CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2615	**Date: December 14, 2012**
	Change Request 7785

NOTE: Transmittal 2457, dated April 27, 2012, is being rescinded and replaced by Transmittal 2615, dated December 14, 2012, to add FISS as a responsible party for requirement 7785.3.4. All other information remains the same.

SUBJECT: Revisions of the Financial Limitation for Outpatient Therapy Services – Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012

I. SUMMARY OF CHANGES: This Change Request extends the therapy cap exceptions process through December 31, 2012 and adds therapy services provided in outpatient hospital settings to the therapy cap effective October 1, 2012.

EFFECTIVE DATE: October 1, 2012
IMPLEMENTATION DATE: October 1, 2012

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	5/10.3/Application of Financial Limitations
R	5/10.4/Claims Processing Requirements for Financial Limitations
R	5/10.5/Notification for Beneficiaries Exceeding Financial Limitations

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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. 100-04	Transmittal: 2615	Date: December 14, 2012	Change Request: 7785

NOTE: Transmittal 2457, dated April 27, 2012, is being rescinded and replaced by Transmittal 2615, dated December 14, 2012, to add FISS as a responsible party for requirement 7785.3.4. All other information remains the same.

SUBJECT: Revisions of the Financial Limitation for Outpatient Therapy Services – Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012

Effective Date: **October 1, 2012**

Implementation Date: October 1, 2012

I. GENERAL INFORMATION

A. Background: The Balanced Budget Act of 1997 enacted financial limitations on outpatient physical therapy, occupational therapy, and speech-language pathology services in all settings except outpatient hospital. Exceptions to the limits were enacted by the Deficit Reduction Act, and have been extended by legislation several times.

B. Policy: Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) extended the therapy caps exceptions process through December 31, 2012 and made several changes affecting the processing of claims for therapy services. Suppliers and providers will continue to use the KX modifier to request an exception to the therapy cap on claims that are over the 2012 cap amounts -- $1880 for occupational therapy services and $1880 for the combined services for physical therapy and speech-language pathology. Use of the KX modifier indicates that the services are reasonable and necessary and that there is documentation of medical necessity in the patient's medical record.

Therapy services furnished in an outpatient hospital setting have been exempt from the application of the therapy caps; however, MCTRJCA requires Original Medicare to temporarily apply the therapy caps (and related provisions) to the therapy services furnished in an outpatient hospital on/after October 1, 2012, and on/before December 31, 2012. Although claims processing requirements associated with the cap are only applicable to hospitals on/after October 1, 2012 (e.g., the exceptions process using the KX modifier or denying claims without the KX modifier if the cap is exceeded), in calculating the cap beginning October 1, 2012, claims paid for hospital outpatient therapy services since January 1, 2012, will be included.

MCTRJCA contains two requirements that become effective on October 1, 2012. The first of these requires suppliers and providers to report the National Provider Identifier (NPI) of the physician, or nonphysician practitioner (NPP) where applicable, responsible for reviewing the therapy plan of care, on the beneficiary's claim for therapy services. For implementation purposes, the physician or NPP (as applicable) certifying the therapy plan of care is reported.

MCTRJCA also calls for a manual medical review process for those exceptions where the beneficiary therapy services for the year reach a threshold of $3,700. The separate thresholds triggering manual medical reviews build upon the separate therapy caps -- one for PT and SLP services combined and one for OT services. Claims with a KX modifier requesting an exception for services above either threshold, per MCTRJCA, are subject to a manual medical review process. The count of services to which these thresholds apply begins on January 1,

2012. Absent Congressional action, manual medical review expires when the exceptions process expires for dates of service after December 31, 2012.

Claims for services at or above the therapy caps or thresholds for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable. While suppliers and providers are not required to issue an Advance Beneficiary Notice (ABN) for these benefit category denials, they are encouraged to issue the voluntary ABN as a courtesy to their patients requiring services over the therapy cap amounts ($1,880 for each cap in CY 2012) to alert them of their possible financial liability.

