

**Blue Cross Blue Shield of Michigan**  
Medicare Advantage Private Fee-for-Service

Outpatient Therapy Cap Exceptions

January 1, 2008  
Updated October 1, 2008

OUTPATIENT THERAPY CAPS

The Balanced Budget Act of 1997 enacted financial limitations (therapy caps) on Medicare covered outpatient physical therapy, occupational therapy, and speech-language pathology services in all settings except outpatient hospitals. The 2006 Deficit Reduction Act enacted exceptions to the caps based on the medical necessity of the service. The Medicare Improvements for Patients and Providers Act of 2008, enacted on July 15, 2008, extended the effective date of the therapy cap exceptions process to December 31, 2009. The dollar amount of the cap is updated annually in accordance with the Medicare Economic Index.

Annual beneficiary limitations are based on therapy services the Medicare beneficiary receives, not the type of practitioner who provides the service. Physical therapists, speech-language pathologists, occupational therapists as well as physicians and certain non-physician practitioners can render a therapy service.

ORIGINAL MEDICARE

The 2008 calendar year limit on incurred expenses for physical therapy and speech language pathology services combined is \$1810. The limit for occupational therapy services is \$1810. Limits apply to outpatient Part B therapy services from all settings except outpatient hospital and hospital emergency room.

Financial limitations are applied to the Medicare Physician Fee Schedule amount (or the amount charged if it is smaller) for therapy services for each beneficiary. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached. Services that meet the cap exceptions criteria must be identified by a modifier on the claim and be supported by documentation.

The financial limits on outpatient therapy services over the last three calendar years are displayed in the following table.

Calendar Year	Physical Therapy and Speech Language Pathology Combined	Occupational Therapy
2008	\$1,810	\$1,810
2007	\$1,780	\$1,780
2006	\$1,740	\$1,740

### MEDICARE ADVANTAGE

Members with select Medicare Advantage private fee-for-service plans are not subject to the financial therapy limitations imposed under Original Medicare for outpatient physical therapy, speech-language pathology therapy and occupational therapy services. All outpatient rehabilitation services must follow the Centers for Medicare & Medicaid Services general coverage guidelines, national coverage determinations, and be consistent with the written coverage decisions of local carriers and fiscal intermediaries with jurisdiction for claims in the geographical area in which services are covered by the plan.

### **Conditions for Payment**

BCBSM Medicare Advantage private fee-for-service plans use the Centers for Medicare & Medicaid Services deemed provider<sup>1</sup> concept for group specific benefits. The table below specifies payment conditions for outpatient rehabilitation services that exceed the financial limitation imposed under Original Medicare.

Conditions For Payment	
Eligible providers	Consistent with Original Medicare
Deemed provider	See terms and conditions on <a href="http://bcbsm.com/ma">bcbsm.com/ma</a>
Payable locations	Consistent with Original Medicare
Frequency	
CPT codes	
Diagnosis restrictions	
Age Restrictions	

### **Reimbursement**

The maximum payment amount for outpatient rehabilitation services is consistent with Original Medicare. The provider will be paid the lesser of Medicare's allowable amount or the provider's charge, minus the member's cost-share. This represents payment in full and providers are not allowed to balance bill the member for the difference between the allowed amount and the charge.

### **Member Cost-Sharing**

- Deemed providers must agree to collect from the member only the cost-sharing amounts described in the table below. They may not otherwise charge or bill the member.

<sup>1</sup> 2008 Terms and conditions

- If the member elects to receive a noncovered service, he or she is responsible for the entire charge associated with the noncovered service.

The cost-sharing chart below identifies members that are not subject to the financial limitation for outpatient rehabilitation services.

Member Cost-Sharing Responsibilities								
Group Name and Number	Annual Deductible		Coinsurance				Out-of-Pocket Maximum	
			Professional Claim		Medicare Limitation Therapy Caps			
	2007	2008	2007	2008	2007	2008	2007	2008
MPSERS 59000	\$250	\$250 all locations except 23 <sup>2</sup>	10% all locations except 21 <sup>3</sup>	10% all locations except 23	Does not apply		\$500	

### Billing Instructions

1. Bill services on the CMS 1500 (8/05) claim form or the 837 equivalent claim.
2. Use the Medicare Advantage private fee-for-service unique billing requirements.
3. Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your National Provider Identifier number on all claims.
5. Submit claims to your local BCBS plan.
6. Use electronic billing:
  - a. Michigan providers:
    - A copy of the BCBSM EDI Professional 837/835 Companion document is available at:  
[http://www.bcbsm.com/pdf/systems\\_resources\\_prof\\_837\\_835.pdf](http://www.bcbsm.com/pdf/systems_resources_prof_837_835.pdf)
  - b. Providers outside of Michigan should contact their local BCBS plan.

<sup>2</sup> Emergency room - 23

<sup>3</sup> Inpatient hospital - 21