CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 1000

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: JULY 19, 2006

Change Request 4300

Transmittal 908, dated April 21, 2006, is rescinded and replaced with Transmittal 1000, dated July 19, 2006. The reason for the recession/replacement is to incorporate information previously issued in transmittal 855, dated February 15, 2006, which was omitted from transmittal 908 manual instruction. All other information remains the same.

SUBJECT: Common Working File (CWF) to the Medicare Beneficiary Database (MBD) Data Exchange Changes

I. SUMMARY OF CHANGES: The CWF to MBD data exchange is being changed to pass additional data to MBD for the 271 response including: remaining smoking and tobacco-use cessation counseling sessions/next eligible date, remaining limitation dollar amount for physical therapy and speech-language pathology services, remaining limitation dollar amount for occupational therapy services, remaining blood deductible, United Mine Worker coverage information, and the National Provider Identifier (NPI).

NEW/REVISED MATERIAL
EFFECTIVE DATE: October 1, 2006
IMPLEMENTATION DATE: October 2, 2006

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:
R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5/10.2/The Financial Limitation

N	32/12.8/Provider Access to Smoking and Tobacco-Use

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 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: 1000	Date: July 19, 2006	Change Request 4300

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I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) for smoking and tobacco-use cessation counseling via CR 3834 dated May 20, 2005. The NCD was effective March 22, 2005, and implemented on July 5, 2005. CR 3929 dated July 15, 2005, implemented frequency editing for the smoking and tobacco-use cessation counseling NCD. Subsequently, CR 4104 dated October 21, 2005, implemented provider ability to view the number of sessions recorded for a beneficiary via inquiry through CWF. With the implementation of CR 4300, CWF shall calculate the coverage period remaining sessions and next eligible date, if no sessions remain, to determine when a beneficiary is eligible for the next smoking and tobacco-use cessation counseling session. The CWF shall pass the data for the current smoking and tobacco-use cessation counseling session period to the Medicare Beneficiary Database (MBD) for the 271 response when requested on the 270. The Multi-Carrier System Desktop Tool (MCSDT) shall display the smoking and tobacco-use cessation counseling session information in a format equivalent to the CWF HIMR screen, as implemented per CR 4104 dated October 21, 2005.

Additionally, CMS issued instructions under CR 4115 dated November 18, 2005, that implemented financial limitations on therapy services, including provider ability to view the therapy cap amount remaining per beneficiary via inquiry through CWF. With the implementation of CR 4300, CWF shall pass the remaining limitation dollar amount for the combined physical therapy and speech-language pathology services as well as a separate remaining limitation dollar amount for occupational therapy services to the MBD for the 271 response when requested on the 270.

Eventually, the HIPAA compliant 270/271 health care eligibility inquiry and response transactions will replace the CWF provider eligibility inquiry transactions. In comparing the CWF provider eligibility inquiry screens to the data being passed from CWF to MBD for the 271 transactions, it was noted blood deductible is missing. Also, United Mine Worker coverage information, including effective and termination dates, is missing from MBD. CWF shall calculate and pass the remaining blood deductible to MBD as well as the United Mine Worker coverage information to include effective and termination dates.

Per the Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered entities must use the National Provider Identifier (NPI) to identify covered healthcare providers in standard electronic transactions. Where a legacy provider identifier is passed from CWF to MBD for the 271 response, copybook changes shall be made to also pass the NPI.

To avoid multiple changes to the CWF to MBD data exchange, our intent is to implement this change at the same time the copybook is changed for CR 4011 dated August 26, 2005, that implemented provider ability to view next eligible dates for preventive services.

