MediServe

More than 25 Years Serving the Rehab and Respiratory Communities
Who We Are

• Rehabilitation
  • Inpatient
  • Outpatient
  • Acute Care
  • Private Practice

• Respiratory

• CORE Focus (Compliance, Outcomes, Revenue, Efficiency)

• 250+ Clients

• Based in Chandler, Arizona
A Few of Our Rehab Clients
Outpatient Therapy Cap

Michael Stevenson, MBA, PT
Director, Product Management

Darlene D’Altorio-Jones, PT, MBA-HCM
Strategist, Rehabilitation Management
OBJECTIVES

- Review the impact of Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA)
- Understand the timelines and actions already taken by CMS
- Discuss how ‘outpatient caps’ can impact other lines of service
- Provide references for additional information
Extends therapy cap exceptions process through December 31, 2012

Adds therapy services provided in outpatient hospital settings other than Critical Access Hospitals (CAHs) to the therapy cap effective October 1, 2012

Requires National Provider Identifier (NPI) of physician certifying therapy plan of care on the claim

Addresses new thresholds for mandatory Manual Medical Review process (MMR)

Claims-based outcomes reporting starting Jan 1, 2013

Therapy Cap Overview

- **Annual Therapy Benefit**
  - Calendar year benefit
  - $1880 PT and SP combined
  - $1880 OT

- **Medicare Part B**
  - MC Reimbursed amounts + Co-pay + Deductible

- **Old Hat for Private Practice, others**

- **Starts Oct 1, 2012 for Hospital OP**
  - Outpatient Therapy Services except CAH

If you are seeing or the patient has been seen this year, money has been paid against both caps.
Automatic Exception

- When PT/SP or OT combined payment reaches $1880, a KX modifier must be applied to the claim so the claim is processed automatically.

- KX modifier implies 'reasonable and necessary services' and 'well documented'.

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 Pub.100-04, Medicare Claims Processing Manual, chapter 25, for more detail.

CMS Manual System

<table>
<thead>
<tr>
<th>CMS Manual System</th>
<th>Department of Health &amp; Human Services (DHHS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pub 100-04 Medicare Claims Processing</td>
<td>Centers for Medicare &amp; Medicaid Services (CMS)</td>
</tr>
<tr>
<td>Transmittal: 2457</td>
<td>Date: April 27, 2012</td>
</tr>
<tr>
<td>Change Request 7785</td>
<td></td>
</tr>
</tbody>
</table>

Starts Oct 1, 2012 for **ALL MEDICARE PART B THERAPY SERVICES** except Critical Access Hospitals

- Three Phases (Start Dates)
  - Letter from MAC in early September
  - Oct 1, Nov 1, Dec 1

**WARNING**
This is only MMR threshold ($3700), not when you start Therapy Cap ($1880.) Therapy Cap for Hospitals starts Oct 1.
Pre-Approval Threshold

- $3700 PT and SP combined
- $3700 OT
- All disciplines must apply separately for MMR exception
  - PT/SP get separate approvals
- Can apply for MMR 15 calendar days before Phase begins
- Up to 20 Treatment Days can be requested
- MAC gets 10 business day review period
  - Considered approved if no response in 10 business days
- 45 day pre-payment review of not pre-approved
Subject: Notification of Request for Exception Requirements for Therapy

Dear Therapy Provider:

Our records show that you’re a provider of physical therapy, speech-language pathology services, or occupational therapy. Beginning October 1, 2012, all Medicare Fee-For-Service therapy claims that combined exceed $3,700 will be subject to manual medical review. To implement this process, CMS has assigned providers to one of three specific phases.

You’re being assigned to Phase I, which starts on October 1, 2012 and runs until December 31, 2012.

Beginning on October 1, 2012, you must request an exception to the medical review for beneficiaries who will exceed $3,700 in therapy services. Any claim which hasn’t received an approved exception shall be subject to complex prepayment medical review. The Medicare contractor to whom you submit claims will have detailed information on its website about how to submit a request.

CMS has the authority to review any claim at any time. Please be sure that all services billed are medically necessary and properly documented. In addition, please explain the therapy limits to your Medicare patients. If you provide services after the $1,880 cap has been reached and they aren’t covered by Medicare, the beneficiary will be responsible for all of the costs for these services.

