Medicare Learning Network
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CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – Section 3401(a) of the Patient Protection and Affordable Care Act (PPACA) imposes a 0.25 percentage point reduction to the Inpatient Prospective Payment System (IPPS) hospital's market basket for fiscal year (FY) 2010, effective for discharges on or after April 1, 2010. The reduction to the market basket will affect IPPS rates for discharges occurring on or after April 1, 2010, through September 30, 2010. Likewise, Section 3401(c) of PPACA imposes a 0.25 percentage point reduction to the Long Term Care Hospital's (LTCH) market basket for FY 2010, effective for discharges on or after April 1, 2010. The reduction to the market basket will affect LTCH rates for discharges occurring on or after April 1, 2010, through September 30, 2010. Section 3401(d) of PPACA imposes a 0.25 percentage point reduction to the Inpatient Rehabilitation Facility market basket for FY 2010, effective for discharges on or after April 1, 2010. This reduction is also resulting in changes to the standard payment conversion factor, payment rates, and the outlier threshold amount.

MLN Matters® Number: MM6899
Related Change Request (CR) #: 6899
Related CR Release Date: April 27, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: R1951CP
Implementation Date: October 4, 2010

Removal of the Provider Reporting Requirement for Total Number of Therapy Visits using Value Codes 50-53

Provider Types Affected

Hospitals, Home Health Agencies (HHAs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Skilled Nursing Facilities (SNFs), and other providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Part A/B Medicare Administrative Contractors (MACs) and Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries are affected.

Provider Action Needed

This article is based on CR 6899, which advises you that the requirement for providers to report the total number of therapy visits using value codes 50 – physical therapy, 51 – occupational therapy, 52 – speech therapy, and 53 – cardiac rehab has been removed. Effective October 1, 2010, providers are no longer required to submit any of the aforementioned value codes when billing for therapy services. The Medicare Claims Processing manual has been updated to

remove this requirement. Please ensure that your billing staffs are aware of this change.

Additional Information

The official instruction issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R1951CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) website. If you have questions, please contact your Medicare FI, A/B MAC, or RHHI at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.