CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1145	**Date: December 29, 2006**
	Change Request 5478

SUBJECT: Outpatient Therapy Cap Exceptions Process for Calendar Year (CY) 2007

I. SUMMARY OF CHANGES: Instructions for use of the automatic process for exceptions to outpatient therapy caps in calendar years 2007. References are added to language on group therapy and students in Pub. 100-02 Benefit Policy Manual. Text was deleted to make the exceptions process entirely automatic.

New / Revised Material
Effective Date: January 1, 2007
Implementation Date: On or before January 29, 2007.

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	5/10.2 - The Financial Limitation
R	5/100.10 - Group Therapy Services (Code 97150)
R	5/100.10.1 - Therapy Students

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1145	Date: December 29, 2006	Change Request: 5478

SUBJECT: Outpatient Therapy Cap Exceptions Process for Calendar Year (CY) 2007

Effective Date: January 1, 2007

Implementation Date: On or before January 29, 2007.

I. GENERAL INFORMATION

A. Background: Financial limitations on Medicare covered therapy services (therapy caps) were implemented on January 1, 2006. In the Deficit Reduction Act, Congress provided that exceptions to this dollar limitation may be made when provision of additional therapy services is determined to be medically necessary. This exceptions process was initially effective only for services provided in CY2006. Recent legislation, the Tax Relief and Health Care Act of 2006, has extended the application of this exceptions process for 1 year, CY2007.

This Change Request provides instructions to contractors regarding the short term implementation of this legislation. During calendar year 2006, local contractor controlled processes implemented the exceptions to the therapy cap. A nationally consistent systematic process to implement the exceptions is preferable to local processes. In order to meet legislated timeframes, local processes will be continued in the short term. These processes will be replaced by national system changes as soon as is practicable. The national process will be described in a subsequent instruction.

B. Policy: Section 1833(g)(5) of the Social Security Act, as amended by the Tax Relief and Health Care Act of 2006, provides that, for services provided during CY2007 contractors shall, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, grant an exception to the therapy cap in certain circumstances. Claims for services above the cap for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable. Providers do not need to issue an Advance Beneficiary Notice for these benefit category denials.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5478.1	Contractors shall apply exceptions in this CR to the therapy financial limitations to services provided to Medicare eligible beneficiaries in CY2007.	X		X	X		X					
5478.1.1	Contractors shall continue to follow previous instructions for claims with dates of service in CY2006.	X		X	X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5478.1.2	The contractor shall grant exceptions for any number of medically necessary services if the beneficiary meets the conditions described in IOM Pub. 100-04, chapter 5, Section 10.2, forCY2007.											
5478.2	Contractors shall inform providers regarding theCY2007 process to request exceptions to the therapy financial limitations using the KX modifier, as described in Medicare manuals 100-02, 100-04, and 100-08.	X		X	X		X					
5478.3	Contractors shall continue in CY2007 to override CWF rejects indicating that a therapy service has exceeded the financial limitation and shall pay for the service if otherwise covered and payable when the claim contains a KX modifier.	X		X	X		X					
5478.4	Contractors shall discontinue the tracking and reporting requirements regarding the therapy financial limitation exceptions created in CR 4364 (Transmittal R52BP, R140PI, and R855CP).	X		X	X		X					
5478.5	Contractors shall subject therapy claims reporting the KX modifier to pre- or post-payment medical review as is consistent with their medical review strategy.	X		X	X		X					
5478.6	When reviewing claims for services excepted from therapy caps where there is evidence of potential provider fraud, the contractor shall follow the instructions in 100-08, chapter 4, on how to treat the claim in CY2007.	X		X	X		X					
5478.7	When reviewing claims for services excepted from therapy caps the contractor shall deny the claim where there is evidence of misrepresentation of facts presented	X		X	X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	to the contractor by that provider in CY2007.											
5478.8	When reviewing claims for services excepted from therapy caps due to a pattern of aberrant billing the contractor shall deny the services that are not reasonable and necessary.	X		X	X		X					
5478.9	Contractors shall not accept requests for manual process exceptions for services provided in CY2007.	x		x	x		x					
5478.9.1	Contractors have discretion as to whether and how to respond to a request for manual process exception for services provided in CY 2007.	X		X	X		X					
5478.10	The contractor shall track workload associated with the Therapy Cap process inCY2007 only to the extent they would normally track workload as part of an activity (e.g., claims processing).	X		X	X		X					
5478.11	The contractor shall track costs associated with the Therapy Cap process in CY2007 only to the extent they would normally track workload as part of an activity (e.g., claims processing_.	X		X	X		X					
5478.12	If unexpected costs related to the exceptions process occur, contractors shall report costs and workload in the line that best reflects the work being performed per the activity dictionary.	X		X	X		X					
5478.13	For CY2007, carriers and fiscal intermediaries shall not report the therapy cap costs and workload.	X		X	X		X					
5478.14	Contractors shall continue to enforce LCDs, since the presence of a KX does not supersede a Local Coverage Determination (LCD) in CY2007.	X		X	X		X					
5478.15	Contractors shall allow automatic	X		X	X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	process exceptions for documented medically necessary services when any condition or complexity occurs regardless of whether it is represented on the list in Pub. 100-04, chapter 5, section 10.2 in CY2007.											
5478.16	Contractors shall update the list of exceptions inCY2007 according to the changes provided in this CR. Note that contractors may expand, but not remove ICD-9s from the where they believe further exceptions should be allowed.	X		X	X		X					
5478.17	Contractors shall allow automatic process exceptions when medically necessary services are provided for two or more separate, billable, conditions in the same calendar year inCY2007.	X		X	X		X					
5478.18	Contractors shall NOT utilize the KX modifier in data analysis as the sole indicator of services that do exceed caps inCY2007. For all claims, there may be services with appropriately used KX modifiers that do not represent services that exceed the cap.	X		X	X		X					
5478.19	Contractors shall utilize consistently the new definitions and examples provided in this transmittal for Pub. 100-02, chapter 15, section 10.2.	X		X	X		X					
5478.20	Contractors shall not require the additional documentation that is encouraged but not required in Pub. 100-02, chapter 15, section 10.2.	X		X	X		X					
5478.21	Contractors shall require that documentation for outpatient therapy services include objective, measurable patient function information, either by using one of the four recommended (but not required) measurement tools, or	X		X	X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	other information as described in Pub 100-02, chapter 15 section 220.3C.											
5478.22	Contractors need not search their files to either retract payment for claims already paid or to retroactively pay CY2007 claims between 1/1/2007 and the implementation date of this Change Request However, contractors shall reopen and/or adjust CY2007 claims between 1/1/2007 and the implementation date of this CR when they are brought to their attention.	X		X	X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5478.23	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next	X		X	X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5478.9	Contractors should note that the manual process for granting exceptions has been removed from the Medicare manuals.
5478.12	CMS does not anticipate any costs associated with the therapy caps process in CY2007.

