



Medicare Critical Access Hospital Version

KEY CONCEPTS OUTLINE

Module 8: Special Billing and Payment Topics for Outpatient Surgery and Therapy Services

- I. Special Rules for Reporting Surgery Procedures
 - A. More information will be provided in Module 10 on the difference between Method I (standard method) and Method II (optional method) billing and reimbursement.
 - B. Multiple Outpatient Surgeries Performed in a Method I or Method II CAH
 1. A CAH is not subject to the OPPOS multiple procedure payment reduction for hospital outpatient services.
 - a. When multiple surgical procedures are performed during the same session, it is not necessary to bill separate charges for each procedure. A CAH can bill a single charge under the revenue code that describes where the procedure was performed (e.g., operating room, treatment room, etc.) with one of the surgical HCPCS codes. <Medicare Claims Processing Manual, Chapter 4, § 180.2>
 - b. For a subsequent surgical procedure(s), if a charge has not been pre-determined (i.e., the charge is associated with a charge code in the charge description master), the CAH can bill using the appropriate HCPCS code(s) and the same revenue code as the first procedure with \$0.00 in the charge field.

Tip: Some hospital billing systems will not allow a \$0.00 charge. In this instance, it is appropriate to bill \$0.01 instead.

- C. Multiple Outpatient Surgeries Performed by Professionals in a Method II CAH
 1. A CAH paid under Method II may receive a reduced payment for multiple surgeries when reporting revenue codes 96X, 97X or 98X for services furnished by physicians and non-physician practitioners. This is referred to as the "multiple procedure payment reduction" (MPPR). <See Medicare Claims Processing Manual, Chapter 4 § 250.15>

- a. For the purposes of Medicare payment, multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient during the same operative session or on the same date of service.
2. When the same physician performs more than one surgical service during the same session, Medicare pays for multiple surgeries by ranking them from the highest Medicare Physician Fee Schedule (MPFS) amount to the lowest MPFS amount. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.15>
 - a. The reimbursement will be 100% of the allowed amount for the surgical code with the highest amount listed in the MPFS.
 - b. The reimbursement for the subsequent surgical code(s) will be 50% of the allowed amount listed in the MPFS. <*Medicare Claims Processing Manual*, Chapter 12, § 40.6>
 - i. When HCPCS codes are reported with revenue codes 96X, 97X or 98X, modifier -51 (multiple procedures) is not required for reporting the additional procedures to initiate the payment reduction.

The beneficiary's deductible and coinsurance are based on the actual amount paid under MPFS for each surgical code.

- ii. In rare cases, modifier -22 (increased procedural services) can bypass the MPPR when applied to services billed under revenue codes 096X, 097X or 098X; however, its use may initiate a medical review. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.15>
- D. Global Surgery for Procedures Performed by Professionals in a Method II CAH
1. A CAH paid under Method II may receive a reduced payment for global surgical procedures when reporting revenue codes 96X, 97X or 98X for services furnished by physicians and non-physician practitioners. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.17>
 - a. The global surgical package includes all necessary services normally furnished by a surgeon before, during, and after a procedure. Medicare payment for the surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty. <See *Medicare One-Time Notification Transmittal 2096*>
 - i. Providers in a Method II CAH should follow the same guidelines as Part B physician services that are available in the *Medicare Claims Processing Manual*, Chapter 12 § 40.

- ii. MACs will allow E/M services rendered during the global period when submitted with modifier -24 (unrelated) or modifier -25 (significant/separately identifiable), when appropriate.

II. Terminated or Discontinued Procedures

A. Termination of Procedures When Anesthesia is Planned or Provided

1. The term "anesthesia" includes local anesthesia, regional blocks, conscious sedation, deep sedation and general anesthesia for purposes of reporting terminated procedures. < *Medicare Claims Processing Manual*, Chapter 4 § 20.6.4(A)>
 - a. "Procedural pre-medication" is not considered anesthesia for purposes of reporting terminated procedures. < *Medicare Claims Processing Manual*, Chapter 4 § 20.6.4(A)>
2. Three possible scenarios
 - a. Termination prior to the patient being prepped and taken to the procedure room.
 - i. The procedure is not reported at all. < *Medicare Claims Processing Manual*, Chapter 4 § 20.6.4(C)>
 - b. Termination after the patient has been prepped and taken to the procedure room but before anesthesia was provided.
 - i. Under these circumstances, the terminated procedure is reported with modifier -73. < *Medicare Claims Processing Manual*, Chapter 4 § 20.6.4(B)>
 - a) This modifier was created so that the costs incurred by the hospital to prepare the patient for the procedure and the resources expended in the procedure room and recovery room, if needed, could be recognized for payment even though the procedure was discontinued.
 - b) Under OPPS, the intended procedure reported with modifier -73 will be paid at 50% of its usual APC payment rate. < *Medicare Claims Processing Manual*, Chapter 4 § 20.6.4(B), 42 *CFR* § 419.44(b)(2)>

c) In a CAH, payment for outpatient services is made at 101% of its reasonable costs for providing services to its patients as determined under the applicable principles of cost reimbursement. Modifier -73 will not automatically initiate a payment reduction. <SSA § 1861(v)(1)(A); 42 CFR 413.70; 42 CFR 413.9(a)>

1) Pre-determined charges (i.e., charge description master) for procedures that are discontinued and reported with modifier -73 should be reduced to reflect the decrease in the actual cost of the services.

CAUTION: *The patient's deductible and coinsurance will be based on the reduced charge for the procedure reported with modifier -73.*

- c. Termination after anesthesia induction or after the procedure has begun (e.g., incision made, intubation started, scope inserted).
- i. Under these circumstances, the terminated procedure is reported with modifier -74. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4(A)>
- a) This modifier was created so that the costs incurred by the hospital to initiate the procedure, including preparation of the patient, the procedure room, and recovery room, could be recognized for payment even though the procedure was discontinued prior to its completion.
- b) Under OPPS, the intended procedure reported with modifier -74 will be paid at 100% of its usual APC payment rate. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4(B), 42 CFR § 419.44(b)(1)>
- c) In a CAH, payment for outpatient services is made at 101% of its reasonable costs for providing services to its patients as determined under the applicable principles of cost reimbursement. Modifier -74 will not affect payment. <SSA § 1861(v)(1)(A), 42 CFR 413.70, 42 CFR 413.9(a)>

CAUTION: *In this scenario, if pre-determined charges are reduced when reported with modifier -74, the patient's deductible and coinsurance will be based on the reduced charge for the procedure.*

3. Limitations on the use of modifiers -73 and -74

- a. Modifiers -73 and -74 are used when a procedure requiring anesthesia was terminated due to extenuating circumstances or circumstances that

threaten the well-being of the patient. < *Medicare Claims Processing Manual*, Chapter 4 § 20.6.4(A)>

- i. Modifier -74 may also be used if a procedure is discontinued, reduced or cancelled at the physician's discretion after induction of anesthesia. < *Medicare Claims Processing Manual*, Chapter 4 § 20.6.4(A)>
- b. Modifiers -73 and -74 are only to be used with discontinued surgical and diagnostic procedures (i.e., colonoscopy) when anesthesia was planned or provided. < *Medicare Claims Processing Manual*, Chapter 4 § 20.6.4(A)>
 - i. CAHs that elect Method II must use modifier -53 to identify an incomplete diagnostic or screening colonoscopy billed with revenue code 096X, 097X, or 098X. Medicare will pay for the discontinued colonoscopy at a rate that is half the value of the completed codes. <See *Medicare Claims Processing Manual* Transmittal 4153>
 - ii. Modifiers -73 and -74 should not be used to indicate discontinued radiology procedures or the discontinuation of other procedures when anesthesia administration was not planned. < *Medicare Claims Processing Manual*, Chapter 4 § 20.6.4(A)>

Case Study 1

Facts: A patient presented to the hospital outpatient surgery department for surgical repair of an initial reducible inguinal hernia (49505). The procedure was cancelled due to a scheduling conflict after the patient had been prepped and escorted to the pre-op holding area.

- How should the hernia repair be billed to Medicare? How will Medicare pay for the procedure?

Modified Facts: A CAH had determined the average price of a hernia repair (49505) to be \$5,000. A charge code for the surgery was created and the charge is selected by the surgical coordinator. The hernia repair was cancelled due to an unexpected drop in the patient's vital signs after the patient had been taken to the procedure room but before induction of anesthesia.

- How should the hernia repair be billed to Medicare?