B. Policy: No policy changes

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4300.1	CWF shall calculate the current coverage period remaining sessions for smoking and tobacco-use cessation counseling visits, G0375 and G0376. For example, the limit is 8 counseling sessions in a 12-month period and the beneficiary already had 2 Medicare allowed visits during the 12-month period, the coverage period remaining sessions would equal 6. If the 12-month period has elapsed, the coverage period starts over and the sessions begin with 8.								X	
4300.1.1	CWF shall calculate the smoking and tobacco-use cessation counseling session next eligible date when no sessions remain for the current period.								X	
4300.2	CWF shall calculate the remaining blood deductible.								X	
4300.3	CWF shall pass the smoking and tobacco-use cessation counseling visits remaining session/next eligible date and the blood deductible calculations to MBD for the 271 response when requested on the 270.								X	MBD
4300.4	CWF calculations, to parallel claims processing, shall include all applicable factors including: • Beneficiary entitlement status • Beneficiary claims history Utilization rules								X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4300.4.1	CWF shall base the calculations on beneficiary data at the time the beneficiary data is extracted.								X	
4300.4.2	CWF shall send an updated record on the next beneficiary extract when any changes occur to the beneficiary master data or claims data that would result in a change to calculations.								X	MBD
4300.5	MCSDT shall display the smoking and tobacco-use cessation counseling session information in a format equivalent to the CWF HIMR screen.						X			
4300.6	CWF shall pass the combined remaining limitation dollar amount for physical therapy and speech-language pathology services to MBD for the 271 response when requested on the 270.								X	MBD
4300.6.1	CWF shall pass the remaining limitation dollar amount for occupational therapy services to MBD for the 271 response when requested on the 270.								X	MBD
4300.6.2	CWF shall send MBD an updated record on the next beneficiary extract when any changes occur to the beneficiary master data or claims data that would result in a change to the remaining limitation dollar amounts.								X	MBD
4300.7	When Medicare may not be primary because of beneficiary United Mine Worker coverage, CWF shall send MBD this coverage information including the effective and termination dates of coverage.								X	MBD
4300.8	Where a legacy provider identifier is passed from CWF to MBD for the 271 response, CWF shall make copybook changes to also pass the NPI.								X	MBD
4300.9	CWF shall create a refresh for the entire beneficiary population for the MBD data extract.								X	MBD

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None. Provider education will be through the 270/271 user material.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
4300.1	CR 3929, issued July 15, 2005, business requirement 3929.1 explains and provides an example of how to calculate the coverage period.
4300.5	CR 4104, issued October 21, 2005, is the instruction for the session display on the CWF HIMR screen.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: NA

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2006 **Implementation Date:** October 2, 2006 **Pre-Implementation Contact(s):** Rich Cuchna @ (410)786-7239, Richard.Cuchna@cms.hhs.gov **Post-Implementation Contact(s):** Rich Cuchna @ (410)786-7239, Richard.Cuchna@cms.hhs.gov	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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10.2 - The Financial Limitation

(Rev. 1000, Issued: 07-19-06, Effective: 10-01-06, Implementation: 10-02-06)

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.

In 2006 Congress passed the Deficit Reduction Act that allows CMS to grant exceptions to therapy caps for services that meet certain qualifications as medically necessary services.

B. Moratoria on 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 extends 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.

C. Application of Financial Limitation (FIs and Carriers) January 1, 2006 through December 31, 2006

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 for exceptions to therapy caps). For 2006, the annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is $1740; the limit for occupational therapy is $1740. 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).

Contractors apply the financial limitations to the allowed amount for therapy services for each beneficiary. The allowed amount is the amount in the Medicare Physician Fee Schedule (or the amount charged if it is smaller) less the coinsurance (20 percent) and any deductible that may apply. If the deductible has been met prior to submission of a therapy claim for $1740 of services, Medicare will pay 80 percent of the allowed amount ($1392) and the beneficiary will pay the 20 percent coinsurance ($348). If the deductible has not been met, the beneficiary will also pay the deductible amount of $124 for 2006.

For claims with dates of service from January 1, 2006, through December 31, 2006, 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 directs 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 automatic exceptions will be found in

the Program Integrity Manual, chapter 3, section 3.4.1.2. Provider and supplier information is in this manual and in CMS IOM Pub. 100-02, chapter 15, section 220.3. Exceptions will be identified by a modifier on the claim.

Providers, suppliers and beneficiaries may all request exceptions from therapy caps. Since in most cases, the providers and suppliers will lead or assist in the request, this manual is written to address them. The same policies apply to beneficiaries who may request exceptions.

Exceptions fall into two categories:

- Automatically excepted services -
    - Certain evaluation services are excepted from therapy caps, although they continue to be therapy services. (See C2a)
    - Certain conditions and complexities are also excepted, when supported by documentation justifying the need for therapy services. (See C1-C4 for lists of automatically excepted services).
    - Contractor articles may describe other exceptions.
- Manual exceptions -
    - In the judgment of the Medicare contractor, an exception for conditions or complexities other than those described above may be justified by documentation indicating that the beneficiary requires therapy beyond the amount payable under the therapy cap for continued safe and effective rehabilitation of health status and/or function within a reasonable amount of time. (See C5)

All exceptions are for current conditions (conditions for which a patient is in treatment during this episode) that require skilled and medically necessary services. An exception is not allowed, even when the patient has a condition or complexity that qualifies for exception to caps, in cases where the services beyond the cap are not necessary, appropriately provided, and documented. For descriptions of covered, reasonable and necessary services and documentation see CMS IOM Pub. 100-02, chapter 15 sections 220 and 230.