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne (claims processing) 410-786-6148, Dorothy Shannon 410-786-3396 (payment policy) or Dan Schwartz (program integrity) 410-786-4197.

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. *For TITLE XVIII Contractors*, use only one of the following statements:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC)*, use only one of the following statements:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above,

to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

10.2 - The Financial Limitation

(Rev. 1145, Issued: 12-29-06, Effective: 01-01-07, Implementation: on or before 01-29-07)

A. Financial Limitation Prior to the Balanced Budget Refinement Act (BBRA)

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, which added §1834(k)(5) to the Act, required payment under a prospective payment system for outpatient rehabilitation services (except those furnished by or under arrangements with a hospital). Outpatient rehabilitation services include the following services:

- Physical therapy (which includes outpatient speech-language pathology); and
- Occupational therapy.

Section 4541(c) of the BBA required application of a financial limitation to all outpatient rehabilitation services (except those furnished by or under arrangements with a hospital). In 1999, an annual per beneficiary limit of $1,500 applied to all outpatient physical therapy services (including speech-language pathology services). A separate limit applied to all occupational therapy services. The limit is based on incurred expenses and includes applicable deductible and coinsurance. The BBA provided that the limits be indexed by the Medicare Economic Index (MEI) each year beginning in 2002.

The limitation is based on the services the Medicare beneficiary receives, not the type of practitioner who provides the service. Therefore, physical therapists, speech-language pathologists, occupational therapists as well as physicians and certain nonphysician practitioners could render a therapy service.

As a transitional measure, effective in 1999, providers/suppliers were instructed to keep track of the allowed incurred expenses. This process was put in place to assure providers/suppliers did not bill Medicare for patients who exceeded the annual limitations for physical therapy, and for occupational therapy services rendered by individual providers/suppliers. In 2003 and later, the limitation was applied through CMS systems.

B. Moratoria *and Exceptions for* Therapy Claims

Section 221 of the BBRA of 1999 placed a 2-year moratorium on the application of the financial limitation for claims for therapy services with dates of service January 1, 2000, through December 31, 2001.

Section 421 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, extended the moratorium on application of the financial limitation to claims for outpatient rehabilitation services with dates of service January 1, 2002, through December 31, 2002. Therefore, the moratorium was for a 3-year period and applied to outpatient rehabilitation claims with dates of service January 1, 2000, through December 31, 2002.

In 2003, there was not a moratorium on therapy caps. Implementation was delayed until September 1, 2003. Therapy caps were in effect for services rendered on September 1, 2003 through December 7, 2003.

Congress re-enacted a moratorium on financial limitations on outpatient therapy services on December 8, 2003 that extend*ed* through December 31, 2005. Caps were implemented again on January 1, 2006 and policies were modified to allow exceptions as directed by the Deficit Reduction Act only for calendar year 2006. *The Tax Relief and Health Care Act of 2006 extended the cap exceptions process through calendar year 2007.*

C. Application of Financial Limitations

Financial limitations on outpatient therapy services, as described above, began for therapy services rendered on or after on January 1, 2006. See C 1 to C 7 of this section when exceptions to therapy caps apply. The limits were $1740 in 2006. For 2007, the annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is $1780; the limit for occupational therapy is $1780. Limits apply to outpatient Part B therapy services from all settings except outpatient hospital (place of service code 22 on carrier claims) and hospital emergency room (place of service code 23 on carrier claims). These excluded hospital services are reported on types of bill 12x or 13x on intermediary claims.

Contractors apply the financial limitations to the Medicare Physician Fee Schedule (MPFS) amount (or the amount charged if it is smaller) for therapy services for each beneficiary.

As with any Medicare payment, beneficiaries pay the coinsurance (20 percent) and any deductible that may apply. For example, in 2007, if the deductible has been met prior to submission of a claim for $1780 of therapy services, Medicare will pay 80 percent, which is $1424. The beneficiary will pay the 20 percent coinsurance, which is $356. If the deductible has not been met, the beneficiary will also pay the deductible amount of $131 and 20 percent of the amount remaining after the deductible is met (20% of $1649), or $329.80 for a total of $460.80. Medicare will pay the remaining 80 percent after the deductible is met or $1319.20. These amounts are for calendar year 2007 and will change each calendar year. Medicare Contractors shall publish the financial limitation amount in educational articles. It is also available at 1-800-Medicare.

For claims with dates of service from January 1, 2006, through December 31, 2007, Medicare shall apply these financial limitations in order, according to the dates when the claims were received. When limitations apply, the Common Working File (CWF) tracks the limits. Shared System Maintainers are not responsible for tracking the dollar amounts of incurred expenses of rehabilitation services for each therapy limit.

In processing claims where Medicare is the secondary payer, the shared system takes the lowest secondary payment amount from MSPPAY and sends this amount on to CWF as the amount applied to therapy limits.

1. Exceptions to Therapy Caps - General

The Deficit Reduction Act of 2006 direct*ed* CMS to develop a process to allow for *exceptions* to the caps in cases where continued therapy services are medically necessary.

Instructions for contractors to manage requests for the automatic process for exceptions will be found in the Program Integrity Manual, chapter 3, section 3.4.1.2. Provider and supplier information *concerning exceptions* is in this manual and in IOM Pub. 100-02, chapter 15, section 220.3. Exceptions *shall* be identified by a modifier on the claim *and supported by documentation*.

Since the providers and suppliers will *take an active role in obtaining an exception for a beneficiary*, this manual *section* is written to address them *as well as Medicare contractors*.

The beneficiary may qualify for use of the cap exceptions at any time during the episode when documented medically necessary services exceed caps. For example, if a beneficiary is being treated for a condition that does not qualify for an exception, should a change in status result in the beneficiary satisfying the requirements for a cap exception, the provider or supplier would utilize the modifier for automatic process exceptions.

In 2006, Exception *Processes* fell into two categories*,* Automatic Process *E*xcept*ions, and* Manual Process Exceptions*. Beginning January 1, 2007, there is no manual process for exceptions. All services that require exceptions to caps shall be processed using the automatic process. All requests for exception are in the form of a KX modifier added to claim lines. (See subsection C6 for use of the KX modifier.)*

Deletion of the manual process for exceptions increases the responsibility of the provider/supplier for determining and documenting that services are appropriate for use of the automatic exception process.