B. Termination of Procedures When Anesthesia is not Planned

1. Modifier -52 should be reported if the patient is prepared and taken to the room where the procedure was to be performed and the procedure was discontinued. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4 (B)>
 - a. Modifier -52 is also used to report procedures, especially radiology procedures, when the service described by a code is not performed in its entirety and no code exists for the services that were provided. <Medicare Claims Processing Manual, Chapter 4 § 20.6.6>
 - i. Under OPSS, the intended procedure reported with modifier -52 will be paid at 50% of its usual APC payment rate, when applicable. <Medicare Claims Processing Manual, Chapter 4 § 20.6.4(B), 42 CFR § 419.44(b)(3)>
 - ii. In a CAH, payment for outpatient services is made at 101% of its reasonable costs for providing services to its patients as determined under the applicable principles of cost reimbursement and modifier -52 will not automatically initiate a payment reduction. <SSA § 1861(v)(1)(A), 42 CFR 413.70, 42 CFR 413.9(a)>
 - a) Pre-determined charges (i.e., charge description master) for procedures that are discontinued and reported with modifier -52 should be reduced to reflect the decrease in the actual cost of the services.

CAUTION: The patient's deductible and coinsurance will be based on the reduced charge for the procedure reported with modifier -52.

III. Bilateral Procedures

- A. Bilateral procedures may be reported with inherently bilateral or conditional bilateral HCPCS codes.
 1. When an inherently bilateral procedure code is performed more than once in a day, the procedure may be reported on a separate line with modifier -76 on the subsequent procedure(s). <Medicare Claims Processing Manual Transmittal 1702>

Inherently bilateral HCPCS codes refer to a single code that describes the procedure performed bilaterally (i.e., bilateral diagnostic mammography).

2. Conditional bilateral codes have a "1" in the "bilateral surgery" field in the Medicare Physician Fee Schedule. <See Handout 11 - *IOCE Specifications*, Section 5.2.1; see *MLN Matters SE1422*>

Conditionally bilateral HCPCS codes refer to a code that is inherently unilateral and should be reported with a modifier to indicate it was performed bilaterally.

- a. Procedures, with a code that is conditionally bilateral, performed bilaterally, should be reported as a single line item with modifier -50 and a unit of "1." <*Medicare Claims Processing Manual*, Chapter 4 §§ 20.6, 20.6.2>

Link: Physician Fee Schedule – Online Lookup under Medicare-Related Sites – Physician/Practitioner

- b. If a bilateral procedure is billed with a modifier -50 and units greater than 1, IOCE edit 74 may cause the claim to be returned to the provider (RTP). <See Handout 11 - *IOCE Specifications*, 6.2 *Edit Descriptions and Reason for Edit Generation Table*, *Edit 74*>
- i. When billing under Method II for physicians and non-physician practitioners, edit 74 will be applied separately to revenue codes 096X, 097X, or 098X. The claim will be returned to the provider (RTP) when modifier -50 and a service unit greater than 1 is reported. <*Medicare Claims Processing Manual*, Chapter 4 § 250.11>
- a) Professional services billed with revenue codes 096X, 097X or 098X should not use modifiers -RT and -LT when modifier -50 is appropriate so that the discounting logic can be appropriately applied. <*Medicare Claims Processing Manual*, Chapter 4 § 250.11>
- 1) Payment will be made based on the usual payment policy indicator adjustment under the MPFS and then multiplied by 115% for the Method II payment adjustment.
- a. Payment for a bilateral procedure with a payment policy indicator of '1' and modifier -50 is based on the lesser of the actual charges or 150% for the MPFS allowed amount.

- b. Payment for a bilateral procedure with a payment policy indicator of '3' and modifier -50 is based on the lesser of the actual charges or 100% of the MPFS allowed amount for *each* side of the body (200%).

CAUTION: *The patient's deductible and coinsurance will be based on the reduced MPFS payment amount, where applicable.*

Case Study 2

Facts: A patient presented to the CAH for a bilateral 3-view knee x-ray (73562). The radiologist has reassigned his benefits to the CAH under Method II billing. Under the MPFS, the payment policy indicator for 73562 is a '3'. The MPFS amount is \$9.55.

- How should the knee x-rays be billed by the facility?
- How will Medicare pay for the facility services?
- How should the knee x-rays be billed by the radiologist?
- How will Medicare pay for the professional services?

IV. Inpatient-Only Procedures

A. Definition of an Inpatient-Only Procedure

1. An inpatient-only procedure is a procedure that CMS has determined may only be safely performed on an inpatient basis. CMS has determined certain procedures are not appropriate to be provided in a hospital outpatient department and designates them "inpatient only" procedures. <Medicare Claims Processing Manual, Chapter 4 § 180.7>

Note: In the CY2021 OPPS Final Rule, CMS adopted a policy to eliminate the inpatient-only list over a period of three years, with 298 procedures removed in CY2021. In the CY2022 OPPS Final Rule, CMS reversed the policy to eliminate the inpatient-only list and returned 294 procedures to the inpatient-only list. Procedures remaining off the inpatient only list for CY2022 are:

22630 – lumbar arthrodesis

23472 – total shoulder arthroplasty

27702 – total ankle arthroplasty

01638 – anesthesia, shoulder replacement

01486 – anesthesia, ankle replacement

Also added in CY2022: 0643T transcatheter left ventricular restoration device implant

2. Inpatient-only procedures have an OPPS status indicator of C on Addendum B. The complete list of inpatient-only procedures is also published in Addendum E to the OPPS Final Rule every year. <Medicare Claims Processing Manual, Chapter 4 § 180.7>

Link: OPPS – Regulations and Notices under Medicare-Related Sites – Hospital

B. Special Consideration for CAHs

1. The IOCE edits for inpatient-only procedures do not apply outpatient surgeries performed in a CAH. <See Handout 11 - IOCE Specifications, 6.2 Edit Descriptions and Reason for Edit Generation Table, Edits 18 and 49>
 - a. Although the edits do not apply, a CAH should seek clarification from their MAC regarding the application of the definition of an inpatient-only procedure in their facilities.
 - b. CMS continues its long-standing recognition that the decision to admit a patient as an inpatient is a complex medical decision, based on the physician's clinical expectation of how long hospital care is anticipated to be necessary, and should consider the individual beneficiary's unique clinical circumstances. <MLN Matters SE19002; MLN Matters MM10080>

V. Outpatient Physical Therapy (PT), Occupational Therapy (OT) and Speech Language Pathology (SLP)

- A. Therapy services performed by a qualified therapist under a therapy plan of care are billed under specific therapy revenue codes and modifiers. < *Medicare Claims Processing Manual*, Chapter 5 § 20.1 >

Therapy revenue codes and modifiers:

- *Physical Therapy – 042X, -GP*
- *Occupational Therapy – 043X, -GO*
- *Speech Therapy and Language Pathology – 044X, -GN*

- B. Therapy services are billed with two types of CPT/HCPCS codes. < *Medicare Claims Processing Manual*, Chapter 5 § 20.2 B, C; *Medicare Claims Process Manual Transmittal 3654* >

CPT code descriptors for PT and OT evaluative procedures (97161-97168) include specific components that are required for reporting, as well as the corresponding typical face-to-face times for each service.

1. Codes that describe a service or procedure not defined by specific time increments (e.g., evaluation codes) and are billed with a unit of one.
2. Codes that describe a service or procedure defined by specific time increments (i.e., 15 minutes), all face-to-face time with the patient in a single day is rounded to the nearest 15-minute increment, subject to the guidelines in the *Medicare Claims Processing Manual*, Chapter 5.
 - a. At least 8 minutes must be provided to report one unit of service.
 - 1) If less than 8 minutes is provided of more than one type of service, the provider may sum the minutes and if the sum is at least 8 minutes, the provider may report one unit of the service performed for the most minutes. < *Medicare Claims Processing Manual*, Chapter 5 § 20.2 B, C >

For example, if one service is provided for 24 minutes, the provider may round to 30 minutes and report 2 units. If a second service is performed on the same day for 26 minutes, the provider may not report an additional 2 units because the total treatment time was 50 minutes which would round to 45 minutes or 3 units. Therefore, the provider must only report 3 units of service, reporting two units for the services with the most minutes.