For all therapy services, including those provided before and after a cap exception is allowed, payment requires that documentation supports the medical necessity of the services**.**

Progressive Corrective Action (PCA) and Medical review have a role in the therapy prior authorization exception process. Although the services may meet the criteria for exception from the cap due to condition or complexity, they are still subject to review to

determine that the services are otherwise covered and appropriately provided. The exception is granted (either automatically or by manual exception) on the clinician's assertion that there is documentation in the record justifying that the services meet the criteria for reasonable and necessary services. For example, the documentation must accurately represent the facts, and there shall be no evidence of abusive or inappropriate use of the process or the services by the provider/supplier.

Services deemed medically necessary are still subject to review related to misrepresentation, fraud or abuse. An example of inappropriate use of the process is the routine application for exceptions after the cap has been exceeded. The routine use of the KX modifier on every claim for a patient that has an excepted condition or complexity, regardless of the impact of the condition on the need for services above the cap, is inappropriate.

Exceptions apply to a number of treatment days of medically necessary services for each discipline separately (for PT, or OT, or SLP), approved by the contractor. Provider/suppliers/beneficiaries may request only 15 treatment days of justified, necessary therapy services above the caps before the services are rendered. However, providers/suppliers/beneficiaries should accompany the request with the plan for the entire episode of care for that patient, including justification for any needed services beyond the 15 currently requested.

Providers/suppliers/beneficiaries should request exceptions before the services are rendered whenever possible. Since there may be a time difference between the services rendered and when the services are processed, it may sometimes be necessary to request exceptions for services already provided. Include documentation and justification of the medical necessity of the services provided. There is no limit on the treatment days of services rendered in the past, but provider/suppliers/beneficiaries are cautioned against abuse of the process by routinely requesting exceptions for past services.

Contractors may approve any number of treatment days of services when documentation justifies the need for those services. The number of treatment days approved is the number of individual days on which a medically necessary service is provided for each discipline, and not consecutive calendar days.

- For example, if 15 treatment days of medically necessary physical therapy is approved, the services may be provided, according to the plan of care, on three days of each week for five weeks. Services are not required to be provided within 15 calendar days. If the patient does not show for approved treatment for three treatment days, then the 15 treatment days would take 6 weeks to provide, as long as they continue to be medically necessary services.

- On a treatment day, the number of services is not limited but each service must be medically necessary.

- The number of medically necessary visits or treatment encounters per treatment day per discipline is not limited. If the patient has services in the morning, leaves, and returns in the afternoon for more services, those services all done on the same date apply to one treatment day of approved treatment.

- The treatment days for PT, OT, and SLP services are separately approved. For example, a contractor may approve SLP 3 times a week for 3 weeks (consistent with the plan of care) for a total of 9 treatment days of SLP services. For the same patient during the same time, a contractor may approve PT 5 times a week for 3 weeks for a total of 15 PT services. If these PT and SLP services occurred on the same day the PT services count for one treatment day of approved PT and the SLP services count for one treatment day of approved SLP.

- Contractors may approve any number of treatment days of previously provided services if they are presented with documentation indicating they were medically necessary. However, retroactive requests are discouraged as they put the patient at financial for disapproved services. Failure to submit requests for cap exceptions prior to the date the cap is surpassed will put the beneficiary at risk of incurring the costs of treatment if the request is denied.

The beneficiary may qualify for an automatic cap exception at any time during the episode when documented medically necessary services exceed caps. For example, should a change in status result in the beneficiary satisfying the requirements for the cap exception the provider or supplier would either utilize the modifier for automatic exceptions or apply for contractor approval. A new condition, occurring during an initial episode for an unrelated condition, would be included in the patient's plan of care and become part of the same episode of care. For example, if a patient was being treated for a condition that was not automatically excepted, but developed a condition that was automatically excepted before discharge from treatment for the initial condition AND that new condition directly and significantly impacts the treatment, then the KX modifier would be used, without contractor approval, for services over the cap while the patient was treated for the condition with the automatic exception.

