

Medicare Claims Processing Manual

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

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

(Rev. 771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33), which added §1834(k)(5) to the Social Security Act (the Act), required that all claims for outpatient rehabilitation, certain audiology 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 including certain audiology services and CORF services submitted on or after April 1, 1998.

The BBA also required payment under a prospective payment system for outpatient rehabilitation services including audiology and 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 physical therapy (which includes outpatient speech-language pathology) services furnished by:

- Comprehensive Outpatient Rehabilitation Facilities (CORFs);
- Outpatient Physical Therapy Providers (OPTs);
- Other Rehabilitation Facilities (ORFs);
- 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)).

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 audiology and CORF services identified by the HCPCS codes in §20 Assignment is mandatory.

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). CAHs are to be paid on a reasonable cost basis.

Fiscal Intermediaries (FIs) process outpatient rehabilitation claims from hospitals, including CAHs, SNFs, CORFs, outpatient rehabilitation agencies, and outpatient physical therapy providers for which they have received a tie in notice from the RO. Carriers process claims from physicians, certain nonphysician practitioners (NPPs), and physical and occupational therapists in private practice (PTPPs and OTPPs). A physician-directed clinic that bills for services furnished incident to a physician's service (see Chapter 15 in Pub. 100-02, Medicare Benefit Policy Manual for a definition of "incident to") bills the carrier.

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.

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

Carriers pay the codes in §20 under the MPFS regardless of whether they may be considered rehabilitation services. However, FIs must use this list to determine whether to pay under outpatient rehabilitation rules or whether payment rules for other types of service may apply, e.g., OPFS 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 the FI for any rehabilitation service (except audiologic function services). Independent audiologists may bill the carrier directly for services rendered to Part B Medicare entitled beneficiaries residing in a SNF, but not in a SNF Part A covered stay. Payment is made based on the MPFS, whether by the carrier or the FI. For beneficiaries not in a covered Part A SNF stay, who are sometimes referred to as beneficiaries in a Part B SNF stay, audiologic function tests are payable under Part B when billed by the SNF as type of bill 22X, or when billed directly to the carrier by the provider or supplier of the service. For tests that include both a professional component and technical component, the SNF may elect to bill the technical component to the FI, but is not required to bill the

service. (The professional component of a service is the direct patient care provided by the physician or audiologist, e.g., the interpretation of a test.)

Payment for rehabilitation 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 PTPPs, OTPPs, or physician performing outpatient services, (e.g., hospital, CORF, etc.), or a clinic billing on behalf of the physician or therapist may bill the carrier on Form CMS-1500.

The MPFS is the basis of payment for outpatient rehabilitation services furnished by PTPPs and OTPPs, 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.”) Such services are billed to the Part B carrier. Assignment is mandatory.

The following table identifies the provider types or physician/nonphysician and to which contractor they may submit bills.

“Provider/Service” Type	Bill to	Bill Type	Comment
Inpatient hospital Part A	FI	11X	Included in PPS
Inpatient SNF Part A	FI	21X	Included in PPS
Inpatient hospital Part B	FI	12X	Hospital may obtain services under arrangements and bill, or rendering provider may bill.
Inpatient SNF Part B except for audiology function tests.	FI	22X	SNF must provide and bill, or obtain under arrangements and bill.
Inpatient SNF Part B audiology function tests only.	FI	22X	SNF may bill the FI or provider of service may bill the carrier.
Outpatient hospital	FI	13X	Hospital may provide and bill or obtain under arrangements and bill, or rendering provider may bill
Outpatient SNF	FI	23X	SNF must provide and bill or obtain under arrangements and bill

“Provider/Service” Type	Bill to	Bill Type	Comment
HHA billing for services rendered under a Part A or Part B home health plan of care.	FI	32X	Service is included in PPS rate. CMS determines whether payment is from Part A or Part B trust fund.
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.	FI	34X	Service not under home health plan of care.
Other Rehabilitation Facility (ORF)	FI	74X	Paid MPFS for outpatient rehabilitation services effective January 1, 1999, and all other services except drugs effective July 1, 2000. Starting April 1, 2002, drugs are paid 95% of the AWP. For claims with dates of service on or after July 1, 2003, drugs and biologicals do not apply in an OPT setting. Therefore, FIs are to advise their OPTs not to bill for them.
Comprehensive Outpatient Rehabilitation Facility (CORF)	FI	75X	Paid MPFS for outpatient rehabilitation services effective January 1, 1999, and all other services except drugs effective July 1, 2000. Starting April 1, 2002, drugs are paid 95% of the AWP.
Physician, NPPs, PTPPs, OTPPs, and, for diagnostic tests only, audiologists (service in hospital or SNF)	Carrier	See Chapter 26 for place of service, and type 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. Otherwise, carrier billing. Note that physician/ NPP/PTPP/OTPP employee of facility may assign benefits to the facility, enabling the facility to bill for physician/therapist to

“Provider/Service” Type	Bill to	Bill Type	Comment
			carrier
Physician/NPP/PTPP/OTPP office, independent clinic or patient’s home	Carrier	See Chapter 26 for place of service, and type of service coding.	Paid via Physician fee schedule.
Practicing audiologist for services defined as diagnostic tests only	Carrier	See Chapter 26 for place of service, and type of service coding.	Some audiologists tests provided in hospitals are considered other diagnostic tests and are subject to HOPPS instead of MPFS for outpatient therapy fee schedule.
Critical Access Hospital - inpatient Part A	FI	85X	Rehabilitation services are paid cost.
Critical Access Hospital - inpatient Part B	FI	85X	Rehabilitation services are paid cost.
Critical Access Hospital – outpatient Part B	FI	85X	Rehabilitation services are paid cost.

Complete Claim form completion requirements are contained in Chapters 25 and 26.

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

If an FI receives a claim for one of the 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 local carrier to obtain the price in order to pay the claim. When requesting the pricing data, it advises the carrier to provide it with the nonfacility fee.

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

10.1 - New Payment Requirement for Intermediaries (FIs)

(Rev. 1, 10-01-03)

A-03-011

Effective with claims with dates of service on or after July 1, 2003, OPTs/Outpatient Rehabilitation Facilities (ORFs), (74X and 75X bill type) are required to report all their services utilizing HCPCS. FIs are required to make payment for these services under the MPFS unless the item or service is currently being paid under the orthotic fee schedule or the item is a drug, biological, supply or vaccine (see below for an explanation of these services).

The CMS currently provides FIs with a CORF supplemental file that contains all physician fee schedule services and their related prices. FIs use this file to price and pay OPT claims. The format of the record layout is provided in Attachment E of PM A-02-090, dated September 27, 2002. This is located at: http://cms.hhs.gov/manuals/pm_trans/A02090.pdf.

Fiscal FIs will be notified in a one-time instruction of updates to this file and when it will be available for retrieval.

If an FI receives a claim for one of the above HCPCS codes with dates of service on or after July 1, 2003, that does not appear on the CORF supplemental file it currently uses to pay the CORF claims, it contacts its local carrier to obtain the price in order to pay the claim. When requesting the pricing data, it advises the carrier to provide it with the nonfacility fee.

10.2 - The Financial Limitation

(Rev. 855, Issued: 02-15-06, Effective: 01-01-06, Implementation: 03-13-06)

A. Financial Limitation Prior to the *Balanced Budget Refinement Act (BBRA)*

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, which added [§1834\(k\)\(5\)](#) to the Act, required payment under a prospective payment system for outpatient rehabilitation services (except those furnished by or under arrangements with a hospital). 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 (except those furnished by or under arrangements with a hospital). In 1999, an annual per beneficiary limit of \$1,500 applied to all outpatient physical therapy services (including speech-language pathology services). A separate limit applied to all occupational therapy services. The limit is based on incurred expenses and includes applicable deductible and coinsurance. The BBA provided that the limits be indexed by the Medicare Economic Index (MEI) each year beginning in 2002.

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 certain nonphysician 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 limitations for physical therapy, and for occupational therapy services rendered by individual providers/suppliers. In 2003 and later, the limitation was applied through CMS systems.

In 2006 Congress passed the Deficit Reduction Act that allows CMS to grant exceptions to therapy caps for services that meet certain qualifications as medically necessary services.

B. Moratoria on Therapy Claims

Section 221 of the *BBRA* 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 (BIPA) 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.

In 2003, there was not a moratorium on therapy caps. Implementation was delayed until September 1, 2003. Therapy caps were in effect for services rendered on September 1, 2003 through December 7, 2003.

Congress re-enacted a moratorium on financial limitations on outpatient therapy services on December 8, 2003 that extends through December 31, 2005. Caps *were* implemented again on January 1, 2006 *and policies were modified to allow exceptions as directed by the Deficit Reduction Act.*

C. Application of Financial Limitation (FIs and Carriers) January 1, 2006 through December 31, 2006

Financial limitations on outpatient therapy services, *as described above*, began for therapy services rendered on or after on January 1, 2006. *(See C 1 to C 7 for exceptions to therapy caps).* For 2006, the annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is \$1740; the limit for occupational therapy is \$1740. Limits apply to outpatient Part B therapy services from all settings except outpatient hospital (place of service code 22 on carrier claims) and hospital emergency room (place of service code 23 on carrier claims).

Contractors apply the financial limitations to the allowed amount for therapy services for each beneficiary. The allowed amount is the amount in the Medicare Physician Fee

Schedule (or the amount charged if it is smaller) less the coinsurance (20 percent) and any deductible that may apply. If the deductible has been met prior to submission of a therapy claim for \$1740 of services, Medicare will pay 80 percent of the allowed amount (\$1392) and the beneficiary will pay the 20 percent coinsurance (\$348). If the deductible has not been met, the beneficiary will also pay the deductible amount of \$124 for 2006.

For claims with dates of service from January 1, 2006, through December 31, 2006, Medicare shall apply these financial limitations in order, according to the dates when the claims were received. When limitations apply, the Common Working File (CWF) tracks the limits. Shared System Maintainers are not responsible for tracking the dollar amounts of incurred expenses of rehabilitation services for each therapy limit.

In processing claims where Medicare is the secondary payer, the shared system takes the lowest secondary payment amount from MSPPAY and sends this amount on to CWF as the amount applied to therapy limits.

