Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2709

SUBJECT: Implementation of the Financial Limitation for Outpatient Rehabilitation Services

This Program Memorandum (PM) supplements PM AB-03-018, (CR 2183), dated February 7, 2003. A new MSN message, new codes, and a carrier action based on CWF trailer have been added with some further clarification. The implementation date of the limitation on outpatient therapy services remains the same. There is a new effective date for the MSN message.

Background

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, which added §1834(k)(5) to the Social Security Act (the Act), required payment under a prospective payment system for outpatient rehabilitation services. Outpatient rehabilitation services include the following services:

- Physical therapy (which includes outpatient speech-language pathology); and
- Occupational therapy.

Section 4541(c) of the BBA required application of a financial limitation to all outpatient rehabilitation services (with the exception of outpatient departments of a hospital) of an annual per beneficiary limit of $1500 for all outpatient physical therapy services (including speech-language pathology services) and a separate $1500 limit for all occupational therapy services. The $1500 limit is based on incurred expenses and includes applicable deductible ($100) and coinsurance (20 percent). The annual limitation does not apply to services furnished directly or under arrangement by a hospital to an outpatient, or to a hospital inpatient who is not in a covered Part A stay. The BBA provided that the $1500 limits be indexed by the Medicare Economic Index (MEI) each year beginning in 2002. This indexed amount is $1590 for 2003.

The limitation is based on the services the Medicare beneficiary receives, not the type of practitioner who provides the service. Therefore, physical therapists, speech-language pathologists, occupational therapists as well as physicians and non-physicians practitioners could render a therapy service.

As a transitional measure, effective in 1999, providers/suppliers were instructed to keep track of the allowed incurred expenses. This process was put in place to assure providers/suppliers did not bill Medicare for patients who exceeded the annual $1500 limitations for physical therapy and for occupational therapy services rendered by individual providers/suppliers.

Moratorium on Therapy Claims

Section 221 of the Balanced Budget Refinement Act of 1999 placed a 2-year moratorium on the application of the financial limitation for claims for therapy services with dates of service January 1, 2000 through December 31, 2001. Section 421 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, extended the moratorium on application of the financial limitation to claims for outpatient rehabilitation services with dates of service January 1, 2002, through December 31, 2002. Therefore, the moratorium was for a 3-year period and applied to outpatient rehabilitation claims with dates of service January 1, 2000, through December 31, 2002.

Application of Financial Limitation (Intermediaries and Carriers)

The moratorium on the application of the financial limitation is no longer in effect. As a result, the following instructions, regarding the financial limitation, supersede current instructions in §3653.Q and 3653.R of the Medicare Part A Intermediary Manual, Part 3. Beginning with claims submitted for dates of service on and after July 1, 2003, apply the financial limitation for occupational therapy and physical therapy (including speech-language pathology) services in a prospective manner through December 31, 2003. For CY 2003, the financial limitation could not be implemented prior to July 1, 2003 because of systems limitations. The full amount applies to that 6 month time period. For each subsequent calendar year, the financial limitations will be effective for the entire calendar year.

There are two separate $1590 limitations: one for physical therapy (including speech-language pathology) services and the other for occupational therapy services. Effective July 1, 2003, for claims with dates of service on or after July 1, 2003, the Common Working File (CWF) will track the $1590 physical therapy (which includes speech language pathology services) and the $1590 occupational therapy financial limitation for outpatient rehabilitation services.

NOTE: Shared System Maintainers will not be responsible for tracking the dollar amounts of incurred expenses of rehabilitation services for each therapy limitation.

This financial limitation is an annual per beneficiary limitation. The $1590 limitation is on the allowed incurred expenses, which are defined as the Medicare Physician Fee Schedule (MPFS) amount prior to any application of deductible ($100) and co-insurance (20 percent). If the beneficiary has already satisfied the Medicare Part B deductible, the maximum amount payable by the Medicare program is $1272; that is 80 percent of the $1590 for PT (including speech language pathology) and 80 percent of the $1590 for OT. The beneficiary is responsible for paying the remaining 20 percent co-insurance.

See the following examples:

EXAMPLE I - Part B Deductible Previously Met:

$1590 (MPFS allowed amount) x 80 percent = $1272 (Medicare reimbursement).

The amount applied to the limitation in this example is $1590. The Medicare program pays $1272 and the beneficiary is responsible for $318 co-insurance.

EXAMPLE II - Part B Deductible Not Met:

$1590 (MPFS allowed amount) - $100 (Part B deductible) = $1490 x 80 percent = $1192 (Medicare reimbursement).

The amount applied to the limitation in this example is $1590. The Medicare program pays $1192 and the beneficiary is responsible for $398, ($100 Part B deductible and $298 co-insurance).

EXAMPLE III - Part B Deductible Previously Met:

$800 (MPFS allowed amount) x 80 percent = $640 (Medicare reimbursement).

The amount applied to the limitation in this example is $800. The Medicare program pays $640 and the beneficiary is responsible for $160 co-insurance.

EXAMPLE IV - Part B Deductible Not Met:

$800 (MPFS allowed amount) - $100 (Part B deductible) = $700 x 80 percent = $560 (Medicare reimbursement).

