient rehabilitation, and CORF services listed in subsections E and F on a separate report from cost based payments. See the PS&R guidelines for specific information.

100 - Special Rules for Comprehensive Outpatient Rehabilitation

Facilities (CORFs)

(Rev. 1, 10-01-03)

100.1 - General

(Rev. 1, 10-01-03)

A3-3370.1, B3-9300.1

The Omnibus Reconciliation Act of 1980 (Public Law 96-499, Section 933) defines CORFs (Comprehensive Outpatient Rehabilitation Facilities) as a distinct type of Medicare provider and adds CORF services as a benefit under Medicare Part B. The Balance Budget Act (P.L.105-33) requires payment under a prospective system for all CORF services.

See chapter 1, for the policy on FI Designations governing CORFs.

See the Medicare Benefit Policy Manual, chapter 12, for a description of covered CORF services.

Physicians' diagnostic and therapeutic services furnished to a CORF patient are not considered CORF physician's services. The physician must bill the area Part B carrier for these services. If they are covered, the carrier reimburses them via the MPFS.

However, other services are considered CORF services to be billed by the CORF to the FI, and are also considered included in the fee amount under the MPFS. These services include such services as administrative services provided by the physician associated with the CORF, examinations for the purpose of establishing and reviewing the plan of care, consultation with and medical supervision of nonphysician staff, team conferences, case reviews, and other facility staff medical and facility administration activities relating to the services described in Medicare Benefit Policy Manual, chapter 12. Related supplies are also included in the MPFS fee amount.

The CORFs bill Medicare with the Form CMS-1450 using HCPCS codes and revenue codes. Usually the zero level revenue code is used. Payment is based on the HCPCS code and related MPFS amount.

Requirements in §§10 - 50 apply to CORF billing. In addition the following requirements apply.

100.1.1 - Allowable Revenue Codes on CORF 75X Bill Types
(Rev. 1876; Issued: 12-18-09; Effective Date: 01-01-10; Implementation Date: 04-05-10)

Effective July 1, 2008, the following revenue codes are allowable for reporting CORF services on 75X bill types:

0270	0274	0279	0410
0412	0419	042X	043X
044X	0550	0559	0560
0569	0636	0771	0900
0911	0914	0919	0942

NOTE: Billed revenue codes not listed in the above list will be returned to the provider by Medicare systems. See Chapter 25, Completing and Processing the CMS-1450 Data Set, for revenue code descriptions.

100.2 - Obtaining Fee Schedule Amounts
(Rev. 1, 10-01-03)
PM AB-00-01, SNF-532.F

The CMS furnishes FIs with an annual therapy abstract file and a CORF supplemental file through the Medicare Telecommunications System. The CMS notifies FIs when new files are available. FIs are responsible for informing CORFs of new fee schedule amounts.

Payment is calculated at 80 percent of the allowed charge after deductible is met. The allowed charge is the lower of billed charges or the fee schedule amount. Unmet deductible is subtracted from the allowed charge, and payment is calculated at 80 percent of the result.

EXAMPLE:

\$120 Provider charge;
\$100 MPFS amount.
Payment is 80 percent of the lower of the actual charge or fee schedule amount, which in this case is \$80.00. (\$100.00 (MPFS) X 80 percent.)

The remaining 20 percent or \$20 is the patient's coinsurance liability.

These codes are updated as needed by CMS.

If the FI receives a claim for a Medicare covered CORF service with dates of service on or after July 1, 2000, that does not appear on its fee schedule abstract file, it has two options for obtaining pricing information:

- It is provided with a therapy abstract file or CORF supplemental file that contains all therapy services and their related prices. This supplemental file contains approximately a million records, and may be used as a resource to extract pricing data as needed. The data in the supplemental file is in the same format as the MPFS abstract file in exhibit 1, but the fields defining the fee and outpatient hospital indicators are not populated, instead they are space-filled.

The FI can contact the local carrier to obtain the price. When requesting the pricing data, it advises the carrier to provide the nonfacility fee from the MPFS. The MPFS supplemental file of physician fee schedule services is available for retrieval through CMS' Mainframe Telecommunications System. The FI is notified yearly of the file retrieval names and dates by a program memorandum or other communication.