For more information on the Medicare Part B outpatient therapy caps and exceptions process, visit https://go.cms.gov/MedRev.
Largely MAC driven

Many MAC presentations this week (Thurs – Friday)

### CMS Manual System

<table>
<thead>
<tr>
<th>Pub 100-20 One-Time Notification</th>
<th>Centers for Medicare &amp; Medicaid Services (CMS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmittal 1117</td>
<td>Date: August 31, 2012</td>
</tr>
<tr>
<td></td>
<td>Change Request 8036</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8036.14</th>
<th>Contractors shall develop a methodology to identify preapproval requests that have been submitted for preapproval and match them to submitted claims for specific periods of time.</th>
</tr>
</thead>
<tbody>
<tr>
<td>8036.15</td>
<td>Contractors shall inform the provider of the tracking mechanism being used for preapproval requests (either approved or denied) and instructions on how to submit the claim and preapproval requests.</td>
</tr>
<tr>
<td>8036.16</td>
<td>When a claim is submitted, contractors shall check to see if the claim has been preapproved or denied. If the contractor can match the claim to a request for preapproval, the contractor shall either approve or deny the claim based on the outcome of the request for preapproval.</td>
</tr>
</tbody>
</table>
Pre-Approval Request Form

Request must include the following documentation (minimum):

- Evaluation and/or re-evaluation of the certified plan of care
- Certification or re-certification
- Clinician legibly signed progress notes
- Treatment encounter notes
- Justification as to medical necessity of services and treatment days being requested

Check your MAC requirements
Therapy Cap Exception Preapproval Request

Request form and documentation on page 2 must be submitted

Part A (facilities) Mail To: WPS Medicare
Attention: MR Department
3333 Farnam St., Suite 600
Omaha, NE 68131

J5-J8 Part B (practitioners) Mail To: WPS Medicare
Attention: MR Department
1717 West Broadway
Madison, WI 53713

Legacy Part B (practitioners) Mail To: WPS Medicare
Attention: MR Department
8120 Penn Ave. S, Suite 20
Bloomington, MN 55431

**WPS only accepts paper submissions mailed to the above addresses**

Beneficiary

HIC # ______________ Date of Birth _______________

Last Name ______________

First Name ______________ Middle Initial ______________

Documentation Required for Therapy Cap Exception:

- Justification for the extended treatment days
- Evaluation/Reevaluation form to include:
  - Physician order
  - Signed and dated certification by physician
  - Date of evaluation
  - Start of care date
  - Medical diagnosis & Treatment diagnosis
  - Onset date
  - Current level of function
  - Prior level of function
  - Plan of Care with long and short term goals
- Previous Therapy administered to include:
  - Date
  - Diagnosis for treatment
  - Modalities administered
  - Discharge summary if applicable
- Three months of recent progress reports and treatment notes detailing service provided for each date of service billed
- Grid reflecting service/HCPCS provided (if applicable)
- Actual minutes provided to support each timed service/HCPCS provided
- Signature and professional identification of personnel providing services
- Advance Beneficiary Notice (if applicable)

SLP: Number of treatment days requested ______________

Expected date range of services: ______________

Requestor Name: ______________

Date of submission: ______________

Phone # and Email address: ______________

Request notification of preapproval status by fax: □ Fax number: ______________

9/21/2012

http://www.wpsmedicare.com/

Don't miss out on important Medicare news! Visit us at http://www.wpsmedicare.com/lisserv to sign up for eNews, or enter your e-mail address here ________, and we'll sign you up.
From CGS:

The decision letter will include a TCE (therapy cap exception) identification number to be used to identify your claim when filed. To ensure proper processing of the claim for these services, insert the TCE identification number assigned to you in block 19 of the CMS 1500 claim form (comments fields/reserved field).
Note: If a provider is delivering outpatient therapy services over the $3700 annual thresholds on or after October 1, 2012 but has not phased-in, they should continue to append the KX HCPCS modifier to that therapy until they phase-in to the prior authorization process.
Penalties

- **Therapy Cap ($1880)**
  - Charges beyond $1880 without KX modifier will be denied. Normal process of re-submission.

