CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3814	**Date: July 27, 2017**
	Change Request 10176

SUBJECT: Updated Editing of Always Therapy Services - MCS

I. SUMMARY OF CHANGES: This Change Request (CR) will implement revised editing of Part B "Always Therapy" services to require the appropriate modifier in order for the service to be accurately applied to the therapy cap.

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

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	5/10.4/Claims Processing Requirements for Financial Limitations

III. FUNDING:
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 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3814	Date: July 27, 2017	Change Request: 10176

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I. GENERAL INFORMATION

A. Background: Services furnished under the outpatient therapy (OPT) services benefit − including speech-language pathology (SLP), occupational therapy (OT) and physical therapy (PT) services − are subject to the financial limitations, known as therapy caps, originally required under §4541 of the 1997 Balanced Budget Act. One cap is for PT and SLP services combined and another cap is for OT services. In order to accrue incurred expenses to the correct therapy cap, one of the three therapy modifiers − GN, GO, or GP − is required to be used on a certain set of Healthcare Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under a SLP, OT, or PT plan of care, respectively.

Medicare recognizes the services furnished under the OPT services benefit as either "always" or "sometimes" therapy and publishes this list as an Annual Update on the Therapy Services Billing webpage at: https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html

On professional claims, each code designated as "always therapy" must always be furnished under an SLP, OT, or PT plan of care, regardless of who furnishes them; and, as such, must always be accompanied by one of the therapy modifiers. In addition, several "always therapy" codes have been identified as discipline specific – requiring the GN modifier for six codes, the GO modifier for four codes, and the GP modifier for four codes.

In addition to therapists in private practice (TPPs) – including physical therapists, occupational therapists, and speech-language pathologists – professional claims for OPT services may be furnished by physicians and certain nonphysician practitioners (NPPs) – specifically physician assistants, nurse practitioners, and certified nurse specialists.

All OPT services furnished by TPPs are always considered therapy services, regardless of whether they are designated as "always therapy" or "sometimes therapy", and the appropriate therapy modifier must be included on the claim. However, it may be clinically appropriate for physicians and NPPs to furnish OPT services that have been designated "sometimes therapy" codes outside a therapy plan of care – in these cases, therapy modifiers are not required and claims may be processed without them.

During analyses of Medicare claims data for OPT services, the Centers for Medicare & Medicaid Services (CMS) has found that these "always therapy" codes and modifiers are not always used in a correct and consistent manner. CMS found OPT professional claims for "always therapy" codes without the required modifiers; and, claims that reported more than one therapy modifier for the same therapy service; e.g., both a GP and GO modifier, when only one modifier is allowed.

These claims represent non-compliant billing by physicians, NPPs, and TPPs and hamper CMS' ability to properly track the therapy caps and analyze claims data for purposes of Medicare program improvements. This CR's requirements will create new edits for Medicare professional claims processing systems to return claims when "always therapy" codes and the associated therapy modifiers are improperly reported.

B. Policy: This CR contains no new policy. The below requirements improve the enforcement of longstanding existing instructions.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10176.1	The contractor shall return/reject claims which contain an "always therapy" procedure code that does not also contain the appropriate "always therapy" modifier of GN, GO, or GP.		X				X			
10176.1.1	The contractors shall return/reject claims using the following messaging: Group Code: CO CARC: 4 RARC: N/A		X							
10176.2	The contractors shall use the "Always Therapy" attachment to determine which procedure codes are "always therapy" and which therapy modifier(s) are also required to be submitted.		X							
10176.3	Contractor shall return/reject claims if any service line on the claim contains more than one occurrence of a modifier GN, GO, or GP.		X				X			
10176.3.1	The contractors shall return/reject claims using the following messaging: Group Code: CO CARC: 4 RARC: N/A		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
10176.4	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 5 business days after receipt of the notification from CMS announcing the availability of the 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			

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	Use of Claim Adjustment Reason Code (CARC) 4 alone, for Business Requirement 3.1, is temporary until a new, more appropriate Remittance Advice Remark Code (RARC) can be requested and used with CARC 16.

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

V. CONTACTS

Pre-Implementation Contact(s): Pamela West, 410-786-2302 or Pamela.West@cms.hhs.gov (Therapy Policy)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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 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.

ATTACHMENTS: 1

Attachment: Always Therapy Codes and Therapy Modifiers

All "Always Therapy" codes require a single GN, GO or GP Therapy Modifier to designate the discipline of the plan of care they're provided under and are used for tracking the financial limitations or therapy caps. Services billed with GP and GN modifiers are tracked to the combined therapy cap for physical therapy (PT) and speech-language pathology (SLP) services; and, services reported with a GO modifier are tracked to the occupational therapy (OT) cap.

