CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2736	**Date: June 28, 2013**
	Change Request 8257

Transmittal 2690, dated May 3, 2013, is being rescinded and replaced by Transmittal 2736, dated June 28, 2013, to correct a date reference in section 100.1.1 of the manual update. All other information remains the same.

SUBJECT: Billing Social Work and Psychological Services in Comprehensive Outpatient Rehabilitation Facilities (CORFs)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the list of HCPCS codes billable in a CORF. It also manualizes billing instructions for a National Coverage Determination related to CORFs that was previously omitted from the Medicare Claims Processing Manual.

EFFECTIVE DATE: October 1, 2012
IMPLEMENTATION DATE: October 7, 2013

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	Table of Contents
R	5/10.3/Application of Financial Limitations
R	5/10.5/Notification for Beneficiaries Exceeding Financial Limitations
R	5/10.7/Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services
R	5/40.2/Applicable Types of Bill
N	5/40.7/Billing for Biofeedback Training for the Treatment of Urinary Incontinence
R	5/100.1.1/Allowable Revenue Codes on CORF 75X Bill Types
R	5/100.4/Outpatient Mental Health Treatment Limitation
R	5/100.11/Billing for Social Work and Psychological Services in a CORF

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor's activities are to be carried out within 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: 2736	Date: June 28, 2013	Change Request: 8257

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SUBJECT: Billing Social Work and Psychological Services in Comprehensive Outpatient Rehabilitation Facilities (CORFs)

EFFECTIVE DATE: October 1, 2012
IMPLEMENTATION DATE: October 7, 2013

I. GENERAL INFORMATION

A. Background: In 2008, the Original Medicare program issued Change Request (CR) 5898, entitled Comprehensive Outpatient Rehabilitation Facility (CORF) Billing Requirement Updates for Fiscal Year (FY) 2008. This CR established a number of edits in Medicare claims processing systems that ensure the correct CPT/HCPCS code and revenue code combinations are billed on CORF claims (type of bill 75X). One of these edits required that CPT code 96152 was the only code that could be billed with medical social services or behavioral health revenue codes on CORF claims.

In September 2009, Medicare issued CR 6005, entitled Comprehensive Outpatient Rehabilitation Facility (CORF) Services. This CR, which updated the Medicare Benefit Policy Manual, created a new HCPCS code, G0409, for billing of social work and psychological services in the CORF setting. At that time, Medicare did not update the claims processing system to replace CPT code 96152 with HCPCS code G0409 in the edit created by CR 5898. The requirements below correct this oversight and also refine the list of revenue codes that can be reported with HCPCS code G0409.

With this CR, Medicare is also correcting another oversight in the therapy chapter of the Medicare Claims Processing Manual. In 2001, Medicare issued CR1535, which implemented a National Coverage Determination (NCD) regarding biofeedback training for the treatment of urinary incontinence. CR 1535 established that biofeedback training may be provided by therapists in facility settings. This billing instruction was not reflected in Chapter 5 of the Medicare Claims Processing Manual.

Finally, Section 603(c) of the American Taxpayer Relief Act of 2012 (ATRA) revised the payment liability for denials resulting from the outpatient therapy caps. The law changes these denials from beneficiary liability to provider liability, effective January 1, 2013. This change has already been implemented by local contractor action. This CR adds the corresponding information to the manual.

B. Policy: This CR contains no new policy. It updates Medicare system edits and billing instructions to more accurately reflect current policy.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8257.1	Medicare contractors shall allow only HCPCS code G0409 to be billed with revenue codes 0569 or 0911 on type of bill 75X.							X				
8257.1.1	Medicare contractors shall return to provider type of bill 75X claims that contain revenue codes 0569 or 0911 with any CPT/HCPCS code other than G0409.	X			X							
8257.2	Medicare contractors shall only allow the following revenue codes to be billed on type of bill 75X: 0270, 0274, 0279, 029x, 0410, 0412, 0419, 042x, 043x, 044x, 0550, 0559, 0569, 0636, 0771, 0911 and 0942.							X				
8257.2.1	Medicare contractors shall return to provider type of bill 75X claims that contain revenue codes which are not allowable.	X			X							
8257.3	Medicare contractors shall accept HCPCS codes 90901 and 90911 on types of bill 12X, 13X, 22X, 23X, 34X, 74X, 75X, and 85X.	X			X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8257.4	MLN Article : A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X			

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
All	These business requirements revise the edits created in BRs 5898.1 and 5898.2.

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

V. CONTACTS

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

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:
No additional funding will be provided by CMS; Contractor's activities are to be carried out within their operating budgets.

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

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

Table of Contents
(Rev. 2736, Issued: 06-28-13)

Transmittals for Chapter 5

40.7 - Billing for Biofeedback Training for the Treatment of Urinary Incontinence

10.3 - Application of Financial Limitations

(Rev. 2736, Issued: 06-28-13, Effective: 10-01-12, Implementation10-07-13)

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

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.