- b. When more than one service is performed in a single day, the total number of minutes of service determines the maximum number of units billed. <Medicare Claims Processing Manual, Chapter 5 § 20.2 B, C>

C. Payment for Therapy Services

1. Therapy services provided by a CAH are paid 101% of their reasonable costs, rather than the MPFS. <Medicare Claims Processing Manual, Chapter 5 § 10>
2. Although a CAH is paid for therapy services based on costs reported on their individual cost report, the multiple procedure payment reduction (MPPR) is standardized across all therapy providers based on what Medicare would have paid under the MPFS. <See Medicare Claims Processing Manual Transmittal 2859>
 - a. Therapy services paid to hospitals under the MPFS are subject to a multiple procedure reduction when more than one therapy service or multiple units of the same therapy service are billed on the same date of service. <One Time Notice Transmittal 1194>

D. Therapy Services Provided by Therapy Assistants

1. Most providers of outpatient therapy services are subject to the following reporting and payment rules when therapy services are provided by therapy assistants. <83 Fed. Reg. 59659-660>
 - a. Effective January 1, 2020, a modifier is reported on therapy provided at least "in part" by a therapy assistant. Initially, therapy was considered provided "in part" by a therapy assistant if more than 10% of the service was provided by a therapy assistant. <83 Fed. Reg. 59659-660>
 - i. Modifier -CQ - outpatient physical therapy services furnished in whole or in part by a physical therapist assistant; and,
 - ii. Modifier -CO - outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant.
 - b. For CY2022, CMS clarified that the 8 minute or "mid-point" rule continues to apply to certain situations where a therapist provides at least 8 minutes of therapy and would be able to report the code without taking into account the therapy provided by the assistant. <86 Fed. Reg. 65169-177>
2. Effective January 1, 2022, a 15% reduction will be applied to therapy services provided in part by a therapy assistant (reported with modifier -CQ or -CO)

and paid under MPFS) for which a therapist did not provide at least 8 minutes of therapy. <83 Fed. Reg. 59659-660; 86 Fed. Reg. 65169-177>

3. Because a CAH is paid based on reasonable costs for outpatient therapy services, neither the reporting requirements nor payment reductions associated with reporting therapy assistant modifiers will apply. <83 Fed. Reg. 59659-660>

F. Modifier -KX Therapy Threshold

1. Therapy services are subject to an annual dollar limitation unless the provider includes modifier -KX denoting the therapy is medically necessary as appropriately documented in the medical record. <Medicare Claims Processing Manual, Chapter 5 § 10.3 B, Bipartisan Budget Act of 2018, Section 50202; 83 Fed. Reg. 59654>
 - a. When therapy exceeds the annual dollar limit or threshold, but the therapy is medically necessary and this is documented in the patient's medical records, the provider should append modifier -KX to all applicable lines. <Medicare Claims Processing Manual, Chapter 5 § 10.3 D, Bipartisan Budget Act of 2018, Section 50202>
2. For CY2023, there is one threshold or limit for physical therapy and speech-language pathology services combined (\$2,230) and a separate threshold for occupational therapy services (\$2,230). <Medicare Claims Processing Manual Transmittal 4419>

G. Manual Review of Therapy

1. For CYs 2018-2028, therapy services that exceed \$3,000 for physical therapy and speech-language pathology combined or \$3,000 for occupational therapy and meet criteria for potential for overpayments (e.g., high denial rate, aberrant billing patterns, or a new provider) are subject to manual review. <Bipartisan Budget Act of 2018; 83 Fed. Reg. 59654>

VI. "Sometimes" and "Always" Therapy Codes

- A. Annually, CMS publishes a list of therapy codes that are identified as "sometimes" therapy or "always" therapy services. <Medicare Claims Processing Manual, Chapter 4 § 200.9>

1. Sometimes therapy

- a. When "sometimes" therapy services are provided under a therapy plan of care, one of the therapy revenue codes and the therapy modifiers must be reported. <Medicare Claims Processing Manual, Chapter 4 § 200.9>

- b. When “sometimes” therapy services are provided outside a plan of care by nursing staff they are reported under the appropriate revenue code without a therapy modifier.
 - i. “Sometimes” therapy services provided outside a plan of care and paid under cost are subject to the incident to coverage requirements, including supervision, discussed in the outpatient coverage module. <77 Fed. Reg. 68424-425>
2. Always therapy
- a. “Always” therapy describes therapy services that will always require reporting modifiers -GP, -GO, or -GN, regardless of who performs the service. <Medicare Claims Processing Manual, Chapter 4 § 200.9>

Link: Therapy Code List under Medicare Related Sites – General

Version 03/03/2023
Check for Updates

CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: A patient presented to the hospital outpatient surgery department for surgical repair of an initial reducible inguinal hernia (49505). The procedure was cancelled due to a scheduling conflict after the patient had been prepped and escorted to the pre-op holding area.

- How should the hernia repair be billed to Medicare? How will Medicare pay for the procedure?

Analysis: The hernia repair should not be billed to Medicare because the procedure was cancelled for a reason unrelated to the patient's condition. Medicare will not pay for the procedure.

Modified Facts: A CAH had determined the average price of a hernia repair (49505) to be \$5,000. A charge code for the surgery was created and the charge is selected by the surgical coordinator. The hernia repair was cancelled due to an unexpected drop in the patient's vital signs after the patient had been taken to the procedure room but before induction of anesthesia.

- How should the hernia repair be billed to Medicare?

Analysis: The hernia repair code should be billed to Medicare with modifier -73; however, Medicare will not automatically discount the payment for the procedure. The CAH should decrease the charge prior to billing. The patient's deductible and coinsurance would be based on the reduced charge.

Case Study 2

Facts: A patient presented to the CAH for a bilateral 3-view knee x-ray (73562). The radiologist has reassigned his benefits to the CAH under Method II billing. Under the MPFS, the payment policy indicator for 73562 is a '3'. The MPFS amount is \$9.55.

- How should the knee x-rays be billed by the facility?
- How will Medicare pay for the facility services?

- How should the knee x-rays be billed by the radiologist?
- How will Medicare pay for the professional services?

Analysis:

The facility could bill the technical component (TC) with either:

- 73562-LT and 73562-RT, both lines would have a unit of 1
- 73562-50, unit of 1
- In either case, the CAH would be paid 101% of its costs (discussed in more detail later)

The radiologist would bill the professional component (PC/-26):

- 73562-50, unit of 1
- The MPFS indicator is set to 3 so the physician would get 100% of MPFS for each x-ray. In this case the payment would be \$19.10.

Version 03/03/2023
Check for Updates

Under Section 1834(g)(2)(B) of the Act, outpatient professional services performed in a Method II CAH are paid 115 percent of such amounts as would otherwise be paid under the Act if the services were not included in the outpatient CAH services.

Section 1833 (a)(1)(F) of the Act stipulates that payment for services performed by a LCSW shall be 80 percent of the lesser of the actual charges for the services or 75 percent of the amount determined for the payment of a psychologist.

Payment is calculated as follows:

((Facility specific MPFS amount times the LCSW reduction (75%)) minus (deductible and coinsurance)) times 115%.

250.15 – Coding and Payment of Multiple Surgeries Performed in a Method II CAH

(Rev. 2333, Issued: 10-28-11, Effective: 04-01-12, Implementation: 04-02-12)

Multiple surgeries rendered by a physician that has reassigned their billing rights to a Method II CAH are payable by Medicare when the procedures are eligible and billed on type of bill 85x with revenue code (RC) 096x, 097x and/or 098x.

Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.

Medicare pays for multiple surgeries by ranking from the highest MPFS amount to the lowest MPFS amount. When the same physician performs more than one surgical service at the same session, the allowed amount is 100% for the surgical code with the highest MPFS amount. The allowed amount for the subsequent surgical codes is based on 50% of the MPFS amount. In addition, special endoscopic pricing rules are applied prior to the multiple surgery rules, if applicable. CAH Method II providers may review the multiple surgery and special endoscopic pricing rules in Pub. 100-04, Chapter 12, Section 40.6. In addition, section 40.6.D addresses rare situations where the above payment rules may be bypassed using modifier 22. Providers shall be aware that CAH claims billed with Modifier 22 may be subject to medical review.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3578	Date: August 5, 2016	Change Request: 9647
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SUBJECT: Multiple Procedure Payment Reduction (MPPR) on the Professional Component (PC) of Certain Diagnostic Imaging Procedures

EFFECTIVE DATE: January 1, 2017

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

IMPLEMENTATION DATE: January 3, 2017

I. GENERAL INFORMATION

A. Background: Medicare currently applies a multiple procedure payment reduction (MPPR) of 25 percent to the professional component (PC) of certain diagnostic imaging procedures. The reduction applies to PC only services, and the PC portion of global services, for the procedures with a multiple surgery value of '4' in the Medicare Fee Schedule database (MPFSDB).

B. Policy: We currently make full payment for the PC of the highest priced procedure and payment at 75 percent for the PC of each additional procedure, when furnished by the same physician (or physician in the same group practice) to the same patient, in the same session on the same day.

Section 502(a)(2) of the Consolidated Appropriations Act of 2016 revised the MPPR for the PC of the second and subsequent procedures from 25 percent to 5 percent of the physician fee schedule amount. The MPPR on the technical component (TC) of imaging remains at 50 percent.

