CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3454	**Date: February 4, 2016**
	Change Request 9489

SUBJECT: Correction to Applying Therapy Caps to Maryland Hospitals and Billing Requirement for Rehabilitation Agencies and Comprehensive Outpatient Rehabilitation Facilities (CORFs)

I. SUMMARY OF CHANGES: This Change Request (CR) modifies the requirements of CR 9223 to ensure therapy caps are applied correctly to claims from certain Maryland hospitals.

EFFECTIVE DATE: For all business requirements, dates of service on or after January 1, 2016. For rehabilitation agency and CORF billing requirement, dates of service on or after July 1, 2016.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 5, 2016

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	1/170.1.1/Payments on the MPFS for Providers With Multiple Service Locations
R	5/10/Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General

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: 3454	Date: February 4, 2016	Change Request: 9489

SUBJECT: Correction to Applying Therapy Caps to Maryland Hospitals and Billing Requirement for Rehabilitation Agencies and Comprehensive Outpatient Rehabilitation Facilities (CORFs)

EFFECTIVE DATE: For all business requirements, dates of service on or after January 1, 2016. For rehabilitation agency and CORF billing requirement, dates of service on or after July 1, 2016.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 5, 2016

I. GENERAL INFORMATION

A. Background: Change Request (CR) 9223 applied the therapy caps and related policies to Maryland outpatient hospital claims (Types of Bill 012x and 013x submitted with CMS Certification Numbers (CCNs) beginning with 21). The CR applied cap amounts based on the submitted charge amount on covered outpatient therapy service lines, before applying coinsurance or deductible. This is the correct application of the cap amounts for the majority of Maryland hospitals.

However, certain specialty hospitals in Maryland are not paid under the Maryland All-Payer Model. These hospitals are paid for therapy services using the Medicare Physician Fee Schedule (MPFS) amounts. The therapy cap amounts for these claims should be the MPFS amount, before applying coinsurance or deductible, not the submitted charge. Since these hospitals also have CCNs beginning with 21, the implementation of CR 9223 caused Medicare systems to begin using the submitted charge amount instead.

As a result of this error, the therapy cap and threshold totals for beneficiaries served by these specialty hospitals is incorrect. In many cases the totals may be overstated. The requirements below correct the error in Medicare systems and instruct the Medicare Administrative Contractors to adjust claims to correct the therapy cap totals for affected beneficiaries.

Additionally, this CR adds instructions to the Medicare Claims Processing Manual to add a new billing requirement for rehabilitation agencies and CORFs when these providers operate multiple sites in differing payment localities as determined by the MPFS. These MPFS payment localities are determined by the 9-digit ZIP code where services are provided. .

B. Policy: For MD hospitals, this CR contains no new policy. It corrects the implementation of the policy established in CR 9223.

This CR adds a new billing requirement policy for rehabilitation agencies and CORFs. When rehabilitation agencies and CORFs furnish a service in an off-site location that is in a different 9-digit ZIP code from that of the primary or parent location, the off-site location ZIP code must be reported on the claim. Since these providers are paid subject to the MPFS, the new billing requirement ensures that payments are adjusted based on the applicable payment locality. Until now, rehabilitation agencies and CORFs did not have a mechanism to accurately report the 9-digit ZIP code for the services they provide in off-site locations with differing payment localities. Where a rehabilitation agency or CORF has only one service location, the ZIP code of the primary site of record is used as the MPFS payment locality.