The amount applied to the limitation in this example is $800. The Medicare program pays $560 and the beneficiary is responsible for $240, ($100 Part B Deductible and $140 co-insurance).

NOTE: In the above examples the MPFS allowed amount is the lower of charges or the MPFS rate times the unit.

The CWF will be tracking the financial limitation based on presence of therapy modifiers GN, GO, and GP, therefore, providers/suppliers must continue to report one of these modifiers for any therapy service that is provided. Note that whenever an outpatient therapy service is billed, the requirements for therapy services must be followed, including a plan of care. The definitions of the therapy modifiers have been changed effective January 1, 2003, they are as follows:

GN	Services delivered under an outpatient speech-language pathology plan of care.
GO	Services delivered under an outpatient occupational therapy plan of care.
GP	Services delivered under an outpatient physical therapy plan of care.

These modifiers do not allow a provider to deliver services that they are not recognized by Medicare to perform.

Only physical therapy, occupational therapy and speech-language pathology services are included in the limitations. Other services such as respiratory therapy, or nutrition therapy should not use the GN, GO, and GP modifiers. For example, if an audiology procedure (HCPCS) code is performed by an audiologist (specialty code "64"), the above modifiers should not be reported, as these procedures are not subject to the financial limitation.

MSN Messages

Existing MSN messages 17.13, and the new MSN messages 17.18 and 17.19 shall be issued on all claims containing outpatient rehabilitation services as noted in this PM.

MSN 17.13 has been revised to read:

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.

Spanish Translation
17.13 - Coda año, Medicare aprueba una cantidad límite por servicios de terapia física y patología del lenguaje. Anualmente también aprueba otra cantidad límite por servicios de terapia ocupacional cuando son facturados por proveedores, terapistas físicos y ocupacionales, médicos y otros practicantes no médicos. La terapia que es medicamente necesaria y que sobrepasa estas cantidades límites está cubierta cuando se recibe en una unidad de hospital ambulatorio.

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

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

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

Note: Add applied amount for individual beneficiaries and the generic limit amount ($1590 in 2003) to all MSN that require them.

Carriers and intermediaries shall use the existing Medicare Summary Notice message 17.6 to inform the beneficiaries that they have reached the financial limitation. Apply this message at the line level:

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

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

Intermediary Requirements

Edit to ensure that the above listed therapy modifiers are present on a claim based on the presence of revenue codes 042X, 043X, or 044X. Claims containing revenue codes 042X, 043X, or 044X without a therapy modifier GN, GO, or GP should be returned to the provider.

The CWF will apply the financial limitation to the following bill types 22X, 23X, 34X, 74X, and 75X, using the MPFS allowed amount (before adjustment for beneficiary liability). The reimbursement field portion of the CWF record will not be used by the CWF to track the financial limitation. The CWF will create a new "line-level" field entitled "Financial Limitation" to be used by Standard Systems to transmit to CWF the amount to be applied to the limitation. The CWF will also create a new line level override code value to be reported in situations where the MPFS allowed amount exceeds the limitation available. This override code can also be used for appeals. (See "Intermediary Action Based on CWF Trailer" below for additional information.)

For SNFs, 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 for 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.

Beneficiaries may not be simultaneously covered by Medicare as an outpatient of a hospital and as a patient in another facility. They must be discharged from the other setting and registered as a

hospital outpatient in order to receive payment for outpatient rehabilitation services in a hospital outpatient setting after the limitation has been reached.

A hospital may bill for services of a facility as hospital outpatient services if that facility meets the requirements of a department of the provider (hospital) under 42CFR 413.65. Facilities that do not meet those requirements are not considered to be part of the hospital and may not bill under the hospital's provider number, even if they are owned by the hospital. For example, services of a CORF must be billed as CORF services and not as hospital outpatient services, even if the CORF is owned by the hospital. Only services billed by the hospital as bill type 12X or 13x are exempt from limitations on therapy services.

Carrier Requirements

All claims containing any of the following list of "Applicable Outpatient Rehabilitation HCPCS Codes" should contain one of the therapy modifiers (GN, GO, GP), except as follows: Claims from physicians (all specialty codes) and non-physician practitioners, including specialty codes "50", "89" and "97" do not have to contain modifiers for the HCPCS codes for casts and splints as noted with a "+" sign below.

For all other claims submitted by physicians or non-physician practitioners (as noted above) containing these applicable HCPCS codes without therapy modifiers, return the claim as unprocessable.

If specialty codes "65", "67", are present on the claim and an applicable HCPCS code is without one of the therapy modifiers (GN, GO, or GP) return the claim as unprocessable.

The CWF will capture the amount and apply it to the limitation whenever a service is billed using the GN, GO or GP modifier. The CWF must also disable the edit involving specialty codes "65", "67", and Type of Service W or U.

Once the financial limitation has been reached, beneficiaries may receive outpatient rehabilitation services furnished directly by or under arrangement with a hospital.

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 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 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 non-physician practitioners, 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.

