Outpatient rehabilitation therapy caps
Applies to:

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

☐ Medicare Plus Blue PPO℠ ☒ Medicare Plus Blue Group PPO℠ ☐ Both

Outpatient rehabilitation

Outpatient rehabilitation services are the evaluation and treatment for injuries and diseases that affect your ability to function.

Original Medicare

Original Medicare covers the evaluation and treatment for injuries and diseases that affect the ability to function when the physician or other health care providers certify the need for it. The Medicare Part B outpatient therapy cap for occupational therapy combined with physical therapy and speech–language therapy is determined by the Centers for Medicare & Medicaid Services each calendar year. The therapy caps are subject to change on an annual basis.

Medicare Plus Blue Group PPO

Medicare Plus Blue Group PPO plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B) and provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows BCBSM to offer enriched plans by using Original Medicare as the base program and adding benefit options.

Under select Medicare Plus Blue Group PPO plans, the Medicare Part B outpatient therapy cap for occupational therapy combined with physical therapy and speech–language therapy doesn't apply.

Conditions for payment

The table below specifies payment conditions for Medicare Part B outpatient rehabilitation services associated with the Part B therapy cap.

Conditions for payment	
Eligible providers	Consistent with Original Medicare
Payable location	
Frequency	
CPT / HCPCS codes	
Diagnosis restrictions	
Age restrictions	

Reimbursement

Medicare Plus Blue Group PPO plan's maximum payment amount for the Medicare Part B outpatient rehabilitation services is consistent with Original Medicare. The provider will be paid the lesser of Medicare's allowed amount or the provider's charge, minus the member's cost share. This represents payment in full and providers cannot balance bill the member for the difference between the allowed amount and the charge.

Member cost–sharing

- Medicare Plus Blue PPO Group providers should collect the applicable cost–sharing from the member at the time of the service. Cost–sharing refers to a flat dollar copayment, a percentage coinsurance or a deductible.
- If the member receives a service that isn't covered, he or she is responsible for the entire charge associated with that service.

For detailed information about Medicare Plus Blue Group PPO member's benefits and cost share, providers may verify member benefits via web–DENIS or by calling CAREN at 1–866–309–1719.

Billing instructions

1. Bill services on the CMS 1500 (8/05) claim form, UB–04 or the 837 equivalent claim.
2. Use the Medicare Advantage PPO 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 ANSI ASC X12N 837 and 835 Institutional Health Care Claim and Health Care Claim Payment/Advice (BCBSM Electronic Data Interchange (EDI) Institutional 837/835 Companion Document) is available at: **http://www.bcbsm.com/pdf/837_835_institutional_companion.pdf**
      - 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**
   b. Providers outside of Michigan should contact their local BCBS plan.