Because the GN, GO, GP therapy modifier is specific to the SLP, OT, PT plan of care, respectively, only one of these modifiers is allowed. As such, the contractor shall return/reject claims if any service line on the claim contains more than one occurrence of the modifiers GN, GO, GP.

In addition, some "Always Therapy" codes have been identified as discipline specific. The GN modifier is specifically required for six codes, and, the GO and GP modifiers are each required on four codes, as noted below.

The current list of "Always Therapy" procedure codes can be found in the 2017 Annual Update in the download section of the Therapy Services webpage at the following link: https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html. These "Always Therapy" codes are noted with a disposition of #5 on this Therapy Code List.

The following six codes require a GN modifier to indicate the service is furnished under a SLP plan of care. The contractor shall return professional claims reporting any of the below six HCPCS codes whenever the GN therapy modifier is missing.

Code	CPT Short Descriptor	Therapy Modifier Required
92521	Evaluation of speech fluency	GN
92522	Evaluate speech production	GN
92523	Speech sound lang comprehend	GN
92524	Behavral qualit analys voice	GN
92597	Oral speech device eval	GN
92607	Ex for speech device rx 1hr	GN

The following four codes require a GO modifier to indicate the service is furnished under an OT plan of care. The contractor shall return professional claims reporting any of the below four HCPCS codes whenever the GO therapy modifier is missing.

Code	CPT Short Descriptor	Therapy Modifier Required
97165	Ot eval low complex 30 min	GO
97166	Ot eval mod complex 45 min	GO

97167	Ot eval high complex 60 min	GO
97168	Ot re-eval est plan care	GO

The following four codes require a GP modifier to indicate the service is furnished under a PT plan of care. The contractor shall return professional claims reporting any of the below four HCPCS codes whenever the GP therapy modifier is missing.

Code	CPT Short Descriptor	Therapy Modifier Required
97161	Pt eval low complex 20 min	GP
97162	Pt eval mod complex 30 min	GP
97163	Pt eval high complex 45 min	GP
97164	Pt re-eval est plan care	GP

The following "Always Therapy" codes require a GN, GO, or GP modifier, as appropriate. The contractor shall return professional claims reporting any of the below 42 HCPCS codes whenever the appropriate therapy modifier of GN, GO, or GP is missing.

Code	CPT Short Descriptor	Therapy Modifier Required
92507	Speech/hearing therapy	GN, GO or GP
92508	Speech/hearing therapy	GN, GO or GP
92526	Oral function therapy	GN, GO or GP
92608	Ex for speech device rx addl	GN, GO or GP
92609	Use of speech device service	GN, GO or GP
96125	Cognitive test by hc pro	GN, GO or GP
97012	Mechanical traction therapy	GN, GO or GP
97016	Vasopneumatic device therapy	GN, GO or GP
97018	Paraffin bath therapy	GN, GO or GP
97022	Whirlpool therapy	GN, GO or GP
97024	Diathermy eg microwave	GN, GO or GP
97026	Infrared therapy	GN, GO or GP
97028	Ultraviolet therapy	GN, GO or GP
97032	Electrical stimulation	GN, GO or GP
97033	Electric current therapy	GN, GO or GP
97034	Contrast bath therapy	GN, GO or GP
97035	Ultrasound therapy	GN, GO or GP
97036	Hydrotherapy	GN, GO or GP
97039	Physical therapy treatment	GN, GO or GP
97110	Therapeutic exercises	GN, GO or GP
97112	Neuromuscular reeducation	GN, GO or GP
97113	Aquatic therapy/exercises	GN, GO or GP
97116	Gait training therapy	GN, GO or GP

97124	Massage therapy	GN, GO or GP
97139	Physical medicine procedure	GN, GO or GP
97140	Manual therapy 1/> regions	GN, GO or GP
97150	Group therapeutic procedures	GN, GO or GP
97530	Therapeutic activities	GN, GO or GP
97532	Cognitive skills development	GN, GO or GP
97533	Sensory integration	GN, GO or GP
97535	Self care mngment training	GN, GO or GP
97537	Community/work reintegration	GN, GO or GP
97542	Wheelchair mngment training	GN, GO or GP
97750	Physical performance test	GN, GO or GP
97755	Assistive technology assess	GN, GO or GP
97760	Orthotic mgmt and training	GN, GO or GP
97761	Prosthetic training	GN, GO or GP
97762	C/o for orthotic/prosth use	GN, GO or GP
97799	Physical medicine procedure	GN, GO or GP
G0281	Elec stim unattend for press	GN, GO or GP
G0283	Elec stim other than wound	GN, GO or GP
G0329	Electromagntic tx for ulcers	GN, GO or GP

10.4 - Claims Processing Requirements for Financial Limitations

(Rev. 3814, Issued: 07-27-17, Effective: 01-01-18, Implementation: 01 -02-18)

A. Requirements – Institutional Claims

Regardless of financial limits on therapy services, CMS requires modifiers (See section 20.1 of this chapter) on specific codes for the purpose of data analysis. Beneficiaries may not be simultaneously covered by Medicare as an outpatient of a hospital and as a patient in another facility. When outpatient hospital therapy services are excluded from the limitation, the beneficiary 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 42 CFR 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 Comprehensive Outpatient Rehabilitation Facility (CORF) must be billed as CORF services and not as hospital outpatient services, even if the CORF is owned by the hospital.

