Attachment - Business Requirements

Pub. 100-04 Transmittal: 2457 Date: April 27, 2012 Change Request: 7785

SUBJECT: Revisions of the Financial Limitation for Outpatient Therapy Services – Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012

Effective Date: October 1, 2012

Implementation Date: October 1, 2012

I. GENERAL INFORMATION

A. Background: The Balanced Budget Act of 1997 enacted financial limitations on outpatient physical therapy, occupational therapy, and speech-language pathology services in all settings except outpatient hospital. Exceptions to the limits were enacted by the Deficit Reduction Act, and have been extended by legislation several times.

B. Policy: 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. Suppliers and providers will continue to use the KX modifier to request an exception to the therapy cap on claims that are over the 2012 cap amounts -- \$1880 for occupational therapy services and \$1880 for the combined services for physical therapy and speech-language pathology. Use of the KX modifier indicates that the services are reasonable and necessary and that there is documentation of medical necessity in the patient's medical record.

Therapy services furnished in an outpatient hospital setting have been exempt from the application of the therapy caps; however, MCTRJCA requires 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 (e.g., the exceptions process using the KX modifier or denying claims without the KX modifier if the cap is exceeded), in calculating the cap beginning October 1, 2012, claims paid for hospital outpatient therapy services since January 1, 2012, will be included.

MCTRJCA contains two requirements that become effective on October 1, 2012. The first of these requires suppliers and providers to report the National Provider Identifier (NPI) of the physician, or nonphysician practitioner (NPP) where applicable, responsible for reviewing the therapy plan of care, on the beneficiary's claim for therapy services. For implementation purposes, the physician or NPP (as applicable) certifying the therapy plan of care is reported.

MCTRJCA also calls for a manual medical review process for those exceptions where the beneficiary therapy services for the year reach a threshold of \$3,700. The separate thresholds triggering manual medical reviews build upon the separate therapy caps -- one for PT and SLP services combined and one for OT services. Claims with a KX modifier requesting an exceptions for services above either threshold, per MCTRJCA, are subject to a manual medical review process. The count of services to which these thresholds apply begins on January 1, 2012. Absent Congressional action, manual medical review expires when the exceptions process expires for dates of service after December 31, 2012.

Claims for services at or above the therapy caps or thresholds for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable. While suppliers and providers are not required to issue an Advance Beneficiary Notice (ABN) for these benefit category denials, they are encouraged