100.3 - Proper Reporting of Nursing Services by CORFs - FIs

(Rev. 1459; Issued: 02-22-08; Effective: 07-01-08; Implementation: 07-07-08)

Nursing services performed in the CORF shall be billed utilizing the following HCPCS code:

G0128 – Direct (Face to Face w/ patient) skilled nursing services of a registered nurse provided in a CORF, each 10 minutes beyond the first 5 minutes.

In addition, HCPCS G0128 is billable with revenue codes 0550 and 0559 only.

100.4 - Outpatient Mental Health Treatment Limitation

(Rev. 1843, Issued: 10-30-09, Effective: 01-01-10, Implementation: 01-04-10)

The Outpatient Mental Health Treatment Limitation (the limitation) is not applicable to CORF services because CORFs do not provide services to treat mental, psychoneurotic and personality disorders that are subject to the limitation in section 1833(c) of the Act. For dates of service on or after July 7, 2008, CPT code 96152 is the only CPT code allowed for health and behavioral intervention services provided in a CORF. This service is not subject to the limitation because it is not a psychiatric mental health treatment service. For dates of service prior to July 7, 2008, the limitation was applied to certain outpatient mental health treatment services when provided in a CORF. For additional information on the limitation, see Publication 100-01, Chapter 3, section 30 and Publication 100-02, Chapter 12, sections 50-50.5.

100.5 - Off-Site CORF Services

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The CORFs may provide physical therapy, speech-language pathology and occupational therapy off the CORF's premises in addition to the home evaluation. Services provided offsite are billed separately and identified as "offsite" on the Form CMS-1450 (UB-04), in the "Remarks" form locator. The charges for offsite visits include any additional charge for providing the services at a place other than the CORF premises. There is no change in the payment method for offsite services.

100.6 - Notifying Patient of Service Denial

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Services may be noncovered because they are statutorily excluded from coverage under Medicare, or because they are not medically reasonable and necessary.

If a service is excluded by statute, the CORF may submit a claim for them to Medicare to obtain a denial prior to billing another insurance carrier. It shows the charges as noncovered, and includes Condition Code 21. It may bill the beneficiary for the excluded services, and need not issue an advance beneficiary notice (ABN). However, when providing therapy services under the financial limitations, the CORF should provide the beneficiary with the Notice of Exclusion of Medicare Benefits (NEMB). The Medicare Claims Processing Manual, Chapter 30, "Limitation on Liability," discusses ABNs for FI processed claims for Part B services.

If, after reviewing the plan of care, the CORF determines that the services to be furnished to the patient are not medically reasonable or necessary, it immediately provides the beneficiary with an ABN. If the patient signs an ABN, the Form CMS-1450 includes occurrence code 32 "Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)" along with the date the ABN was signed.

If the beneficiary insists that a claim be submitted for payment, the CORF must indicate on the bill (billed separately from bills with covered charges) that it is being submitted at the beneficiary's request. This is done by using condition code 20.

If during the course of the patient's treatment the FI advises the CORF that covered care has ceased, the CORF must notify the beneficiary (or the beneficiary's representative) immediately.

NOTE: Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.

100.7 - Payment of Drugs, Biologicals, and Supplies in a CORF

(Rev. 1459; Issued: 02-22-08; Effective: 07-01-08; Implementation: 07-07-08)

Drugs

Drugs and biologicals generally do not apply in a CORF setting. Therefore, contractors are to advise their CORFs not to bill for them.

Supplies

The CORFs should not bill for the supplies they furnish when such supplies are part of the practice expense for that service. Under the MPFS, nearly all of these expenses are already taken into account in the practice expense relative values. However, CORFs may bill separately for certain splint and cast supplies, represented by HCPCS codes Q4001 through Q4051, when furnishing a cast/strapping application service in the CPT code series 29000 through 29750.

Vaccines

The CORFs should refer to Chapter 18, Preventive and Screening Services, for billing guidance on influenza, pneumococcal pneumonia, and Hepatitis B vaccines and their administration.

100.8 - Billing for DME, Prosthetic and Orthotic Devices, and Surgical Dressings

(Rev. 1593, Issued: 09-12-08; Effective Date: 07-01-08; Implementation Date: 12-12-08)

The CORFs bill DME on Form CMS-1500 to the DMERC except for claims for implanted DME, which are billed on Form CMS-1500 to the local carrier. If the CORF does not have a supplier billing number from the National Supplier Clearinghouse (NSC), it may contact the NSC to secure one. If the local carrier has issued the CORF a provider number for billing physician services, the CORF may not use the same number when billing for DME.