1. Exceptions to Therapy Caps - General

The Deficit Reduction Act of 2006 directs CMS to develop a process to allow for exceptions to the caps in cases where continued therapy services are medically necessary. Instructions for contractors to manage requests for automatic exceptions will be found in the Program Integrity Manual, chapter 3, section 3.4.1.2. Provider and supplier information is in this manual and in CMS IOM Pub. 100-02, chapter 15, section 220.3. Exceptions will be identified by a modifier on the claim.

Providers, suppliers and beneficiaries may all request exceptions from therapy caps. Since in most cases, the providers and suppliers will lead or assist in the request, this manual is written to address them. The same policies apply to beneficiaries who may request exceptions.

Exceptions fall into two categories:

- *Automatically excepted services-*
 - *Certain evaluation services are excepted from therapy caps, although they continue to be therapy services. (See C2a)*
 - *Certain conditions and complexities are also excepted, when supported by documentation justifying the need for therapy services. (See C1-C4 for lists of automatically excepted services).*
 - *Contractor articles may describe other exceptions.*
- *Manual exceptions-*
 - *In the judgment of the Medicare contractor, an exception for conditions or complexities other than those described above may be justified by documentation indicating that the beneficiary requires therapy beyond the amount payable under the therapy cap for continued safe and effective*

rehabilitation of health status and/or function within a reasonable amount of time. (See C5)

All exceptions are for current conditions (conditions for which a patient is in treatment during this episode) that require skilled and medically necessary services. An exception is not allowed, even when the patient has a condition or complexity that qualifies for exception to caps, in cases where the services beyond the cap are not necessary, appropriately provided, and documented. For descriptions of covered, reasonable and necessary services and documentation see CMS IOM Pub. 100-02, chapter 15 sections 220 and 230.

For all therapy services, including those provided before and after a cap exception is allowed, payment requires that documentation supports the medical necessity of the services.

Progressive Corrective Action (PCA) and Medical review have a role in the therapy prior authorization exception process. Although the services may meet the criteria for exception from the cap due to condition or complexity, they are still subject to review to determine that the services are otherwise covered and appropriately provided. The exception is granted (either automatically or by manual exception) on the clinician's assertion that there is documentation in the record justifying that the services meet the criteria for reasonable and necessary services. For example, the documentation must accurately represent the facts, and there shall be no evidence of abusive or inappropriate use of the process or the services by the provider/supplier.

Services deemed medically necessary are still subject to review related to misrepresentation, fraud or abuse. An example of inappropriate use of the process is the routine application for exceptions after the cap has been exceeded. The routine use of the KX modifier on every claim for a patient that has an excepted condition or complexity, regardless of the impact of the condition on the need for services above the cap, is inappropriate.

Exceptions apply to a number of treatment days of medically necessary services for each discipline separately (for PT, or OT, or SLP), approved by the contractor. Provider/suppliers/beneficiaries may request only 15 treatment days of justified, necessary therapy services above the caps before the services are rendered. However, providers/suppliers/beneficiaries should accompany the request with the plan for the entire episode of care for that patient, including justification for any needed services beyond the 15 currently requested.

Providers/suppliers/beneficiaries should request exceptions before the services are rendered whenever possible. Since there may be a time difference between the services rendered and when the services are processed, it may sometimes be necessary to request exceptions for services already provided. Include documentation and justification of the medical necessity of the services provided. There is no limit on the treatment days of services rendered in the past, but provider/suppliers/beneficiaries are cautioned against abuse of the process by routinely requesting exceptions for past services.

Contractors may approve any number of treatment days of services when documentation justifies the need for those services. The number of treatment days approved is the number of individual days on which a medically necessary service is provided for each discipline, and not consecutive calendar days.

- For example, if 15 treatment days of medically necessary physical therapy is approved, the services may be provided, according to the plan of care, on three days of each week for five weeks. Services are not required to be provided within 15 calendar days. If the patient does not show for approved treatment for three treatment days, then the 15 treatment days would take 6 weeks to provide, as long as they continue to be medically necessary services.*
- On a treatment day, the number of services is not limited but each service must be medically necessary.*
- The number of medically necessary visits or treatment encounters per treatment day per discipline is not limited. If the patient has services in the morning, leaves, and returns in the afternoon for more services, those services all done on the same date apply to one treatment day of approved treatment.*
- The treatment days for PT, OT, and SLP services are separately approved. For example, a contractor may approve SLP 3 times a week for 3 weeks (consistent with the plan of care) for a total of 9 treatment days of SLP services. For the same patient during the same time, a contractor may approve PT 5 times a week for 3 weeks for a total of 15 PT services. If these PT and SLP services occurred on the same day the PT services count for one treatment day of approved PT and the SLP services count for one treatment day of approved SLP.*
- Contractors may approve any number of treatment days of previously provided services if they are presented with documentation indicating they were medically necessary. However, retroactive requests are discouraged as they put the patient at financial for disapproved services. Failure to submit requests for cap exceptions prior to the date the cap is surpassed will put the beneficiary at risk of incurring the costs of treatment if the request is denied.*

The beneficiary may qualify for an automatic cap exception at any time during the episode when documented medically necessary services exceed caps. For example, should a change in status result in the beneficiary satisfying the requirements for the cap exception the provider or supplier would either utilize the modifier for automatic exceptions or apply for contractor approval. A new condition, occurring during an initial episode for an unrelated condition, would be included in the patient's plan of care and become part of the same episode of care. For example, if a patient was being treated for a condition that was not automatically excepted, but developed a condition that was automatically excepted before discharge from treatment for the initial condition AND that new condition directly and significantly impacts the treatment, then the KX modifier would be used, without contractor approval, for services over the cap while the patient was treated for the condition with the automatic exception.

Providers and suppliers are encouraged to anticipate the need to request exceptions from the cap and apply before the cap is met. Routine submission for exceptions when patients are not receiving rehabilitative treatment is an abuse of the process. Routine submission of requests after the cap has been met is also an abuse of the process.

2. Automatic Exceptions

No specific documentation is submitted to the contractor if the beneficiary qualifies for the automatic cap exception for an active condition when documentation justifies medically necessary services above the caps. However, the provider must maintain documentation of medical necessity in the beneficiary's clinical records and justify the clinician's decision that the beneficiary qualified for the automatic cap exception for medically necessary services. This documentation shall be submitted in response to any subsequent claim review. The provider/suppliers/beneficiaries may include, at their discretion, a summary that specifically addresses the justification for therapy cap exception. A list of the excepted evaluation codes are in C2a. A list of the ICD-9 codes for conditions and complexities is in C3.

a. Exceptions for Evaluation Services

Evaluation permits the provider to determine if the current status of the beneficiary requires therapy services. Any subsequent treatment procedures for such beneficiaries would need to meet the cap exception requirements to be covered.

CMS will except the following therapy evaluation procedures from caps after the therapy caps are reached:

*92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105,
97001, 97002, 97003, 97004.*

These codes will continue to be reported as outpatient therapy procedures as described in the Claims Processing Manual chapter 5, section 20(B) "Applicable Outpatient Rehabilitation HCPCS Codes."

When submitting claims for necessary evaluation services that exceed the caps, providers and suppliers are instructed to attach the KX modifier' (See section C5) to evaluation procedures listed above to identify them as an excepted therapy procedure. The modifier alerts the contractor to override a denial for that service due to the cap.

Documentation shall provide the complaint, or condition that indicates why the evaluation was necessary. Documentation shall describe any complexities that directly and substantially impact the patient's treatment.

b. Exceptions for Condition or Complexities Identified by ICD-9 codes.

Based upon analysis of claims data, research and evidence based practice guidelines, CMS has identified conditions and complexities that will be excepted from caps. This list

appears in C3. A number of factors were considered in development of the list, after considerable study and extensive clinical input. Among the considerations were:

- Data analysis of conditions or complexities with consistently higher likelihood that a beneficiary would appropriately receive services in excess of the therapy cap limitations.
- Conditions which, although they do not often appropriately exceed caps, might result in significant harm if treatment were delayed for manual approval of further necessary services after the cap is reached.
- Volume of services for the conditions, extensive clinical input, and other considerations.

The CMS is aware that there are exceptions that can be debated. This list also represents a balance of the concerns about impact on the patients' continuity of care, volume of manual review, and potential improper use of the modifier.

1. Conditions are represented on the list below without an asterisk (*). When a condition is the reason for the exception, that condition must be related to the therapy goals and must directly and significantly impact the rate of recovery such that it is appropriate to exceed the caps. For example, if the condition underlying the reason for therapy is V43.64, hip replacement, the treatment may have a goal to ambulate 60' with stand-by assistance and a KX modifier may be appropriate for gait training (assuming the severity of the patient is such that the services exceed the cap). Alternatively, it would not be appropriate to use the KX modifier for a patient who recovered from hip replacement last year and is being treated this year for a sprain that is not represented on the list as an exception.

Complexities are identified in the list below with asterisks (*). Exceptions for these complexities, in combination with other conditions that are not on the list, will directly and significantly impact the rate of recovery for the condition being treated. List in your documentation both the disorder treated and one of the complexities. Describe why or how the complexity affects treatment. For example: Cardiac dysrhythmia is not a condition for which a therapist would directly treat a patient, but such dysrhythmias may so directly and significantly affect the pace of progress in treatment for other conditions as to require an exception to caps for necessary services. Documentation should indicate that the progress was affected by the complexity and the extended services are necessary.

DO NOT USE ICD-9 codes that do not describe a specific underlying condition or specific body part(s) affected that resulted in the current therapy episode of care. Only the clearly identifiable conditions described in the following table would qualify for the automatic cap exception based upon clinical condition. **This condition or complexity must directly and significantly affect the type, frequency, intensity and/or duration of required, medically necessary, skilled services over the cap.**

3. ICD-9 Codes That Qualify for the Automatic Therapy Cap Exception Process Based Upon Clinical Condition or Complexity

When using this table, refer to the ICD-9 code book for coding instructions. Exceptions apply only to the codes listed. When two codes are listed in the left cell in a row, all the codes between them are also excepted. If one code is in the cell, only that one code is excepted.

The presence of a diagnosis on the code list for excepted conditions or complexity does not mean that all services for this condition or complexity are excepted from caps. Exception requires that a beneficiary is currently being treated for a condition or complexity on the list. ALSO, the severity of the condition or related therapy disorder for which that patient is treated is such that the skills of a therapist are required for services to address the medical needs above therapy caps that meet the qualifications for reasonable and necessary services. Documentation in the record must always justify the medical necessity of the services both before the cap is reached and after the cap has been reached.

