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Financial Limitation of Claims for Outpatient Rehabilitation Services

This article explains the Centers for Medicare & Medicaid Services' (CMS) implementation of the financial limitation for outpatient rehabilitation services including physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) claims submitted with dates of service on and after July 1, 2003.

Background

Financial limits on outpatient PT services provided in private practice settings began in 1972, and included OT services provided in private practice settings in 1987. The Balanced Budget Act of 1997 expanded the caps to include all PT, SLP, and OT services in every outpatient setting except outpatient hospital. These caps were effective in 1999, but were not fully implemented due to Y2K issues. The Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act of 2000 suspended the caps for the years 2000, 2001, and 2002. The moratorium expired on December 31, 2002.

Description

The caps apply to outpatient rehabilitation (PT, SLP, and OT) services provided by any provider/supplier except outpatient therapy services provided by: 1) a hospital to an outpatient or to an inpatient who has exhausted Part A benefits and 2) another entity under an arrangement with a hospital to provide the same services to the same beneficiaries.

NOTE: Only services billed by the hospital as bill type 12x or 13x are exempt from limitations on therapy services.

For skilled nursing facilities (SNF), this limitation does apply to rehabilitation services furnished to those SNF residents in non-covered 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 -- use bill type 23x (see CR 2674). For SNF residents in non-Medicare certified portions of the facility and SNF non-residents 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.

Limitations do not apply to SNF residents in a covered Part A stay, including swing beds. Rehabilitation services are included within the global Part A per diem payment that the SNF receives under the PPS for the covered stay. Similarly, limitations do not apply to any therapy services billed under PPS Home Health or inpatient hospitals, including critical access hospitals.

The limits apply to outpatient rehabilitation therapy services provided by:

- Physicians;
- Nurse practitioners;
- Clinical nurse specialists;
- Physician's assistants;
- Physical therapists;

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• Occupational therapists; and

• Speech-language pathologists.

- Settings affected by the caps consist of all settings paid using the Medicare Physician Fee Schedule except the outpatient hospital setting including:
- Comprehensive outpatient rehabilitation facilities;
- Outpatient physical therapy providers, e.g., outpatient rehabilitation facilities/rehabilitation agencies;
- Part B services in skilled nursing facilities (see above details for SNF settings);
- Home health agencies providing therapies to patients who are not homebound;
- Physician offices;
- Non-physician practitioner offices; and
- Physical and occupational therapist private practices.

The 2003 limits per beneficiary per year are:

- $1590 for PT and SLP combined; and
- $1590 for OT.

In 2003, the caps will be implemented beginning with claims submitted for dates of service on and after July 1, 2003. Due to systems limitations, the caps could not be implemented between January 1, 2003 and June 30, 2003. The full $1590 limit is available for beneficiary use between July 1, 2003 and December 31, 2003. In 2004 and subsequent years, the caps will apply to the entire year.

Billing Instructions

Therapy services, no matter who performs them, must meet the standards and conditions that apply to therapy services. For example, there must be an appropriate plan of care and documentation that supports medical necessity whenever therapy services are billed to Medicare.

Deductibles and co-insurance are subtracted from the allowed amount. For example, if the deductible for the year has been met and services are received that total $1590 (the limit of the allowed amount), Medicare pays 80 percent of the allowed amount ($1272) and the beneficiary pays $318 in co-insurance.

Providers/suppliers must continue to add a modifier (GP, GN, GO) to claims, which identify the type of service (PT, SLP, OT) that represents the therapy plan of care. A therapy plan of care is required whenever therapy services, represented by therapy codes noted below, are billed to Medicare. Therapy service claims without modifiers on applicable HCPCS or revenue codes will be returned.

NOTE: For the first time, these limits will be tracked for all provider/supplier types, including physicians' and non-physician practitioners' (NPP) claims. Claim payment depends on the use of the modifier. Therefore everyone, including physicians and NPPs who provide these services, should make certain that the appropriate modifier (GN, GO or GP) is included on each code for therapy services. Modifiers should reflect the plan of care under which the service is provided, rather than the specialty of the person who provides the service. Certain HCPCS codes may be used under more than one type of plan of care (PT, OT, SLP), in which case the physician or NPP should chose the appropriate modifier for their plan. Failure to include one of these code modifiers for these services will result in the claim/service being returned as unprocessable.

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Applicable Outpatient Rehabilitation HCPCS Codes

The following codes apply to each financial limitation except as noted below. These codes supersede the codes listed in §3653 of the Medicare Part A Intermediary Manual, Part 3: (NOTE: listing of the following codes does not imply that services are covered.)