100.10 - Group Therapy Services (Code 97150)

(Rev. 1145, Issued: 12-29-06, Effective: 01-01-07, Implementation: on or before 01-29-07)

Policies for group therapy services for CORF are the same as group therapy services for other Part B outpatient services. See Pub 100-02, chapter 15, section 230.

100.10.1 - Therapy Students

(Rev. 1145, Issued: 12-29-06, Effective: 01-01-07, Implementation: on or before 01-29-07)

Policies for therapy students for CORF are the same as policies for therapy students for other Part B outpatient services. See Pub. 100-02, chapter 15, section 230.

100.11 - Billing for Social Work and Psychological Services in a CORF

(Rev. 1459; Issued: 02-22-08; Effective: 07-01-08; Implementation: 07-07-08)

The CORF providers shall only bill social work and psychological services with the following CPT code:

96152 – Health and Behavior Intervention, Each 15 Minutes, Face-to-Face; Individual

In addition, CPT 96152 shall only be billed with revenue code 0560, 0569, 0900, 0911, 0914 and 0919.

100.12 - Billing for Respiratory Therapy Services in a CORF

(Rev. 1459; Issued: 02-22-08; Effective: 07-01-08; Implementation: 07-07-08)

The CORF providers shall only bill respiratory therapy services with revenue codes 0410, 0412 and 0419. See Chapter 25, Completing and Processing the CMS-1450 Data Set, for revenue code descriptions.

Exhibit 1 - Physician Fee Schedule Abstract File

(Rev. 515, Issued: 04-01-05, Effective: 01-03-05, Implementation: 07-05-05)

This file contains nonfacility fee schedule payment amounts for the outpatient rehabilitation, and CORF HCPCS codes listed in §20. These codes are identified in the abstract file by a value of “R” in the fee indicator field. The file includes fee schedule payment amounts by locality and is available via the CMS Mainframe Telecommunications System (formerly referred to as the Network Data Mover).

Record Length: 60
Record Format: FB
Block size: 6000
Character Code: EBCDIC
Sort Sequence: Carrier, Locality HCPCS Code, Modifier

Data Element Name	COBOL Location	Picture	Value
1 – HCPCS	1-5	X(05)	
2 – Modifier	6-7	X(02)	

3 – Filler	8-9	X(02)	
4 -- Non-Facility Fee	10-16	9(05)V99	
5 – Filler	17-23	X(07)	
6 – Filler	24-30	X(07)	
7 -- Carrier Number	31-35	X(05)	
8 – Locality	36-37	X(02)	Identical to the radiology/diagnostic fees
9 – Filler	38-40	X(03)	
10 -- Fee Indicator	41-41	X(1)	“R” - Rehab/Audiology/CORF services
11 -- Outpatient Hospital indicator	42-42	X(1)	“0” - Fee applicable in hospital outpatient setting “1” - Fee not applicable in hospital outpatient setting
12 – Filler	43-60	X(18)	

Upon CMS notification, the contractor is responsible for retrieving this file and making payment based on 80 percent of the lower of the actual charge or fee schedule amount indicated on the file after the Part B deductible has been met. The CMS will notify contractors of updates to the MPFS, file names and when the updated files will be available for retrieval. Upon retrieval, contractors disseminate the fee schedules to their providers. The file is also available on the CMS Web site in the Public Use Files (PUF) area.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R2328CP</u>	10/27/2011	Claim Adjustment Reason Code (CARC) Used for Therapy Claims Subject to the Multiple Procedure Payment Reduction	04/02/2012	7564
<u>R2160CP</u>	02/18/2011	Correction to Manual References in Chapter 5, Section 20.2	05/19/2011	7315
<u>R2121CP</u>	12/17/2010	Reporting of Service Units With HCPCS	03/21/2011	7247
<u>R2091CP</u>	11/12/2010	Correct Reporting of Modifiers and Revenue Codes on Claims for Therapy Services	04/04/2011	7170
<u>R2073CP</u>	10/22/2010	Therapy Cap Values for Calendar Year (CY) 2011	01/03/2011	7107
<u>R2055CP</u>	09/17/2010	Therapy Cap Values for Calendar Year (CY) 2011 – Rescinded and replaced by Transmittal 2073	01/03/2011	7107
<u>R2044CP</u>	09/03/2010	Revisions and Re-issuance of Audiology Policies	09/30/2010	6447
<u>R2007CP</u>	07/23/2007	Revisions and Re-issuance of Audiology Policies – Rescinded and replaced by Transmittal 2044	08/11/2010	6447
<u>R1985CP</u>	06/11/2010	Clarifications and Updates of Therapy Services Policies	07/11/2010	6980
<u>R1975CP</u>	05/28/2010	Revisions and Re-issuance of Audiology Policies - Rescinded and replaced by Transmittal 2007	07/28/2010	6447
<u>R1951CP</u>	04/27/2010	Removal of the Provider Reporting Requirement for Total Number of Therapy Visits Using Value Codes 50-53	10/04/2010	6899
<u>R1921CP</u>	02/19/2010	Billing for Services Related to Voluntary Uses	04/05/2010	6563

