

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3995	Date: March 9, 2018
	Change Request 10509

SUBJECT: Correction to Pub. 100-04, Chapter 5

I. SUMMARY OF CHANGES: This Change Request makes updates to Chapter 5, section 10.4 to ensure the list of Types of Bill is consistent with current Medicare policy.

EFFECTIVE DATE: June 11, 2018

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: June 11, 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: 3995	Date: March 9, 2018	Change Request: 10509
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I. GENERAL INFORMATION

A. Background: Change Request (CR) 8426 updated the Medicare Claims Processing Manual to apply the therapy caps and related policies to Critical Access Hospital (CAH) claims. That CR did not update a list of Types of Bill subject to the policies in Chapter 5, section 10.4 to include CAHs. This CR corrects this oversight.

B. Policy: No new policy. The CR updates the manual to more accurately reflect current policy.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility							
		A/B MAC			D M E	Shared-System Maintainers			Other
		A	B	H H H		F I S S	M C S	V M S	
10509.1	Contractors shall be aware of the manual updates in Pub. 100-04, Chapter 5, Section 10.4.	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E	C E D I
		A	B	H H H		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
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Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov

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: 0

Medicare Claims Processing Manual

Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services

Table of Contents
(Rev. 3995, Issued: 03-09-18)

10.4 - Claims Processing Requirements for Financial Limitations *(Rev.3995, Issued: 03-09-18, Effective: 06-11-18, Implementation: 06-11-18)*

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 *12X (with Critical Access Hospital CMS Certification Numbers)*, 22X, 23X, 34X, 74X, 75X and 85X using the *lesser of the* MPFS allowed amount (before adjustment for beneficiary liability) *or the amount charged*.

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.