The current payment, and payment as of January 1, 2017, are summarized in the attached example.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility									
		A/B MAC		D M E	Shared- System Maintainers				Other		
		A	B		H H H	M A C	F I S S	M C S		V M S	C W F
9647.1	For services furnished on or after dates of service January 1, 2017, contractors shall pay 95 percent of the fee schedule amount for the PC of each additional procedure furnished by the same physician (or physician in the same group practice) to the same patient, in the same session on the same day.	X	X			X					
9647.2	Contractors shall change the reduction value to 5 percent for multiple procedure indicator 4 in field 21 of the MPFSDB and apply the 5 percent reduction to the PC of services performed on or after January 1, 2017.		X			X					

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 2096	Date: June 22, 2018	Change Request: 10425
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Transmittal 2013, dated January 26, 2018, is being rescinded and replaced by Transmittal 2096, dated, June 22, 2018 to remove the terminated HCPCS codes from business requirement 10425.2.1. All other information remains the same.

SUBJECT: Global Surgical Days for Critical Access Hospital (CAH) Method II

EFFECTIVE DATE: July 1, 2018

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

IMPLEMENTATION DATE: July 2, 2018

I. GENERAL INFORMATION

A. Background: This Change Request (CR) is for the global surgical periods for Critical Access Hospital (CAH) Method II providers to mirror the logic historically applied to physicians and non-physician practitioners that bill their own services to the Multi-Carrier System (MCS).

Physicians and non-physician practitioners billing on Type of Bill (TOB) 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (using revenue codes 96X, 97X, or 98X) based on the Medicare Physician Fee Schedule (MPFS) supplemental file.

The global surgical package, also called global surgery, includes all necessary services normally furnished by a surgeon before, during, and after a procedure. Medicare payment for the surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty.

Position 13-15 of the MPFSDB provides the postoperative periods that apply to each surgical procedure. The payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and, sometimes, YYY.

This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

000 = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.

010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.

090 = Major surgery with a (one) 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.

XXX = Global concept does not apply.

YYY = A/B Medicare Administrative Contractor (MAC) (Part A) determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

Codes with "YYY" are A/B MAC (Part B)-priced codes, for which A/B MACs (Part B) determine the global period (the global period for these codes will be 0, 10, or 90 days). Note that not all A/B MAC (Part B)-priced codes have a "YYY" global surgical indicator; sometimes the global period is specified.

CAH Method II providers need to follow the same guidelines as Part B physician services that are available in Pub. 100-04, Chapter 12, Section 40. See Chapter 23 of Pub. 100-04, section 50.6 for the record layout of the Payment Policy Indicator file.

B. Policy: This CR contains no new policy. It improves the implementation of existing Medicare payment policies.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility									
		A/B MAC			D M E	Shared-System Maintainers				Other	
		A	B	H H H		F M V C	M C M S	V M S	C W F		
10425.1	Contractors shall recognize claims with Current Procedural Terminology (CPT) codes that have a global period of 0, 10 or 90 on the MPFS file labeled global surgery for the following: Type of bill (TOB): 85x Revenue codes (REV): 96X, 97X and/or 98X.					X				X	
10425.2	Contractors shall create an overridable line level edit to assign when an incoming TOB 85X is received with Evaluation and Management (E/M) services equal to or within a global period of a surgical procedure claim in history that has the same rendering physician National Provider Identifier (NPI). Global Periods: 1. 0 – Same day as surgery 2. 10 – Same day as surgery plus 10 days after the surgery. (Example: Date of surgery – January 5, Last day of postoperative period – January 15) 3. 90 – Same day as the surgery plus 90 days after the surgery. (Example: Date of surgery – January 5, Last day of postoperative period April 5).					X				X	

Number	Requirement	Responsibility									
		A/B MAC			D M E M A C	Shared- System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
10425.3	The contractor shall create an Informational Unsolicited Response (IUR) when an incoming surgical claim with global periods is received and there is a TOB 85X, in history, with a covered E/M service (see BR 2.1) subject to a global period and does not contain a modifier of 24 or 25.									X	
10425.4	Upon receipt of the IUR, the Contractor shall perform an automated adjustment to the paid CAH outpatient (85x) E/M claim to recoup the applicable line level payment.					X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC			D M E M A C	C E D I		
		A	B	H H H				
10425.5	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X						

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4153	Date: October 26, 2018	Change Request: 10937
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SUBJECT: Incomplete Colonoscopies Billed with Modifier 53 for Critical Access Hospital (CAH) Method II Providers

EFFECTIVE DATE: April 1, 2019

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

IMPLEMENTATION DATE: April 1, 2019

I. GENERAL INFORMATION

A. Background: Physicians and non-physician practitioners billing on type of bill (TOB) 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (revenue code (REV) 96X, 97X, or 98X) based on the Medicare Physician Fee Schedule (MPFS) supplemental file.

Prior to calendar year (CY) 2015, according to Current Procedural Terminology (CPT) instruction, an incomplete colonoscopy was defined as a colonoscopy that did not evaluate the colon past the splenic flexure (the distal third of the colon). Physicians were previously instructed to report an incomplete colonoscopy with 45378 and append modifier 53 (discontinued procedure), which is paid at the same rate as a sigmoidoscopy.

In CY 2015, the CPT instruction changed the definition of an incomplete colonoscopy to a colonoscopy that does not evaluate the entire colon. The 2015 CPT Manual states, "When performing a diagnostic or screening endoscopic procedure on a patient who is scheduled and prepared for a total colonoscopy, if the physician is unable to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances, report 45378 (colonoscopy) or 44388 (colonoscopy through stoma) with modifier 53 and provide appropriate documentation." Therefore, in accordance with the change in CPT Manual language, the Centers for Medicare & Medicaid Services (CMS) has applied specific values in the Medicare physician fee schedule for the following codes: 44388-53, 45378-53, G0105-53, and G0121-53.

The Medicare physician fee schedule will have specific values for codes 44388-53, 45378-53, G0105-53, and G0121-53. Given that the new CPT definition of an incomplete colonoscopy also includes colonoscopies where the colonoscope is advanced past the splenic flexure but not to the cecum, CMS has established new values for incomplete diagnostic and screening colonoscopies performed on or after January 1, 2016. Incomplete colonoscopies are reported with the 53 modifier. Medicare will pay for the interrupted colonoscopy at a rate that is calculated using one-half the value of the inputs for the codes.

In situations where a CAH has elected payment Method II for CAH patients, payment shall be consistent with payment methodologies currently in place as outlined in PUB. 100-04, chapter 12, section 30.1 and chapter 18, section 60.2. As such, instruct CAHs that elect Method II payment to use modifier "53" to identify an incomplete screening colonoscopy (physician professional service(s) billed in revenue code (096X, 097X, and/or 098X). Such CAHs will also bill the technical or facility component of the interrupted colonoscopy in revenue code 075X (or other appropriate revenue code) using the "-73" or "-74" modifier as appropriate.

B. Policy: N/A

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility									
		A/B MAC			D M E M A C	Shared- System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
10937.1	Contractors shall apply the incomplete colonoscopies MPFS rate amount when billed with the following: TOB: 85x (CAH Method II) REV: 096x, 097x or 098x HCPCS: 44388, 45378, G0105 or G0121 Modifier: 53	X				X					
10937.2	FISS shall apply the CAH Method II payment methodology. (Based on the lesser of the actual charge or the MPFS for modifier 53. Minus deductible and coinsurance *115 %.) TOB: 85x (CAH Method II) REV codes: 096x, 097x or 098x HCPCS codes: 44388, 45378, G0105 or G0121 Modifier: 53.					X					
10937.3	Contractors shall use the following claim adjustment reason code on the remittance advice notice for service lines for which they have applied the Incomplete Colonoscopies payment methodologies. 59 - Processed based on multiple or concurrent procedure rules. (For example, multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	X				X					
10937.4	Contractors shall use the group code "CO" contractual obligation, on the remittance advice notices when the incomplete colonoscopies payment methodologies are applied.	X				X					
10937.5	Contractors shall use the following message on the Medicare Summary Notice for claims for which MPFS methodology was applied.	X				X					

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared- System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	30.1 The approved amount is based on a special payment method. OR 30.1 La cantidad aprobada está basada en un método especial de pago.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
10937.6	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X				

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

Medicare Claims Processing Manual

Chapter 04 – Part B Hospital (Including Inpatient Hospital part B and OPPS)

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(Rev.4153, Issued: 10-26-18)

Transmittals for Chapter 04

250.18 - Incomplete Colonoscopies (Codes 44388, 45378, G0105 and G0121)

Version 03/03/2023
Check for Updates

250.18 Incomplete Colonoscopies (Codes 44388, 45378, G0105 and G0121)**(Rev. 4153, Issued: 10-26-18, Effective: 04-01-19, Implementation: 04-01-19)**

An incomplete colonoscopy, e.g., the inability to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances, is billed and paid using colonoscopy through stoma code 44388, colonoscopy code 45378, and screening colonoscopy codes G0105 and G0121 with modifier “-53.” (Code 44388 is valid with modifier 53 beginning January 1, 2016.) The Medicare physician fee schedule database has specific values for codes 44388-53, 45378-53, G0105-53 and G0121-53. An incomplete colonoscopy performed prior to January 1, 2016, is paid at the same rate as a sigmoidoscopy. Beginning January 1, 2016, Medicare will pay for the interrupted colonoscopy at a rate that is calculated using one-half the value of the inputs for the codes.