Providers and suppliers are encouraged to anticipate the need to request exceptions from the cap and apply before the cap is met. Routine submission for exceptions when patients are not receiving rehabilitative treatment is an abuse of the process. Routine submission of requests after the cap has been met is also an abuse of the process.

2. Automatic Exceptions

No specific documentation is submitted to the contractor if the beneficiary qualifies for the automatic cap exception for an active condition when documentation justifies medically necessary services above the caps. However, the provider must maintain documentation of medical necessity in the beneficiary's clinical records and justify the clinician's decision that the beneficiary qualified for the automatic cap exception for medically necessary services. This documentation shall be submitted in response to any

subsequent claim review. The provider/suppliers/beneficiaries may include, at their discretion, a summary that specifically addresses the justification for therapy cap exception. A list of the excepted evaluation codes are in C2a. A list of the ICD-9 codes for conditions and complexities is in C3.

a. Exceptions for Evaluation Services

Evaluation permits the provider to determine if the current status of the beneficiary requires therapy services. Any subsequent treatment procedures for such beneficiaries would need to meet the cap exception requirements to be covered.

CMS will except the following therapy evaluation procedures from caps after the therapy caps are reached:

> 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."

When submitting claims for necessary evaluation services that exceed the caps, providers and suppliers are instructed to attach the KX modifier' (See section C5) to evaluation procedures listed above to identify them as an excepted therapy procedure. The modifier alerts the contractor to override a denial for that service due to the cap.

Documentation shall provide the complaint, or condition that indicates why the evaluation was necessary. Documentation shall describe any complexities that directly and substantially impact the patient's treatment.

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

Based upon analysis of claims data, research and evidence based practice guidelines, CMS has identified conditions and complexities that will be excepted from caps. This list appears in C3. A number of factors were considered in development of the list, after considerable study and extensive clinical input. Among the considerations were:

- Data analysis of conditions or complexities with consistently higher likelihood that a beneficiary would appropriately receive services in excess of the therapy cap limitations.

- Conditions which, although they do not often appropriately exceed caps, might result in significant harm if treatment were delayed for manual approval of further necessary services after the cap is reached.

- Volume of services for the conditions, extensive clinical input, and other considerations.

The CMS is aware that there are exceptions that can be debated. This list also represents a balance of the concerns about impact on the patients' continuity of care, volume of manual review, and potential improper use of the modifier.

Conditions are represented on the list below without an asterisk (*). When a condition is the reason for the exception, that condition must be related to the therapy goals and must directly and significantly impact the rate of recovery such that it is appropriate to exceed the caps. 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.

Complexities are identified in the list below with asterisks (*). Exceptions for these complexities, in combination with other conditions that are not on the list, will directly and significantly impact the rate of recovery for the condition being treated. List in your documentation both the disorder treated and one of the complexities. Describe why or how the complexity affects treatment. For example: Cardiac dysrhythmia is not a condition for which a therapist would directly treat a patient, but such dysrhythmias may so directly and significantly affect the pace of progress in treatment for other conditions as to require an exception to caps for necessary services. Documentation should indicate that the progress was affected by the complexity and the extended services are necessary.

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. Only the clearly identifiable conditions described in the following table would qualify for the automatic cap exception based upon clinical condition. **This condition or complexity must directly and significantly affect the type, frequency, intensity and/or duration of required, medically necessary, skilled services over the cap.**

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

When using this table, refer to the ICD-9 code book for coding instructions. Exceptions apply only to the codes listed. 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 presence of a diagnosis on the code list for excepted conditions or complexity does not mean that all services for this condition or complexity are excepted from caps. Exception requires that a beneficiary is currently being treated for a condition or complexity on the list. ALSO, the severity of the condition or related therapy disorder for

which that patient is treated is such that the skills of a therapist are required for services to address the medical needs above therapy caps that meet the qualifications for reasonable and necessary services. Documentation in the record must always justify the medical necessity of the services both before the cap is reached and after the cap has been reached.

Complexities are comorbidities or complicating circumstances and do not, alone, justify an exception from caps. A complexity must be reported with another condition (which may or may not be listed as an excepted condition) when both are concurrently influencing the length or intensity of treatment such that therapy caps are exceeded by necessary services. Utilize the KX modifier on each line of the claim for the excepted medically necessary services. Document carefully both the complexity and the other condition. The necessary, skilled treatment for the other condition must be directly and significantly affected by the complexity, causing services to be extended appropriately beyond the cap.

