Related MLN Matters Article #: MM5478

Date Posted: January 8, 2007

Related CR #: 5478

Outpatient Therapy Cap Exception Process for 2007

Key Words

MM5478, CR5478, R1145CP, R181P1, R63BP, Outpatient, Therapy, Cap, Process

Provider Types Affected

Providers, physicians, and non-physician practitioners (NPPs) who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), carriers, and Part A/B Medicare Administrative Contractors (A/B MACs) under the Part B benefit for therapy services

Key Points

- The effective date of the instruction is January 1, 2007.
- The implementation date is on or before January 29, 2007.
- Section 1833(g)(5) of the Social Security Act provided that, for services rendered during calendar year 2006, FIs, RHHIs, and carriers could, in certain circumstances, grant an exception to the therapy cap when requested by the individual enrolled under the Part B benefit (or by a person acting on behalf of that individual).
- On January 1, 2006, Medicare implemented financial limitations on covered therapy services (therapy caps).
- However, the 2006 Deficit Reduction Act provided for exceptions to this dollar limitation when the provision of additional therapy services is determined to be medically necessary. This exceptions process has been extended by recent legislation (the Tax Relief and Health Care Act of 2006) for one year (calendar year 2007).
- A therapy cap exception may be made when a beneficiary requires continued skilled therapy (in other words, 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. Documentation supporting the medical necessity of those therapy services must be kept on file by the provider.
- In 2006, exception processes fell into two categories, automatic, and manual; but beginning January 1, 2007, there is no manual process for exceptions, and all services that require exceptions to caps will be processed using the automatic process.

- CR5478, from which MLN Matters article MM5478 is taken, provides instructions to contractors regarding the short-term implementation of this legislation.

Exceptions for Conditions or Complexities Identified by International Classification of Diseases-Version 9 (ICD-9) Codes

CR5478 and MM5478 provide instructions to contractors regarding the short-term implementation of this legislation. Details about these instructions follow. Also, reference Table 1 on pages 3-9 of MM5478 and pages 15-19 of CR5478 for more information.

- Contractors will grant exceptions for any number of medically necessary services if the beneficiary meets the conditions described in the *Medicare Claims Processing Manual* (100-04), Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Section 10.2 (The Financial Limitation) for 2007 (displayed in Table 1).
- The ICD-9 codes describe the most typical conditions (etiology or underlying medical diagnoses) that may result in exceptions (marked X) and complexities that might cause medically necessary therapy services to qualify for the automatic process exception (marked *) for each discipline separately.
- When the cell in Table 1 is marked with a dash (-), the diagnosis code in the corresponding row is not appropriate for services by the discipline in the corresponding column. Therefore, services provided by that discipline for that diagnosis do not qualify for exception to caps. Services may be appropriate when provided by that discipline for another diagnosis appropriate to the discipline, which may or may not be on this table, and that diagnosis should be documented on the claim, if possible, or in the medical record.
- Medicare contractors will allow automatic process exceptions for diagnoses in Table 1 or any other diagnosis for which therapy services are appropriate when the beneficiary needs therapy services above the therapy cap (due to the occurrence of any condition or complexity that is appropriately documented).

Additional Details Included in CR5478

- For the therapy Healthcare Common Procedure Coding System (HCPCS) codes subject to the cap limits in the provider's claims to be excepted, the provider must include the KX modifier to indicate that the clinician attests that services are medically necessary and justification is documented in the medical record.
- In CY 2007, when claims contain a KX modifier, contractors will override edits that indicate that a therapy service has exceeded the financial limitation, and will pay for the service if it is otherwise covered and payable.
- Contractors will not use the KX modifier as the sole indicator of services that exceed caps in 2007, because there will be services with appropriately used KX modifiers that do not represent services that exceed the cap.
- Contractors will require that the documentation for outpatient therapy services include objective, measurable patient function information by:

  - Including information as described in the *Medicare Benefit Policy Manual* (Publication 100-02), chapter 15 (Covered Medical and Other Health Services), Section 220.3C (Documentation Requirements for Therapy Services -- Evaluation/Re-Evaluation and Plan of Care); or
  - Using one of the four recommended (but not required) measurement tools listed below:
    - National Outcomes Measurement System (NOMS) by the American Speech-Language Hearing Association,
    - Patient Inquiry by Focus On Therapeutic Outcomes, Inc. (FOTO),
    - Activity Measure – Post Acute Care (AM-PAC), or
    - OPTIMAL by the American Physical Therapy Association.
- If one of these instruments is not in the patient's medical record, the record must contain documentation to indicate objective, measurable beneficiary physical function including, for example:
  - Functional assessment individual item and summary scores (and comparisons to prior assessment scores) from commercially available therapy outcomes instruments other than those listed above; or
  - Functional assessment scores (and comparisons to prior assessment scores) from tests and measurements validated in the professional literature that are appropriate for the condition/function being measured; or
  - Other measurable progress towards identified goals for functioning in the home environment at the conclusion of this therapy episode of care.
- The automatic exceptions process for therapy claims reporting the KX modifier does not preclude these claims from being subject to review. The contractor may review claims when they are potentially fraudulent, where there is evidence of misrepresentation of facts, or where there is a pattern of aberrant billing.
- Claims for services above the cap, which are denied, are considered benefit category denials, and the beneficiary is liable. Providers do not need to issue an Advance Beneficiary Notice for these benefit category denials.
- Contractors do not have to search their files to either retract payment for claims already paid or to retroactively pay claims, but will reopen and/or adjust claims brought to their attention.

Note: CR5478 also relocates some information. Comprehensive Outpatient Rehabilitation Facilities (CORF) policies for 1) Group therapy services and 2) Therapy students are the same as other Part B outpatient services policies for group therapy services and therapy students, and can now be found in the *Medicare Benefit Policy Manual*, chapter 15, Section 230.

Important Links

The related MLN Matters article can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5478.pdf on the CMS website.

CR5478 is actually issued in three separate transmittals, one for each manual being revised.

Providers can find these transmittals at:

1. The *Medicare Claims Processing Manual* transmittal - Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Section 10.2 (The Financial Limitation) for 2007 at http://www.cms.hhs.gov/transmittals/downloads/R1145CP.pdf;
2. The *Medicare Benefit Policy Manual* transmittal - Chapter 15 (Covered Medical and Other Health Services), Section 220.3C (Documentation Requirements for Therapy Services -- Evaluation/Re-Evaluation and Plan of Care) at http://www.cms.hhs.gov/transmittals/downloads/R63BP.pdf; and
3. The *Medicare Program Integrity Manual* transmittal - Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 3.4.1.1.1 (Exception From the Uniform Dollar Limitation ("Therapy Cap")) at http://www.cms.hhs.gov/transmittals/downloads/R181PI.pdf on the CMS website.