As such, instruct CAHs that elect Method II payment to use modifier “-53” to identify an incomplete screening colonoscopy (physician professional service(s) billed in revenue code 096X, 097X, and/or 098X).

CAH Method II shall be consistent with the guidelines outlined in PUB. 100-04, chapter 12, section 30.1 and chapter 18, section 60.2.

Version 03/03/2023
Check for Updates

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



MLN Matters® Number: SE1422 **Revised** Related Change Request (CR) #: N/A

Article Release Date: January 17, 2018 Effective Date: N/A

Related CR Transmittal #: N/A Implementation Date: N/A

Medically Unlikely Edits (MUE) and Bilateral Surgical Procedures

Note: This article was revised with more details and examples and was re-issued on January 17, 2018. Providers who perform bilateral surgical procedures should review the entire article.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for all Medicare Fee-For-Service (FFS) physicians, non-physician practitioners, providers, and other health care professionals who bill Medicare Administrative Contractors (MACs) for bilateral surgical procedures for Medicare beneficiaries using the Physician Fee Schedule (PFS).

Provider Action Needed

The purpose of this article is to inform providers that Medically Unlikely Edits (MUEs) may render certain claim lines for bilateral surgical procedures unpayable. Providers and suppliers billing using the PFS are reminded that Medicare billing instructions require claims for certain bilateral surgical procedures to be filed using a -50 modifier and One Unit of Service (UOS).

Make sure your billing staffs examine their process for filing claims for bilateral surgical procedures and services to ensure the -50 modifier is used in accordance with Medicare correct coding and claims submission instructions.

Background

Healthcare Common Procedure Coding System (HCPCS) coding for bilateral surgical procedures differs from CPT coding guidelines.

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Coding claims for surgical procedures performed bilaterally depends on:

- The HCPCS code descriptor,
- The “Bilateral Indicator” assigned to the HCPCS code (that is, whether special payment rules apply), and
- The nature of the service.

The “National Correct Coding Initiative (NCCI)” manual specifies that modifier -50 is used to report bilateral surgical procedures as a single UOS. The NCCI manual warns that MUE edits based on established CMS policies may limit units of service and are predicated on the assumption that claims are coded in accordance with these Medicare instructions. Consequently, many bilateral procedures have an MUE value of 1.

Bilateral indicators only apply to the Physician Fee Schedule (PFS) and not to other Medicare payment systems.

Bilateral Indicators

Bilateral Indicator	What Does this Bilateral Indicator Mean?
0	<p>No bilateral payment adjustment 150% payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides and (b) 100% of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is \$125. The physician reports code XXXXX-LT with an actual charge of \$100 and XXXXX-RT with an actual charge of \$100. Payment should be based on the fee schedule amount (\$125) since it is lower than the total actual charges for the left and right sides (\$200). The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.</p>
1	<p>150% Bilateral payment adjustment 150% payment adjustment for bilateral procedures applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), base the payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules.</p>

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Bilateral Indicator	What Does this Bilateral Indicator Mean?
2	<p>Bilateral procedure 150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for both sides on the lower of (a) the total actual charge by the physician for both sides, or (b) 100% of the fee schedule for a single code. Example: The fee schedule amount for code YYYYYY is \$125. The physician reports code YYYYYY-LT with an actual charge of \$100 and YYYYYY-RT with an actual charge of \$100. Payment should be based on the fee schedule amount (\$125) since it is lower than the total actual charges for the left and right sides (\$200). The RVUs are based on a bilateral procedure because (a) the code descriptor specifically states that the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or (c) the procedure is usually performed as a bilateral procedure.</p>
3	<p>No bilateral payment adjustment The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral surgeries.</p>

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Examples of Correct Coding for Bilateral Surgical Procedures for PFS

Bilateral Indicator	Expected Units of Service if performed bilaterally	Modifier based on Laterality	HCPCS code descriptor and <i>Explanation of Correct Coding</i>
1	1	50	23515 Open treatment of clavicular fracture, includes internal fixation, when performed. <i>The code descriptor does not identify this procedure as a bilateral procedure (or unilateral or bilateral), so when performed bilaterally at the same operative session physicians must report the procedure with modifier “-50” as a single line item using one UOS. Do not use modifiers RT and LT when modifier -50 applies.</i>
2	1		52290 Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral . <i>The code descriptor identifies this procedure as a unilateral or bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier “-50”.</i>
2	1		64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral ; by injections (includes imaging guidance, when performed). <i>The code descriptor identifies this procedure as a bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier “-50”.</i>

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Examples of Incorrect Coding for Bilateral Surgical Procedures for PFS

Bilateral Indicator	Expected Units of Service if performed bilaterally	Modifier based on Laterality	Second Modifier	HCPCS code descriptor and <i>Explanation of Incorrect Coding</i>
1	1	RT	LT	23515 Open treatment of clavicular fracture, includes internal fixation, when performed. <i>The code descriptor does not identify this procedure as a bilateral procedure (or unilateral or bilateral), so when performed bilaterally at the same operative session physicians must report the procedure with modifier “-50” as a single line item using one UOS. Do not use modifiers RT and LT when modifier -50 applies.</i>
2	1		LT	52290 Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral . <i>The code descriptor identifies this procedure as a unilateral or bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier “-50”. Do not report the procedure using two line items using RT and LT modifiers.</i>
2	1	RT		52290 Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral . <i>The code descriptor identifies this procedure as a unilateral or bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier “-50”. Do not report the procedure using two line items using RT and LT modifiers.</i>

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Bilateral Indicator	Expected Units of Service if performed bilaterally	Modifier based on Laterality	Second Modifier	HCPCS code descriptor and <i>Explanation of Incorrect Coding</i>
2	2			64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral ; by injections (includes imaging guidance, when performed). <i>The code descriptor identifies this procedure as a bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item. Do not report two UOS.</i>
2	1	50		64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral ; by injections (includes imaging guidance, when performed). <i>The code descriptor identifies this procedure as a bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item. Do not report the procedure with modifier “-50”.</i>

Request for Reopening of a Claim

For all MUE edit denials, including both MAI of 2 and 3, if the provider identifies a clerical error and the correct value is equal to or less than the MUE, the provider may request a reopening (i.e., a Clerical Error Reopening (CER)) to correct its billing of the claim as an alternative to filing a formal appeal. Providers can request a CER through their Medical Administrative Contractor. Providers are reminded this approach is allowable to redress underpayments resulting from unintentional errors, but it nonetheless delays full payment. For example, if the provider identifies a denial of a bilateral surgical service because it was billed with two UOS instead of being billed with one UOS and a -50 modifier, the provider may request a reopening to correct the coding/billing error, although providers should be aware that reopening requests do not extend the window for filing appeals. More importantly, though, the provider should bring his billing into compliance with CMS instructions, using one UOS and the -50 modifier to avoid future denials and delays in payment.

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Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net-work-MLN/MLNMattersArticles/index.html> under - How Does It Work.

You may also want to review the following publications:

- For information on Clerical Error Reopenings (CERs) consult the Claims Processing Manual Pub. 100-04 Chapter 34 and work with your Medicare Administrative Contractor
- For information on MUE Adjudication Indicators (MAIs) review the Revised Modification to the Medically Unlikely Edit (MUE) Program available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8853.pdf>
- For information on Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS) consult the Claims Processing Manual Pub. 100-04 Chapter 4 Section 20.6 - Use of Modifiers
- A podcast transcript on the MUEs at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/2015-05-21-Medically-Unlikely-Edits-Compliant-PodcastTranscript.pdf>.
- MLN Matters article MM6526 “Payment of Bilateral Procedures in a Method II Critical Access Hospital (CAH)” at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6526.pdf>.

Document History

Date of Change	Description
January 17, 2018	This article was revised with more details and examples and was re-issued.
June 30, 2014	Initial article released.