The CWF applies the financial limitation to the following bill types 22X, 23X, 34X, 74X and 75X using the MPFS allowed amount (before adjustment for beneficiary liability).

For SNFs, the financial limitation does apply to rehabilitation services furnished to those SNF residents in noncovered 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, services furnished to 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. For SNF residents in non-Medicare certified portions of the facility and SNF nonresidents 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 when outpatient hospital therapy services are excluded from the limitation.

B. Requirements - Professional Claims

Claims containing any of the "always therapy" codes *must* have one of the therapy modifiers appended (GN, GO, GP*). Contractors shall return claims for "always therapy" codes when they do not contain appropriate therapy modifiers for the*

applicable HCPCS codes. In addition, when any code on the list of therapy codes is submitted with specialty codes "65" (physical therapist in private practice), "67" (occupational therapist in private practice), or "15" (speech-language pathologist in private practice) they always represent therapy services, because they are provided by therapists. Contractors shall return claims for these services when they do not contain therapy modifiers for the applicable HCPCS codes.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 2.

Group Code: CO
CARC: 4
RARC: N/A
MSN: N/A

The CMS identifies certain codes listed at: http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage as "sometimes therapy" services, regardless of the presence of a financial limitation. Claims from physicians (all specialty codes) and nonphysician practitioners, including specialty codes "50" (Nurse Practitioner), "89," (Clinical Nurse Specialist), and "97," (Physician Assistant) may be processed without therapy modifiers when they are not therapy services. On review of these claims, "sometimes therapy" services that are not accompanied by a therapy modifier must be documented, reasonable and necessary, and payable as physician or nonphysician practitioner services, and not services that the contractor interprets as therapy services.

The CWF will capture the amount and apply it to the limitation whenever a service is billed using the GN, GO, or GP modifier.

C. Contractor Action Based on CWF Trailer

Upon receipt of the CWF error code/trailer, contractors are responsible for assuring that payment does not exceed the financial limitations, when the limits are in effect, except as noted below.

In cases where a claim line partially exceeds the limit, the contractor 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 are $15 under the limit. There is a $15 allowed amount remaining that Medicare will cover before the cap is reached.

Incoming claim: Line 1 MPFS allowed amount is $50.

Line 2 MPFS allowed amount is $25.
Line 3, MPFS allowed amount is $30.

Based on this example, lines 1 and 3 are denied and line 2 is paid. The contractor reports in the “Financial Limitation" field of the CWF record “$25.00 along with the CWF override code. The contractor always applies the amount that would least exceed the limit. Since institutional claims systems cannot split the payment on a line, CWF will allow payment on the line that least exceeds the limit and deny other lines.

D. Additional Information for Contractors During the Time Financial Limits Are in Effect With or Without Exceptions

Once the limit 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 that exceed the limit should be denied.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO or PR (as defined by section 10.5)
CARC: 119
RARC: N/A
MSN: 20.5

In situations where a beneficiary is close to reaching the financial limitation and a particular claim might exceed the limitation, the provider/supplier should bill the usual and customary charges for the services furnished even though such charges might exceed the limit. The CWF will return an error code/trailer that will identify the line that exceeds the limitation.

Because CWF applies the financial limitation according to the date when the claim was received (when the date of service is within the effective date range for the limitation), it is possible that the financial limitation will have been met before the date of service of a given claim. Such claims will prompt the CWF error code and subsequent contractor denial.

When the provider/supplier knows that the limit has been reached, and exceptions are either not appropriate or not available, further billing should not occur. The provider/supplier should inform the beneficiary of the limit and their option of receiving further covered services from an outpatient hospital when outpatient hospital therapy services are excluded from the limitation (unless consolidated billing rules prevent the use of the outpatient hospital setting). If the beneficiary chooses to continue treatment at a setting other than the outpatient hospital where medically necessary services may be 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.

If a beneficiary elects to receive services that exceed the cap limitation and a claim is submitted for such services, the resulting determination is subject to the administrative appeals process as described in subsection C. of section 10.3 and Pub. 100-04, Chapter 29.