Also, use of the automatic process for exception does not exempt services from manual or other medical review processes as described in 100-08, Chapter 3, Section 3.4.1.1.1 . Rather, atypical use of the automatic exception process may invite contractor scrutiny. Particular care should be taken to document improvement and avoid billing for services that do not meet the requirements for skilled services, or which are described as maintenance rather than rehabilitative treatment (See Pub. 100-02, chapter 15, sections 220.2, 220.3, and 230).

The KX modifier, described in subsection C6, is added to claim lines to indicate that the clinician attests that services are medically necessary and justification is documented in the medical record.

2. Automatic Process Exceptions

An exception may be made when the patient's condition is justified by documentation indicating that the beneficiary requires continued skilled therapy, i.e., 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.

No specific documentation is submitted to the contractor for automatic process exceptions. *The clinician is responsible for consulting guidance in the Medicare manuals and in the professional literature to determine if the beneficiary may qualify for the automatic process exception when documentation justifies medically necessary services above the caps. The clinician's opinion is not binding on the Medicare contractor who makes the final determination concerning whether the claim is payable*.

*D*ocumentation *justifying the services* shall be submitted in response to any *Additional Documentation Request (ADR) for claims that are selected for medical review. Follow the documentation requirements in Pub. 100-02, chapter 15, section 220.3*. *If medical records are requested for review, clinicians* may include, at their discretion, a summary that specifically addresses the justification for therapy cap exception.

In making a decision about whether to utilize the automatic process exception, clinicians shall consider, for example, whether services are appropriate to:

- *the patient's condition including the diagnosis, complexities and severity (*A list of the excepted evaluation codes are in C.2.a. A list of the ICD-9 codes for conditions and complexities *that <u>might</u> qualify a beneficiary for exception to caps* is in 10.2 C3*);*
- *the services provided including their type, frequency and intensity;*
- *the interaction of current active conditions and complexities that directly and significantly influence the treatment such that it causes services to exceed caps.*

In addition, the following should be considered before using the automatic exception process:

a. Exceptions for Services

Evaluation. The CMS will except therapy evaluation procedures from caps <u>after</u> 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 *are* appropriate in 200*7*. Contact the Medicare contractor for instruction if the evaluation codes change in later years:

92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 97001, 97002, 97003, 97004.

These codes will continue to be reported as outpatient therapy procedures as described in the Claims Processing Manual, Chapter 5, Section 20(B) "Applicable Outpatient Rehabilitation HCPCS Codes." Definition of evaluations and documentation is found in Pub 100-02, section*s* 220 and 230.

Other Services. There are a number of sources that suggest the amount of certain services that may be typical, either per service, per episode, per condition, or per discipline. For example, see the CSC- Utilization and Edit Report, 2006, Appendices at www.cms.hhs.gov/TherapyServices (Studies and Reports). Professional literature and guidelines from professional associations also provide a basis on which to estimate whether the type, frequency and intensity of services are appropriate to an individual. Clinicians and contractors should utilize available evidence related to the patient's condition to justify provision of medically necessary services to individual beneficiaries, especially when they exceed caps. Contractors shall not limit medically necessary services that are justified by scientific research applicable to the beneficiary. Neither contractors nor clinicians shall utilize professional literature and scientific reports to justify payment for continued services after an individual's goals have been met earlier than is typical. Conversely, professional literature and scientific reports shall not be used as justification to deny payment to patients whose needs are greater than is typical or when the patient's condition is not represented by the literature.

b. Exceptions for Condition*s* or Complexities Identified by ICD-9 codes.

Clinicians may utilize the automatic process for exception for any diagnosis for which they can justify services exceeding the cap. Based upon analysis of claims data, research and evidence based practice guidelines, CMS has identified conditions and complexities *represented by ICD-9 codes. Except in very rare circumstances, one or more of these diagnoses will be appropriate for patients who require therapy services that exceed therapy* caps. This list appears in 10.2 C3. *Clinicians may use the automatic process of exception for beneficiaries who do not have a condition or complexity on this list; however, they must justify carefully the provision of a therapy service that exceeds caps for that patient's condition.*

NOT ALL patients who have a condition or complexity on the list are "automatically" excepted from therapy caps. *See Pub. 100-02, chapter 15, section 230.3 for documenting the patient's condition and complexities. Contractors may scrutinize claims from providers whose services exceed caps more frequently than is typical.*

*Regardless of the condition, t*he patient must also meet other requirements for coverage. For example, the patient must require skilled treatment for a covered, medically necessary service; the services must be appropriate in type, frequency and duration for the patient's condition and service must be documented appropriately. Guidelines for utilization of therapy services may be found in Medicare manuals, Local Coverage

Determinations of Medicare contractors, and professional guidelines issued by associations and states.

Bill the most relevant diagnosis. As always, when billing for therapy services, the ICD-9 code that best relates to the reason for the treatment shall be on the claim, unless there is a compelling reason. For example, when a patient with diabetes is being treated for gait training due to amputation, the preferred diagnosis is abnormality of gait (which characterizes the treatment). Where it is possible in accordance with State and local laws and the contractors Local Coverage Determinations, avoid using vague or general diagnoses. When a claim includes several types of services, or where the physician/NPP must supply the diagnosis, it may not be possible to use the most relevant therapy code in the primary position. In that case, the relevant code should, if possible, be on the claim in another position.

Codes representing the medical condition that caused the treatment are used when there is no code representing the treatment. Complicating conditions are preferably used in non-primary positions on the claim and are billed in the primary position only in the rare circumstance that there is no more relevant code.

When a *patient's* condition is the reason for the exception, that condition must be related to the therapy goals and must either be the condition that is being treated or a *complexity* that directly and significantly impacts the rate of recovery of the condition being treated such that it is appropriate to exceed the caps. *Codes marked as complexities represented by ICD-9 codes on the list below are unlikely to require therapy services that would exceed the caps unless they occur in a patient who also has another condition (either listed or not listed). Therefore, documentation for an exception should indicate how the complexity (or combination of complexities) directly and significantly affects treatment for a therapy condition.* For example, if the condition underlying the reason for therapy is V43.64, hip replacement, the treatment may have a goal to ambulate 60' with stand-by assistance and a KX modifier may be appropriate for gait training (assuming the severity of the patient is such that the services exceed the cap). Alternatively, it would not be appropriate to use the KX modifier for a patient who recovered from hip replacement last year and is being treated this year for a sprain that is not represented on the list as an exception *and for which extensive therapy exceeding caps is not justified.*

DO NOT USE ICD-9 codes that do not describe a specific underlying condition or specific body part(s) affected that resulted in the current therapy episode of care. In order to qualify the beneficiary for use of the automatic process for exception, the condition or complexity must directly and significantly affect the type, frequency, intensity and/or duration of required, medically necessary, skilled services such that it causes those services to exceed the cap.