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Attachment - Business Requirements

Pub. 100-04	Transmittal: 2859	Date: January 17, 2014	Change Request: 8426
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SUBJECT: Applying the Therapy Caps to Critical Access Hospitals

EFFECTIVE DATE: January 1, 2014

IMPLEMENTATION DATE: January 31, 2014

I. GENERAL INFORMATION

A. Background: Section 4541(c) of the Balanced Budget Act of 1997 amended section 1833(g) of the Act to create annual limits on per beneficiary incurred expenses on therapy services known as “therapy caps.” This provision expressly applies the therapy caps to outpatient therapy services described under section 1861(p) of the Act, which also applies to therapy services described under sections 1861(g) and 1861(l)(2) of the Act, and exempts outpatient therapy services described under section 1833(a)(8)(B) of the Act, which is known as the “outpatient hospital services exemption.” When the therapy caps were implemented in CY 1999, CMS interpreted the outpatient hospital services exemption to include therapy services furnished by a critical access hospital (CAH).

The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) temporarily removed the outpatient hospital services exemption from October 1, 2012 through December 31, 2012. CMS concluded that the MCTRJCA amendment only affected the outpatient hospital services described under section 1833(a)(8)(B) of the Act for which payment is made under section 1834(k)(1)(B) of the Act.

The American Taxpayer Relief Act of 2012 (ATRA) removed the outpatient hospital services exemption through December 31, 2013. The ATRA also amended the Act to count outpatient therapy services furnished between January 1, 2013 and December 31, 2013 by a CAH towards a beneficiary’s annual cap and threshold using the amount that would be payable if such services were paid under section 1834(k)(1)(B) of the Act instead of being paid under section 1834(g) of the Act. The ATRA amendment specifically does not change the method of payment for outpatient therapy services furnished by a CAH. CMS concluded that the ATRA amendment does not explicitly make the therapy caps applicable to services furnished by CAHs, but provides a methodology to count CAH services towards the caps using the Medicare Physician Fee Schedule rate. As a result, from October 1, 2012 to December 31, 2013, CAH services continued to be exempt from the therapy caps, whereas services furnished in outpatient hospital settings are subject to the cap policies.

In August 2012, CMS issued Change Request 7881, which created a mechanism to allow Medicare Administrative Contractors (MACs) both to count CAH services towards the cap amounts and to apply the caps to services furnished by CAHs, if necessary. In order to ensure that CAH services counted towards the cap amounts without being subject to the cap policy, CMS issued subsequent instructions for MACs to automatically apply the KX modifier to CAH services found to be over the caps, effective January 1, 2013.

B. Policy: This policy applies the therapy caps to therapy services furnished by a CAH as required by modifications to the regulation at §410.59 and §410.60. Beginning January 1, 2014, outpatient therapy services furnished by a CAH are subject to the therapy cap and related policies. If extended without modification the exceptions process, including the use of the KX modifier to attest the medical necessity of therapy services above the caps, will apply to services furnished by a CAH in CY 2014. If extended without modification the manual medical review of claims in excess of the \$3,700 threshold will apply to services furnished by a CAH in CY 2014. Accordingly, the requirements below instruct the MACs to no longer automatically apply the KX modifier to CAH services, effective January 1, 2014.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
8426.1	Medicare contractors shall update the legislation effective screen for legislation effective indicator B so that the effective through date is 12/31/2015.	X								
8426.2	Medicare contractors shall ensure that if a claim with type of bill 12x and a CAH provider number, or type of bill 85x receives one of the therapy cap edits from CWF, the contractor automatically places a KX modifier on the identified claim lines only if the dates of service are between January 1, 2013 and December 31, 2013.	X								
8426.3	Medicare contractors shall ensure that if a claim with type of bill 12x and a CAH provider number, or type of bill 85x is rejected by CWF due to the \$3,700 threshold, the contractor automatically applies the CWF override code only if the dates of service are between January 1, 2013 and December 31, 2013.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
8426.4	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in	X				

Number	Requirement	Responsibility				
		A/B MAC			D M E	C E D I
		A	B	H H H	M A C	
	billing and administering the Medicare program correctly.					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
8426.2 & 8426.3	These requirements revise the conditions of Expert Claims Processing System (ECPS) events created by previous instructions.

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

V. CONTACTS

Pre-Implementation Contact(s): Simone Dennis, Simone.Dennis@cms.hhs.gov (Policy Contact) , Wil Gehne, Wilfried.Gehne@cms.hhs.gov (Institutional Claims Contact)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

10.3 - Application of Financial Limitations

(Rev. 2859, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-31-14)

(Additions, deletions or changes to the therapy code list are updated via a Recurring Update Notification)

Financial limitations on outpatient therapy services, as described above, began for therapy services rendered on or after on January 1, 2006. References and policies relevant to the exceptions process in this chapter apply only when exceptions to therapy caps are in effect. For dates of service before October 1, 2012, limits apply to outpatient Part B therapy services furnished in all settings except outpatient hospitals, including hospital emergency departments. These excluded hospital services are reported on *types of bill* 12x or 13x, or 85x. Effective for dates of service on or after October 1, 2012, the limits also apply to outpatient Part B therapy services furnished in outpatient hospitals other than Critical Access Hospitals. During this period, only *type of bill* 12x claims with a CMS certification number in the *Critical Access Hospital* range and *type of bill* 85x claims are excluded. *Effective for dates of service on or after January 1, 2014, the limits also apply to Critical Access Hospitals.*

Contractors apply the financial limitations to the MPFS amount (or the amount charged if it is smaller) for therapy services for each beneficiary.

As with any Medicare payment, beneficiaries pay the coinsurance (20 percent) and any deductible that may apply. Medicare will pay the remaining 80 percent of the limit after the deductible is met. These amounts will change each calendar year.

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.

A. Exceptions to Therapy Caps - General

The following policies concerning exceptions to caps due to medical necessity apply only when the exceptions process is in effect. With the exception of the use of the KX modifier, the guidance in this section concerning medical necessity applies as well to services provided before caps are reached.

Provider and supplier information concerning exceptions is in this chapter and in Pub. 100-02, Chapter 15, section 220.3. Exceptions shall be identified by a modifier on the claim and supported by documentation.

The beneficiary may qualify for use of the cap exceptions at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps. All requests for exception are in the form of a KX modifier added to claim lines. (See subsection D. for use of the KX modifier.)

Use of the exception process does not exempt services from manual or other medical review processes as described in Pub. 100-08. Rather, atypical use of the automatic exception process may invite contractor scrutiny. Particular care should be taken to document improvement and avoid billing for services that do not meet the requirements for skilled services, or for services which are maintenance rather than rehabilitative treatment (see Pub. 100-02, Chapter 15, sections 220.2, 220.3, and 230).

The KX modifier, described in subsection D., is added to claim lines to indicate that the clinician attests that services are medically necessary and justification is documented in the medical record.

B. Exceptions Process

An exception may be made when the patient's condition is justified by documentation indicating that the beneficiary requires continued skilled therapy, i.e., therapy beyond the amount payable under the therapy cap, to achieve their prior functional status or maximum expected functional status within a reasonable amount of time.

No special documentation is submitted to the contractor for exceptions. The clinician is responsible for consulting guidance in the Medicare manuals and in the professional literature to determine if the beneficiary may qualify for the exception because documentation justifies medically necessary services above the caps. The clinician's opinion is not binding on the Medicare contractor who makes the final determination concerning whether the claim is payable.

Documentation justifying the services shall be submitted in response to any Additional Documentation Request (ADR) for claims that are selected for medical review. Follow the documentation requirements in Pub. 100-02, Chapter 15, section 220.3. If medical records are requested for review, clinicians may include, at their discretion, a summary that specifically addresses the justification for therapy cap exception.

In making a decision about whether to utilize the exception, clinicians shall consider, for example, whether services are appropriate to--

- The patient's condition, including the diagnosis, complexities, and severity;
- The services provided, including their type, frequency, and duration; and
- The interaction of current active conditions and complexities that directly and significantly influence the treatment such that it causes services to exceed caps.

In addition, the following should be considered before using the exception process:

1. Exceptions for Evaluation Services

Evaluation-- The CMS will except therapy evaluations from caps after the therapy caps are reached when evaluation is necessary, e.g., to determine if the current status of the beneficiary requires therapy services. For example, the following CPT codes for evaluation procedures may be appropriate:

92521, 92522, 92523, 92524, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004.

These codes will continue to be reported as outpatient therapy procedures as listed in the Annual Therapy Update for the current year at:

http://www.cms.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage.

They are not diagnostic tests. Definitions of evaluations and documentation are found in Pub. 100-02, sections 220 and 230.

