Medicare Learning Network
MLN Matters
CMS Centers for Medicare & Medicaid Services
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – ***Effective March 1, 2008,*** Medicare fee-for-service 837P and CMS-1500 claims must include an NPI in the primary fields on the claim (i.e., the billing, pay-to, and rendering fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim. You may not submit claims containing only a legacy identifier in the primary fields. Failure to submit an NPI in the primary fields will result in your claim being rejected or returned as unprocessable beginning March 1, 2008. Until further notice, you may continue to include legacy identifiers only for the secondary fields.

MLN Matters Number: MM5871 | Related Change Request (CR) #: 5871

Related CR Release Date: January 10, 2008 | Effective Date: January 1, 2008

Related CR Transmittal #: R1407CP | Implementation Date: January 14, 2008

Outpatient Therapy Caps With Exceptions Start January 1, 2008

Provider Types Affected

Therapists and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), or Medicare Administrative Contractors (A/B MAC)) for therapy services for Medicare beneficiaries.

Provider Action Needed

CR 5871, from which this article is taken announces the dollar amount of outpatient therapy caps for 2008, and clarifies the *Medicare Claims Processing Manual* regarding exceptions to outpatient therapy services.

On January 1, 2008, the financial limits on outpatient therapy services will be $1,810 for combined physical therapy and speech-language pathology services; and $1,810 for occupational therapy services.

You should make sure that your billing staffs are aware of these new outpatient therapy caps. You might also want to refer to the updated *Medicare Claims Processing Manual,* Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Section 10.2 (The Financial Limitation), for the complete documentation of the outpatient therapy services exceptions clarifications (which are summarized below). The complete revised manual sections are attached to CR5871, which is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1407CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

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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 services. The 2006 Deficit Reduction Act enacted exceptions to the limits, and the Medicare, Medicaid, and SCHIP Extension Act of 2007 extended the cap exceptions process through June 30, 2008. The dollar amount of the cap is updated annually in accordance with the Medicare Economic Index.

CR 5871, from which this article is taken announces the dollar amount of outpatient therapy caps for 2008. Effective January 1, 2008, the financial limits on outpatient therapy services will be $1,810 for combined physical therapy and speech-language pathology services; and $1,810 for occupational therapy services. Exceptions are allowed for medically necessary outpatient therapy services.

The financial limits on outpatient therapy services over the last three years are displayed in Table 1.

Table 1
Financial Limits on Outpatient Therapy Services*

Year	Physical Therapy and Speech Language Pathology Combined	Occupational Therapy
2008	$1,810	$1,810
2007	$1,780	$1,780
2006	$1,740	$1,740

Note: Medicare pays up to 80% of the limits after the deductible has been met.

The Medicare Summary Notice (MSN) message 38.18 has been updated to read: "ALERT: Coverage by Medicare is limited to *$1,780 in 2007 and $1,810 in 2008* for outpatient physical therapy and speech-language pathology combined. Occupational therapy services have the same limits. Medicare pays up to 80 percent of the limits after the deductible has been met. Exceptions to these limits apply to therapy billed by hospital outpatient departments and may also apply to medically necessary services."

CR 5871 also clarifies the *Medicare Claims Processing Manual,* Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Section 10.2 (The Financial Limitation), regarding exceptions to outpatient therapy services (except when

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billed by outpatient hospitals). A summary of the major manual clarifications follows:

1. Section 10.2, Subsection B. Moratoria and Exceptions for Therapy Claims
   Future exceptions language added as follows:
   The cap exception for therapy services billed by outpatient hospitals was part of the original legislation (Balanced Budget Act of 1997), 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, as they did for 2007 and as they again extended through June 30, 2008, as part of the Medicare, Medicaid, and SCHIP Extension Act of 2007.
2. Section 10.2, Subsection C-1 Exceptions to Therapy Caps – General
   When the exceptions process (as directed by legislation) is in effect the policies in this section apply. Further, with the exception of the use of the KX modifier, the guidance in this section applies to all therapy services addressed by this section.

   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.
3. Section 10.2, Subsection C-2 Automatic Process Exceptions
   Beginning January 1, 2007, all exceptions are processed automatically. You should be aware that the term "automatic process exceptions" indicates that the claims processing for the exception is automatic, and not that the exception, itself, is automatic.

   In making a decision about whether to utilize the automatic process for exception, clinicians should consider, (among other considerations) whether services are appropriate to the patient's condition including the diagnosis, complexities and severity You should be aware that the list of the ICD-9 codes (for conditions and complexities that might qualify a beneficiary for exception to caps) that is found in the table in subsection 10.2 C-3 is only a guideline; and neither assures that services on the list will be excepted, nor limits the provision of covered and medically necessary services for conditions that are not on the list.

   Not all patients who have a condition or complexity on the ICD-9 code list are "automatically" excepted from therapy caps. You should see the *Medicare Benefit Policy Manual,* Chapter 15 (Covered Medical and Other Health Services), Section 230.3 (Practice of Speech-Language Pathology) for documenting the patient's condition and complexities. Note that Medicare contractors may scrutinize claims from providers whose services exceed caps more frequently than is typical. Further guidance on billing therapy services are found in the Local Coverage Determinations of some contractors.

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4. Subsection C-3. ICD-9 Codes That are Likely to Qualify for the Automatic Process Therapy Cap Exception Based Upon Clinical Condition or Complexity

   Some Medicare contractors' Local Coverage Determinations do not allow the use of some of the codes on the list in this Subsection to be in the primary diagnosis position on a claim. If your contractor has determined that these codes do not characterize patients who require medically necessary services, you may not use these codes. Rather, to describe the patient's condition, you must use a billable diagnosis code that your contractor allows.

   Medicare will apply therapy caps to services based on the medical necessity of the service for the patient's condition, not on the condition itself. 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.

   You may use the automatic process for exception for medically necessary services when the patient has a billable condition that is not on the list in this subsection. The diagnosis on this list may be put in a secondary position on the claim and/or in the medical records, as your contractor directs.

Additional Information

You can find more information about the outpatient therapy caps for 2008, and the *Medicare Claims Processing Manual* clarifications regarding exceptions to outpatient therapy services by going to CR 5871, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1407CP.pdf* on the CMS website. The updated *Medicare Claims Processing Manual,* Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Section 10.2 (The Financial Limitation) is an attachment to that CR.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

News Flash - It's Not Too Late to Get the Flu Shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. But re-vaccination is necessary each year because flu viruses change each year. Please encourage your Medicare patients who haven't already done so to get their annual flu shot. – And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot – Not the Flu! Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition MLN Matters article SE0748 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf* on the CMS website."

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