3. ICD-9 Codes That Qualify for the Automatic Process Therapy Cap Exception Based Upon Clinical Condition or Complexity

When using this table, refer to the ICD-9 code book for coding instructions. Some contractors' Local Coverage Determinations do not allow the use of some of the codes on this list in the primary diagnosis position on a claim. If the contractor has determined that these codes do not characterize patients who require medically necessary services,

providers/suppliers may not use these codes, but must utilize a *contractor listed* billable diagnosis code to describe the patient's condition. *P*roviders/suppliers may use the automatic process *for exception for medically necessary services* when the patient has a *contractor listed* billable condition *that is not on the list below*. In that case, the diagnosis *on the list below must* be put in a secondary position on the claim and/or in the medical records, as the contractor directs.

When two codes are listed in the left cell in a row, all the codes between them are also excepted. If one code is in the cell, only that one code is excepted. The descriptions in the table are not always identical to those in the ICD-9 code book, but may be summaries. Contact your contractor for interpretation if you are not sure that a condition or complexity is applicable for automatic process exception.

It is very important to recognize that most of the conditions on this list would not ordinarily result in services exceeding the cap. Use the KX modifier only in cases where the condition of the individual patient is such that services are APPROPRIATELY provided in an episode that exceeds the cap. In most cases, the severity of the condition, comorbidities, or complexities will contribute to the necessity of services exceeding the cap, and these should be documented. Routine use of the KX modifier for all patients with these conditions will likely show up on data analysis as aberrant and invite inquiry. Be sure that documentation is sufficiently detailed to support the use of the modifier.

The following ICD-9 codes describe the conditions (etiology or underlying medical conditions) that may result in excepted conditions *(marked X)* and complexities (marked *) that *MIGHT* cause medically necessary therapy services to qualify for the automatic process exception *for each discipline separately. When the field corresponding to the therapy discipline treating and the diagnosis code is marked with a dash (–)services by that discipline are not appropriate for that diagnosis and, therefore, services do not qualify for exception to caps.*

These codes are grouped only to facilitate reference to them. The codes may be used only when the code is applicable to the condition being actively treated. For example, an exception should not be claimed for a diagnosis of hip replacement when the service provided is for an unrelated dysphagia.

Key	
Automatic (only ICD-9 needed on claim)	*X*
Complexity (requires another ICD-9 on claim)	*
Does not serve as qualifying ICD-9 on claim	--

ICD-9 Cluster	***ICD-9 (Cluster) Description***	***PT***	***OT***	***SLP***
V43.61-V43.69	*Joint Replacement*	*X*	*X*	--
V45.4	*Arthrodesis Status*	*	*	--
V45.81-V45.82 and V45.89	*Other Postprocedural Status*	*	*	--
V49-61-V49.67	*Upper Limb Amputation Status*	*X*	*X*	--
V49.71-V49.77	*Lower Limb Amputation Status*	*X*	*X*	--
V54.10-V54.29	*Aftercare for Healing Traumatic or Pathologic Fracture*	*X*	*X*	--

V58.71-V58.78	*Aftercare Following Surgery to Specified Body Systems, Not Elsewhere Classified*	*	*	*
244.0-244.9	*Acquired Hypothyroidism*	*	*	*
250.00-251.9	*Diabetes Mellitus and Other Disorders of Pancreatic Internal Secretion*	*	*	*
276.0-276.9	*Disorders of Fluid, Electrolyte, and Acid-Base Balance*	*	*	*
278.00-278.01	*Obesity and Morbid Obesity*	*	*	*
280.0-289.9	*Diseases of the blood and blood-forming organs*	*	*	*
290.0-290.43	*Dementias*	*	*	*
294.0-294.9	*Persistent Mental Disorders due to Conditions Classified Elsewhere*	*	*	*
295.00-299.91	*Other Psychoses*	*	*	*
300.00-300.9	*Anxiety, Disassociative and Somatoform Disorders*	*	*	*
310.0-310.9	*Specific Nonpsychotic Mental Disorders due to Brain Damage*	*	*	*
311	*Depressive Disorder, Not Elsewhere Classified*	*	*	*
315.00-315.9	*Specific delays in Development*	*	*	*
317	*Mild Mental Retardation*	*	*	*
320.0-326	*Inflammatory Diseases of the Central Nervous System*	*	*	*
330.0-337.9	*Hereditary and Degenerative Diseases of the Central Nervous System*	*X*	*X*	*X*
340-345.91 and 348.0-349.9	*Other Disorders of the Central Nervous System*	*X*	*X*	*X*
353.0-359.9	*Disorders of the Peripheral Nervous system*	*X*	*X*	--
365.00-365.9	*Glaucoma*	*	*	*
369.00-369.9	*Blindness and Low Vision*	*	*	*
386.00-386.9	*Vertiginous Syndromes and Other Disorders of Vestibular System*	*	*	*
389.00-389.9	*Hearing Loss*	*	*	*
401.0-405.99	*Hypertensive Disease*	*	*	*
410.00-414.9	*Ischemic Heart Disease*	*	*	*
415.0-417.9	*Diseases of Pulmonary Circulation*	*	*	*
420.0-429.9	*Other Forms of Heart Disease*	*	*	*
430-438.9	*Cerebrovascular Disease*	*X*	*X*	*X*
440.0-448.9	*Diseases of Arteries, Arterioles, and Capillaries*	*	*	*

Key	
Automatic (only ICD-9 needed on claim)	X
Complexity (requires another ICD-9 on claim)	*
Does not serve as qualifying ICD-9 on claim	--