Complexities are comorbidities or complicating circumstances and do not, alone, justify an exception from caps. A complexity must be reported with another condition (which may or may not be listed as an excepted condition) when both are concurrently influencing the length or intensity of treatment such that therapy caps are exceeded by necessary services. Utilize the KX modifier on each line of the claim for the excepted medically necessary services. Document carefully both the complexity and the other condition. The necessary, skilled treatment for the other condition must be directly and significantly affected by the complexity, causing services to be extended appropriately beyond the cap.

It is very important to recognize that most of the conditions on this list would not ordinarily result in services exceeding the cap. Use the KX modifier only in cases where the condition of the individual patient is such that services are APPROPRIATELY provided in an episode that exceeds the cap. In most cases, the severity of the condition, comorbidities, or complexities will contribute to the necessity of services exceeding the cap, and these should be documented. Routine use of the KX modifier for all patients with these conditions will likely show up on data analysis as aberrant and invite inquiry. Be sure that documentation is sufficiently detailed to support the use of the modifier.

*The following ICD-9 codes describe the conditions (etiology or underlying medical conditions) that may result in excepted conditions and complexities (marked *) that may cause medically necessary therapy services to qualify for the automatic therapy cap exception. If a diagnosis code is not listed here, then the disorder may still qualify for an exception by approval of a Medicare contractor. These codes are grouped only to facilitate reference to them. The codes apply to all therapy disciplines, but may be used only when the code is applicable to the condition being actively treated. For example, an exception should not be claimed for a diagnosis of hip replacement when the service provided is for an unrelated dysphagia.*

ICD-9	DESCRIPTION
V43.64	JOINT REPLACEMENT, HIP
V43.65	JOINT REPLACEMENT, KNEE
V43.61	JOINT REPLACEMENT, SHOULDER
V49.63-49.67	UPPER LIMB AMPUTATION STATUS
V49.73-49.77	LOWER LIMB AMPUTATION STATUS
250 – 250.93	DIABETES MELLITUS*
278.01-278.02	OVERWEIGHT, OBESITY, AND OTHER HYPERALIMENTATION*
290.0-290.4	DEMENTIAS*
294.0-294.9	PERSISTENT MENTAL DISORDERS DUE TO CONTIONS CLASSIFIED ELSEWHERE*
311	DEPRESSIVE DISORDER NEC*
323.0-323.0	ENCEPHALITIS, MYELITIS, AND ENCEPHALOMYELITIS*
331.0-331.9	OTHER CEREBRAL DEGENERATIONS
332.0-332.1	PARKINSON'S DISEASE
333.0-333.99	OTHER EXTRAPYRAMIDAL DISEASES AND ABNORMAL MOVEMENT DISORDERS
334.0-334.9	SPINOCEREBELLAR DISEASE
335.0-335.9	ANTERIOR HORN CELL DISEASE
336.0-336.9	OTHER DISEASES OF SPINAL CORD
337.20-337.29	REFLEX SYMPATHETIC DYSTROPHY
340	MULTIPLE SCLEROSIS
342.00-342.9	HEMIPLEGIA AND HEMIPARESIS
343.0-343.9	INFANTILE CEREBRAL PALSY
344.00-344.9	OTHER PARALYTIC SYNDROMES

348.9-348.9	<i>OTHER CONDITIONS OF BRAIN</i>
349.0-349.9	<i>OTHER AND UNSPECIFIED DISORDERS OF THE NERVOUS SYSTEM</i>
353-357	<i>NEUROPATHIES</i>
359.0-359.9	<i>MUSCULAR DYSTROPHIES AND OTHER MYOPATHIES</i>
386.0-386.9	<i>VERTIGINOUS SYNDROMES AND OTHER DISORDERS OF VESTIBULAR SYSTEM*</i>
401.0-401.9	<i>ESSENTIAL HYPERTENSION*</i>
402.00-402.91	<i>HYPERTENSIVE HEART DISEASE*</i>
414.00-414.9	<i>OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE*</i>
415.0-415.19	<i>ACUTE PULMONARY HEART DISEASE*</i>
416.0-416.9	<i>CHRONIC PULMONARY HEART DISEASE*</i>
427.0-427.0	<i>CARDIAC DYSRHYTHMIAS*</i>
428.0-428.9	<i>CONGESTIVE HEART FAILURE*</i>
430-432.9	<i>INTRACRANIAL HEMORRHAGES</i>
433.0-434.9	<i>OCCLUSION AND STENOSIS OF PRECEREBRAL AND CEREBRAL ARTERIES (FOR OCCLUSION ONLY)</i>
436	<i>ACUTE, BUT ILL-DEFINED, CEREBROVASCULAR DISEASE</i>
437.0-437.9	<i>OTHER AND ILL-DEFINED CEREBROVASCULAR DISEASE</i>
438.0-438.9	<i>LATE EFFECTS OF CEREBROVASCULAR DISEASE</i>
443.0-443.9	<i>OTHER PERIPHERAL VASCULAR DISEASE*</i>
453.0-453.9	<i>OTHER VENOUS EMBOLISM AND THROMBOSIS*</i>
457.0-457.1	<i>POSTMASTECTOMY LYMPHEDEMA SYNDROME AND OTHER LYMPHEDEMA</i>
478.30-478.5	<i>DISEASES OF VOCAL CORDS OR LARYNX</i>
486	<i>PNEUMONIA, ORGANISM UNSPECIFIED*</i>
490-496	<i>CHRONIC OBSTRUCTIVE PULMONARY DISEASES*</i>

<i>710.0-710.9</i>	<i>DIFFUSE DISEASES OF CONNECTIVE TISSUE</i>
<i>707.99-707.9</i>	<i>CHRONIC ULCER OF SKIN*</i>
<i>711.00-711.99</i>	<i>ARTHROPATHY ASSOCIATED WITH INFECTIONS*</i>
<i>713.0-713.8</i>	<i>ARTHROPATHY ASSOCIATED WITH OTHER DISORDERS CLASSIFIED ELSEWHERE*</i>
<i>714.0-714.9</i>	<i>RHEUMATOID ARTHRITIS AND OTHER INFLAMMATORY POLYARTHROPATHIES*</i>
<i>715.09</i>	<i>OSTEOARTHRITIS AND ALLIED DISORDERS</i>
<i>715.11</i>	<i>OSTEOARTHRITIS, LOCALIZED, PRIMARY, SHOULDER REGION</i>
<i>715.15</i>	<i>OSTEOARTHRITIS, LOCALIZED, PRIMARY, PELVIC REGION AND THIGH</i>
<i>715.16</i>	<i>OSTEOARTHRITIS, LOCALIZED, PRIMARY, LOWER LEG</i>
<i>715.91</i>	<i>OSTEOARTHRITIS, UNSPECIFIED IF GEN. OR LOCAL, SHOULDER</i>
<i>715.96</i>	<i>OSTEOARTHRITIS, UNSPECIFIED IF GEN. OR LOCAL, LOWER LEG</i>
<i>718.44</i>	<i>CONTRACTURE OF HAND</i>
<i>718.49</i>	<i>CONTRACTURE OF JOINT, MULTIPLE SITES</i>
<i>719.7</i>	<i>DIFFICULTY WALKING*</i>
<i>721.91</i>	<i>SPONDYLOSIS WITH MYELOPATHY</i>
<i>723.4</i>	<i>OTHER DISORDERS OF THE CERVICAL REGION, BRACHIA NEURITIS OR RADICULITIS NOS</i>
<i>724.02</i>	<i>SPINAL STENOSIS, LUMBAR REGION</i>
<i>724.3</i>	<i>OTHER AND UNSPECIFIED DISORDERS OF THE BACK, SCIATICA*</i>
<i>724.4</i>	<i>OTHER AND UNSPECIFIED DISORDERS OF THE BACK, THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS, UNSPECIFIED*</i>
<i>726.10-726.19</i>	<i>ROTATOR CUFF DISORDER AND ALLIED SYNDROMES</i>
<i>727.61-727.62</i>	<i>RUPTURE OF TENDON, NONTRAUMATIC</i>
<i>733.00</i>	<i>OSTEOPOROSIS WITH WEDGING OF VERTEBRA</i>

780.93	<i>MEMORY LOSS</i>
781.2	<i>ABNORMALITY OF GAIT</i>
781.3	<i>LACK OF COORDINATION</i>
781.8	<i>NEUROLOGIC NEGLECT SYNDROME</i>
781.92	<i>SYMPTOMS INVOLVING NERVOUS AND MUSCULOSKELETAL SYMPTOMS, ABNORMAL POSTURE*</i>
784.3-784.69	<i>APHASIA AND OTHER SPEECH DISTURBANCES</i>
787.2	<i>DYSPHASIA</i>
806.00-806.99	<i>FRACTURE OF VERTEBRAL COLUMN WITH SPINAL CORD INJURY</i>
810.00-810.13	<i>FRACTURE OF CLAVICLE</i>
811.00-811.19	<i>FRACTURE OF SCAPULA</i>
812.00-812.59	<i>FRACTURE OF HUMERUS</i>
813.00-813.93	<i>FRACTURE OF RADIUS AND ULNA</i>
820.00-820.9	<i>FRACTURE OF NECK OF FEMUR</i>
821.0-821.39	<i>FRACTURE OF OTHER AND UNSPECIFIED PARTS OF FEMUR</i>
828.0-828.1	<i>MULTIPLE FRACTURES INVOLVING BOTH LOWER LIMBS, LOWER WITH UPPER LIMB, AND LOWER LIMB(S) WITH RIB(S) AND STERNUM</i>
852.00-852.59	<i>SUBARACHNOID, SUBDURAL, AND EXTRADURAL HEMORRHAGE, FOLLOWING INJURY</i>
853.00-853.19	<i>OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE FOLLOWING INJURY</i>
854.00-854.19	<i>INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE</i>
881.0-881.2	<i>OPEN WOUND OF ELBOW, FOREARM, AND WRIST</i>
882.0-882.2	<i>OPEN WOUND OF HAND WITH TENDON INVOLVEMENT</i>
884.0-884.2	<i>MULTIPLE AND UNSPECIFIED OPEN WOUND OF UPPER LIMB WITH TENDON INVOLVEMENT</i>

887.0 – 887.7	TRAUMATIC AMPUTATION OF ARM AND HAND (COMPLETE) (PARTIAL)
897.0-897.7	TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL)
952.00-952.9	SPINAL CORD INJURY WITHOUT EVIDENCE OF SPINAL BONE INJURY
941.00-952.9	BURNS
959.01	HEAD INJURY

4. Additional Exceptions for Complexity

While a beneficiary may not automatically qualify for a cap exception solely based on one of the underlying medical conditions in the table in C3, or conditions in combination with complexities in the table in C3, the beneficiary may still qualify for an automatic cap exception for other clinical complexities. Following are clinical complexities that can justify an automatic exception to the therapy caps for any condition that necessitates skilled therapy services, regardless of whether it is on the list in the table in C3. As in all exceptions, the services rendered above the caps must be documented, covered, medically necessary services. The mere existence of one of these complexities does not assure that the services were medically necessary. The clinician's documentation must justify the use of the modifier.

