CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2523	**Date: August 24, 2012**
	Change Request 7891

SUBJECT: Revised Medicare Summary Notice (MSN) Message Regarding Outpatient Therapy Caps

I. SUMMARY OF CHANGES: The purpose of this Change Request is to revise the Medicare Summary Notice (MSN) message 17.13 to reflect that hospital outpatient claims are no longer exempt from the therapy caps, effective 10/1/2012.

EFFECTIVE DATE: October 1, 2012
IMPLEMENTATION DATE: October 1, 2012

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	21/50.17/Nonphysician Services
R	21/90.17/Servicios Que No Fueron Prestados Por Doctores

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out with their operating budgets.

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

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 2523	Date: August 24, 2012	Change Request: 7891

SUBJECT: Revised Medicare Summary Notice (MSN) Message Regarding Outpatient Therapy Caps

Effective Date: October 1, 2012

Implementation Date: October 1, 2012

I. GENERAL INFORMATION

A. Background: Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) extended the therapy caps exceptions process through December 31, 2012 and made several changes affecting the processing of claims for therapy services. Therapy services furnished in an outpatient hospital setting had previously been exempt from the application of the therapy caps; however, MCTRJCA required Original Medicare to temporarily apply the therapy caps (and related provisions) to the therapy services furnished in an outpatient hospital on/after October 1, 2012, and on/before December 31, 2012. Although claims processing requirements associated with the cap are only applicable to hospitals on/after October 1, 2012, claims paid for hospital outpatient therapy services since January 1, 2012, are included in calculating the cap beginning October 1, 2012.

Currently, when therapy services are paid by Medicare, the beneficiary receives the following message on their MSN:

17.13 - Medicare approves a limited dollar amount each year for physical therapy and speech-language pathology services and a separate limit each year for occupational therapy services when billed by providers, physical and occupational therapists, physicians, and other non-physician practitioners. Medically necessary therapy over these limits is covered when received at a hospital outpatient department or when approved by Medicare.

Since therapy services in hospital outpatient departments are not exempt from the therapy caps on/after October 1, 2012, this message must be revised. The message also does not conform with current length limitations for MSN messages. Therefore, the message is revised by this transmittal to read:

17.13 – Each year, Medicare pays for a limited amount of physical therapy and speech-language pathology services and a separate amount of occupational therapy services. Medically necessary therapy over these limits is covered when approved by Medicare.

B. Policy: This transmittal contains no new policy. It revises an MSN message to more accurately reflect Medicare policy.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7891.1	Medicare contractors shall revise MSN message 17.13 to read: English version: Each year, Medicare pays for a limited amount of physical therapy and speech-language pathology services and a separate amount of occupational therapy services. Medically necessary therapy over these limits is covered when approved by Medicare. Spanish version: Cada año, Medicare paga por una cantidad limitada de servicios de terapia física y de patología (habla-lenguaje) y una cantidad aparte de servicios de terapia ocupacional. La terapia necesaria por razones médicas sobre estos límites está cubierta cuando sea aprobada por Medicare.	X		X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

X-Ref Requirement Number	Recommendations or other supporting information:
	None

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Institutional Claims Processing: Yvonne Young, yvonne.young@cms.hhs.gov, 410-786-1886
Practitioner Claims Processing: April Billingsley, april.billingsley@cms.hhs.gov, 410-786-0140
Payment Policy: Pam West, pamela.west@cms.hhs.gov, 410-786-2302

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

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*, include the following statement:

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

50.17 - Nonphysician Services

(Rev. 2523; Issued: 08-24-12; Effective: 10-01-12; Implementation: 10-01-12)

17.1 - Services performed by a private duty nurse are not covered.

17.2 - This anesthesia service must be billed by a doctor.

17.3 - This service was denied because you did not receive it under the direct supervision of a doctor.

17.4 - Services performed by an audiologist are not covered except for diagnostic procedures.

17.5 - Your provider's employer must file this claim and agree to accept assignment.