- **Manual Medical Review ($3700)**
  - Failure to acquire pre-approval will result in a 45-day pre-payment review
Progressive Barriers to Access

$0-$1880
• Normal claims submission

$1880-$3700
• Automatic exemption
• Requires KX modifier for Medically Necessary Services

$3700+
• Manual Medical Record Review
• Phased in from Oct - Dec

**Liability notice sent to beneficiaries in September may scare off those in need.**
Liability notice sent to beneficiaries in September.

You will need to educate them or lose those who fear financial risk.

Dear Medicare Patient:

Our records show that Medicare has paid at least $1,700 for your therapy services so far this year. Medicare limits how much it pays for your medically necessary outpatient therapy services in one calendar year. These limits are called “therapy caps.” The therapy cap amounts for 2012 are:

- $1,880 for physical therapy (PT) and speech-language pathology (SLP) services combined
- $1,880 for occupational therapy (OT) services

Medicare will keep paying its share for your therapy services until the total amount paid reaches either one of the therapy cap limits. This total amount includes what Medicare paid and any amounts paid by you, like the deductible and coinsurance.

If your therapy services go over the $1,880 therapy cap limit, your therapist or doctor can ask for an exception. Even if your therapist or doctor asks for an exception, this isn’t a guarantee that you won’t have to pay for costs above the $1,880 therapy cap amounts. If Medicare decides, at any time (even after your therapy services have been paid for), that your therapist or doctor didn’t show enough proof that your therapy services were medically necessary, you may have to pay for the total cost of the services above the $1,880 therapy cap amounts. Talk to your therapist or doctor about any therapy services you’ll get for the rest of the year.

Where to get more information:

If you have questions about this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or, visit http://go.cms.gov/Medicare.
PreApproval Reviews over $3700

- **Phase I**: October - December
- **Phase II**: November - December
- **Phase III**: December

![MediServe Logo](MediServe Logo)
Therapy Cap / MMR Timeline

- **September**: $1700 Letters to Beneficiaries, MMR Letters to Providers, MAC Provider Education
- **October**: $1880 Capped Therapy Benefit, Apply for MMR, MMR Phase 1
- **November**: CMS updates HET with benefits beyond $1880, MMR Phase 2
- **December**: Congressional action required to extend therapy caps beyond December 31, 2012, MMR Phase 3
- **January**: $1880 Capped Therapy Benefit in effect for Hospital OP

$1880 Cap Related
MMR Related
Other Activities
Q: Will evaluations be covered if the patient is over the cap limit?

A: Source: Trailblazer

Exceptions for Evaluation Services
Evaluation
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 evaluation procedures may be appropriate:

The following is a list of evaluation codes: 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 97001, 97002, 97003 and 97004.

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

Documentation shall provide the complaint or condition that indicates why the evaluation was necessary. Documentation shall describe any complexities that directly and substantially impact the patient’s treatment.
Claims submitted late by previous providers

- 12 month submission window for claims
- *Ask patient about recent therapy services*

Inaccurate benefit reported

- HETs only reporting up to $1880 until Oct 1
- *Verify benefits throughout the episode*
- Conservative approach to MMR and Cap threshold
  - Do not globally apply KX modifiers by default for all charges. Likely to trigger an audit

Be aware of your own claims schedule
Claims Timeline Caution

October

Oct 1
CMS Updates Benefit Consumed to HET

Oct 5
Hospital Claims Submitted

Oct 7
Hospital Claims Posted to HET

Oct 15
Late Charges from another provider

Oct 7
Verify new benefit level.

November

Nov 1
CMS Updates Benefit Consumed to HET

Nov 5
Hospital Claims Submitted

Nov 7
Hospital Claims Posted to HET

Nov 7
Verify new benefit level.