Rev #	Issue Date	Subject	Impl Date	CR#
		of Advanced Beneficiary Notices of Noncoverage (ABNs)		
<u>R1894CP</u>	01/15/2010	Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs) – Rescinded and replaced by Transmittal 1921	04/05/2010	6563
<u>R1876CP</u>	12/18/2009	Coverage of Kidney Disease Patient Education Services	04/05/2010	6557
<u>R1860CP</u>	11/20/2009	Therapy Cap Values for Calendar Year (CY) 2010	01/04/2010	6660
<u>R1851CP</u>	11/13/2009	Therapy Cap Values for Calendar Year (CY) 2010 – Rescinded and replaced by Transmittal 1860	01/04/2010	6660
<u>R1850CP</u>	11/13/2009	2010 Annual Update to the Therapy Code List	01/04/2010	6719
<u>R1843CP</u>	10/30/2009	Outpatient Mental Health Treatment Limitation	01/04/2010	6686
<u>R1840CP</u>	10/29/2009	Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs) – Rescinded and replaced by Transmittal 1894	04/05/2010	6563
<u>R1733CP</u>	05/08/2009	Manual Clarification for Skilled Nursing Facility (SNF) and Therapy Billing	04/27/2009	6407
<u>R1717CP</u>	04/24/2009	Speech-Language Pathology Practice Payment Policy	07/06/2009	6381
<u>R1706CP</u>	03/27/2009	Manual Clarification for Skilled Nursing Facility (SNF) and Therapy Billing – Rescinded and replaced by Transmittal 1733	04/27/2009	6407
<u>R1678CP</u>	02/13/2009	Outpatient Therapy Caps With Exceptions in CY 2009	04/06/2009	6321

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R1631CP</u>	11/07/2008	Extension of Therapy Cap Exception Process	12/08/2008	6222
<u>R1593CP</u>	09/12/2008	Smoking and Tobacco Use Cessation Counseling Billing Update for Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Physical Therapy Providers (OPTs)	12/12/2008	6163
<u>R1472CP</u>	03/06/2008	Update of Institutional Claims References	04/07/2008	5893
<u>R1459CP</u>	02/22/2008	Comprehensive Outpatient Rehabilitation Facility (CORF) Billing Requirement Updates for Fiscal Year (FY) 2008	07/07/2008	5898
<u>R1421CP</u>	01/25/2008	Update of Institutional Claims References - Rescinded and Replaced by Transmittal 1472	04/07/2008	5893
<u>R1414CP</u>	01/17/2008	Outpatient Therapy Caps Without KX Modifier Exceptions Start January 1, 2008	01/07/2008	5871
<u>R1407CP</u>	01/10/2008	Outpatient Therapy Caps Without KX Modifier Exceptions Start January 1, 2008 – Replaced by Transmittal 1414	01/07/2008	5871
<u>R1377CP</u>	11/23/2007	2008 Annual Update to the Therapy Code List	01/07/2008	5810
<u>R1183CP</u>	02/09/2007	Infrared Therapy Devices	01/16/2007	5421
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<u>R941CP</u>	05/05/2006	Changes Conforming to CR 3648 Instructions for Therapy Services	10/02/2006	4014
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<u>R001CP</u>	10/01/2003	Initial Publication of Manual	NA	NA

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