- The beneficiary was discharged from a hospital or SNF within 30 treatment days of starting this episode of outpatient therapy. Indicate date of discharge and name of hospital or SNF.
- The beneficiary has, in addition to another disease or condition being treated, generalized musculoskeletal conditions or conditions affecting multiple sites not listed as automatically excepted by condition that will directly and significantly impact the rate of recovery.
- The beneficiary has a mental or cognitive disorder in addition to the condition being treated that will directly and significantly impact the rate of recovery.

For the above complexities, list in your documentation all relevant disorders or conditions and describe the impact. For example: A sprained ankle does not qualify for exception by condition, but if the patient also has a dysfunctional wrist on the opposite side that precludes the use of a cane, it would cause a direct and significant impact on the patient's need for skilled physical therapy, and might require services that exceed caps.

- The beneficiary requires PT and SLP services concurrently. If the combination of the two services causes the cap to be exceeded for necessary services, the services are excepted from the PT/SLP cap. There is no affect on the OT cap.

- *The beneficiary had a prior episode of outpatient therapy during this calendar year for a different condition. The second condition treated in the year may not be on the list of excepted conditions. IF services are medically necessary and would be payable under the cap, an exception is allowed if prior use of services for a different condition caused the cap to be exceeded and the medically necessary services to be denied. In cases where the beneficiary was treated in the same year for the same condition, contractor approval is required for use of the KX modifier.*
- *The beneficiary requires this treatment in order to return to a pre-morbid living environment. Document what environment and what is needed to return. For example: Patient is progressing (see FIM scores) and has good potential for completing goals for independent toileting which is required for discharge from the nursing home setting and return to the assisted living facility where she resided prior to the CVA.*
- *The beneficiary requires this treatment plan in order to reduce Activities of Daily Living assistance or Instrumental Activities of Daily Living assistance to pre-morbid levels. Document prior level of independence and current assistance needs.*
- *The beneficiary indicates he/she does not have access to outpatient hospital therapy services. List reasons that justify why the patient cannot obtain excepted services from an outpatient hospital. Reasonable justifications include residents of skilled nursing facilities prevented by consolidated billing from accessing hospital services, debilitated patients for whom transportation to the hospital is a physical hardship, or lack of therapy services at hospital in the beneficiary's county. If there is any question that the justification may not be accepted as reasonable, submit a request to the contractor.*

5. Exception Process for Contractor Approval

If the beneficiary does not automatically qualify for a cap exception based upon clinical condition or clinical complexity at the onset of the treatment episode, the beneficiary or their representative (including providers and suppliers) may submit a request for a cap exception to the contractor for review at any time during the episode. It is recommended that the request be submitted as early as the clinician determines that the beneficiary may need services beyond the cap limits. Failure to submit requests for cap exceptions prior to the date the cap is surpassed will put the beneficiary at risk of incurring the costs of treatment if the request is denied. The provider will be responsible for collecting payments for costs incurred.

Medicare contractors have 10 business days from contractor receipt to respond to requests. When requests for services are approved as medically necessary Medicare contractors shall pay for any necessary services provided within the number of approved treatment days regardless of whether those necessary services were provided before or

after receipt of the request. Contractors shall approve requested services by allowing a specific number of days of treatment for each discipline (PT, OT, and SLP separately).

*Providers are discouraged from submitting routine or excessive requests, or excessive requests for services already rendered. **Routine use of the KX modifier for all patients with these conditions will likely show up on data analysis as aberrant and invite inquiry.***

The letter of request, including the number of treatment days requested and the justification for the medically necessary services must be submitted to the contractor by fax with supporting documentation, unless the contractor specifically requests or allows phone or mail requests. The request and all documentation required for medical review listed in 220.3 must be sent in together. Keep the fax receipt in the record. If mailed requests are allowed, certified mail will document receipt at the contractor. If phone requests are allowed, both the contractor and the provider/supplier shall document the request and the contractor's response. The documentation requirements are the same as the documentation required to be kept in the medical record for services that are automatically excepted and is described in section C2 through C4 above. In the case of services not automatically excepted, send these documents to the contractor with a request. Include any further justification the provider or supplier believes may be helpful to the contractor in determining that the services are (were or will be) necessary and appropriately provided. For example, outcome measurements that indicate the patient is progressing, has good prognosis, but has not reached expected outcomes for the condition, or research that indicates the length of treatment for this condition is appropriate.

If the contractor approves the cap exception,

- *The provider maintains a copy of the approval in the beneficiary's clinical record and shall present such documentation during any subsequent claim review.*

***Note:** By approving the cap exception, the contractor has determined, based on information provided by the provider/supplier that the requested services are medically necessary.*

- *The provider shall attach the KX modifier (See C1 above) to all therapy procedures subject to the caps.*
- *If the clinician determines that the episode of treatment appropriately extends beyond the original duration estimate in the plan of care approved by the contractor (or the number of treatment days approved), the provider shall submit a request for further cap exception using the procedures described above.*

If the contractor disapproves the request for exception, the contractor shall notify the provider/supplier within 10 business days of the receipt of the request and shall include the reason for the disapproval.

If the beneficiary does not automatically qualify for a cap exception, and is not approved for an exception by the contractor, then the therapy services furnished during that episode are subject to the cap.

When the provider/supplier determines that not all of the requested and approved services are necessary, the exception no longer applies and, use of the KX modifier is not allowed.

6. Appeals Related to Disapproval of Cap Exceptions

Disapproval of Requested Exception from Caps. When a beneficiary's services exceed therapy caps, services are no longer covered and are denied as a benefit category denial. The DRA allows that certain services that would not be covered due to caps, but are medically necessary, may be covered if they meet certain criteria. Therefore, when a service beyond the cap is determined to be medically necessary, it is covered and payable. But, when a service provided beyond the cap (outside the benefit) is determined to be NOT medically necessary, it is denied as a benefit category denial.

Services without a Medicare benefit may be billed to Medicare with a GY modifier for the purpose of obtaining a denial that can be used with other insurers. See CMS IOM Pub. 100-04 Chapter 1, Section 60 for appropriate use of modifiers.

APPEALS – Further details concerning appeals is found in CMS IOM Pub. 100-02, chapter 29. A contractor's decision regarding a "therapy cap exception" request is not an initial claim determination as defined in 42 CFR 405.924, and is not subject to the administrative appeals process (as outlined in Publication 100-04 Chapter 29). However, if a beneficiary whose exception request is not approved elects to receive services that exceed the cap limitation and a claim is submitted for such services, the resulting determination would be subject to the administrative appeals process.

7. Use of the KX Modifier for Therapy Cap Exceptions

When the beneficiary qualifies for a therapy cap exception, the provider shall add a KX modifier to the therapy HCPCS subject to the cap limits.

- The codes subject to the therapy cap tracking requirements are listed in a table in the Claims Processing Manual, chapter 5, section 20(B), "Applicable Outpatient Rehabilitation HCPCS Codes."*
- The GN, GO, or GP therapy modifiers are currently required. In addition to the KX modifier, the GN, GP and GO modifiers shall continue to be used.*
- By attaching the KX modifier, the provider is attesting that the services billed:*

- *Qualified for the cap exception either automatically or by contractor approval;*
- *Are reasonable and necessary services that require the skills of a therapist; and*
- *Are justified by appropriate documentation in the medical record.*

If this attestation is determined to be inaccurate, the provider/supplier is subject to sanctions resulting from providing inaccurate information on a claim.

When the KX modifier is attached to a therapy HCPCS, the contractor will not count the expenditure against the applicable PT/SLP or OT cap amount. Instead, contractors will override the CWF system reject and pay the claim if it is otherwise payable.

Providers and suppliers shall continue to attach correct coding initiative (CCI) HCPCS modifiers under current instructions.

If a claim is submitted and the cap is exceeded, those services will be denied. The provider/supplier/beneficiary may request and the contractor may retroactively approve an exception to the cap for any number of medically necessary services. Contractors may reopen and adjust the claim for which retroactive approval was granted, if it is brought to their attention.

D. MSN Messages

Existing MSN message 38.18 shall continue to appear on all Medicare MSN forms. It has been updated to the following:

- ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2006. The limits are \$1,740 for PT and SLP combined and \$1,740 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to *certain therapy approved by Medicare or to* therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE.

Spanish Translation:

ALERTA: La cobertura de Medicare estará limitada para los servicios de terapia física ambulatoria (PT, por sus siglas en inglés), terapia de patología del habla (SLP, por sus siglas en inglés), y terapia *ocupacional* (OT) si son recibidos entre el 1 de enero de 2006 y el 31 de diciembre de 2006. Estos límites son \$1,740 para PT y SLP combinados y \$1,740 para OT. Medicare paga hasta 80 por ciento de los límites después que se haya pagado el deducible. Estos límites no se aplican a *cierta terapia aprobada por Medicare ni* terapia que usted obtenga en los departamentos de hospital para paciente ambulatorio, a menos que usted sea un residente y ocupe una cama certificada por Medicare en un

centro de enfermería especializada. Si tiene preguntas, por favor llame GRATIS al 1-800-MEDICARE.

Existing MSN messages 17.13, 17.18 and 17.19 shall be issued on all claims containing outpatient rehabilitation services as noted in this PM. Add applied amount for individual beneficiaries and the generic limit amount (e.g., \$1740 in 2006) to all MSN that require them.

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 *or when approved by Medicare.*

Spanish Translation

17.13 - *Cada* 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, terapeutas 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 *o cuando está aproba por Medicare.*

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 lenguaje 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.

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.

E. FI Requirements

1. General Requirements

Regardless of financial limits on therapy services, CMS requires modifiers (See Sec. 20.1 of this chapter) on specific codes for the purpose of data analysis. Edit to ensure that the 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, GP, or GO should be returned to the provider.