Other Services-- There are a number of sources that suggest the amount of certain services that may be typical, either per service, per episode, per condition, or per discipline. For example, see the CSC - Therapy Cap Report, 3/21/2008, and CSC - Therapy Edits Tables 4/14/2008 at www.cms.hhs.gov/TherapyServices (Studies and Reports), or more recent utilization reports. Professional literature and guidelines from professional associations also provide a basis on which to estimate whether the type, frequency, and intensity of services are appropriate to an individual. Clinicians and contractors should utilize available evidence related to the patient's condition to justify provision of medically necessary services to individual beneficiaries, especially when they exceed caps. Contractors shall not limit medically necessary services that are justified by scientific research applicable to the beneficiary. Neither contractors nor clinicians shall utilize professional literature and scientific reports to justify payment for continued services after an individual's goals have been met earlier than is typical. Conversely, professional literature and scientific

reports shall not be used as justification to deny payment to patients whose needs are greater than is typical or when the patient's condition is not represented by the literature.

2. Exceptions for Medically Necessary Services

Clinicians may utilize the process for exception for any diagnosis or condition for which they can justify services exceeding the cap. Regardless of the diagnosis or condition, the patient must also meet other requirements for coverage.

Bill the most relevant diagnosis-- As always, when billing for therapy services, the ICD-9 code that best relates to the reason for the treatment shall be on the claim, unless there is a compelling reason to report another diagnosis code. For example, when a patient with diabetes is being treated with therapy for gait training due to amputation, the preferred diagnosis is abnormality of gait (which characterizes the treatment). Where it is possible in accordance with State and local laws and the contractors' local coverage determinations, avoid using vague or general diagnoses. When a claim includes several types of services, or where the physician/NPP must supply the diagnosis, it may not be possible to use the most relevant therapy diagnosis code in the primary position. In that case, the relevant diagnosis code should, if possible, be on the claim in another position.

Codes representing the medical condition that caused the treatment are used when there is no code representing the treatment. Complicating conditions are preferably used in non-primary positions on the claim and are billed in the primary position only in the rare circumstance that there is no more relevant code.

The condition or complexity that caused treatment to exceed caps must be related to the therapy goals and must either be the condition that is being treated or a complexity that directly and significantly impacts the rate of recovery of the condition being treated such that it is appropriate to exceed the caps. Documentation for an exception should indicate how the complexity (or combination of complexities) directly and significantly affects treatment for a therapy condition.

If the contractor has determined that certain codes do not characterize patients who require medically necessary services, providers/suppliers may not use those codes, but must utilize a billable diagnosis code allowed by their contractor to describe the patient's condition. Contractors shall not apply therapy caps to services based on the patient's condition, but only on the medical necessity of the service for the condition. If a service would be payable before the cap is reached and is still medically necessary after the cap is reached, that service is excepted.

Contact your contractor for interpretation if you are not sure that a service is applicable for exception.

It is very important to recognize that most conditions 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. 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.

In justifying exceptions for therapy caps, clinicians and contractors should not only consider the medical diagnoses and medical complications that might directly and significantly influence the amount of treatment required. Other variables (such as the availability of a caregiver at home) that affect appropriate treatment shall also be considered. Factors that influence the need for treatment should be supportable by published research, clinical guidelines from professional sources, and/or clinical or common sense. See Pub. 100-02, Chapter 15, section 220.3 for information related to documentation of the evaluation, and section 220.2 on medical necessity for some factors that complicate treatment.

NOTE: The patient's lack of access to outpatient hospital therapy services alone, when outpatient hospital therapy services are excluded from the limitation, does not justify excepted services. 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 hospitals in the beneficiary's county may or may not qualify as justification for continued services above the caps. The patient's condition and complexities might justify extended services, but their location does not. For dates of service on or after October 1, 2012, therapy services furnished in an outpatient hospital are not excluded from the limitation.

C. Appeals Related to Disapproval of Cap Exceptions

Disapproval of Exception from Caps-- 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. Contractors may review claims with KX modifiers to determine whether the services are medically necessary, or for other reasons. Services that exceed therapy caps but do not meet Medicare criteria for medically necessary services are not payable even when clinicians recommend and furnish these services.

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 Pub. 100-04, Chapter 1, section 60.4 for appropriate use of modifiers.

APPEALS –If a beneficiary whose excepted services do not meet the Medicare criteria for medical necessity elects to receive such services and a claim is submitted for such services, the resulting determination would be subject to the administrative appeals process. Further details concerning appeals are found in Pub. 100-04, Chapter 29.

D. Use of the KX Modifier for Therapy Cap Exceptions

When exceptions are in effect and the beneficiary qualifies for a therapy cap exception, the provider shall add a KX modifier to the therapy HCPCS code subject to the cap limits. The KX modifier shall not be added to any line of service that is not a medically necessary service; this applies to services that, according to a local coverage determination by the contractor, are not medically necessary services.

The codes subject to the therapy cap tracking requirements for a given calendar year are listed at: http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage.

The GN, GO, or GP therapy modifiers are currently required to be appended to therapy services. In addition to the KX modifier, the GN, GP and GO modifiers shall continue to be used. Providers may report the modifiers on claims in any order. If there is insufficient room on a claim line for multiple modifiers, additional modifiers may be reported in the remarks field. Follow the routine procedure for placing HCPCS modifiers on a claim as described below.

- For professional claims, sent to the carrier or A/B MAC, refer to:
 - Medicare Claims Processing Manual, Pub.100-04, Chapter 26, for more detail regarding completing the CMS-Form 1500 claim form, including the placement of HCPCS modifiers. **NOTE:** The CMS-Form 1500 currently has space for providing two modifiers in block 24D, but, if the provider has more than two to report, he/she can do so by placing the -99 modifier (which indicates multiple modifiers) in block 24D and placing the additional modifiers in block 19.
 - The ASC X12N 837 Health Care Claim: Professional Implementation Guide for more detail regarding how to electronically submit a health care claim transaction, including the placement of HCPCS modifiers. The ASC X12N 837 implementation guides are the standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for submitting health care claims electronically. The 837 professional transaction currently permits the placement of up to four modifiers, in the 2400 loop, SV1 segment, and

data elements SV101-3, SV101-4, SV101-5, and SV101-6. Copies of the ASC X12N 837 implementation guides may be obtained from the Washington Publishing Company.

- For claims paid by a carrier or A/B MAC, it is only appropriate to append the KX modifier to a service that reasonably may exceed the cap. Use of the KX modifier when there is no indication that the cap is likely to be exceeded is abusive. For example, use of the KX modifier for low cost services early in an episode when there is no evidence of a previous episode that might have exceeded the cap is inappropriate.
- For institutional claims, sent to the FI or A/B MAC:
 - When the cap is exceeded by at least one line on the claim, use the KX modifier on all of the lines on that institutional claim that refer to the same therapy cap (PT/SLP or OT), regardless of whether the other services exceed the cap. For example, if one PT service line exceeds the cap, use the KX modifier on all the PT and SLP service lines (also identified with the GP or GN modifier) for that claim. When the PT/SLP cap is exceeded by PT services, the SLP lines on the claim may meet the requirements for an exception due to the complexity of two episodes of service.
 - Use the KX modifier on either all or none of the SLP lines on the claim, as appropriate. In contrast, if all the OT lines on the claim are below the cap, do not use the KX modifier on any of the OT lines, even when the KX modifier is appropriately used on all of the PT lines. Refer to Medicare Claims Processing Manual, Pub.100-04, Chapter 25, for more detail.

By appending the KX modifier, the provider is attesting that the services billed:

- Are reasonable and necessary services that require the skills of a therapist; (See Pub. 100-02, Chapter 15, section 220.2); and
- Are justified by appropriate documentation in the medical record, (See Pub. 100-02, Chapter 15, section 220.3); and
- Qualify for an exception using the automatic process exception.

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 appended to a therapy HCPCS code, the contractor will override the CWF system reject for services that exceed the caps and pay the claim if it is otherwise payable.

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

If a claim is submitted without KX modifiers and the cap is exceeded, those services will be denied. In cases where appending the KX modifier would have been appropriate, contractors may reopen and/or adjust the claim, if it is brought to their attention.

Services billed after the cap has been exceeded which are not eligible for exceptions may be billed for the purpose of obtaining a denial using condition code 21.

E. Therapy Cap Manual Review Threshold

For calendar year 2012, there shall be two total therapy service thresholds of \$3700 per year: one annual threshold each for

- (1) Occupational therapy services.
- (2) Physical therapy services and speech-language pathology services combined.

Services shall accrue toward the thresholds beginning with claims with dates of service on and after January 1, 2012. The thresholds shall apply to both services showing the KX modifier and those without the modifier. Beginning with claims with dates of service on and after October 1, 2012, contractors shall apply the thresholds to claims exceeding it by suspending the claim for manual review. Instructions regarding the manual review process may be found in the Program Integrity Manual.