Additional Information for Carriers and Intermediaries

Once the limitation is reached, if a claim is submitted, CWF returns an error code stating the financial limitation has been met. Over applied lines will be identified at the line level. The outpatient rehabilitation therapy services should be denied. Use group code PR and claim adjustment reason code 119, benefit maximum for this time period has been reached, in the provider remittance advice to establish the reason for denial. The provider/physician/supplier should advise the beneficiary that a claim for services that exceeds the $1590 limitation is being denied pursuant to §1833(g) of the Social Security Act (42 U.S.C. §1395(g)). The providers/suppliers should inform the beneficiary that any additional outpatient rehabilitation services in this setting would result in the beneficiary exceeding the financial limitation, but medically necessary services above the limit may be obtained at an outpatient hospital. Such notification will allow the beneficiary to make an informed choice about continuing to receive services from the provider/physician/supplier or to change to a hospital outpatient department. This is advised because the beneficiary is responsible for payment of all outpatient rehabilitation services that exceeded the financial limitation on an annual basis.

In situations where a beneficiary is close to reaching the financial limitation and a particular claim might exceed the limitation, the provider should bill the usual and customary charge for the service furnished even though such charge might exceed the $1590 limit. For example, a beneficiary to date received services for which the total amount of payment and the beneficiary coinsurance total $1575**.** The beneficiary then received 3 services - 1 at $50; 1 at $25; and 1 at $30. CWF will return an error code/trailer that will identify the line that exceeds the limitation.

When the financial limitation has been exceeded and the beneficiary chooses to continue treatment at a setting other than the outpatient hospital where medically necessary services are covered, the services may be billed at the rate the provider/supplier determines. Services provided in a capped setting after the limitation has been reached are not Medicare benefits and are not governed by Medicare policies.

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.

Intermediary Action Based on CWF Trailer

Upon receipt of the CWF error code/trailer, you are responsible for assuring that payment does not exceed the financial limitation (except as noted below).

In cases where a claim line partially exceeds the limit, you must adjust the line based on information contained in the CWF trailer. For example, where the MPFS allowed amount is greater than the financial limitation available, always report the MPFS allowed amount in the "Financial Limitation" field of the CWF record and include the CWF override code. See example below for situations where the claim contains multiple lines that exceed the limit.

Example:

Services received to date: $1575

Incoming claim: Line 1 MPFS allowed amount of $50.00
Line 2 MPFS allowed amount of $25.00
Line 3 MPFS allowed amount of $30.00

Based on this example, deny lines 1 and 3 and pay line 2. Report in the "Financial Limitation" field of the CWF record, $25.00 along with CWF override code. Always apply the amount that would least exceed the limit. Since the intermediary systems cannot split the payment on a line, CWF will allow payment on the line that least exceeds the limit and deny other lines.

Provider Notification

Advise providers/suppliers that they may use the Notice of Exclusions from Medicare Benefits (NEMB Form No. CMS-20007 & Formulario No. CMS-20007) or a similar form of their own design to notify beneficiaries of the therapy financial limitations and that these limits are applied in all settings except hospital outpatient departments. ABNs cannot be used because of the statutory nature of the financial limitations. Therefore, providers/suppliers should inform beneficiaries that beneficiaries are responsible for 100% of the costs of therapy services above each respective therapy $1590 limit, unless this outpatient care is furnished directly or under arrangement by a hospital. It is the provider's responsibility to present each beneficiary with accurate information about the therapy limits and that, where necessary, appropriate care above the $1590 limit can be obtained at a hospital outpatient therapy department. Advise providers/suppliers to use the Notice of Exclusion from Medicare Benefits (NEMB) form to inform beneficiaries of the therapy financial limitation at their first therapy encounter with the beneficiary. When using the NEMB form, the practitioner checks box #1 and writes the reason for denial in the space provided at the top of the form. For CY 2003, provide the following: "Medicare will not pay for: physical therapy and speech-language pathology services over $1590 (including dates of service from July 1, 2003 through December 31, 2003)." This same information is provided for occupational therapy services over the $1590 limit for the same time period, as appropriate.

The NEMB form can be found at: http://www.cms.hhs.gov/medlearn/refabn.asp

Providers who bill to intermediaries will find the amount a beneficiary has accrued toward the financial limitations on the HIQA. Suppliers who bill to carriers may call the contractor to obtain the amount accrued until the HIPAA system is operational. When the HIPAA system goes into effect, all providers/suppliers and contractors may access the accrued amount of therapy services from the ELGA and ELGB screens.

You must notify your providers/suppliers of this information by posting on your Web site, within 2 weeks of receiving this PM and publishing this information in your next regularly scheduled bulletin. Provider education is essential in order for the financial limitation to be applied correctly. If you have electronic bulletin boards or listserv that are used to communicate with your community, post this message to your providers/suppliers using that facility. Instruct providers/suppliers about the new definitions of the modifiers and their use and remind all providers/suppliers that a plan of care must be on file.

The *effective date* for this PM is October 1, 2003.

The *implementation date* for this PM is October 1, 2003.

This PM may be discarded after October 1, 2005.

These instructions should be implemented within your current operating budget.

If you have any questions, contact your local regional office.