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 Comprehensive Outpatient Rehabilitation Facility (CORF) must be billed as CORF services and not a 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.

2. When Financial Limits Are in Effect

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, 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—FIs 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.

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. Also, limitations do not apply to any therapy services billed under PPS Home Health, or inpatient hospitals including critical access hospitals.

F. Carrier Requirements when Financial Limits are in Effect

Claims containing any of the “Applicable Outpatient Rehabilitation HCPCS Codes” in section 20 below marked “always therapy” (underlined) codes should contain one of the therapy modifiers (GN, GO, GP). All claims submitted for codes underlined but without a therapy modifier shall be returned as unprocessable.

When any code on the list of “Applicable Outpatient Rehabilitation HCPCS Codes” codes are submitted with specialty codes “65” (physical therapist in private practice), and “67” (occupational therapist in private practice), they always represent therapy services, because they are provided by therapists. Carriers shall return claims for these services when they do not contain therapy modifiers for the applicable HCPCS codes.

The “Applicable Outpatient Rehabilitation HCPCS Codes in section 20 of this chapter that are marked (+) are sometimes therapy codes. Claims from physicians (all specialty codes) and nonphysician practitioners, including specialty codes “50,” “89,” and “97” may be processed without therapy modifiers. On review of these claims, 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, except when the place of service code is 22 (outpatient hospital) or 23 (emergency room-hospital). The CWF has disabled the edit involving specialty codes “65” and “67” and Type of Service W or U.

G. FI Action Based on CWF Trailer During the Time Therapy Limits are in Effect

Upon receipt of the CWF error code/trailer, FIs 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 FI 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: Based on the 2006 limit of \$1740 for a beneficiary who has paid the deductible and the coinsurance:

Services received to date \$1725 (\$15 under the limit)

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 FI reports in the "Financial Limitation" field of the CWF record "\$25.00 along with the CWF override code. The FI always applies the amount that would least exceed the limit. Since the FI systems cannot split the payment on a line, CWF will allow payment on the line that least exceeds the limit and deny other lines.

H. Additional Information for Carriers and FIs During the Time Financial Limits Are in Effect

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 FIs and carriers 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/supplier should advise the beneficiary that a claim for services that exceeds the limitation is being denied pursuant to §1833(g) of the Act (42U.C.S. §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/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 exceed the financial limit 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/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, 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 (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.

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

I. Provider Notification for Beneficiaries Exceeding Therapy Limits

Contractors will advise providers/suppliers to notify beneficiaries of the therapy financial limitations at their first therapy encounter with the beneficiary. Providers/suppliers should inform beneficiaries that beneficiaries are responsible for 100 percent of the costs of therapy services above each respective therapy limit, unless this outpatient care is furnished directly or under arrangements by a hospital. Patients who are residents in a Medicare certified part of a SNF may not utilize outpatient hospital services for therapy services over the financial limits, because consolidated billing rules require all services to be billed by the SNF.

NEMB 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 limits can be obtained at a hospital outpatient therapy department. ***Medicare contractors shall*** advise providers/suppliers to use the Notice of Exclusion from Medicare Benefits (NEMB Form No. CMS 20007 & Formulario No. CMS 20007) form, or a similar form of their own design to inform beneficiaries of the therapy financial limitation ***and the cap exclusion process.***

When using the NEMB form, the practitioner checks box number 1 and writes the reason for denial in the space provided at the top of the form. Provide the following reason: "Medicare will not pay for physical therapy and speech-language pathology services over (add the dollar amount of the cap and the year or the dates of service to which it applies, e.g., \$1740 in 2006) ***unless the beneficiary qualifies for a cap exception.***" Providers are to supply this same information for occupational therapy services over the limit for the same time period, as appropriate.

The NEMB form can be found at: <http://www.cms.hhs.gov/medicare/bni/>

When using the NEMB form, the practitioner checks box number 1 and writes the reason for denial in the space provided at the top of the form. The following reason *is suggested*: “*Services do not qualify for exception to therapy caps*. Medicare will not pay for physical therapy and speech-language pathology services over (add the dollar amount of the cap and the year or the dates of service to which it applies, e.g., \$1740 in 2006).” Providers are to supply this same information for occupational therapy services over the limit for the same time period, as appropriate.

ABN An Advance Beneficiary Notice (ABN) is required to be given to a beneficiary whenever the treating clinician determines that the services being provided are no longer expected to be covered because they do not satisfy Medicare’s medical necessity requirements. The ABN informs the beneficiary of their potential financial obligation to the provider and provides guidance regarding appeal rights. ABN applies to services that are provided BEFORE the cap is exceeded.

After the cap is exceeded, only the NEMB is appropriate, regardless of whether the services were excepted from the cap. For example, if services are provided over the cap for an excepted condition, when the therapist determines that the services no longer meet the criteria for reasonable and necessary services, an NEMB and not an ABN is provided to the patient.

At the time the clinician determines that skilled services are not necessary, the clinical goals have been met, or that there is no longer potential for the rehabilitation of health and/or function in a reasonable time, the beneficiary should be informed. If the beneficiary requests further services, inform the beneficiary that Medicare will not likely provide additional coverage. Use the ABN form for this purpose if the services are within the cap, and use the NEMB for services after the cap is exceeded.

Access to Accrued Amount All providers and contractors may access the accrued amount of therapy services from the ELGA screen inquiries into CWF. Providers who bill to FIs will also find the amount a beneficiary has accrued toward the financial limitations on the HIQA. *Some suppliers and providers billing to carriers may, in addition, have access the accrued amount of therapy services from the ELGB screen inquiries into CWF.* Suppliers who do not have access to these inquiries may call the contractor to obtain the amount accrued.

20 - HCPCS Coding Requirement

(Rev. 805, Issued: 01-06-06, Effective: 01-01-06, Implementation: 02-06-06)

A. Uniform Coding

Section 1834(k)(5) of the Act requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility (CORF) services be reported using a uniform coding system. The Healthcare Common Procedure Coding System/Current Procedural Terminology, 2006 Edition (HCPCS/CPT-4) is the coding

system used for the reporting of these services. The uniform coding requirement in the Act is specific to payment for all CORF services and outpatient rehabilitation therapy services - including physical therapy, occupational therapy, and speech-language pathology - that is provided and billed to carriers and fiscal intermediaries (FIs). The Medicare physician fee schedule (MPFS) is used to make payment for these therapy services at the nonfacility rate.

Effective for claims submitted on or after April 1, 1998, providers that had not previously reported HCPCS/CPT for outpatient rehabilitation and CORF services began using HCPCS to report these services. This requirement does not apply to outpatient rehabilitation services provided by:

- Critical access hospitals, which are paid on a cost basis, not MPFS;
- RHCs, and FQHCs for which therapy is included in the all-inclusive rate; or
- Providers that do not furnish therapy services.

The following “providers of services” must bill the FI for outpatient rehabilitation services using HCPCS codes:

- Hospitals (to outpatients and inpatients who are not in a covered Part A¹ stay);
- Skilled nursing facilities (SNFs) (to residents not in a covered Part A¹ stay and to nonresidents who receive outpatient rehabilitation services from the SNF);
- Home health agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care² (POC);
- Comprehensive outpatient rehabilitation facilities (CORFs); and
- Providers of outpatient physical therapy and speech-language pathology services (OPTs), also known as rehabilitation agencies (previously termed outpatient physical therapy facilities in this instruction).

Note 1. The requirements for hospitals and SNFs apply to inpatient Part B and outpatient services only. Inpatient Part A services are bundled into the respective prospective payment system payment; no separate payment is made.

Note 2. For HHAs, HCPCS/CPT coding for outpatient rehabilitation services is required only when the HHA provides such service to individuals that are not homebound and, therefore, not under a Home Health plan of care.

The following practitioners must bill the carriers for outpatient rehabilitation therapy services using HCPCS/CPT codes:

- Physical therapists in private practice (PTPPs),

- Occupational therapists in private practice (OTPPs),
- Physicians, including MDs, DOs, podiatrists and optometrists, and
- Certain nonphysician practitioners (NPPs), acting within their State scope of practice, e.g., nurse practitioners and clinical nurse specialists.

Providers billing to intermediaries shall report:

- The date the therapy plan of care was either established or last reviewed (see §220.1.3B) in Occurrence Code 17, 29, or 30.
- The first day of treatment in Occurrence Code 35, 44, or 45.

B. Applicable Outpatient Rehabilitation HCPCS Codes

The CMS identifies the following codes as therapy services, regardless of the presence of a financial limitation. Therapy services include only physical therapy, occupational therapy and speech-language pathology services. Therapist means only a physical therapist, occupational therapist or speech-language pathologist. Therapy modifiers are GP for physical therapy, GO for occupational therapy, and GN for speech-language pathology. Check the notes below the chart for details about each code.

When in effect, any financial limitation will also apply to services represented by the following codes, except as noted below.

NOTE: Listing of the following codes does not imply that services are covered or applicable to all provider settings.

64550+	90901+	<u>92506Δ</u>	<u>92507Δ</u>	<u>92508</u>	<u>92526</u>
<u>92597</u>	<u>92605****</u>	<u>92606****</u>	<u>92607</u>	<u>92608</u>	<u>92609</u>
92610+	92611+	92612+	92614+	92616+	95831+
95832+	95833+	95834+	95851+	95852+	96105+
96110+✓	96111+✓	<u>97001</u>	<u>97002</u>	<u>97003</u>	<u>97004</u>
<u>97010****</u>	<u>97012</u>	<u>97016</u>	<u>97018</u>	<u>97022</u>	<u>97024</u>
<u>97026</u>	<u>97028</u>	<u>97032</u>	<u>97033</u>	<u>97034</u>	<u>97035</u>
<u>97036</u>	<u>97039*◇</u>	<u>97110</u>	<u>97112</u>	<u>97113</u>	<u>97116</u>
<u>97124</u>	<u>97139*◇</u>	<u>97140</u>	<u>97150</u>	<u>97530</u>	97532+
<u>97533</u>	<u>97535</u>	<u>97537</u>	<u>97542</u>	97597+ε	97598+ε

97602+****ε	97605+ε	97606+ε	<u>97750</u>	<u>97755</u>	<u>97760**Δ</u>
<u>97761</u>	<u>97762</u>	<u>97799*</u>	<u>G0281</u>	<u>G0283</u>	<u>G0329</u>
0019T+***	0029T+***				

* The physician fee schedule abstract file does not contain a price for CPT codes 97039, 97139, or 97799, since the carrier prices them. Therefore, the FI must contact the carrier to obtain the appropriate fee schedule amount in order to make proper payment for these codes.