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
451.0-453.9 and 456.0-459.9	Diseases of Veins and Lymphatics, and Other Diseases of Circulatory System	*	*	*
465.0-466.19	Acute Respiratory Infections	*	*	*
478.30-478.5	Paralysis, Polyps, or Other Diseases of Vocal Cords	*	*	*
480.0-486	Pneumonia	*	*	*
490-496	Chronic Obstructive Pulmonary Disease and Allied Conditions	*	*	*
507.0-507.8	Pneumonitis due to solids and liquids	*	*	*
510.0-519.9	Other Diseases of Respiratory System	*	*	*
560.0-560.9	Intestinal Obstruction Without Mention of Hernia	*	*	*
578.0-578.9	Gastrointestinal Hemorrhage	*	*	*
584.5-586	Renal Failure and Chronic Kidney Disease	*	*	*
590.00-599.9	Other Diseases of Urinary System	*	*	*
682.0-682.8	Other Cellulitis and Abscess	*	*	--
707.00-707.9	Chronic Ulcer of Skin	*	*	--
710.0-710.9	Diffuse Diseases of Connective Tissue	*	*	*
711.00-711.99	Arthropathy Associated with Infections	*	*	--
712.10-713.8	Crystal Arthropathies and Arthropathy Associated with Other Disorders Classified Elsewhere	*	*	--
714.0-714.9	Rheumatoid Arthritis and Other Inflammatory Polyarthropathies	*	*	--
715.00-715.98	Osteoarthrosis and Allied Disorders (Complexity except as listed below)	*	*	--
715.09	Osteoarthritis and allied disorders, multiple sites	X	X	--
715.11	Osteoarthritis, localized, primary, shoulder region	X	X	--
715.15	Osteoarthritis, localized, primary, pelvic region and thigh	X	X	--
715.16	Osteoarthritis, localized, primary, lower leg	X	X	--
715.91	Osteoarthritis, unspecified id gen. or local, shoulder	X	X	--
715.96	Osteoarthritis, unspecified if gen. or local, lower leg	X	X	--
716.00-716.99	Other and Unspecified Arthropathies	*	*	--
717.0-717.9	Internal Derangement of Knee	*	*	--
718.00-718.99	Other Derangement of Joint (Complexity except as listed below)	*	*	--
718.49	Contracture of Joint, Multiple Sites	X	X	--
719.00-719.99	Other and Unspecified Disorders of Joint (Complexity except as listed below)	*	*	--
719.7	Difficulty Walking	X	X	--
720.0-724.9	Dorsopathies	*	*	--

Key	
Automatic (only ICD-9 needed on claim)	X
Complexity (requires another ICD-9 on claim)	*
Does not serve as qualifying ICD-9 on claim	--

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
725-729.9	Rheumatism, Excluding Back (Complexity except as listed below)	*	*	--
726.10-726.19	Rotator Cuff Disorder and Allied Syndromes	X	X	--
727.61-727.62	Rupture of Tendon, Nontraumatic	X	X	--
730.00-739.9	Osteopathies, Chondropathies, and Acquired Musculoskeletal Deformities (Complexity except as listed below)	*	*	--
733.00	Osteoporosis	X	X	--
741.00-742.9 and 745.0-748.9 and 754.0-756.9	Congenital Anomalies	*	*	*
780.31-780.39	Convulsions	*	*	*
780.71-780.79	Malaise and Fatigue	*	*	*
780.93	Memory Loss	*	*	*
781.0-781.99	Symptoms Involving Nervous and Musculoskeletal System (Complexity except as listed below)	*	*	*
781.2	Abnormality of Gait	X	X	--
781.3	Lack of Coordination	X	X	--
783.0-783.9	Symptoms Concerning Nutrition, Metabolism, and Development	*	*	*
784.3-784.69	Aphasia, Voice and Other Speech Disturbance, Other Symbolic Dysfunction	*	*	X
785.4	Gangrene	*	*	--
786.00-786.9	Symptoms involving Respiratory System and Other Chest Symptoms	*	*	*
787.2	Dysphagia	*	*	X
800.00-828.1	Fractures (Complexity except as listed below)	*	*	--
806.00-806.9	Fracture of Vertebral Column With Spinal Cord Injury	X	X	--
810.11-810.13	Fracture of Clavicle	X	X	--
811.00-811.19	Fracture of Scapula	X	X	--
812.00-812.59	Fracture of Humerus	X	X	--
813.00-813.93	Fracture of Radius and Ulna	X	X	--
820.00-820.9	Fracture of Neck of Femur	X	X	--
821.00-821.39	Fracture of Other and Unspecified Parts of Femur	X	X	--
828.0-828.1	Multiple Fractures Involving Both Lower Limbs, Lower with Upper Limb, and Lower Limb(s) with Rib(s) and Sternum	X	X	--
830.0-839.9	Dislocations	X	X	--
840.0-848.8	Sprains and Strains of Joints and Adjacent Muscles	*	*	--
851.00-854.19	Intracranial Injury, excluding those With Skull Fracture	X	X	X

Key	
Automatic (only ICD-9 needed on claim)	X
Complexity (requires another ICD-9 on claim)	*
Does not serve as qualifying ICD-9 on claim	--

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
880.00-884.2	Open Wound of Upper Limb	*	*	--
885.0-887.7	Traumatic Amputation, Thumb(s), Finger(s), Arm and Hand (complete)(partial)	X	X	--
890.0-894.2	Open Wound Lower Limb	*	*	--
895.0-897.7	Traumatic Amputation, Toe(s), Foot/Feet, Leg(s) (complete)(partial)	X	X	--
905.0-905.9	Late Effects of Musculoskeletal and Connective Tissue Injuries	*	*	*
907.0-907.9	Late Effects of Injuries to the Nervous System	*	*	*
941.00-949.5	Burns	*	*	*
952.00-952.9	Spinal Cord Injury Without Evidence of Spinal Bone Injury	X	X	X
953.0-953.8	Injury to Nerve Roots and Spinal Plexus	X	X	*
959.01	Head Injury, Unspecified	X	X	X

4. Additional *Considerations for* Exceptions

In justifying exceptions for therapy caps, clinicians and contractors should not only consider the medical diagnoses and medical complications that might directly and significantly influence the amount of treatment required. Other variables that affect appropriate treatment shall also be considered. Factors that influence the need for treatment should be supportable by published research, clinical guidelines from professional sources, and/or clinical/common sense. See Pub. 100-02, chapter 15, section 230.3 subsections related to documentation of the evaluation, and section 220.2 medical necessity for some factors that complicate treatment.