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. All requests for exception are in the

form of a KX modifier added to claim lines. (See subsection D. for use of the KX modifier.)

Use of the exception process does not exempt services from manual or other medical review processes as described in Pub. 100-08. Rather, atypical use of the 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. Exceptions Process

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

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

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

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

- The patient's condition, including the diagnosis, complexities, and severity;
- The services provided, including their type, frequency, and duration;
- The interaction of current active conditions and complexities that directly and significantly influence the treatment such that it causes services to exceed caps.

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

1. Exceptions for Evaluation Services

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

> 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, *96125,* 97001, 97002, 97003, 97004.

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

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

2. Exceptions for Medically Necessary Services

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

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

possible to use the most relevant therapy diagnosis code in the primary position. In that case, the relevant diagnosis code should, if possible, be on the claim in another position.

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

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

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

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

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

In justifying exceptions for therapy caps, clinicians and contractors should not only consider the medical diagnoses and medical complications that might directly and significantly influence the amount of treatment required. Other variables (such as the availability of a caregiver at home) that affect appropriate treatment shall also be considered. Factors that influence the need for treatment should be supportable by published research, clinical guidelines from professional sources, and/or clinical or common sense. See Pub. 100-02, chapter 15, section 220.3 for information related to documentation of the evaluation, and section 220.2 on medical necessity for some factors that complicate treatment.

NOTE: The patient's lack of access to outpatient hospital therapy services alone, when outpatient hospital therapy services are excluded from the limitation, does not justify excepted services. Residents of skilled nursing facilities prevented by consolidated

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

C. Appeals Related to Disapproval of Cap Exceptions

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

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

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

D. Use of the KX Modifier for Therapy Cap Exceptions

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

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

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

- For professional claims, sent to the carrier or A/B MAC, refer to:

- Pub.100-04, Medicare Claims Processing Manual, chapter 26, for more detail regarding completing the CMS-Form 1500 claim form, including the placement of HCPCS modifiers. **NOTE**: The CMS-Form 1500 currently has space for providing two modifiers in block 24D, but, if the provider has more than two to report, he/she can do so by placing the -99 modifier (which indicates multiple modifiers) in block 24D and placing the additional modifiers in block 19.

- The ASC X12N 837 Health Care Claim: Professional Implementation Guide for more detail regarding how to electronically submit a health care claim transaction, including the placement of HCPCS modifiers. The ASC X12N 837 implementation guides are the standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for submitting health care claims electronically. The 837 professional transaction currently permits the placement of up to four modifiers, in the 2400 loop, SV1 segment, and data elements SV101-3, SV101-4, SV101-5, and SV101-6. Copies of the ASC X12N 837 implementation guides may be obtained from the Washington Publishing Company.

- For claims paid by a carrier or A/B MAC, it is only appropriate to append the KX modifier to a service that reasonably may exceed the cap. Use of the KX modifier when there is no indication that the cap is likely to be exceeded is abusive. For example, use of the KX modifier for low cost services early in an episode when there is no evidence of a previous episode that might have exceeded the cap is inappropriate.

- For institutional claims, sent to the FI or A/B MAC:

  - When the cap is exceeded by at least one line on the claim, use the KX modifier on all of the lines on that institutional claim that refer to the same therapy cap (PT/SLP or OT), regardless of whether the other services exceed the cap. For example, if one PT service line exceeds the cap, use the KX modifier on all the PT and SLP service lines (also identified with the GP or GN modifier) for that claim. When the PT/SLP cap is exceeded by PT services, the SLP lines on the claim may meet the requirements for an exception due to the complexity of two episodes of service.

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

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

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

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

- Qualify for an exception using the automatic process exception.

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

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

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

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

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

E. Therapy Cap Manual Review Threshold

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

(1) Occupational therapy services.

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

Services shall accrue toward the thresholds beginning with claims with dates of service on and after January 1, 2012. The thresholds shall apply to both services showing the KX modifier and those without the modifier. Beginning with claims with dates of service on and after October 1, 2012, contractors shall apply the thresholds to claims exceeding it by suspending the claim for manual review. Instructions regarding the manual review process may be found in the Program Integrity Manual.

F. Identifying the Certifying Physician

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

physician/NPP identified for a therapy plan of care must be included on the therapy claim.

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

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

For situations where the physician/NPP is both the certifier of the plan of care and furnishes the therapy service, he/she supplies his/her own information, including the NPI, in the appropriate referring provider loop (or, appropriate block on the 1500 form). This is applicable to those therapy services that are personally furnished by the physician/NPP as well as to those services that are furnished incident to their own and delivered by "qualified personnel" (see section 230.5 of this manual for qualifications for incident to personnel).