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 and complexities (marked *) that may cause medically necessary therapy services to qualify for the automatic therapy cap exception. If a diagnosis code is not listed here, then the disorder may still qualify for an exception by approval of a Medicare contractor. These codes are grouped only to facilitate reference to them. The codes apply to all therapy disciplines, but 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.

ICD-9	DESCRIPTION
V43.64	JOINT REPLACEMENT, HIP
V43.65	JOINT REPLACEMENT, KNEE
V43.61	JOINT REPLACEMENT, SHOULDER
V49.63-49.67	UPPER LIMB AMPUTATION STATUS
V49.73-49.77	LOWER LIMB AMPUTATION STATUS
250 – 250.93	**DIABETES MELLITUS***
278.01-278.02	**OVERWEIGHT, OBESITY, AND OTHER HYPERALIMENTATION ***
290.0-290.4	**DEMENTIAS***
294.0-294.9	**PERSISTENT MENTAL DISORDERS DUE TO CONTIONS CLASSIFIED ELSEWHERE***

311	**DEPRESSIVE DISORDER NEC***
323.0-323.0	**ENCEPHALITIS, MYELITIS, AND ENCEPHALOMYELITIS***
331.0-331.9	OTHER CEREBRAL DEGENERATIONS
332.0-332.1	PARKINSON'S DISEASE
333.0-333.99	OTHER EXTRAPYRAMIDAL DISEASES AND ABNORMAL MOVEMENT DISORDERS
334.0-334.9	SPINOCEREBELLAR DISEASE
335.0-335.9	ANTERIOR HORN CELL DISEASE
336.0-336.9	OTHER DISEASES OF SPINAL CORD
337.20-337.29	REFLEX SYMPATHETIC DYSTROPHY
340	MULTIPLE SCLEROSIS
342.00-342.9	HEMIPLEGIA AND HEMIPARESIS
343.0-343.9	INFANTILE CEREBRAL PALSY
344.00-344.9	OTHER PARALYTIC SYNDROMES
348.9-348.9	OTHER CONDITIONS OF BRAIN
349.0-349.9	OTHER AND UNSPECIFIED DISORDERS OF THE NERVOUS SYSTEM
353-357	NEUROPATHIES
359.0-359.9	MUSCULAR DYSTROPHIES AND OTHER MYOPATHIES
386.0-386.9	**VERTIGINOUS SYNDROMES AND OTHER DISORDERS OF VESTIBULAR SYSTEM***
401.0-401.9	**ESSENTIAL HYPERTENSION***
402.00-402.91	**HYPERTENSIVE HEART DISEASE***
414.00-414.9	**OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE***
415.0-415.19	**ACUTE PULMONARY HEART DISEASE***
416.0-416.9	**CHRONIC PULMONARY HEART DISEASE***
427.0-427.0	**CARDIAC DYSRHYTHMIAS***
428.0-428.9	**CONGESTIVE HEART FAILURE***
430-432.9	INTRACRANIAL HEMORRHAGES
433.0-434.9	OCCLUSION AND STENOSIS OF PRECEREBRAL AND CEREBRAL ARTERIES (**FOR OCCLUSION ONLY**)
436	ACUTE, BUT ILL-DEFINED, CEREBROVASCULAR DISEASE
437.0-437.9	OTHER AND ILL-DEFINED CEREBROVASCULAR DISEASE
438.0-438.9	LATE EFFECTS OF CEREBROVASCULAR DISEASE
443.0-443.9	**OTHER PERIPHERAL VASCULAR DISEASE***
453.0-453.9	**OTHER VENOUS EMBOLISM AND THROMBOSIS***
457.0-457.1	POSTMASTECTOMY LYMPHEDEMA SYNDROME AND OTHER LYMPHEDEMA
478.30-478.5	DISESASES OF VOCAL CORDS OR LARYNX
486	**PNEUMONIA, ORGANISM UNSPECIFIED***
490-496	**CHRONIC OBSTRUCTIVE PULMONARY DISEASES***
710.0-710.9	DIFFUSE DISEASES OF CONNECTIVE TISSUE
707.99-707.9	**CHRONIC ULCER OF SKIN***
711.00-711.99	**ARTHROPATHY ASSOCIATED WITH INFECTIONS***
713.0-713.8	**ARTHROPATHY ASSOCIATED WITHOTHER DISCORDERS CLASSIFIED ELSEWHERE***