However, in cases where the beneficiary was treated in the same year for different episodes of the same condition, s*pecial attention should be paid to justifying the second episode as appropriate and necessary and not merely an extension of the first episode, separated so as to fabricate a complexity to justify the exception to therapy caps. If the services are appropriate, they should meet other criteria for exception.*

Note that the patient's lack of access to outpatient hospital therapy *services alone does not* justify excepted services. Residents of skilled nursing facilities prevented by consolidated billing from accessing hospital services, debilitated patients for whom transportation to the hospital is a physical hardship or lack of therapy services at hospitals in the beneficiary's county *may or may not qualify for continued services above the caps*. *The patient's condition and complexities might justify extended services, but their location does not.*

***5*. Appeals Related to Disapproval of Cap Exceptions**

Disapproval of Exception from Caps. The DRA allows that certain services that would not be covered due to caps, but are medically necessary, may be covered if they meet certain criteria. Therefore, when a service beyond the cap is determined to be medically necessary, it is covered and payable. But, when a service provided beyond the cap (outside the benefit) is determined to be NOT medically necessary, it is denied as a benefit category denial. *Contractors may review claims with KX modifiers to determine whether the services are medically necessary, or for other reasons. Services that exceed therapy caps but do not meet Medicare criteria for medically necessary services are not payable even when clinicians recommend and furnish and these services.*

Services without a Medicare benefit may be billed to Medicare with a GY modifier for the purpose of obtaining a denial that can be used with other insurers. See CMS IOM Pub. 100-04 Chapter 1, Section 60 for appropriate use of modifiers.

APPEALS –*If* a beneficiary whose exception *services do not need the Medicare criteria for medical necessity* elects to receive *such* services and a claim is submitted for such services, the resulting determination would be subject to the administrative appeals

process. Further details concerning appeals are found in CMS IOM Pub. 100-04, chapter 29.

6. Use of the KX Modifier for Therapy Cap Exceptions

When the beneficiary qualifies for a therapy cap exception, the provider shall add a KX modifier to the therapy HCPCS subject to the cap limits The KX modifier shall not be added to any line of service that is not a medically necessary service; this applies to services that, according to a Local Coverage Determination by the contractor, are not medically necessary services.

The codes subject to the therapy cap tracking requirements are listed in a table in the Claims Processing Manual, Pub. 100-04, chapter 5, section 20(B), "Applicable Outpatient Rehabilitation HCPCS Codes."

The GN, GO, or GP therapy modifiers are currently required. In addition to the KX modifier, the GN, GP and GO modifiers shall continue to be used. Providers may report the modifiers on claims in any order. If there is insufficient room on a claim line for multiple modifiers, additional modifiers may be reported in the remarks field. Follow the routine procedure for placing HCPCS modifiers on a claim as described below.

- For professional claims, sent to the carrier, refer to:

  - Pub.100-04 Medicare Claims Processing Manual, Chapter 26, for more detail regarding completing the CMS- *Form* 1500 claim form, including the placement of HCPCS modifiers. Note that the CMS-*Form*1500 claim form currently has space for providing two modifiers in block 24D, but, if you have more than two to report, you can do so by placing the -99 modifier (which indicates multiple modifiers) in block 24D and placing the additional modifiers in block 19.

You may access the Medicare Claims Processing Manual at this web address http://www.cms.hhs.gov/Manuals/

From this site, click the links to Internet-Only Manuals (IOMs), then Pub. 100-04 to reach the Medicare Claims Processing Manual.

  - The ASC X12N 837 Health Care Claim: Professional Implementation Guide, Version 4010A1, for more detail regarding how to electronically submit a health care claim transaction, including the placement of HCPCS modifiers. The ASC X12N 837 implementation guides are the standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for submitting health care claims electronically. The 837 professional transaction currently permits the placement of up to four modifiers, in the 2400 loop, SV1 segment, data elements SV101-3, SV101-4, SV101-5, and SV101-6. You may obtain copies of the ASC X12N 837 implementation guides from the Washington Publishing Company.

- For claims paid to carriers, it is only appropriate to use a KX for a service that reasonably may exceed the cap. Use of the KX modifier when there is no indication that the cap is likely to be exceeded is abusive. For example, use of the KX modifier for low cost services early in an episode when there is no evidence of a previous episode that might have exceeded the cap is inappropriate.

- For institutional claims, sent to the FI:

- 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 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 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 is appropriately used on all of the PT lines.

- Refer to Pub.100-04 Medicare Claims Processing Manual, Chapter 25, for more detail regarding completing the CMS- *Form* 1450 claim form, including the placement of HCPCS modifiers.

You may access the Medicare Claims Processing Manual at this web address http://www.cms.hhs.gov/Manuals/ From this site, click the links to Internet-Only Manuals (IOMs), then Pub. 100-04 to reach the Medicare Claims Processing Manual.

- By attaching the KX modifier, the provider is attesting that the services billed:

- Are reasonable and necessary services that require the skills of a therapist; (See CMS Pub. 100-02, chapter 15, section 220.2 B); and
- Are justified by appropriate documentation in the medical record, (See CMS Pub. 100-02, chapter 15, section 220.3); and
- Qualify for an exception using the automatic process exception.

If this attestation is determined to be inaccurate, the provider/supplier is subject to sanctions resulting from providing inaccurate information on a claim.

- When the KX modifier is attached to a therapy HCPCS, the contractor will override the CWF system reject *for services that exceed the caps* and pay the claim if it is otherwise payable.

- Providers and suppliers shall continue to attach correct coding initiative (CCI) HCPCS modifiers under current instructions.

- If a claim is submitted without KX modifiers and the cap is exceeded, those services will be denied. *In cases where the KX would have been appropriate, c*ontractors may reopen and*/or* adjust the claim, if it is brought to their attention.

- Services billed after the cap has been exceeded which are not eligible for exceptions may be billed for the purpose of obtaining a denial using condition code 21.

D. *MSN* Messages

Existing MSN message 38.18 shall continue to appear on all Medicare MSN forms. It has been updated to the following:

- ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2007. The limits are $1,740 in 2006 and $1,780 in 2007 for PT and SLP combined and $1,740 in 2006 and $1,780 in 2007 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE.

  Spanish Translation

  ALERTA: La cobertura de Medicare estará limitada para los servicios de terapia física ambulatoria (PT, por sus siglas en inglés), terapia de patología del habla (SLP, por sus siglas en inglés), y terapia ocupacional (OT) si son recibidos entre el 1 de enero de 2006 y el 31 de diciembre de 2007. Estos límites son $1,740 en 2006 y $1,780 en 2007 para PT y SLP combinados y $1,740 en 2006 y $1,780 en 2007 para OT. Medicare paga hasta 80 por ciento de los límites después que se haya pagado el deducible. Estos límites no se aplican a cierta terapia aprobada por Medicare ni a terapia que usted obtenga en los departamentos de hospital para paciente ambulatorio, a menos que usted sea un residente y ocupe una cama certificada por Medicare en un centro de enfermería especializada. Si tiene preguntas, por favor llame GRATIS al 1-800-MEDICARE.