17.6 - Full payment was not made for this service(s) because the yearly limit has been met.

17.7 - This service must be performed by a licensed clinical social worker.

17.8 - Payment was denied because the maximum benefit allowance has been reached.

17.9 - Medicare (Part A/Part B) pays for this service. The provider must bill the correct Medicare contractor.

(**NOTE**: Insert appropriate program. Message is used for Part A claims received by Part B or Part B claims received by Part A.)

17.10 - The allowance has been reduced because the anesthesiologist medically directed concurrent procedures.

17.11 - This item or service cannot be paid as billed.

17.12 - This service is not covered when provided by an independent therapist.

17.13 - *Each year, Medicare pays for a limited amount of physical therapy and speech-language pathology services and a separate amount of occupational therapy services. Medically necessary therapy over these limits is covered when approved by Medicare.*

17.14 - Charges for maintenance therapy are not covered.

17.15 - This service cannot be paid unless certified by your physician every (___) days. (**NOTE**: Insert appropriate number of days.)

17.16 - The hospital should file a claim for Medicare benefits because these services were performed in a hospital setting.

17.17 - Medicare already paid for an initial visit for this service with this physician, another physician in his group practice, or a provider. Your doctor or provider must use a different code to bill for subsequent visits.

17.18 - ($) has been applied during this calendar year (CCYY) towards the ($) limit on outpatient physical therapy and speech-language pathology benefits.

17.19 - ($) has been applied during this calendar year (CCYY) towards the ($) limit on outpatient occupational therapy benefits.

90.17 - Servicios Que No Fueron Prestados Por Doctores

(Rev. 2523; Issued: 08-24-12; Effective: 10-01-12; Implementation: 10-01-12)

17.1 - Servicios realizados por una enfermera privada no están cubiertos.

17.2 - Su médico debe facturar por este servicio de anestesia.

17.3 - Este servicio se denegó porque usted no lo recibió bajo la supervisión directa de un médico.

17.4 - Servicios realizados por un audiólogo no son cubiertos, excepto por procedimientos diagnósticos.

17.5 - El patrón de su proveedor debe enviar esta reclamación y estar de acuerdo en aceptar la asignación.

17.6 - Debido a que usted alcanzó su límite anual por este servicio, no se hará un pago completo.

17.7 - Este servicio debe ser realizado por un trabajador social clínico autorizado.

17.8 - El pago fue denegado debido a que usted alcanzó el pago máximo del beneficio.

17.9 - Este servicio es pagado por Medicare (Parte A/Parte B). El proveedor debe enviar la factura al contratista de Medicare correcto.

17.10 - La cantidad aprobada ha sido reducida porque el anestesiólogo dirigió procedimientos médicos concurrentes.

17.11 - Este servicio no se puede pagar según facturado.

17.12 - Este servicio no es cubierto cuando es proporcionado por un terapísta independiente.

17.13 - *Cada año, Medicare paga por una cantidad limitada de servicios de terapia física y de patología (habla-lenguaje) y una cantidad aparte de servicios de terapia ocupacional. La terapia necesaria por razones médicas sobre estos límites está cubierta cuando sea aprobada por Medicare.*

17.14 - Los costos por terapia de mantenimiento no están cubiertos.

17.15 - Este servicio no puede ser pagado si no está certificado por su médico cada (___) días.

17.16 - El hospital debe radicar una reclamación por los beneficios de Medicare porque estos servicios fueron prestados en un hospital.

17.17 - Medicare ya pagó una visita inicial por este servicio con este médico, otro médico de su mismo grupo, o un proveedor. Su médico o proveedor debe usar un código distinto para facturar visitas subsiguientes.

17.18 - En este año (CCYY), ($) han sido deducidos de la cantidad límite de ($) por los beneficios de terapia física ambulatoria y de patología del lenguage hablado.

17.19 - En este año (CCYY), ($) han sido deducidos de la cantidad límite de ($) por los beneficios de terapia ocupacional ambulatoria.