◇ Effective January 1, 2006, these codes will no longer be valued under the MPFS. They will be priced by the carriers.

Δ Effective January 1, 2006, the code descriptors for these services have been changed.

** CPT code 97760 should not be reported with CPT code 97116 for the same extremity.

*** The physician fee schedule abstract file does not contain a price for CPT codes 0019T or 0029T since they are priced by the carrier. In addition, the carrier determines coverage for these codes. Therefore, the FI contacts the carrier to obtain the appropriate fee schedule amount.

**** These HCPCS/CPT codes are bundled under the MPFS. They are bundled with any therapy codes. Regardless of whether they are billed alone or in conjunction with another therapy code, never make payment separately for these codes. If billed alone, HCPCS/CPT codes marked as “****” shall be denied using the existing MSN language. For remittance advice notices, use group code CO and claim adjustment reason code 97 that says: “Payment is included in the allowance for another service/procedure.” Use reason code 97 to deny a procedure code that should have been bundled. Alternatively, reason code B15, which has the same intent, may also be used.

✓ If billed by an outpatient hospital department, these HCPCS codes are paid using the Outpatient Prospective Payment System (OPPS).

Underlined codes are “always therapy” services, regardless of who performs them. These codes always require therapy modifiers (GP, GO, GN).

ε If billed by a hospital subject to OPPS for an outpatient service, these HCPCS codes – also indicated as “sometimes therapy” services - will be paid under the OPPS when the service is not performed by a qualified therapist and it is inappropriate to bill the service under a therapy plan of care. The requirements for other “sometimes therapy” codes, described below, apply.

+ These HCPCS/CPT codes sometimes represent therapy services. However, these codes always represent therapy services and require the use of a therapy modifier when performed by therapists.

There are some circumstances when these codes will not be considered representative of therapy services and therapy limits (when they are in effect) will not apply. Codes marked + are not therapy services when:

- It is not appropriate to bill the service under a therapy plan of care, and
- They are billed by practitioners/providers of services who are not therapists, i.e., physicians, clinical nurse specialists, nurse practitioners and psychologists; or they are billed to fiscal intermediaries by hospitals for outpatient services which are performed by non-therapists as noted in Note "ع" above.

While the "+" designates that a particular HCPCS/CPT code will not of itself always indicate that a therapy service was rendered, these codes always represent therapy services when rendered by therapists or by practitioners who are not therapists in situations where the service provided is integral to an outpatient rehabilitation therapy plan of care. For these situations, these codes must always have a therapy modifier. For example, when the service is rendered by either a doctor of medicine or a nurse practitioner (acting within the scope of his or her license when performing such service), with the goal of rehabilitation, a modifier is required. When there is doubt about whether a service should be part of a therapy plan of care, the contractor shall make that determination.

"Outpatient rehabilitation therapy" refers to skilled therapy services, requiring the skills of qualified therapists, performed for restorative purposes and generally involving ongoing treatments as part of a therapy plan of care. In contrast, a non-therapy service is a service performed by non-therapist practitioners, without an appropriate rehabilitative plan or goals, e.g., application of a surface (transcutaneous) neurostimulator – CPT code 64550, and biofeedback training by any modality – CPT code 90901. When performed by therapists, these are "always" therapy services. Contractors have discretion to determine whether circumstances describe a therapy service or require a rehabilitation plan of care.

The underlined HCPCS codes on the above list do not have a + sign because they are considered "always therapy" codes and always require a therapy modifier. Therapy services, whether represented by "always therapy" codes, or + codes in the above list performed as outpatient rehabilitation therapy services, must follow all the policies for therapy services (e.g., Pub. 100-04, chapter 5; Pub. 100-02, chapters 12 and 15).

C. Additional HCPCS Codes

Some HCPCS/CPT codes that are not on the list of therapy services should not be billed with a modifier. For example, outpatient non-rehabilitation HCPCS codes G0237, G0238, and G0239 should be billed without therapy modifiers. These HCPCS codes describe services for the improvement of respiratory function and may represent either "incident to" services or respiratory therapy services that may be appropriately billed in the CORF setting. When the services described by these G-codes are provided by physical therapists (PTs) or occupational therapists (OTs) treating respiratory conditions,

they are considered therapy services and must meet the other conditions for physical and occupational therapy. The PT or OT would use the appropriate HCPCS/CPT code(s) in the 97000 – 97799 series and the corresponding therapy modifier, GP or GO, must be used.

Another example of codes that are not on the list of therapy services and should not be billed with a therapy modifier includes the following HCPCS codes: 95860, 95861, 95863, 95864, 95867, 95869, 95870, 95900, 95903, 95904, and 95934. These services represent diagnostic services - not therapy services; they must be appropriately billed and shall not include therapy modifiers.

Other codes not on the above list, and not paid under another fee schedule, are appropriately billed with therapy modifiers when the services are furnished by therapists or provided under a therapy plan of care and where the services are covered and appropriately delivered (e.g., the therapist is qualified to provide the service). One example of non-listed codes where a therapy modifier is indicated, regards the provision of services described in the CPT code series, 29000 through 29590, for the application of casts and strapping. Some of these codes previously appeared on the above list, but were deleted because we determined that they represented services that are most often performed outside a therapy plan of care. However, when these services are provided by therapists or as an integral part of a therapy plan of care, the CPT code must be accompanied with the appropriate therapy modifier.

NOTE: The above lists of HCPCS/CPT codes are intended to facilitate the contractor's ability to pay claims under the MPFS. It is not intended to be an exhaustive list of covered services, imply applicability to provider settings, and does not assure coverage of these services.

20.1 - Discipline Specific Outpatient Rehabilitation Modifiers - All Claims

(Rev. 759, Issued: 11-18-05, Effective: 01-01-06, Implementation: 01-03-06)

Modifiers are used to identify therapy services whether or not financial limitations are in effect. When limitations are in effect, the CWF tracks the financial limitation based on the presence of therapy modifiers. Providers/suppliers must continue to report one of these modifiers for any therapy code on the list of applicable therapy codes except as noted in §20 of this chapter. Consult §20 for the list of codes to which modifiers must be applied. These modifiers do not allow a provider to deliver services that they are not qualified and recognized by Medicare to perform.

The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered:

- GN Services delivered under an outpatient speech-language pathology plan of care;
- GO Services delivered under an outpatient occupational therapy plan of care; or,

- GP Services delivered under an outpatient physical therapy plan of care.

This is applicable to all claims from physicians, nonphysician practitioners (NPPs), PTPPs, OTPPs, CORFs, OPTs, hospitals, SNFs, and any others billing for physical therapy, speech-language pathology or occupational therapy services as noted on the applicable code list in §20 of this chapter.

Modifiers GN, GO, and GP refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services. They should never be used with codes that are not on the list of applicable therapy services. For example, respiratory therapy services, or nutrition therapy services shall not be represented by therapy codes which require GN, GO, and GP modifiers.

20.2 - Reporting of Service Units With HCPCS - Form CMS-1500 and Form CMS-1450

(Rev. 515, Issued: 04-01-05, Effective: 01-03-05, Implementation: 07-05-05)

Effective with claims submitted on or after April 1, 1998, providers billing on Form CMS-1450 are required to report the number of units for outpatient rehabilitation and certain audiology services based on the procedure or service, e.g., based on the HCPCS code reported instead of the revenue code. This was already in effect for billing on the Form CMS-1500. CORFs report their full range of CORF services on the Form CMS-1500. Units are reported based on the number of times the procedure, as described in the HCPCS code definition, is performed. When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe (“untimed” HCPCS), the provider enters “1” in units. Since providers may perform a number of procedures or services during a single visit, the number of units may exceed the number of visits. Visits should not be reported as units for these services.

EXAMPLE: A beneficiary received occupational therapy (HCPCS code 97530 which is defined in 15 minute intervals) for a total of 60 minutes. The provider would then report revenue code 043X in FL 42, HCPCS code 97530 in FL 44, and 4 units in FL 46.

Providers billing on Form CMS-1450 (UB-92) should report Value Code 50, 51, or 52, as appropriate in FLs 39-41, the total number of physical therapy, occupational therapy, or speech therapy visits provided from start of care through the billing period. This item is visits, not service units. This is not required on the Form CMS-1500.

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any calendar day** using CPT codes and the appropriate number of units of service. For any single CPT code, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes, then 2 units should be billed. Time intervals for larger numbers of units are as follows:

Units Reported on the Claim Number Minutes

3 units > 38 minutes to < 53 minutes

4 units > 53 minutes to < 68 minutes

5 units > 68 minutes to < 83 minutes

6 units > 83 minutes to < 98 minutes

7 units > 98 minutes to < 113 minutes

8 units > 113 minutes to < 128 minutes

The pattern remains the same for treatment times in excess of 2 hours. Providers should not bill for services performed for less than 8 minutes. The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

The beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. The time spent delivering each service, described by a timed code, should be recorded. (The length of the treatment to the minute could be recorded instead.) **If more than one CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time.** For example, if 24 minutes of code 97112 and 23 minutes of code 97110 were furnished, then the total treatment time was 47 minutes; so only 3 units can be billed for the treatment. The correct coding is 2 units of code 97112 and one unit of code 97110, assigning more units to the service that took the most time.

NOTE: The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the eighth should be excluded from the total count. The timing of active treatment counted includes all direct treatment time.

20.3 - Determining What Time Counts Towards 15-Minute Timed Codes - All Claims

(Rev. 1, 10-01-03)

A3-3653, SNF-532.C, AB-00-39

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as "intra-service care" begins when the therapist or physician (or an assistant under the supervision of a physician or therapist) is directly working with the patient to

deliver treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment.

The time counted is the time the patient is treated. For example, if gait training in a patient with a recent stroke requires both a therapist and an assistant, or even two therapists, to manage in the parallel bars, each 15 minutes the patient is being treated can count as only one unit of code 97116. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.

20.4 - Coding Guidance for Certain Physical Medicine CPT Codes - All Claims

(Rev. 1, 10-01-03)

AB-00-39

The following provides guidance about the use of codes 96105, 97150, 97545, 97546, and G0128.

- CPT Codes 96105, 97545, and 97546.