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	
9489.1	The contractor shall apply the Medicare Physician Fee Schedule amount on covered outpatient therapy service lines, before applying coinsurance or deductible, to the therapy financial limitation amount on claims with: • Type of Bill 012x and 013x • CCN beginning with '21,' and • Maryland Waiver Indicator on the provider file is N. Note: A waiver indicator of N means the hospital is not paid under the Maryland All-Payer Model.					X				
9489.2	The contractor shall ensure the Maryland Waiver Indicator on the provider file is N for the following CCNs: 2102V0 213478 214000 214003 214013 213028 213029 215034 214012 213301	X								
9489.3	The contractor shall adjust claims that meet the following criteria: • CCN listed in 9489.2 • Type of Bill 012x and 013x • Revenue code 042X, 043X or 044X • Dates of service on or after January 1, 2016 and	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Receipt date before the implementation date of this CR.									
9489.3.1	The contractor shall ensure that adjustments update the beneficiary's therapy cap and threshold total, but are not reflected on the remittance advice.	X								
9489.3.2	The contractor shall complete the adjustments within 30 days of the implementation date of this CR.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9489.4	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:
9489.3.1	Tape-to-tape flag 'U' may be used to prevent claims from being reported on the remittance advice.

X-Ref Requirement Number	Recommendations or other supporting information:
9489.1	This requirement has no impact on the payment amount calculated for the therapy service. This change only affects the amount reported to CWF in the "Financial Limitation" field.

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

170.1.1 – Payments on the MPFS for Providers With Multiple Service Locations

(Rev.3454, Issued:02-04-16 , Effective: 07-01-16, Implementation: 07-05-16)

Services that are paid subject to the Medicare Physician Fee Schedule (MPFS) are adjusted based on the applicable payment locality. Medicare systems determine which locality applies using ZIP codes. In cases where the provider has only one service location, the payment locality used to calculate the fee amount is determined using the ZIP code of the master address contained in the Medicare contractors' provider file.

Increasingly, hospitals operate off-site outpatient facilities. Other institutional outpatient service providers, *including rehabilitation agencies and Comprehensive Outpatient Rehabilitation Facilities, may* operate multiple *sites*. In some cases, these additional locations are in a different payment locality than the parent provider. In order for MPFS payments to be accurate, the nine-digit ZIP code of the satellite facility is used to determine the locality in these cases.

Medicare outpatient service providers report the nine-digit ZIP code of the service facility location in the 2310E loop of the 837 Institutional claim transaction. Direct Data Entry submitters also are required to report the nine-digit ZIP code of the service facility location for off-site or multiple satellite office outpatient facilities. Paper submitters report this information in Form Locator (FL) 01 on the paper claim form. Medicare systems use this service facility ZIP code to determine the applicable payment locality whenever it is present.

10 - Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General

(Rev.3454, Issued: 02-04-16, Effective: 07-01-16, Implementation: 07-05-16)

Language in this section is defined or described in Pub. 100-02, chapter 15, sections 220 and 230.

Section §1834(k)(5) to the Social Security Act (the Act), requires that all claims for outpatient rehabilitation services and comprehensive outpatient rehabilitation facility (CORF) services, be reported using a uniform coding system. The CMS chose HCPCS (Healthcare Common Procedure Coding System) as the coding system to be used for the reporting of these services. This coding requirement is effective for all claims for outpatient rehabilitation services and CORF services submitted on or after April 1, 1998.

The Act also requires payment under a prospective payment system for outpatient rehabilitation services including CORF services. Effective for claims with dates of service on or after January 1, 1999, the Medicare Physician Fee Schedule (MPFS) became the method of payment for outpatient therapy services furnished by:

- Comprehensive outpatient rehabilitation facilities (CORFs);
- Outpatient physical therapy providers (OPTs), also known as rehabilitation agencies;
- Hospitals (to outpatients and inpatients who are not in a covered Part A stay);
- Skilled nursing facilities (SNFs) (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF); and
- Home health agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care (POC)).

NOTE: No provider or supplier other than the SNF will be paid for therapy services during the time the beneficiary is in a covered SNF Part A stay. For information regarding SNF consolidated billing see chapter 6, section 10 of this manual.

Similarly, under the HH prospective payment system, HHAs are responsible to provide, either directly or under arrangements, all outpatient rehabilitation therapy services to beneficiaries receiving services under a home health POC. No other provider or supplier will be paid for these services during the time the beneficiary is in a covered Part A stay. For information regarding HH consolidated billing see chapter10, section 20 of this manual.