714.0-714.9	**RHEUMATOID ARTHRITIS AND OTHER INFLAMMATORY POLYARTHROPATHIES***
715.09	OSTEOARTHRITIS AND ALLIED DISORDERS
715.11	OSTEOARTHRITIS, LOCALIZED, PRIMARY, SHOULDER REGION
715.15	OSTEOARTHRITIS, LOCALIZED, PRIMARY, PELVIC REGION AND THIGH
715.16	OSTEOARTHRITIS, LOCALIZED, PRIMARY, LOWER LEG
715.91	OSTEOARTHRITIS, UNSPECIFIED ID GEN. OR LOCAL, SHOULDER
715.96	OSTEOARTHRITIS, UNSPECIFIED IF GEN. OR LOCAL, LOWER LEG
718.44	CONTRACTURE OF HAND
718.49	CONTRACTURE OF JOINT, MULTIPLE SITES
719.7	**DIFFICULTY WALKING***
721.91	SPONDYLOSIS WITH MYELOPATHY
723.4	OTHER DISORDERS OF THE CERVICAL REGION, BRACHIA NEURITIS OR RADICULITIS NOS
724.02	SPINAL STENOSIS, LUMBAR REGION
724.3	**OTHER AND UNSPECIFIED DISORDERS OF THE BACK, SCIATICA***
724.4	**OTHER AND UNSPECIFIED DISORDERS OF THE BACK, THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS, UNSPECIFIED***
726.10-726.19	ROTATOR CUFF DISORDER AND ALLIED SYNDROMES
727.61-727.62	RUPTURE OF TENDON, NONTRAUMATIC
733.00	OSTEOPOROSIS WITH WEDGING OF VERTEBRA
780.93	MEMORY LOSS
781.2	ABNORMALITY OF GAIT
781.3	LACK OF COORDINATION
781.8	NEUROLOGIC NEGLECT SYNDROME
781.92	**SYMPTOMS INVOLVING NERVOUS AND MUSCULOSKELETAL SYMPTOMS, ABNORMAL POSTURE***
784.3-784.69	APHASIA AND OTHER SPEECH DISTURBANCES
787.2	DYSPHASIA
806.00-806.99	FRACTURE OF VERTEBRAL COLUMN WITH SPINAL CORD INJURY
810.00-810.13	FRACTURE OF CLAVICLE
811.00-811.19	FRACTURE OF SCAPULA
812.00.812.59	FRACTURE OF HUMERUS
813.00-813.93	FRACTURE OR RADIUS AND ULNA
820.00-820.9	FRACTURE OF NECK OF FEMUR
821.0-821.39	FRACTURE OF OTHER AND UNSPECIFIED PARTS OF FEMUR
828.0-828.1	MULTIPLE FRACTURES INVOLVING BOTH LOWER LIMBS, LOWER WITH UPPER LIMB, AND LOWER LIMB(S) WITH RIB(S) AND STERNUM
852.00-852.59	SUBARACHNOID, SUBDURAL, AND EXTRADURAL HEMORRHAGE, FOLLOWING INJURY
853.00-853.19	OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE FOLLOWING INJURY
854.00-854.19	INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE

881.0-881.2	OPEN WOUND OF ELBOW, FOREARM, AND WRIST
882.0-882.2	OPEN WOUND OF HAND WITH TENDON INVOLVEMENT
884.0-884.2	MULTIPLE AND UNSPECIFIED OPEN WOUND OF UPPER LIMB WITH TENDON INVOLVEMENT
887.0 – 887.7	TRAUMATIC AMPUTATION OF ARM AND HAND (COMPLETE) (PARTIAL)
897.0-897.7	TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL)
952.00-952.9	SPINAL CORD INJURY WITHOUT EVIDENCE OF SPINAL BONE INJURY
941.00-952.9	BURNS
959.01	HEAD INJURY

4. Additional Exceptions for Complexity

While a beneficiary may not automatically qualify for a cap exception solely based on one of the underlying medical conditions in the table in C3, or conditions in combination with complexities in the table in C3, the beneficiary may still qualify for an automatic cap exception for other clinical complexities. Following are clinical complexities that can justify an automatic exception to the therapy caps for <u>any</u> condition that necessitates skilled therapy services, regardless of whether it is on the list in the table in C3**.** As in all exceptions, the services rendered above the caps must be documented, covered, medically necessary services. The mere existence of one of these complexities does not assure that the services were medically necessary. The clinician's documentation must justify the use of the modifier.