Providers report code 96105, assessment of aphasia with interpretation and report in 1-hour units. This code represents formal evaluation of aphasia with an instrument such as the Boston Diagnostic Aphasia Examination. If this formal assessment is performed during treatment, it is typically performed only once during treatment and its medical necessity should be documented. If the test is repeated during treatment, the medical necessity of the repeat administration of the test must also be documented. It is common practice for regular assessment of a patient's progress in therapy to be documented in the chart, and this may be done using test items taken from the formal examinations. This is considered to be part of the treatment and should not be billed as 96105 unless a full, formal assessment is completed.

Other timed physical medicine codes are 97545 and 97546. The interval for code 97545 is 2 hours and for code 97546, 1 hour. These are specialized codes to be used in the context of rehabilitating a worker to return to a job. The expectation is that the **entire** time period specified in the codes 97545 or 97546 would be the treatment period, since a shorter period of treatment could be coded with another code such as codes 97110, 97112, or 97537. (Codes 97545 and 97546 were developed for reporting services to persons in the Worker's Compensation program, thus we do not expect to see them reported for Medicare patients except under very unusual circumstances. Further, we would not expect to see code 97546 without also seeing code 97545 on the same claim. Code 97546, when used, is used in conjunction with 97545.)

20.5 – CORF/OPT Edit for Billing Inappropriate Supplies

(Rev. 319, Issued: 10-22-04, Effective: 07-01-01, Implementation: 04-04-05)

Supplies furnished by CORFs/OPTs are considered part of the practice expense. Under the Medicare Physician Fee Schedule (MPFS) these expenses are already taken into account in the practice expense relative values. Therefore, CORFs/OPTs should not bill for the supplies they furnish except for the splint and cast, level II HCPCS Q codes associated with the level I HCPCS in the 29000 series.

The shared system maintainer will return to CORFs/OPTs any claims that they receive that contain a supply revenue code 270 without the splint and cast Level II HCPCS Q codes and the related Level I applicable HCPCS codes in the 29000 series.

The appropriate Level II HCPCS “Q” codes to be used are Q4001 thru Q4049.

The appropriate Level I HCPCS codes associated with the Level II HCPCS “Q” codes are 29000 thru 29085; 29105 thru 29131; and 29305 thru 29515.

30 - Special Claims Processing Rules for Outpatient Rehabilitation Claims - Form CMS-1500

(Rev. 1, 10-01-03)

Rules for completing a Form CMS-1500 and electronic formats are in Chapter 26. Instructions in §§10.1, 20.1, 20.2, 20.3 and 20.4 above also apply.

30.1 - Determining Payment Amounts

(Rev. 1, 10-01-03)

Carriers use the MPFS to determine payment for outpatient rehabilitation services. Payment rules are the same as those for other services paid on the MPFS.

Assignment is mandatory.

See chapter 23, for a description of the MPFS.

30.2 - Applicable Carrier CWF Type of Service Codes

(Rev. 1, 10-01-03)

The carrier assigns the type of service code before submitting the claim record to CWF.

U = Occupational therapy

W= Physical therapy

40 - Special Claims Processing Rules for Outpatient Rehabilitation Claims - Form CMS-1450

(Rev. 1, 10-01-03)

40.1 - Determining Payment Amounts - FIs

(Rev. 1, 10-01-03)

PM AB-00-01, SNF-532.F

See §100.2.

40.2 - Applicable Bill Types - FIs

(Rev. 1, 10-01-03)

A3-3653.B

The appropriate bill types requiring HCPCS coding under this payment system are: 12X, 13X, 22X, 23X, 34X, 74X, 75X, and 83X.

40.3 - Applicable Revenue Codes - FIs

(Rev. 1, 10-01-03)

SNF-532.A, PM A-98-63, A3-3653.C

The appropriate revenue codes for reporting outpatient rehabilitation services are

0420 - Physical Therapy Services

0430 - Occupational Therapy Services

0440 - Speech pathology services

0470 - Audiology

The general classification of revenue codes is all that is needed for billing. If, however, providers choose to use more specific revenue code classifications, the FI should accept them. Reporting of services is not limited to specific revenue codes; e.g., services other than therapy may be included on the same claim.

Many therapy services may be provided by both physical and occupational therapists. Other services may be delivered by either occupational therapists or speech-language pathologists. Therefore, providers report outpatient rehabilitation HCPCS codes in conjunction with the appropriate outpatient rehabilitation revenue code based on the type

of therapist who delivered the service, or, if a therapist does not deliver the service, then on the type of therapy under the plan of care (POC) for which the service is delivered.

40.4 - FI Edit Requirements for Revenue Codes

(Rev. 1, 10-01-03)

A3-3653.H, SNF-532.E

The FIs edit to assure the presence of a HCPCS code when revenue codes 0420, 0430, 0440, or 0470 are reported. However, they do not edit the matching of revenue code to HCPCS codes or edit to limit provider reporting to only those HCPCS listed in this instruction.

40.5 - Line Item Date of Service Reporting on Form CMS-1450

(Rev. 1, 10-01-03)

A3-3653.K, SNF-532.D

Providers are required to report line item dates of service per revenue code line for outpatient rehabilitation services and audiology services. CORFs are also required to report their full range of CORF services by line item date of service. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item date of service for hardcopy is reported in FL 45 "Service Date" (MMDDYY). For ANSI X12N and the Form CMS-1450 (UB-92) flat file, the date is reported as CCYYMMDD. See example below of reporting line item dates of service. This example is for physical therapy services provided twice during a billing period.

ASC X 12 837

When using the 837 Health Care Claim version 3051 implementations 3A.01 or 1A.C1, or the 837 Health Care Claim HIPAA version (when implemented), the provider reports as follows:

LX*1~

SV2*0420*HC:97001*GP*60.9*UN*1~

DTP*472*D8*20021006~

LX*2~

SV2*0420*HC:97110*GP*44.02*UN*2~

DTP*472*D8*20021029~

Form CMS-1450 (UB-92) flat file

Record Type	Revenue Code	HCPCS	Modifier	Dates of Service	Units	Total Charges
61	0420	97001	GP	20021006	1	\$60.90
61	0420	97110	GP	20021029	2	\$44.02

Paper CMS-1450

FL 42	FL 44	FL 45	FL 46	FL 47
0420	97001GP	100602	1	\$60.90
0420	97110GP	102902	2	\$44.02

The FI returns bills that span two or more dates if a line item date of service is not entered for each HCPCS reported. Line item date of service reporting became effective for claims with dates of service on or after October 1, 1998.

Providers report line item dates of service in revenue code order by date of service. Services that do not require line item date of service reporting may be reported before or after those services that require line item reporting.

50 - CWF and PS&R Requirements - FIs

(Rev. 1, 10-01-03)

A3-3653.P

The FI reports the procedure codes in the financial data section (field 65a-65j) of the PS&R record. It includes revenue code, HCPCS, units, and covered charges in the record. Where more than one HCPCS procedure is applicable to a single revenue code, the provider reports each HCPCS and related charge on a separate line. The FI reports the payment amount before adjustment for beneficiary liability in field 65g "Rate" and the actual charge in field 65h "Covered Charges." The PS&R system includes outpatient rehabilitation, audiology and CORF services listed in subsections E and F on a separate report from cost based payments. See the PS&R guidelines for specific information.

100 - Special Rules for Comprehensive Outpatient Rehabilitation Facilities (CORFs)

(Rev. 1, 10-01-03)

100.1 - General

(Rev. 1, 10-01-03)

A3-3370.1, B3-9300.1

The Omnibus Reconciliation Act of 1980 (Public Law 96-499, Section 933) defines CORFs (Comprehensive Outpatient Rehabilitation Facilities) as a distinct type of Medicare provider and adds CORF services as a benefit under Medicare Part B. The Balance Budget Act (P.L.105-33) requires payment under a prospective system for all CORF services.

See chapter 1, for the policy on FI Designations governing CORFs.

See the Medicare Benefit Policy Manual, Chapter 12, for a description of covered CORF services.

Physicians' diagnostic and therapeutic services furnished to a CORF patient are not considered CORF physician's services. The physician must bill the area Part B carrier for these services. If they are covered, the carrier reimburses them via the MPFS.

However, other services are considered CORF services to be billed by the CORF to the FI, and are also considered included in the fee amount under the MPFS. These services include such services as administrative services provided by the physician associated with the CORF, examinations for the purpose of establishing and reviewing the plan of care, consultation with and medical supervision of nonphysician staff, team conferences, case reviews, and other facility staff medical and facility administration activities relating to the services described in Medicare Benefit Policy Manual, Chapter 12. Related supplies are also included in the MPFS fee amount.

CORFs bill Medicare with the Form CMS-1450 using HCPCS codes and revenue codes. Usually the zero level revenue code is used. Payment is based on the HCPCS code and related MPFS amount.

Requirements in §§10 - 50 apply to CORF billing. In addition the following requirements apply.

100.2 - Obtaining Fee Schedule Amounts

(Rev. 1, 10-01-03)

PM AB-00-01, SNF-532.F

The CMS furnishes FIs with an annual therapy abstract file and a CORF supplemental file through the Medicare Telecommunications System. The CMS notifies FIs when new files are available. FIs are responsible for informing CORFs of new fee schedule amounts.

Payment is calculated at 80 percent of the allowed charge after deductible is met. The allowed charge is the lower of billed charges or the fee schedule amount. Unmet deductible is subtracted from the allowed charge, and payment is calculated at 80 percent of the result.

EXAMPLE:

\$120 Provider charge;

\$100 MPFS amount.

Payment is 80 percent of the lower of the actual charge or fee schedule amount, which in this case is \$80.00. (\$100.00 (MPFS) X 80 percent.)

The remaining 20 percent or \$20 is the patient's coinsurance liability.

These codes are updated as needed by CMS.

If the FI receives a claim for a Medicare covered CORF service with dates of service on or after July 1, 2000, that does not appear on its fee schedule abstract file, it has two options for obtaining pricing information:

- It is provided with a therapy abstract file or CORF supplemental file that contains all therapy services and their related prices. This supplemental file contains approximately a million records, and may be used as a resource to extract pricing data as needed. The data in the supplemental file is in the same format as the MPFS abstract file in exhibit 1, but the fields defining the fee and outpatient hospital indicators are not populated, instead they are space-filled.