to issue the voluntary ABN as a courtesy to their patients requiring services over the therapy cap amounts (\$1,880 for each cap in CY 2012) to alert them of their possible financial liability.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
			A D	F	C A R	R H		Shared- System			OTHE R	
		M A C	M A C		R I E R	I	F 1 S	M C S	V M S	C W F		
7785.1	Medicare contractors shall ensure that exceptions to the therapy caps are made only when outpatient therapy services report modifier KX.	X		X	X	X				X	ani kanada aran aran aran aran aran aran aran	
7785.2	Effective for dates of service on or after October 1, 2012, Medicare contractors shall edit to enforce the therapy caps for outpatient therapy services on institutional claims provided in outpatient hospital settings.									X		
7785.2.1	Medicare contractors shall edit to enforce the therapy caps if the following criteria are present: • Type of bill 12X (excluding Critical Access Hospital CCNs in the range 1300-1399) or 13X • Revenue code 042X, 043X or 044X • Modifier GN, GO or GP and • Date of service on or after October 1, 2012.						X			X		
7785.2.2	Medicare contractors shall bypass the edits to enforce the therapy caps if modifier KX is present on a therapy service line.									X		
7785.3	Medicare contractors shall accumulate per-beneficiary total payment amounts for outpatient therapy services, including payments made beyond the therapy caps, for use in applying additional thresholds of \$3700.									X		
7785.3.1	Medicare contractors shall accumulate separate perbeneficiary totals for the new thresholds: • Physical therapy and speech-language pathology combined, and • Occupational therapy.									X		
7785.3.2	Medicare contractors shall apply outpatient therapy service payments to the new thresholds in the same manner currently used to apply payments to the therapy cap amounts.							in the second se		X		
7785.3.3	Medicare contractors shall apply outpatient therapy services provided in outpatient hospital settings to the new thresholds.									X		
7785.3.4	The new thresholds shall accrue for claims with dates of service from January 1 through December 31, 2012.									X		
7785.4	Medicare contractors shall manually review claims containing any therapy service that exceeds the applicable threshold amount for claims with dates of service on and	X		X	X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A D F / M I B E			C A R	R H H	Shared- System				OTHE R	
			M A		R I E	Î	F I S	M C S	V M	С		
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· · · · · · · · · · · · · · · · · · ·	after October 1, 2012.			L								
7785.4.1	Medicare contractors shall reject outpatient therapy service lines when the applicable threshold amount is greater than \$3700 before the current service payment is applied, if the KX modifier is on the claim.	The state of the s								X		
	NOTE: The edit shall be overrideable.			<u> </u>		<u> </u>		L				
7785.4.2	Medicare contractors shall suspend any claims rejected per requirement 7785.4.1.	X		X	X	X	X					
	NOTE: The details regarding handling the suspended claims will be provided in a separate instruction.											
7785.5	Medicare contractors shall update the payments applied to the therapy caps and the new \$3700 thresholds to reflect all therapy services provided in hospital outpatient settings with dates of service in 2012 that were processed before October 1, 2012.									X		
7785.6	Medicare contractors shall display the total amount applied toward the therapy caps and thresholds on all applicable screens and inquiry mechanisms.									X		
7785.7	Medicare contractors shall instruct providers to report the NPI of the physician certifying the therapy plan of care in the Attending Physician field on institutional claims for outpatient therapy services, for dates of service on and after October 1, 2012.	X		X		X						
7785.7.1	Medicare contractors shall instruct providers that in cases where different professionals certify the OT, PT or SLP plan of care to report the additional NPI in the Referring Physician field (loop 2310F) on institutional claims for outpatient therapy services, for dates of service on and after October 1, 2012.	X		X		X						
7785.8	Medicare contractors shall instruct providers to report the physician/NPP certifying the therapy plan of care on professional claims, including his/her NPI, for outpatient therapy services for dates of service on and after October 1, 2012.	X			X							
7785.8.1	Medicare contractors shall instruct providers that, for claims processing purposes, the certifying physician/NPP is considered a referring provider (per Pub. 100-02, Chapter 15, section 220.1.1), and the providers are to follow claims processing instructions for reporting the referring provider to report this individual on a claim.	X			X							
7785.8.2	For electronic claims, Medicare contractors shall	X			X		T					
, , 00.0.2	instruct providers to report the referring provider,	-										

Number	Requirement	Responsibility (place an "X" in each applicable column)											
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		M A C	M A C		R I E R	I	FISS	M C S	V M S	C W F			
	including his/her NPI, per the instructions in the appropriate ASC X12 837 Technical Report 3 (TR3).				-		3		a .				
7785.8.3	For paper claims, Medicare contractors shall instruct providers to report the referring provider, including his/her NPI, per the instructions in IOM Pub. 100-04, Chapter 26, section 10.	X			X								
7785.8.4	Medicare contractors shall return as unprocessable any claim for a therapy service which does not include at least one referring provider and his/her NPI, i.e., a referring provider identified at the claim level.	X			X								
7785.8.4.1	When returning claims returned as unprocessable per BR 7785.8.4, contractors shall use the following claim adjustment reason code:	X			X						***************************************		
	16 Referral absent or 5 exceeded.												
7785.8.4.2	When returning claims returned as unprocessable per BR 7785.8.4, contractors shall use the following remittance advice remark codes:	X			X								
	N28 Missing/incomplete/invalid referring 5 provider name.												
	N28 Missing/incomplete/invalid referring 6 provider primary identifier.												

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in eac applicable column)							each		
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7785.9	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 site 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 your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X	X					

IV. SUPPORTING INFORMATION

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

X-Ref	Recommendations or other supporting information:
Requireme nt Number	
7785.3.2	Current requirements regarding co-insurance, multiple procedure payment reductions or other payment adjustments will be applied to the new thresholds.
7785.6	Currently, CWF displays amounts up to the current therapy cap amount of \$1880 and does not display amounts over \$1880. This limitation on the displayed amount is removed by this requirement.

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

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