29065+ 29075+ 29085+ 29086+ 29105+ 29125+ 29126+ 29130+ 29131+ 29200

29220 29240 29260 29280 29345+ 29355+ 29365+ 29405+ 29425+ 29445+

29505+ 29515+ 29520 29530 29540 29550 29580+ 29590 64550 90901
90911 92506 92507 92508 92526 92597 92601++ 92602++ 92603++

92604++ 92607 92608 92609 92610 92611 92612 92614 92616 95831

95832 95833 95834 95851 95852 96000 96001 96002 96003 96105

96110* 96111 96115 97001 97002 97003 97004 97012 97016 97018

97020 97022 97024 97026 97028 97032 97033 97034 97035 97036

97039 97110 97112 97113 97116 97124 97139 97140 97150 97504**

97520 97530 97532 97533 97535 97537 97542 97601+ 97703 97750

97799* V5362* V5363* V5364* G0279*** G0280*** G0281 G0283 0020T***0029T***

* The physician fee schedule abstract file described below does not contain a price for codes 96110, 97799, V5362, V5363, and V5364 since they are priced by the carrier. Therefore, contact the

carrier to obtain the appropriate fee schedule amount in order to make proper payment for these codes.

** Code 97504 should not be reported with code 97116. However, if code 97504 was performed on an upper extremity and code 97116 (gait training) was also performed, both codes may be billed with modifier 59 to denote a separate anatomic site.

*** The physician fee schedule abstract file described below does not contain a price for codes G0279, G0280, 0020T, 0029T since they are priced by the carrier. In addition, coverage for these codes is determined by the carrier. Therefore, contact the carrier to obtain the appropriate fee schedule amount.

+ These codes for casts and splints will not apply to the financial limitations when billed by physicians and NPPs, as appropriate. When these codes are billed by other providers/suppliers (bill types 22X, 23X, 34X, 74X, and 75X) or physical therapists or occupational therapists in private practice, specialty codes "65" and "67," they must be billed with a GO or GP modifier. Specialty codes 73 and 74 were not included because they are no longer applicable.

++ If an audiology procedure (HCPCS) code is performed by an audiologist, the above modifiers should not be reported, as these procedures are not subject to the financial limitation. When these HCPCS codes are billed under a speech language pathology plan of care, they should be accompanied with a GN modifier and applied to the financial limitation.

Beneficiary Notification

Providers/suppliers will be denied payment for services that exceed the limitations. Therefore, it is recommended that they make every effort to learn if prior therapy was performed before a patient is accepted for treatment. Since CMS can only report claims that have been submitted, providers/suppliers should track expenditures in their own facility or office and inform beneficiaries when they may become liable for payment. Providers and suppliers are encouraged to inform beneficiaries that they will be responsible for 100 percent of therapy costs after the limit has been met unless additional services are furnished directly or under arrangement by a hospital. It is recommended that they notify beneficiaries about this responsibility at the first therapy encounter, thereby allowing beneficiaries to make informed decisions regarding their continued care and financial responsibility.

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CMS developed the Notice of Exclusion from Medicare Benefits (NEMB) (Form No. CMS-20007 and Formulario No. CMS-20007) to assist in informing beneficiaries that the services they are receiving are excluded from Medicare benefits. Use of the NEMB form is optional. Providers/suppliers may develop their own process to communicate to beneficiaries that they will be billed for services over the cap. (Do not use the Advance Beneficiary Notice form.)

The NEMB form can be found at: http://www.cms.hhs.gov/medlearn/refabn.asp. (Page down twice for both English and Spanish versions.)

On the NEMB, check Box #1 and write a reason for the limitations as follows: "Medicare will not pay for physical therapy and speech-language pathology over $1590 (including dates of service from July 1, 2003 through December 31, 2003)." Substitute "occupational therapy services" in place of PT and SLP for patients under an OT plan of care.

Beginning on July1, 2003, CMS will include a generic message on each Medicare Summary Notice (MSN) containing therapy services which states that Medicare provides up to $1590 a year for PT and SLP services combined and up to $1590 for OT services and that additional medically necessary services over these limits are covered only in a hospital outpatient department. CMS will track the total dollar amount of allowed costs for therapy services reported for payment. Beneficiaries will receive a message on the MSN indicating when the caps have been exceeded and payment is denied. Beginning October 1, 2003, CMS plans to include an MSN message that informs beneficiaries of the amount of allowed cost that has accrued during this calendar year toward the cap. Providers (facilities) with access to HIQA may obtain the accrued amounts for beneficiaries from this database. When HIPAA goes into effect, (planned for October 2003) the accrued therapy amounts will be available on the ELGA and ELGB screens. Beneficiaries and providers without access to this information may contact the call center at their intermediary or carrier to obtain these amounts.

Appeals

Beneficiaries may appeal claims denied due to exceeding therapy caps. The beneficiary is to be advised of his or her appeal rights set forth in 42 CFR Part 405, subpart G. Physicians, therapists, and other suppliers who accept assignment may also appeal denials. Physicians, therapists and other suppliers who do not accept assignment, and institutional providers do not have the right to appeal.

For additional information about the financial limitation for outpatient rehabilitation services, refer to CR 2709 which can be accessed at http://www.cms.hhs.gov/manuals/memos/comm_date_dsc.asp. A PowerPoint presentation that CMS developed to assist providers in understanding these financial limits is available at http://www.cms.hhs.gov/medlearn/therapy.