October

Likely Missing September Claims. Use 8/30 date
1. Education, Regulatory Resource
   • Blogs, Webinars (http://www.mediserve.com/blog/)

2. Weekly Open Webinars for clients
   • Every Thursday from 12:30-1:30 ET through October 17, 2012

MediLinks (Hospital based)
• Authorization Management
• Tasks Lists
• Scheduling
• Documentation
• Charge capture
• Full HL7 EMR integration

Appointments Everywhere
• Enterprise Scheduling
• IRF Scheduling
• Rehab Scheduling
• Authorization Management
• Tasks Lists
• Full HL7 EMR integration

Attigo (Private Practice)
• Complete EMR
• Integrated Billing / Clearinghouse
• Authorization Management
• Tasks Lists
• Scheduling, Call Reminders
• Documentation
Other Resources

CMS Therapy Caps webpage
http://www.cms.gov/Medicare/Billing/TherapyServices/index.html?redirect=/TherapyServices/05_Annual_Therapy_Update.asp14

MedLearn Matters – Therapy Cap Revisions

Transmittal 2537 (CR 7881) – MC Claims Process

Transmittal 1117 (CR8036) – MC MMR

MedLearn Matters – MMR

CMS MMR Audio Transcript
http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODFSpecialODF.html

MedLearn Matters – Applying KX modifier to the claim
<table>
<thead>
<tr>
<th>CMS Manual System</th>
<th>Department of Health &amp; Human Services (DHHS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pub 100-20 One-Time Notification</td>
<td>Centers for Medicare &amp; Medicaid Services (CMS)</td>
</tr>
<tr>
<td>Transmittal 1117</td>
<td>Date: August 31, 2012</td>
</tr>
<tr>
<td></td>
<td>Change Request 8036</td>
</tr>
</tbody>
</table>

CMS will inform the contractors of the budget they are to use for this project. When the funds have been exhausted, contractors shall stop doing preapproval for therapy services. Contractors shall notify providers by posting on their Websites when they have stopped doing the reviews.
How Caps Affect Other Post Acute Provision of Care and Some ‘Inpatient’ Levels Too!

It’s not just about OP!
Other Cap Scenarios / Discussions

- All therapy services paid under Medicare Part B
  - Except Critical Access designated Hospitals
- TOB – Type of Bill – what exactly does that mean?
- Medicare Part B includes some services provided in ‘acute care’
  - Observation Beds, (TOB 13 X)
  - Part A benefit exhausted – Type B Benefit allowable service,. Part B Only Beneficiary (TOB 12 X)
- SNF – Non PPS covered Part B Benefit Eligible.
- CORF and Other ORF providers of Part B therapy.
What picture comes to mind for you?
Part B Therapy Providers

- Per Open Door Forum 08/07/2012
- Applies to ALL Part B outpatient therapy settings & providers.

The therapy cap applies to all Part B outpatient therapy settings and providers including:
- private practices,
- skilled nursing facilities,
- home health agencies,
- outpatient rehabilitation facilities, and
- comprehensive outpatient rehabilitation facilities.

Special Open Door Forum: Manual Medical Review of Therapy Claims
Tuesday August 7; 2-3:30pm ET
Conference Call Only

Beginning this year, the therapy cap will also apply to therapy services furnished in hospital outpatient departments (HOPDs) until December 31, 2012. Before 2012, therapy provided in hospital outpatient departments did not count towards the therapy cap.
Any Type vs. 12x & 13x

• Any type part B provider? !!
  • Even though transmittal lists 12X (Hospital Inpatient) & 13X (Hospital Outpatient) and calls them ‘Hospital OP Dept’, it really applies whenever patients Part B coverage applies to the billing situation taking all guidance into consideration.

What does the $3,700 represent? The $3,700 represents the total allowed charges under Part B for services furnished by any type of Part B provider who can provide therapy services other than a critical access hospital.

This would include hospital outpatient departments and skilled nursing facilities course for physicians, independent practitoning physical therapists or occupational therapists.
Q&A snippet from CMS instruction 08/07.

Will Gehne: But if it’s being billed under (inaudible) 34X so that it’s somehow services outside of a home health plan of treatment and paid on the physician fee scheduled basis then it would be applied (inaudible).

(Georgia Farris): OK. So, if it’s a PPS episode, then this is not effected to us at all.

Will Gehne: Correct.