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

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

G. MSN Messages

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

10.5 - Notification for Beneficiaries Exceeding Financial Limitations

(Rev. 2736, Issued: 06-28-13, Effective: 10-01-12, Implementation10-07-13)

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. *Prior to 2013, Medicare instructed* providers/suppliers to inform beneficiaries that beneficiaries were responsible for 100 percent of the costs of therapy services above each respective therapy limit *(cap),* unless this outpatient care was furnished directly or under arrangements by a hospital when outpatient hospital therapy services *were* excluded from the limitation. *The American Taxpayer Relief Act (ATRA) of 2012 amended §1833(g)(5) of the Social Security Act (the Act) providing limitation of liability protections (under §1879 of the Act) to beneficiaries with respect to outpatient therapy services that exceed therapy cap amounts, furnished on or after January 1, 2013. Thus, effective January 1, 2013, assignment of liability has changed for therapy services exceeding the cap that don't qualify for a coverage exception. The provider/supplier is financially responsible when Medicare denies payment for therapy services above the cap that don't qualify for a coverage exception unless a valid Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, was issued per CMS guidelines.*

Providers were previously encouraged to use either a form of their own design or a voluntary ABN when providing therapy above the cap where no exception was applied; however, this instruction is no longer valid. When providing therapy services above the cap that don't qualify for the exceptions process, the provider/supplier must now issue a mandatory ABN in order to transfer financial responsibility to the beneficiary. When the ABN is used as a mandatory notice, providers must adhere to the ABN form instructions and guidance published in Chapter 30, Section 50 of this manual. The ABN and

instructions can be found at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html .

When issuing the ABN for therapy in excess of therapy caps, the following *language* is suggested for *the "Reason Medicare May Not Pay" section*: "Medicare *won't* 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 *you qualify* for an exception *to this cap amount*. *Your services don't qualify for an exception.* " Providers *should use similar language* for occupational therapy services *when* appropriate. A cost estimate for the services *should be included per the ABN form instructions. Therapy cost estimates can be listed as a cost per service or as a projected total cost for a certain amount of therapy provided over a specified time period.*

ABN *issuance remains mandatory before* the cap is exceeded *when services aren't expected to be covered by Medicare because they are not medically reasonable and necessary. When* the clinician determines that skilled services are not medically 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 *will be getting* services *that don't meet the medical necessity requirements for Medicare payment,* the ABN *must* be issued prior to delivering *these* services. The ABN informs the beneficiary of his/her potential financial obligation to the provider, *allows him/her to choose whether or not to get the services,* and provides *information* regarding appeal rights.

When a provider/supplier expects that Medicare will deny payment on a claim for therapy services because they are not medically reasonable and necessary, regardless of whether or not therapy limits are met, the ABN must be issued before providing the services in order to transfer financial responsibility to the beneficiary.

10.7 - Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services

(Rev. 2736, Issued: 06-28-13, Effective: 10-01-12, Implementation10-07-13)

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

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

For subsequent units and procedures with dates of service prior to April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment is made for the PE for services submitted on professional claims (any claim submitted using the 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).

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

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

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

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.

40.2 - Applicable Types of Bill

(Rev. 2736, Issued: 06-28-13, Effective: 10-01-12, Implementation10-07-13)

The appropriate types of bill for submitting outpatient rehabilitation services are: 12X, 13X, 22X, 23X, 34X, 74X, 75X, and *85X*.

40.7 - Billing for Biofeedback Training for the Treatment of Urinary Incontinence

(Rev.2736, Issued: 06-28-13, Effective: 10-01-12, Implementation10-07-13)

Medicare covered biofeedback training for the treatment of urinary incontinence may be provided by physical therapists in facility settings. For information regarding the coverage of this service, see the Medicare National Coverage Determinations Manual, Chapter 1, Section 30.1.1. Medicare pays for this service under the Medicare Physician Fee Schedule.

Providers bill this service on one of the types of bill listed in section 40.2 using revenue code 042X and one of the following HCPCS codes:

- *90901 - Biofeedback training by any modality*
- *90911 - Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry*

100.1.1 - Allowable Revenue Codes on CORF 75X Bill Types

(Rev. 2736, Issued: 06-28-13, Effective: 10-01-12, Implementation10-07-13)

Effective October 1, 2012, the following revenue codes are allowable for reporting CORF services on 75X bill types:

0270	0274	0279	029X
0412	0419	042X	0410
044X	0550	0559	043X
0636	0771	0911	0569
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.

100.4 - Outpatient Mental Health Treatment Limitation

(Rev. 2736, Issued: 06-28-13, Effective: 10-01-12, Implementation10-07-13)

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 October 1, 2012, HCPCS* code *G0409* is the only code allowed for *social work and psychological* services *furnished* in a CORF. This service is not subject to the limitation because it is not a psychiatric mental health treatment service.

For additional information on the limitation, see Publication 100-01, Chapter 3, section 30 and Publication 100-02, Chapter 12, sections 50-50.5.

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

(Rev Issued: 06-28-13, Effective: 10-01-12, Implementation10-07-13)

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

G0409 – Social work and psychological services, directly relating to and/or the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF-qualified social worker or psychologist in a CORF)

In addition, *HCPCS code G0409* shall only be billed with revenue code 0569 *or* 0911.