Section 143 of the Medicare Improvements for Patients and Provider's Act of 2008 (MIPPA) authorizes the Centers for Medicare & Medicaid Services (CMS) to enroll speech-language pathologists (SLP) as suppliers of Medicare services and for SLPs to begin billing Medicare for outpatient speech-language pathology services furnished in private practice beginning July 1, 2009. Enrollment will allow SLPs in private practice to bill Medicare and receive direct payment for their services. Previously, the Medicare program could only pay SLP services if an institution, physician or nonphysician practitioner billed them.

In Chapter 23, as part of the CY 2009 Medicare Physician Fee Schedule Database, the descriptor for PC/TC indicator "7", as applied to certain HCPCS/CPT codes, is described as specific to the services of privately practicing therapists. Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice.

The MPFS is used as a method of payment for outpatient rehabilitation services furnished under arrangement with any of these providers.

In addition, the MPFS is used as the payment system for CORF services identified by the HCPCS codes in §20. Assignment is mandatory.

Services that are paid subject to the MPFS are adjusted based on the applicable payment locality. Rehabilitation agencies and CORFs with service locations in different payment localities shall follow the instructions for multiple service locations in chapter 1, section 170.1.1.

The Medicare **allowed charge** for the services is the lower of the actual charge or the MPFS amount. The Medicare payment for the services is 80 percent of the allowed charge after the Part B deductible is met. Coinsurance is made at 20 percent of the lower of the actual charge or the MPFS amount. The general coinsurance rule (20 percent of the actual charges) does not apply when making payment under the MPFS. This is a final payment.

The MPFS does not apply to outpatient rehabilitation services furnished by critical access hospitals (CAHs) or hospitals in Maryland. CAHs are to be paid on a reasonable cost basis. Maryland hospitals are paid under the Maryland All-Payer Model.

Contractors process outpatient rehabilitation claims from hospitals, including CAHs, SNFs, HHAs, CORFs, outpatient rehabilitation agencies, and outpatient physical therapy providers for which they have received a tie in notice from the Regional Office (RO). These provider types submit their claims to the contractors using the ASC X12 837 institutional claim format or the CMS-1450 paper form when permissible. Contractors also process claims from physicians, certain nonphysician practitioners (NPPs), therapists in private practices (TPPs), (which are limited to physical and occupational therapists, and speech-language pathologists in private practices), and physician-directed clinics that bill for services furnished incident to a physician's service (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, for a definition of "incident to"). These provider types submit their claims to the contractor using the ASC X 12 837 professional claim format or the CMS-1500 paper form when permissible.

There are different fee rates for nonfacility and facility services. Chapter 23 describes the differences in these two rates. (See fields 28 and 29 of the record therein described). Facility rates apply to professional services performed in a facility other than the professional's office. Nonfacility rates apply when the service is performed in the professional's office. The nonfacility rate (that is paid when the provider performs the

services in its own facility) accommodates overhead and indirect expenses the provider incurs by operating its own facility. Thus it is somewhat higher than the facility rate.

Contractors pay the nonfacility rate on institutional claims for services performed in the provider's facility. Contractors may pay professional claims using the facility or nonfacility rate depending upon where the service is performed (place of service on the claim), and the provider specialty.

Contractors pay the codes in §20 under the MPFS on professional claims regardless of whether they may be considered rehabilitation services. However, contractors must use this list for institutional claims to determine whether to pay under outpatient rehabilitation rules or whether payment rules for other types of service may apply, e.g., OPPS for hospitals, reasonable costs for CAHs.

Note that because a service is considered an outpatient rehabilitation service does not automatically imply payment for that service. Additional criteria, including coverage, plan of care and physician certification must also be met. These criteria are described in Pub. 100-02, Medicare Benefit Policy Manual, chapters 1 and 15.