- The beneficiary was discharged from a hospital or SNF within 30 treatment days of starting this episode of outpatient therapy. Indicate date of discharge and name of hospital or SNF.

- The beneficiary has, in addition to another disease or condition being treated, generalized musculoskeletal conditions or conditions affecting multiple sites not listed as automatically excepted by condition that will directly and significantly impact the rate of recovery.

- The beneficiary has a mental or cognitive disorder in addition to the condition being treated that will directly and significantly impact the rate of recovery.

For the above complexities, list in your documentation all relevant disorders or conditions and describe the impact. For example: A sprained ankle does not qualify for exception by condition, but if the patient also has a dysfunctional wrist on the opposite side that precludes the use of a cane, it would cause a direct and significant impact on the patient's need for skilled physical therapy, and might require services that exceed caps.

- The beneficiary requires PT and SLP services concurrently. If the combination of the two services causes the cap to be exceeded for necessary services, the services are excepted from the PT/SLP cap. There is no affect on the OT cap.

- The beneficiary had a prior episode of outpatient therapy during this calendar year for a different condition. The second condition treated in the year may not be on the list of excepted conditions. IF services are medically necessary and would be payable under the cap, an exception is allowed if prior use of services for a different condition caused the cap to be exceeded and the medically necessary services to be denied. In cases where the beneficiary was treated in the same year for the same condition, contractor approval is required for use of the KX modifier.

- The beneficiary requires this treatment in order to return to a premorbid living environment. Document what environment and what is needed to return. For example: Patient is progressing (see FIM scores) and has good potential for completing goals for independent toileting which is required for discharge from the nursing home setting and return to the assisted living facility where she resided prior to the CVA.

- The beneficiary requires this treatment plan in order to reduce Activities of Daily Living assistance or Instrumental Activities of Daily Living assistance to premorbid levels. Document prior level of independence and current assistance needs.

- The beneficiary indicates he/she does not have access to outpatient hospital therapy services. List reasons that justify why the patient cannot obtain excepted services from an outpatient hospital. Reasonable justifications include 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 hospital in the beneficiary's county. If there is any question that the justification may not be accepted as reasonable, submit a request to the contractor.

5. Exception Process for Contractor Approval

If the beneficiary does not automatically qualify for a cap exception based upon clinical condition or clinical complexity at the onset of the treatment episode, the beneficiary or their representative (including providers and suppliers) may submit a request for a cap exception to the contractor for review at any time during the episode. It is recommended that the request be submitted as early as the clinician determines that the beneficiary may need services beyond the cap limits. Failure to submit requests for cap exceptions prior to the date the cap is surpassed will put the beneficiary at risk of incurring the costs of treatment if the request is denied. The provider will be responsible for collecting payments for costs incurred.

Medicare contractors have 10 business days from contractor receipt to respond to requests. When requests for services are approved as medically necessary Medicare contractors shall pay for any necessary services provided within the number of approved treatment days regardless of whether those necessary services were provided before or

after receipt of the request. Contractors shall approve requested services by allowing a specific number of days of treatment for each discipline (PT, OT, and SLP separately).

Providers are discouraged from submitting routine or excessive requests, or excessive requests for services already rendered. **Routine use of the KX modifier for all patients with these conditions will likely show up on data analysis as aberrant and invite inquiry.**

The letter of request, including the number of treatment days requested and the justification for the medically necessary services must be submitted to the contractor by fax with supporting documentation, unless the contractor specifically requests or allows phone or mail requests. The request and all documentation required for medical review listed in 220.3 must be sent in together. Keep the fax receipt in the record. If mailed requests are allowed, certified mail will document receipt at the contractor. If phone requests are allowed, both the contractor and the provider/supplier shall document the request and the contractor's response. The documentation requirements are the same as the documentation required to be kept in the medical record for services that are automatically excepted and is described in section C2 through C4 above. In the case of services not automatically excepted, send these documents to the contractor with a request. Include any further justification the provider or supplier believes may be helpful to the contractor in determining that the services are (were or will be) necessary and appropriately provided. For example, outcome measurements that indicate the patient is progressing, has good prognosis, but has not reached expected outcomes for the condition, or research that indicates the length of treatment for this condition is appropriate.