Existing MSN messages 17.13, 17.18 and 17.19 shall be issued on all claims containing outpatient rehabilitation services as noted in *this manual*. Add applied amount for individual beneficiaries and the generic limit amount (e.g., $1740 in 2006 and $1780 in 2007) to all MSN that require them.

- 17.13 - Medicare approves a limited dollar amount each year for physical therapy and speech-language pathology services and a separate limit each year for occupational therapy services when billed by providers, physical and occupational therapists, physicians, and other non-physician practitioners. Medically necessary therapy over these limits is covered when received at a hospital outpatient department or when approved by Medicare.

Spanish Translation
17.13 Cada año, Medicare aprueba una cantidad límite por servicios de terapia física y patología del lenguaje. Anualmente también aprueba otra cantidad límite por servicios de terapia ocupacional cuando son facturados por proveedores, terapistas físicos y ocupacionales, médicos y otros practicantes no médicos. La terapia que es médicamente necesaria y que sobrepasa estas cantidades límites está cubierta cuando se recibe en una unidad de hospital ambulatorio o cuando está aprobada por Medicare.

- 17.18 - ($) has been applied during this calendar year (CCYY) towards the ($) limit on outpatient physical therapy and speech-language pathology benefits.

Spanish Translation 17.18 - En este año (CCYY), ($) han sido deducidos de la cantidad límite de ($) por los beneficios de terapia física ambulatoria y de patología del lenguage hablado.

- 17.19 ($) has been applied during this calendar year (CCYY) towards the ($) limit on outpatient occupational therapy benefits.

Spanish Translation 17.19 - En este año (CCYY), ($) han sido deducidos de la cantidad límite de ($) por los beneficios de terapia ocupacional ambulatoria.

Carriers and intermediaries shall use the existing Medicare Summary Notice message 17.6 to inform the beneficiaries that they have reached the financial limitation. Apply this message at the line level:

- 17.6 - Full payment was not made for this service because the yearly limit has been met.

Spanish Translation 17.6 - Debido a que usted alcanzó su límite anual por este servicio, no se hará un pago completo.

E. FI Requirements

1. General Requirements

Regardless of financial limits on therapy services, CMS requires modifiers (See Sec. 20.1 of this chapter) on specific codes for the purpose of data analysis. Edit to ensure that the therapy modifiers are present on a claim based on the presence of revenue codes 042X, 043X, or 044X. Claims containing revenue codes 042X, 043X, or 044X without a therapy modifier GN, GP, or GO should be returned to the provider.

Beneficiaries may not be simultaneously covered by Medicare as an outpatient of a hospital and as a patient in another facility. They must be discharged from the other setting and registered as a hospital outpatient in order to receive payment for outpatient rehabilitation services in a hospital outpatient setting after the limitation has been reached.

A hospital may bill for services of a facility as hospital outpatient services if that facility meets the requirements of a department of the provider (hospital) under 42 CFR 413.65. Facilities that do not meet those requirements are not considered to be part of the hospital and may not bill under the hospital's provider number, even if they are owned by the hospital. For example, services of a Comprehensive Outpatient Rehabilitation Facility (CORF) must be billed as CORF services and not a hospital outpatient services, even if the CORF is owned by the hospital. Only services billed by the hospital as bill type 12X or 13X are exempt from limitations on therapy services.

2. When Financial Limits Are in Effect

The CWF applies the financial limitation to the following bill types 22X, 23X, 34X, 74X and 75X using the MPFS allowed amount (before adjustment for beneficiary liability). For SNFs, the financial limitation does apply to rehabilitation services furnished to those SNF residents in noncovered stays (bill type 22X) who are in a Medicare-certified section of the facility—i.e., one that is either certified by Medicare alone, or is dually certified (by Medicare as a SNF and by Medicaid as a nursing facility (NF). For SNF residents, consolidated billing requires all outpatient rehabilitation services be billed to Part B by the SNF. If a resident has reached the financial limitation, and remains in the Medicare-certified section of the SNF, no further payment will be made to the SNF or any other entity. Therefore, SNF residents who are subject to consolidated billing may not obtain services from an outpatient hospital after the cap has been exceeded.

Once the financial limitation has been reached, SNF residents who are in a **non-Medicare certified** section of the facility—i.e., one that is certified only by Medicaid as a NF or that is not certified at all by either program—FIs use bill type 23X. 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), medically necessary outpatient therapy may be covered at an outpatient hospital facility after the financial limitation has been exceeded.

Limitations do not apply for SNF residents in a covered Part A stay, including swing beds. Rehabilitation services are included within the global Part A per diem payment that the SNF receives under the PPS for the covered stay. Also, limitations do not apply to any therapy services billed under PPS Home Health, or inpatient hospitals including critical access hospitals.

F. Carrier Requirements when Financial Limits are in Effect

Claims containing any of the "Applicable Outpatient Rehabilitation HCPCS Codes" in section 20 below marked "always therapy" (underlined) codes should contain one of the therapy modifiers (GN, GO, GP). All claims submitted for codes underlined but without a therapy modifier shall be returned as unprocessable.

When <u>any</u> code on the list of "Applicable Outpatient Rehabilitation HCPCS Codes" codes are submitted with specialty codes "65" (physical therapist in private practice), and

"67" (occupational therapist in private practice), they always represent therapy services, because they are provided by therapists. Carriers shall return claims for these services when they do not contain therapy modifiers for the applicable HCPCS codes.

The "Applicable Outpatient Rehabilitation HCPCS Codes in section 20 of this chapter that are marked (+) are sometimes therapy codes. Claims from physicians (all specialty codes) and nonphysician practitioners, including specialty codes "50," "89," and "97" may be processed without therapy modifiers. On review of these claims, services that are not accompanied by a therapy modifier must be documented, reasonable and necessary, and payable as physician or nonphysician practitioner services, and not services that the contractor interprets as therapy services.

The CWF will capture the amount and apply it to the limitation whenever a service is billed using the GN, GO, or GP modifier, except when the place of service code is 22 (outpatient hospital) or 23 (emergency room-hospital). The CWF has disabled the edit involving specialty codes "65" and "67" and Type of Service W or U.

G. FI Action Based on CWF Trailer During the Time Therapy Limits are in Effect

Upon receipt of the CWF error code/trailer, FIs are responsible for assuring that payment does not exceed the financial limitations, when the limits are in effect, except as noted below.