Payment for rehabilitation services provided to Part A inpatients of hospitals or SNFs is included in the respective PPS rate. Also, for SNFs (but not hospitals), if the beneficiary has Part B, but not Part A coverage (e.g., Part A benefits are exhausted), the SNF must bill for any rehabilitation service.

Payment for rehabilitation therapy services provided by home health agencies under a home health plan of care is included in the home health PPS rate. HHAs may submit bill type 34X and be paid under the MPFS if there are no home health services billed under a home health plan of care at the same time, and there is a valid rehabilitation POC (e.g., the patient is not homebound).

An institutional employer (other than a SNF) of the TPPs, or physician performing outpatient services, (e.g., hospital, CORF, etc.), or a clinic billing on behalf of the physician or therapist may bill the contractor on a professional claim.

The MPFS is the basis of payment for outpatient rehabilitation services furnished by TPPs, physicians, and certain nonphysician practitioners or for diagnostic tests provided incident to the services of such physicians or nonphysician practitioners. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, for a definition of "incident to, therapist, therapy and related instructions.") Such services are billed to the contractor on the professional claim format. Assignment is mandatory.

The following table identifies the provider and supplier types, and identifies which claim format they may use to submit claims for outpatient therapy services to the contractor.

"Provider/Supplier Service" Type	**Format**	**Bill Type**	**Comment**
Inpatient SNF Part A	Institutional	21X	Included in PPS
Inpatient hospital Part B	Institutional	12X	Hospital may obtain services under arrangements and bill, or rendering provider may bill.
Inpatient SNF Part B (audiology tests are not included)	Institutional	22X	SNF must provide and bill, or obtain under arrangements and bill.
Outpatient hospital	Institutional	13X	Hospital may provide and bill or obtain under arrangements and bill.
Outpatient SNF	Institutional	23X	SNF must provide and bill or obtain under arrangements and bill.

"Provider/Supplier Service" Type	Format	Bill Type	Comment
HHA billing for services not rendered under a Part A or Part B home health plan of care, but rendered under a therapy plan of care.	Institutional	34X	Service not under home health plan of care.
Outpatient physical therapy providers (OPTs), also known as rehabilitation agencies	Institutional	74X	Paid MPFS for outpatient rehabilitation services.
Comprehensive Outpatient Rehabilitation Facility (CORF)	Institutional	75X	Paid MPFS for outpatient rehabilitation services and all other services except drugs. Drugs are paid 95% of the AWP.
Physician, NPPs, TPPs, (therapy services in hospital or SNF)	Professional	See Chapter 26 for place of service coding.	Payment may not be made for therapy services to Part A inpatients of hospitals or SNFs, or for Part B SNF residents. NOTE: Payment may be made to physicians and NPPs for their professional services defined as "sometimes therapy" (not part of a therapy plan) in certain situations; for example, when furnished to a beneficiary registered as an outpatient of a hospital.
Physician/NPP/TPPs office, or patient's home	Professional	See Chapter 26 for place of service coding.	Paid via MPFS.
Critical Access Hospital - inpatient Part B	Institutional	12X	Rehabilitation services are paid at cost.
Critical Access Hospital – outpatient Part B	Institutional	85X	Rehabilitation services are paid at cost.

For a list of the outpatient rehabilitation HCPCS codes see §20.

If a contractor receives an institutional claim for one of these HCPCS codes with dates of service on or after July 1, 2003, that does not appear on the supplemental file it currently uses to pay the therapy claims, it contacts its professional claims area to obtain the non-facility price in order to pay the claim.

NOTE: The list of codes in §20 contains commonly utilized codes for outpatient rehabilitation services. Contractors may consider other codes on institutional claims for payment under the MPFS as outpatient rehabilitation services to the extent that such codes are determined to be medically reasonable and necessary and could be performed within the scope of practice of the therapist providing the service.