• Be AWARE... Not updated since 10/27/11
Effective for claims with dates of service on or after January 1, 1999, the Medicare Physician Fee Schedule (MPFS) became the method of payment for outpatient therapy services furnished by:

- **Comprehensive Outpatient Rehabilitation Facilities (CORFs);**
- **Outpatient physical therapy providers (OPTs);**
- **Other rehabilitation facilities (ORFs);**
- **Hospitals (to outpatients and inpatients who are not in a covered Part A stay);**
- **Skilled nursing facilities (SNFs) (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF); and**
- **Home health agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care (POC)).**
• Know your TOB
• Review historical volumes of practice.
• Apply Cap Process for all Part B; (non-PPS driven care).
• The appropriate types of bill for submitting outpatient rehabilitation services, and requiring HCPCS coding to ensure payment under the MPFS are: 12X, 13X, 22X, 23X, 34X, 74X, and 75X when therapy is provided.
CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 2537

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: August 31, 2012

Change Request 7881

SUBJECT: Expiration of 2012 Therapy Cap Revisions and User-Controlled Mechanism to Identify Legislative Effective Dates

I. SUMMARY OF CHANGES: The purpose of the Change Request is to create the new mechanism.

EFFECTIVE DATE: January 1, 2013

IMPLEMENTATION DATE: January 7, 2013
Updates Claims Processing Manual Chapter 5

A. Background: Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) extended the therapy caps exceptions process through December 31, 2012 and made several changes affecting the processing of claims for therapy services. Therapy services furnished in an outpatient hospital setting had previously been exempt from the application of the therapy caps; however, MCTRJCA required Original Medicare to temporarily apply the therapy caps (and related provisions) to the therapy services furnished in an outpatient hospital on/after October 1, 2012, and on/before December 31, 2012. Although claims processing requirements associated with the cap are only applicable to hospitals on/after October 1, 2012, claims paid for hospital outpatient therapy services since January 1, 2012, are included in calculating the cap beginning October 1, 2012.

MCTRJCA also required a manual review process for those exceptions where the beneficiary therapy services for the year reach a threshold of $3,700. The separate thresholds triggering manual medical reviews build upon the separate therapy caps -- one for PT and SLP services combined and one for OT services. The count of services to which these thresholds apply begins on January 1, 2012.
Part B requires payment of a monthly premium that is *usually taken out of* the beneficiary's Social Security, Railroad Retirement, or Office of Personnel Management Retirement payment.

Part B costs $99.90 per month in 2012.

UNDERSTANDING THE MEDICARE PART B BENEFIT

Medicare Part B, referred to as “Medical Insurance”, helps cover doctors’ services, certain medical items, and outpatient care. Part B also covers medical services such as physical therapy and some home health care furnished by hospitals, SNFs, and other institutional providers, when the beneficiary does not qualify for Part A benefits.

A provider can determine if a beneficiary has Part B benefits by looking at the beneficiary’s red, white, and blue Medicare card.

If the beneficiary's Medicare card says “Medical (Part B)”, he or she is entitled to Part B benefits.
• A patient not formally admitted who remains in observation is in an (OP status) of care.
• Billing Requirement: Observation services are reported on Bill Type 13X.
• Ancillary services performed while the patient is in observation status are reported (and covered by part B benefits), using the appropriate Revenue and CPT/HCPCS codes. Coded to the highest level of specificity.
• Subject to Cap & Threshold
OPPS – Excludes Therapy Payment

- OPPS = Outpatient Prospective Payment System. When PPS; *generally there is No Cap/Threshold.* 
  **OPPS Definition draws questions!**

- Here is an EXCEPTION ... I believe...

Certain types of services are excluded from payment under the OPPS (e.g., clinical diagnostic laboratory services, outpatient therapy services, and screening and diagnostic mammography). For more information about services that are excluded from payment under the OPPS, refer to Section 1833(t) of the Act and the “Code of Federal Regulations” at 42 CFR 419.22 located at [http://www.gpo.gov/fdsys/search/home.action](http://www.gpo.gov/fdsys/search/home.action) on the U.S. Government Printing Office website.
• Outpatient Prospective Payment System – PPS normally excludes a Cap situation; Right?
• Title 42 419.22 (h) specifically excludes therapy services from bundled payment of OPPS.
• May also be paid by Part B... therefore = Caps/Thresholds? Appears so!