F. Identifying the Certifying Physician

Therapy plans of care must be certified by a physician or non-physician practitioner (NPP), per the requirements in the Medicare Benefit Policy Manual, Pub.100-02, Chapter 15, section 220.1.3. Further, the National Provider Identifier (NPI) of the certifying physician/NPP identified for a therapy plan of care must be included on the therapy claim.

For the purposes of processing professional claims, the certifying physician/NPP is considered a referring provider. At the time the certifying physician/NPP is identified for a therapy plan of care, private practice therapists (PPTs), physicians or NPPs, as appropriate, submitting therapy claims, are to treat it as if a referral has occurred for purposes of completing the claim and to follow the instructions in the appropriate ASC X12 837 Professional Health Care Claim Technical Report 3 (TR3) for reporting a referring provider (for paper claims, they are to follow the instructions for identifying referring providers per Chapter 26 of this IOM) . These instructions include requirements for reporting NPIs.

Currently, in the 5010 version of the ASC X12 837 Professional Health Care Claim TR3, referring providers are first reported at the claim level; additional referring providers are reported at the line level only when they are different from that identified at the claim level. Therefore, there will be at least one referring provider identified at the claim level on the ASC X12 837 Professional claim for therapy services. However, because of the hierarchical nature of the ASC X12 837 health care claim transaction, and the possibility of other types of referrals applying to the claim, the number of referring providers identified on a professional claim may vary. For example, on a claim where one physician/NPP has certified all the therapy plans of care, and there are no other referrals, there would be only one referring provider identified at the claim level and none at the line levels. Conversely, on a claim also containing a non-therapy referral made by a different physician/NPP than the one certifying the therapy plan of care, the billing provider may elect to identify either the nontherapy or the therapy referral at the claim level, with the other referral(s) at the line levels. Similarly, on a claim having different certifying physician/NPPs for different therapy plans of care, only one of these physician/NPPs will be identified at the claim level, with the remainder identified at the line levels. These scenarios are only examples: there may be other patterns of representing referring providers at the claim and line levels depending upon the circumstances of the care and the manner in which the provider applies the requirements of the ASC X12 837 Professional Health Care Claim TR3.

For situations where the physician/NPP is both the certifier of the plan of care and furnishes the therapy service, he/she supplies his/her own information, including the NPI, in the appropriate referring provider loop (or, appropriate block on the 1500 form). This is applicable to those therapy services that are personally furnished by the physician/NPP as well as to those services that are furnished incident to their own and delivered by “qualified personnel” (see section 230.5 of this manual for qualifications for incident to personnel).

Contractors shall edit to ensure that there is at least one claim-level referring provider identified on professional therapy claims, and shall use the presence of the therapy modifiers (GN, GP, GO) to identify those claims subject to this requirement.

For the purposes of processing institutional claims, the certifying physician/NPP and their NPI are reported in the Attending Provider fields on institutional claim formats. Since the physician/NPP is certifying the

therapy plan of care for the services on the claim, this is consistent with the National Uniform Billing Committee definition of the Attending Provider as “the individual who has overall responsibility for the patient’s medical care and treatment” that is reported on the claim. In cases where a patient is receiving care under more than one therapy plan of care (OT, PT, or SLP) with different certifying physicians/NPPs, the second certifying physicians/NPP and their NPI are reported in the Referring Physician fields on institutional claim formats.

G. MSN Messages

Existing MSN messages 38.18, 17.13, 17.18 and 17.19 shall be issued on all claims containing outpatient rehabilitation services as noted in this manual. Contractors add the applied amount for individual beneficiaries and the generic limit amount to all MSNs that require them. For details of these MSNs, see: http://www.cms.gov/MSN/02_MSN%20Messages.asp

10.4 - Claims Processing Requirements for Financial Limitations

(Rev. 2859, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-31-14)

A. Requirements – Institutional Claims

Regardless of financial limits on therapy services, CMS requires modifiers (See section 20.1 of this chapter) on specific codes for the purpose of data analysis. Beneficiaries may not be simultaneously covered by Medicare as an outpatient of a hospital and as a patient in another facility. When outpatient hospital therapy services are excluded from the limitation, the beneficiary must be discharged from the other setting and registered as a hospital outpatient in order to receive payment for outpatient rehabilitation services in a hospital outpatient setting after the limitation has been reached.

A hospital may bill for services of a facility as hospital outpatient services if that facility meets the requirements of a department of the provider (hospital) under 42 CFR 413.65. Facilities that do not meet those requirements are not considered to be part of the hospital and may not bill under the hospital’s provider number, even if they are owned by the hospital. For example, services of a Comprehensive Outpatient Rehabilitation Facility (CORF) must be billed as CORF services and not as hospital outpatient services, even if the CORF is owned by the hospital.

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

For SNFs, the financial limitation does apply to rehabilitation services furnished to those SNF residents in noncovered stays (bill type 22X) who are in a Medicare-certified section of the facility—i.e., one that is either certified by Medicare alone, or is dually certified by Medicare as a SNF and by Medicaid as a nursing facility (NF). For SNF residents, consolidated billing requires all outpatient rehabilitation services be billed to Part B by the SNF. If a resident has reached the financial limitation, and remains in the Medicare-certified section of the SNF, no further payment will be made to the SNF or any other entity. Therefore, SNF residents who are subject to consolidated billing may not obtain services from an outpatient hospital after the cap has been exceeded.

Once the financial limitation has been reached, services furnished to SNF residents who are in a non-Medicare certified section of the facility—i.e., one that is certified only by Medicaid as a NF or that is not certified at all by either program—use bill type 23X. For SNF residents in non-Medicare certified portions of the facility and SNF nonresidents who go to the SNF for outpatient treatment (bill type 23X), medically necessary outpatient therapy may be covered at an outpatient hospital facility after the financial limitation has been exceeded when outpatient hospital therapy services are excluded from the limitation.

B. Requirements - Professional Claims

Claims containing any of the “always therapy” codes should have one of the therapy modifiers appended (GN, GO, GP). When any code on the list of therapy codes is submitted with specialty codes “65” (physical therapist in private practice), “67” (occupational therapist in private practice), or “15” (speech-language pathologist in private practice) they always represent therapy services, because they are provided by therapists. Contractors shall return claims for these services when they do not contain therapy modifiers for the applicable HCPCS codes.

The CMS identifies certain codes listed at:

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

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

C. Contractor Action Based on CWF Trailer

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

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

EXAMPLE:

Services received to date are \$15 under the limit. There is a \$15 allowed amount remaining that Medicare will cover before the cap is reached.

Incoming claim: Line 1 MPFS allowed amount is \$50.
 Line 2 MPFS allowed amount is \$25.
 Line 3, MPFS allowed amount is \$30.

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

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

Once the limit is reached, if a claim is submitted, CWF returns an error code stating the financial limitation has been met. Over applied lines will be identified at the line level. The outpatient rehabilitation therapy services that exceed the limit should be denied. The contractors use claim adjustment reason code 119 - Benefit maximum for this time period or occurrence has been reached- in the provider remittance advice to

establish the reason for denial. Provider liability (group code CO) or beneficiary liability (group code PR) are reported on the remittance advice as defined by section 10.5.

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

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

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

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

10.6 - Functional Reporting

(Rev. 2859, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-31-14)

A. General

Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) amended Section 1833(g) of the Act to require a claims-based data collection system for outpatient therapy services, including physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services. 42 CFR 410.59, 410.60, 410.61, 410.62 and 410.105 implement this requirement. The system will collect data on beneficiary function during the course of therapy services in order to better understand beneficiary conditions, outcomes, and expenditures.

Beneficiary function information is reported using 42 nonpayable functional G-codes and seven severity/complexity modifiers on claims for PT, OT, and SLP services. Functional reporting on one functional limitation at a time is required periodically throughout an entire PT, OT, or SLP therapy episode of care.

The nonpayable G-codes and severity modifiers provide information about the beneficiary's functional status at the outset of the therapy episode of care, including projected goal status, at specified points during treatment, and at the time of discharge. These G-codes, along with the associated modifiers, are required at specified intervals on all claims for outpatient therapy services – not just those over the cap.

B. Application of New Coding Requirements

This functional data reporting and collection system is effective for therapy services with dates of service on and after January 1, 2013. A testing period will be in effect from January 1, 2013, until July 1, 2013, to allow providers and practitioners to use the new coding requirements to assure that systems work. Claims for therapy services furnished on and after July 1, 2013, that do not contain the required functional G-code/modifier information will be returned or rejected, as applicable.