The FI can contact the local carrier to obtain the price. When requesting the pricing data, it advises the carrier to provide the nonfacility fee from the MPFS. The MPFS supplemental file of physician fee schedule services is available for retrieval through CMS' Mainframe Telecommunications System. The FI is notified yearly of the file retrieval names and dates by a program memorandum or other communication.

100.3 - Proper Reporting of Code G0128 by CORFs - FIs

(Rev. 1, 10-01-03)

A3-3653

Code G0128 was created for use by CORFs to report nursing services provided to beneficiaries as part of their plan of care but not bundled into other services billed to the beneficiary (either by the CORF or by a physician or other practitioner associated with the CORF). The definition of this code is as follows:

- Direct (face-to-face with the patient) skilled nursing services of a registered nurse provided in a comprehensive outpatient rehabilitation facility, each 10 minutes beyond the first 5 minutes.

Thus, code G0128 is used to bill for services that are specified in the beneficiary's plan of care that are not part of other services. Examples of services that cannot be billed under code G0128 are:

1. If a nurse participates in a physician service, e.g., taking the history or reviewing medication as part of an evaluation and management visit (HCPCS codes 99201 - 99275) or as part of a service during the global surgical period, assisting in a procedure, teaching the patient regarding a procedure or treatment suggested during the physician or other practitioner visit, providing information to the patient about consequences or complications of a treatment, or responding to telephone calls resulting from the physician visit, then the nursing services are part of the physician visit and cannot be separately billed by the CORF.
2. If a nurse takes vital signs (pulse, blood pressure, weight, respiratory rate) associated with a physician or therapy visit, this time cannot be billed using G0128.
3. If a wound dressing is required after a debridement (HCPCS codes 11040 - 11044) or whirlpool treatment (HCPCS code 97601) and the nurse dresses the wound, the payment for the dressing change is included in the code for debridement or whirlpool and cannot be separately billed under code G0128.
4. Collecting a laboratory specimen, including phlebotomy.

Co-treatment by a nurse with a physical or occupational therapist or speech and language pathologist is not generally separately reimbursed unless a separate nursing service is clearly identifiable in the plan of care and in the documentation.

The definition of skilled services is that it generally requires the skill of a registered nurse to perform the service. Some examples include procedures such as insertion of a urinary catheter, intramuscular injections, bowel disimpaction, nursing assessment, and education. Education, for example, would include teaching a patient proper technique for in-and-out urethral catheterization, skin care for decubitus ulcer, and care/teaching of a colostomy.

Administrative tasks or documentation should not be billed under code G0128.

100.4 - Application of the Outpatient Mental Health Treatment Limitation to CORF Claims

(Rev. 1, 10-01-03)

A3-3653

Section §1833 of the Act payment requires that payment be made at 62.5 percent of the allowed amount for CORF mental health treatment services. The allowed amount is the lower of the MPFS amount or billed charges. Therefore, the FI makes payment at 62.5 percent of 80 percent of the allowed amount (or in effect 50 percent) for outpatient mental health treatment services. Hence, if the MPFS amount for a mental health treatment service provided in a CORF is \$100, this amount is multiplied by 62.5 percent (the mental health treatment limitation). The resulting amount of \$62.50 is then

multiplied by 80 percent, which yields the Medicare payment of \$50. The remaining 20 percent or the balance of \$12.50, is the coinsurance responsibility of the beneficiary. The FI reports the amount in excess of the mental health limitation amount, \$37.50, in the provider remittance advice with group code PR and claim adjustment reason code 122, Psychiatric reduction. This limitation may not be included in the coinsurance amount.

Unmet deductible must be subtracted from the allowed amount met before applying the 62.5 percent.

100.5 - Off-Site CORF Services

(Rev. 1, 10-01-03)

CORF-403.D

CORFs may provide physical, speech and occupational therapy off the CORF's premises in addition to the home evaluation. Services provided offsite are billed separately and identified as "offsite" on the Form CMS-1450 (UB-92), in FL 84, Remarks. The charges for offsite visits include any additional charge for providing the services at a place other than the CORF premises. There is no change in the payment method for offsite services.

100.6 - Notifying Patient of Service Denial

(Rev. 1, 10-01-03)

CORF-410, PM A-01-77

Services may be noncovered because they are statutorily excluded from coverage under Medicare, or because they are not medically reasonable and necessary.

If a service is excluded by statute, the CORF may submit a claim for them to Medicare to obtain a denial prior to billing another insurance carrier. It shows the charges as noncovered (FL 48 on the Form CMS-1450 (UB-92)), and includes Condition Code 21 in FL 24-30). It may bill the beneficiary for the excluded services, and need not issue an advance beneficiary notice (ABN). However, when providing therapy services under the financial limitations, the CORF should provide the beneficiary with the Notice of Exclusion of Medicare Benefits (NEMB). The Medicare Claims Processing Manual, Chapter 30, "Limitation on Liability," discusses ABNs for FI processed claims for Part B services.

If, after reviewing the plan of care, the CORF determines that the services to be furnished to the patient are not medically reasonable or necessary, it immediately provides the beneficiary with an ABN. If the patient signs an ABN, the Form CMS-1450 includes occurrence code 32 "Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)" (FL 32-36) along with the date the ABN was signed.

If the beneficiary insists that a claim be submitted for payment, the CORF must indicate on the bill (billed separately from bills with covered charges) that it is being submitted at the beneficiary's request. This is done by using condition code 20.

If during the course of the patient's treatment the FI advises the CORF that covered care has ceased, the CORF must notify the beneficiary (or the beneficiary's representative) immediately.

100.7 - Payment of Drugs, Biologicals, and Supplies in a CORF

(Rev. 1, 10-01-03)

A3-3653

Drugs

Drugs and biologicals do not apply in an OPT setting. Therefore, FIs are to advise their OPTs not to bill for them.

Supplies

OPTs should not bill for the supplies they furnish. Since supplies are part of the practice expense, under the MPFS these expenses are already taken into account in the practice expense relative values.

Vaccines

OPTs should not be providing influenza, pneumococcal pneumonia, and Hepatitis B vaccines and their administration.

100.8 - Billing for DME, Prosthetic and Orthotic Devices, and Surgical Dressings

(Rev. 1, 10-01-03)

CORF-412

The CORFs bill DME on Form CMS-1500 to the DMERC except for claims for implanted DME, which are billed on Form CMS-1500 to the local carrier. If the CORF does not have a supplier billing number from the National Supplier Clearinghouse (NSC), it may contact the NSC to secure one. If the local carrier has issued the CORF a provider number for billing physician services, the CORF may not use the same number when billing for DME.

The CORFs bill the FI for prosthetic/orthotic devices and surgical dressings on Form CMS-1450. Form completion requirements are contained in Chapter 25100.9 - Surgical Dressings

If the CORF supplies the surgical dressings for its patients, it bills using revenue code 0623 “Surgical Dressings.” The appropriate HCPCS code for the dressing is reported.

The FI makes payment based on the surgical dressing fee schedule.

100.10 - Group Therapy Services (Code 97150)

(Rev. 1, 10-01-03)

CR 2225, A3-1872 Dated 1-24-03, A3-3653, B3-15302-15304

Carriers pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services. The individuals can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.

100.10.1 - Therapy Students

(Rev. 1, 10-01-03)

A. General

Only the services of the therapist can be billed and paid under Medicare Part B. The services performed by a student are not reimbursed even if provided under “line of sight” supervision of the therapist; however, the presence of the student “in the room” does not make the service unbillable. Pay for the direct (one-to-one) patient contact services of the physician or therapist provided to Medicare Part B patients. Group therapy services performed by a therapist or physician may be billed when a student is also present “in the room”.

EXAMPLES:

Therapists may bill and be paid for the provision of services in the following scenarios:

- The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.

- The qualified practitioner is responsible for the services and as such, signs all documentation. (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician's service, not for the student's services).

B. Therapy Assistants as Clinical Instructors

Physical therapist assistants and occupational therapy assistants are not precluded from serving as clinical instructors (CIs) for therapy students, while providing services within their scope of work and performed under the direction and supervision of a licensed physical or occupational therapist to a Medicare beneficiary.

C. Services Provided Under Part A and Part B

The payment methodologies for Part A and B therapy services rendered by a student are different. Under the MPFS (Medicare Part B), Medicare pays for services provided by physicians and practitioners that are specifically authorized by statute. Students do not meet the definition of practitioners under Medicare Part B. Under SNF PPS, payments are based upon the case mix or RUG category that describes the patient. In the rehabilitation groups, the number of therapy minutes delivered to the patient determines the RUG category. Payment levels for each category are based upon the costs of caring for patients in each group rather than providing specific payment for each therapy service as is done in Medicare Part B.

Exhibit 1 - Physician Fee Schedule Abstract File

(Rev. 515, Issued: 04-01-05, Effective: 01-03-05, Implementation: 07-05-05)

This file contains nonfacility fee schedule payment amounts for the outpatient rehabilitation, and CORF HCPCS codes listed in §20. These codes are identified in the abstract file by a value of "R" in the fee indicator field. The file includes fee schedule payment amounts by locality and is available via the CMS Mainframe Telecommunications System (formerly referred to as the Network Data Mover).

Record Length: 60
Record Format: FB
Block size: 6000
Character Code: EBCDIC
Sort Sequence: Carrier, Locality HCPCS Code, Modifier

Data Element Name	COBOL Location	Picture	Value
1 – HCPCS	1-5	X(05)	
2 – Modifier	6-7	X(02)	
3 – Filler	8-9	X(02)	
4 -- Non-Facility Fee	10-16	9(05)V99	
5 – Filler	17-23	X(07)	
6 – Filler	24-30	X(07)	
7 -- Carrier Number	31-35	X(05)	
8 – Locality	36-37	X(02)	Identical to the radiology/diagnostic fees
9 – Filler	38-40	X(03)	
10 -- Fee Indicator	41-41	X(1)	"R" - Rehab/Audiology/CORF services
11 -- Outpatient Hospital indicator	42-42	X(1)	"0" - Fee applicable in hospital outpatient setting "1" - Fee not applicable in hospital outpatient setting
12 – Filler	43-60	X(18)	

Upon CMS notification, the contractor is responsible for retrieving this file and making payment based on 80 percent of the lower of the actual charge or fee schedule amount indicated on the file after the Part B deductible has been met. The CMS will notify contractors of updates to the MPFS, file names and when the updated files will be available for retrieval. Upon retrieval, contractors disseminate the fee schedules to their providers. The file is also available on the CMS Web site in the Public Use Files (PUF) area.