42 C.F.R. § 419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.
Title 42 - Public Health

(h) Outpatient therapy services described in section 1833(a)(8) of the Act.
• Rare occasion; beneficiary has part B Benefits only.
• People that do not have enough quarters to qualify for part A, may purchase part B.
• Dependent on coordination of benefits; therapy services provided while in an inpatient level of care may be subject to 12x billing.
• If so, Caps & Thresholds are applied.
• PHASE IN of Threshold Notification/Approval process may cause you to be in PHASE ONE!
• How did CMS allocate phase 1, 2, & 3?
• Took into **account provider characteristics** and historical number of persons over the cap.
• They then spread out the workload.
• IRF hospital-outpatient facilities have **provider characteristics** with high volume historical numbers of persons that would have reached the cap.
• Why? Multi-service neuro patients!
• If the beneficiary has Part B, but not Part A coverage (e.g., Part A benefits are exhausted), the SNF must bill for rehabilitation services.
• For SNF residents, consolidated billing requires all outpatient rehabilitation services be billed to Part B by the SNF.
• 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)
• TOB 23 X; Subject to Cap & Thresholds
• Review MBPM Chapter 8; Section 30.7 !!
• How does this affect Home Health Agencies? Some Payments?

• Home health benefit may be A or B covered:
  
  • Home health therapy services covered under a home health plan of care (PPS) is not cap driven even if a hospital owns the HHA.
  
  • HHAs may submit bill type 34X and be paid under the MPFS (Part B), if there are no home health services billed under a home health plan of care at the same time, and there is a valid rehabilitation POC.
  
  • Home Health Services provided by a non-HHA under part B – Apply Cap & Threshold.
CORF:

• Effective for claims with dates of service on or after January 1, 1999, the Medicare Physician Fee Schedule (MPFS) became the method of payment for outpatient therapy services, including CORFs.
• CORF’s are paid under part B Benefit and therefore Caps/Thresholds are applied.
• CORFs may ALSO provide physical therapy, speech-language pathology and occupational therapy off the CORF’s premises in addition to a home evaluation.
• CORF TOB is 75 X and is billed using Physician Fee Schedule.
• If covered under Part B, Caps & Thresholds apply.

100.1.1 - Allowable Revenue Codes on CORF 75X Bill Types
(Rev. 1876; Issued: 12-18-09; Effective Date: 01-01-10; Implementation Date: 04-05-10)

Effective July 1, 2008, the following revenue codes are allowable for reporting CORF services on 75X bill types:

<table>
<thead>
<tr>
<th>0270</th>
<th>0274</th>
<th>0279</th>
<th>0410</th>
</tr>
</thead>
<tbody>
<tr>
<td>0412</td>
<td>0419</td>
<td>042X</td>
<td>043X</td>
</tr>
<tr>
<td>044X</td>
<td>0550</td>
<td>0559</td>
<td>0560</td>
</tr>
<tr>
<td>0569</td>
<td>0636</td>
<td>0771</td>
<td>0900</td>
</tr>
<tr>
<td>0911</td>
<td>0914</td>
<td>0919</td>
<td>0942</td>
</tr>
</tbody>
</table>

NOTE: Billed revenue codes not listed in the above list will be returned to the provider by Medicare systems. See Chapter 25, Completing and Processing the CMS-1450 Data Set, for revenue code descriptions.
• Claims paid to Critical Access Hospitals are excluded from cap requirements at this time.
• The TOB – 85X would designate CAH and will be ignored for therapy cap inclusion.
• Congress may change this in future rule making but for now, **CAH are exempt** from Cap & Threshold application while receiving part B therapy services.
• These are the many other scenarios that may affect the need to follow the therapy Cap & Threshold approval process.
• Be certain you are well aware of these many different applications.
• Stay tuned for any further information that helps delineate the validity of ALL Medicare Part B Benefit application.
• Follow Mediserve.com/Blog
  • For Breaking News & Information
Contact Us!

Mike Stevenson  
Director Of Product Mgmt.  
mikes@mediserve.com

Darlene D’Altorio-Jones  
Strategist, Rehab Mgmt.  
djones@mediserve.com

Follow her blog:  
www.mediserve.com/blog

Find more information:  
www.mediserve.com  
www.attigotherapy.com

Find us on Twitter, Facebook and LinkedIn

Stop by our booths at ARN, AMRPA, APTA-PPS and APTA-CSM!