In cases where a claim line partially exceeds the limit, the FI must adjust the line based on information contained in the CWF trailer. For example, where the MPFS allowed amount is greater than the financial limitation available, always report the MPFS allowed amount in the "Financial Limitation" field of the CWF record and include the CWF override code. See example below for situations where the claim contains multiple lines that exceed the limit.

EXAMPLE: Based on the 2007 limit of $1780 for a beneficiary who has paid the deductible and the coinsurance:

Services received to date $1765 ($15 under the limit)
Incoming claim: Line 1 MPFS allowed amount is $50.
Line 2 MPFS allowed amount is $25.
Line 3, MPFS allowed amount is $30.

Based on this example, lines 1 and 3 are denied and line 2 is paid. The FI reports in the "Financial Limitation" field of the CWF record "$25.00 along with the CWF override code. The FI always applies the amount that would least exceed the limit. Since the FI systems cannot split the payment on a line, CWF will allow payment on the line that least exceeds the limit and deny other lines.

H. Additional Information for Carriers and FIs During the Time Financial Limits Are in Effect With or Without Exceptions

Once the limit is reached, if a claim is submitted, CWF returns an error code stating the financial limitation has been met. Over applied lines will be identified at the line level. The outpatient rehabilitation therapy services that exceed the limit should be denied. The FIs and carriers use group code PR and claim adjustment reason code 119 - Benefit maximum for this time period or occurrence has been reached- in the provider remittance advice to establish the reason for denial.

In situations where a beneficiary is close to reaching the financial limitation and a particular claim might exceed the limitation, the provider/supplier should bill the usual and customary charges for the services furnished even though such charges might exceed the limit. The CWF will return an error code/trailer that will identify the line that exceeds the limitation.

Because CWF applies the financial limitation according to the date when the claim was received (when the date of service is within the effective date range for the limitation), it is possible that the financial limitation will have been met before the date of service of a given claim. Such claims will prompt the CWF error code and subsequent contractor denial.

When the provider/supplier knows that the limit has been reached, further billing should not occur. The provider/supplier should inform the beneficiary of the limit and their option of receiving further covered services from an outpatient hospital (unless consolidated billing rules prevent the use of the outpatient hospital setting). If the beneficiary chooses to continue treatment at a setting other than the outpatient hospital where medically necessary services may be covered, the services may be billed at the rate the provider/supplier determines. Services provided in a capped setting after the limitation has been reached are not Medicare benefits and are not governed by Medicare policies.

If a beneficiary elects to receive services that exceed the cap limitation and a claim is submitted for such services, the resulting determination is subject to the administrative appeals process as described in subsection C.6 of this section and Pub. 100-04, chapter 29.

I. Provider Notification for Beneficiaries Exceeding Therapy Limits

Contractors will advise providers/suppliers to notify beneficiaries of the therapy financial limitations at their first therapy encounter with the beneficiary. Providers/suppliers should inform beneficiaries that beneficiaries are responsible for 100 percent of the costs of therapy services above each respective therapy limit, unless this outpatient care is furnished directly or under arrangements by a hospital. Patients who are residents in a Medicare certified part of a SNF may not utilize outpatient hospital services for therapy services over the financial limits, because consolidated billing rules require all services to be billed by the SNF. However, when therapy cap exceptions apply, SNF residents may qualify for exceptions that allow billing within the consolidated billing rules.

NEMB It is the provider's responsibility to present each beneficiary with accurate information about the therapy limits, and that, where necessary, appropriate care above the limits can be obtained at a hospital outpatient therapy department. Although use of the NEMB form is not a Medicare requirement, Medicare contractors shall advise providers/suppliers to use the Notice of Exclusion from Medicare Benefits (NEMB Form No. CMS 20007 & Formulario No. CMS 20007) form, or a similar form of their own design to inform beneficiaries of the therapy financial limitation and the cap exclusion process.

The NEMB form can be found at: http://www.cms.hhs.gov/medicare/bni/

When using the NEMB form, the practitioner checks box number 1 and writes the reason for denial in the space provided at the top of the form. The following reason is suggested: "Services do not qualify for exception to therapy caps. Medicare will not pay for physical therapy and speech-language pathology services over (add the dollar amount of the cap and the year or the dates of service to which it applies, e.g., $1780 in 2007) unless the beneficiary qualifies for a cap exception." Providers are to supply this same information for occupational therapy services over the limit for the same time period, as appropriate.

ABN An Advance Beneficiary Notice (ABN) is required to be given to a beneficiary whenever the treating clinician determines that the services being provided are no longer expected to be covered because they do not satisfy Medicare's medical necessity requirements. The ABN informs the beneficiary of their potential financial obligation to the provider and provides guidance regarding appeal rights. ABN applies to services that are provided BEFORE the cap is exceeded.

After the cap is exceeded, only the NEMB is appropriate, regardless of whether the services were excepted from the cap. For example, if services are provided over the cap for an excepted condition, when the therapist determines that the services no longer meet the criteria for reasonable and necessary services, an NEMB and not an ABN is provided to the patient.

At the time the clinician determines that skilled services are not necessary, the clinical goals have been met, or that there is no longer potential for the rehabilitation of health and/or function in a reasonable time, the beneficiary should be informed. If the beneficiary requests further services, inform the beneficiary that Medicare will not likely provide additional coverage. Use the ABN form for this purpose if the services are within the cap, and use the NEMB for services after the cap is exceeded.

Access to Accrued Amount All providers and contractors may access the accrued amount of therapy services from the ELGA screen inquiries into CWF. Provider/suppliers may access remaining therapy services limitation dollar amount through the 270/271 eligibility inquiry and response transaction. Providers who bill to FIs will also find the amount a beneficiary has accrued toward the financial limitations on the HIQA. Some suppliers and providers billing to carriers may, in addition, have access the accrued amount of therapy services from the ELGB screen inquiries into CWF.

Suppliers who do not have access to these inquiries may call the contractor to obtain the amount accrued.

100.10 - Group Therapy Services (Code 97150)

(Rev. 1145, Issued: 12-29-06, Effective: 01-01-07, Implementation: on or before 01-29-07)

Policies for group therapy services for CORF are the same as group therapy services for other Part B outpatient services. See Pub 100-02, chapter 15, section 230.

100.10.1 - Therapy Students

(Rev. 1145, Issued: 12-29-06, Effective: 01-01-07, Implementation: on or before 01-29-07)

Policies for therapy students for CORF are the same as policies for therapy students for other Part B outpatient services. See Pub. 100-02, chapter 15, section 230.