If the contractor approves the cap exception,

- The provider maintains a copy of the approval in the beneficiary's clinical record and shall present such documentation during any subsequent claim review.

  Note: By approving the cap exception, the contractor has determined, based on information provided by the provider/supplier that the requested services are medically necessary.

- The provider shall attach the KX modifier (See C1 above) to all therapy procedures subject to the caps.

- If the clinician determines that the episode of treatment appropriately extends beyond the original duration estimate in the plan of care approved by the contractor (or the number of treatment days approved), the provider shall submit a request for further cap exception using the procedures described above.

If the contractor disapproves the request for exception, the contractor shall notify the provider/supplier within 10 business days of the receipt of the request and shall include the reason for the disapproval.

If the beneficiary does not automatically qualify for a cap exception, and is not approved for an exception by the contractor, then the therapy services furnished during that episode are subject to the cap.

When the provider/supplier determines that not all of the requested and approved services are necessary, the exception no longer applies and, use of the KX modifier is not allowed.

6. Appeals Related to Disapproval of Cap Exceptions

Disapproval of Requested Exception from Caps. When a beneficiary's services exceed therapy caps, services are no longer covered and are denied as a benefit category denial. 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.

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 – Further details concerning appeals is found in CMS IOM Pub. 100-02, chapter 29. A contractor's decision regarding a "therapy cap exception" request is not an initial claim determination as defined in 42 CFR 405.924, and is not subject to the administrative appeals process (as outlined in Publication 100-4 Chapter 29). However, if a beneficiary whose exception request is not approved elects to receive services that exceed the cap limitation and a claim is submitted for such services, the resulting determination would be subject to the administrative appeals process.

7. 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 codes subject to the therapy cap tracking requirements are listed in a table in the Claims Processing Manual, 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.

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

- Qualified for the cap exception either automatically or by contractor approval;

- Are reasonable and necessary services that require the skills of a therapist; and

- Are justified by appropriate documentation in the medical record.

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 not count the expenditure against the applicable PT/SLP or OT cap amount. Instead, contractors will override the CWF system reject 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 and the cap is exceeded, those services will be denied. The provider/supplier/beneficiary may request and the contractor may retroactively approve an exception to the cap for any number of medically necessary services. Contractors may reopen and adjust the claim for which retroactive approval was granted, if it is brought to their attention.

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, 2006. The limits are $1,740 for PT and SLP combined and $1,740 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 2006. Estos límites son $1,740 para PT y SLP combinados y $1,740 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 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 PM. Add applied amount for individual beneficiaries and the generic limit amount (e.g., $1740 in 2006) 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 medicamente necesaria y que sobrepasa estas cantidades límites está cubierta cuando se recibe en una unidad de hospital ambulatorio o cuando está aproba 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 42CFR 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 2006 limit of $1740 for a beneficiary who has paid the deductible and the coinsurance:

Services received to date $1725 ($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

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 has been reached- in the provider remittance advice to establish the reason for denial. The provider/supplier should advise the beneficiary that a claim for services that exceeds the limitation is being denied pursuant to §1833(g) of the Act (42U.C.S. §1395(g)). The providers/ suppliers should inform the beneficiary that any additional outpatient rehabilitation services in this setting would result in the beneficiary exceeding the financial limitation, but medically necessary services above the limit may be obtained at an outpatient hospital. Such notification will allow the beneficiary to make an informed choice about continuing to receive services from the provider/supplier or to change to a hospital outpatient department. This is advised because the beneficiary is responsible for payment of all outpatient rehabilitation services that exceed the financial limit on an annual basis.

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.

Beneficiaries may appeal claims denied due to exceeding therapy limits. The beneficiary is to be advised of his or her appeal rights set forth in 42CFR Part 405, Subpart G. Physicians, nonphysician practitioners, therapists and other suppliers who accept assignment may also appeal denials. Physicians, nonphysician practitioners, therapists and other suppliers who do not accept assignment and institutional providers do not have the right to appeal.

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.

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. 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.

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., $1740 in 2006) 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.

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

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. *Providers/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.

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12.8 - Provider Access to Smoking and Tobacco-Use Cessation Counseling Services Eligibility Data

(Rev. 1000, Issued: 07-19-06; Effective: 10-01-06; Implementation: 10-02-06)

Providers may access coverage period remaining smoking and tobacco-use cessation counseling sessions and a next eligible date, when there are no remaining sessions, through the 270/271 eligibility inquiry and response transaction.