| CMS Manual System | Department of Health & Human Services (DJHS) |
|---|---|
| Pub 100-08 Medicare Program Integrity | Centers for Medicare & Medicaid Services (CMS) |
| Transmittal 245 | Date: FEBRUARY 29, 2008 |
| | Change Request 5945 |

**SUBJECT: Processing Part B Therapy Claims While the Therapy Cap Exceptions Process is in Effect**

**I. SUMMARY OF CHANGES:** Chapter 3, is being updated to state that the instructions shall apply whenever an exceptions process to the therapy caps is in effect.

**NEW/REVISED MATERIAL**
**EFFECTIVE DATE: JANUARY 1, 2008**
**IMPLEMENTATION DATE: March 31, 2008**

***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**

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 3/3.4.1.1.1/Exception From the Uniform Dollar Limitation (“Therapy Cap”) |

**III. FUNDING:**

**SECTION A: For Fiscal Intermediaries and Carriers:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

**SECTION B: For Medicare Administrative Contractors (MACs):**
The Medicare administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted 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.

**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

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

# Attachment - Business Requirements

| Pub. 100-08 | Transmittal: 245 | Date: February 29, 2008 | Change Request: 5945 |
|---|---|---|---|

**SUBJECT: Processing Part B Therapy Claims While the Therapy Cap Exceptions Process is in Effect**

**Effective Date: January 1, 2008**
**Implementation Date: March 31, 2008**

## 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. The Tax Relief and Health Care Act of 2006 extended the application exceptions to the therapy cap, which were implemented as an automated process for exception through calendar year 2007. Recent legislation further extended the exceptions process through June 30, 2008.

This transmittal updates the Program Integrity Manual (PIM) chapter 3, § 3.4.1.1.1 to provide instructions for processing Part B therapy claims whenever exceptions to the therapy caps are in effect.

**B. Policy:** Contractors shall continue the automatic process for exception from the therapy cap described in CMS Pub. 100-08, chapter 3, §3.4.1.1.1, including appropriate medical review activities, whenever the therapy caps are in effect. When brought to the contractor's attention by a provider, supplier, or beneficiary, claims for medically necessary therapy services provided between January 1, 2008 and the implementation date of this CR, which were rejected or denied due to exceeding the therapy cap shall be reopened and/or adjusted.

## II. BUSINESS REQUIREMENTS TABLE

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER: PSCs who perform "straight" Medical Review |
| | | | | | | | FISS | MCS | VMS | CWF | |
| 5945.1 | Contractors shall continue the automatic process for exceptions from the part B therapy cap, described in CMS Pub. 100-08, chapter 3, §3.4.1.1.1, whenever the therapy cap exceptions process is in effect. | X | | X | X | X | | | | | X |
| 5945.2 | The contractor shall reopen and/or adjust any claims | X | | X | X | X | | | | | X |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER: PSCs who perform "straight" Medical Review |
| | | | | | | | FISS | MCS | VMS | CWF | |
| | for medically necessary outpatient therapy services provided between January 1, 2008 and the implementation date of this CR, which were rejected or denied due to exceeding the therapy cap, when such claims are brought to the attention of the contractor by the provider/supplier/beneficiary. | | | | | | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | FISS | MCS | VMS | CWF | |
| | **N/A** | | | | | | | | | | |

## IV. SUPPORTING INFORMATION

**A. For any recommendations and supporting information associated with listed requirements, use the box below:**

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|
| 5945.1 | CMS will provide additional instruction in the future regarding the status of the therapy cap exceptions process after June 30, 2008. |

**B. For all other recommendations and supporting information, use this space: None.**

## V. CONTACTS

**Pre-Implementation Contact(s):** Kimberly Spalding (Kimberly.spalding@cms.hhs.gov)

**Post-Implementation Contact(s):** Regional offices for FIs and carriers; project officers for A/B MACs and PSCs who perform medical review of lab claims

## VI. FUNDING

**A. For *Fiscal Intermediaries and Carriers,* use only one of the following statements:** No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

**B. *For Medicare Administrative Contractors (MACs),* use the following statement:** 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 allotted 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.

## 3.4.1.1.1 - Exception From the Uniform Dollar Limitation ("Therapy Cap")

***(Rev. 245; Issued: 02-29-08; Effective: 01-01-08; Implementation: 03-31-08)***

*Financial limitations on therapy services (therapy caps) were originally initiated by the Balanced Budget Act of 1997 and have been implemented at times without an exceptions process. During a time when no exceptions process exists, contractors shall deny claims for Part B occupational, physical, and speech-language pathology therapy services, except for hospital outpatient therapy services, which exceed the therapy cap. There is no therapy cap for hospital outpatient therapy services.*

Automatic *Process for* Exception from *the* Therapy Cap

Section 1833(g)(5) of the Social Security Act provides that 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.

For *therapy services provided during a time when a therapy cap exceptions process is in effect,* the contractor shall presume the beneficiary to be excepted from the therapy cap without submission of request for exception or supporting documentation if:

- The beneficiary meets specific conditions listed in CMS Pub.100-04, chapter 5, §10.2 for exception from the therapy cap, or

- The beneficiary does not meet the specific criteria in CMS Pub.100-04, chapter 5, §10.2, but has a need for medically necessary therapy services above the therapy cap.

In both of these situations, the contractor shall require that the therapist maintain on file, necessary documentation to support the medical necessity of therapy services. Documentation requirements are found in CMS Pub.100-02, chapter 15, section 230.3.

Request for Exception from Therapy Caps

Contractors shall not require providers to submit written requests for exception from the therapy cap. Instead, the placement of the KX modifier on the claim shall be interpreted as a request for exception from the cap. For beneficiaries who the clinician believes will require therapy treatment days in excess of those payable under the therapy cap, and who meet the above bulleted criteria for automatic exception, the Medicare contractor shall require the provider to maintain sufficient documentation on file to support the medical necessity for this service. Use of the KX modifier shall be interpreted as the therapist's attestation that services provided above the cap are medically necessary.

The contractor shall require the provider to maintain on file documentation in accordance with CMS Pub.100-02, chapter 15, section 220.3 and CMS Pub.100-04, chapter 5, sections 10.2 and 20 with the request for treatment days in excess of those payable under the therapy cap.

If the clinician attests that the requested services are medically necessary by using a KX modifier on the claim line, the contractor may make the determination that the claim is medically necessary. That determination is binding on the contractor in the absence of:

- potential fraud; or
- evidence of misrepresentation of facts presented to the contractor, or
- A pattern of aberrant billing by a provider.

Should such evidence of potential fraud, misrepresentation, or aberrant billing patterns by a provider be found, claims are subject to medical review regardless of whether the KX modifier was used on the claim.

Progressive corrective action (PCA) and medical review have a role in the therapy 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 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 patterns of aberrant billing of the services by the provider/supplier. Services deemed medically necessary are still subject to review related to fraud or abuse. An example of inappropriate use of the process is 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.