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
							FISS	MCS	VMS	CWF	
7785.1	Medicare contractors shall ensure that exceptions to the therapy caps are made only when outpatient therapy services report modifier KX.	X		X	X	X	X			X	
7785.2	Effective for dates of service on or after October 1, 2012, Medicare contractors shall edit to enforce the therapy caps for outpatient therapy services on institutional claims provided in outpatient hospital settings.									X	
7785.2.1	Medicare contractors shall edit to enforce the therapy caps if the following criteria are present: • Type of bill 12X (excluding Critical Access Hospital CCNs in the range 1300-1399) or 13X • Revenue code 042X, 043X or 044X • Modifier GN, GO or GP and • Date of service on or after October 1, 2012.						X			X	
7785.2.2	Medicare contractors shall bypass the edits to enforce the therapy caps if modifier KX is present on a therapy service line.									X	
7785.3	Medicare contractors shall accumulate per-beneficiary total payment amounts for outpatient therapy services, including payments made beyond the therapy caps, for use in applying additional thresholds of $3700.									X	
7785.3.1	Medicare contractors shall accumulate separate per-beneficiary totals for the new thresholds: • Physical therapy and speech-language pathology combined, and • Occupational therapy.									X	
7785.3.2	Medicare contractors shall apply outpatient therapy service payments to the new thresholds in the same manner currently used to apply payments to the therapy cap amounts.									X	
7785.3.3	Medicare contractors shall apply outpatient therapy									X	

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	
	services provided in outpatient hospital settings to the new thresholds.										
7785.3.4	The new thresholds shall accrue for claims with dates of service from January 1 through December 31, 2012.						X			X	
7785.4	Medicare contractors shall manually review claims containing any therapy service that exceeds the applicable threshold amount for claims with dates of service on and after October 1, 2012.	X		X	X	X	X				
7785.4.1	Medicare contractors shall reject outpatient therapy service lines when the applicable threshold amount is greater than $3700 before the current service payment is applied, if the KX modifier is on the claim. **NOTE:** The edit shall be overrideable.									X	
7785.4.2	Medicare contractors shall suspend any claims rejected per requirement 7785.4.1. **NOTE:** The details regarding handling the suspended claims will be provided in a separate instruction.	X		X	X	X	X				
7785.5	Medicare contractors shall update the payments applied to the therapy caps and the new $3700 thresholds to reflect all therapy services provided in hospital outpatient settings with dates of service in 2012 that were processed before October 1, 2012.									X	
7785.6	Medicare contractors shall display the total amount applied toward the therapy caps and thresholds on all applicable screens and inquiry mechanisms.									X	
7785.7	Medicare contractors shall instruct providers to report the NPI of the physician certifying the therapy plan of care in the Attending Physician field on institutional claims for outpatient therapy services, for dates of service on and after October 1, 2012.	X		X		X					
7785.7.1	Medicare contractors shall instruct providers that in cases where different professionals certify the OT, PT or SLP plan of care to report the additional NPI in the Referring Physician field (loop 2310F) on institutional claims for outpatient therapy services, for dates of service on and after October 1, 2012.	X		X		X					
7785.8	Medicare contractors shall instruct providers to report the physician/NPP certifying the therapy plan of care on professional claims, including his/her NPI, for outpatient therapy services for dates of service on and after October 1, 2012.	X			X						
7785.8.1	Medicare contractors shall instruct providers that, for	X			X						

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	
	claims processing purposes, the certifying physician/NPP is considered a referring provider (per Pub. 100-02, Chapter 15, section 220.1.1), and the providers are to follow claims processing instructions for reporting the referring provider to report this individual on a claim.										
7785.8.2	For electronic claims, Medicare contractors shall instruct providers to report the referring provider, including his/her NPI, per the instructions in the appropriate ASC X12 837 Technical Report 3 (TR3).	X			X						
7785.8.3	For paper claims, Medicare contractors shall instruct providers to report the referring provider, including his/her NPI, per the instructions in IOM Pub. 100-04, Chapter 26, section 10.	X			X						
7785.8.4	Medicare contractors shall return as unprocessable any claim for a therapy service which does not include at least one referring provider and his/her NPI, i.e., a referring provider identified at the claim level.	X			X						
7785.8.4.1	When returning claims returned as unprocessable per BR 7785.8.4, contractors shall use the following claim adjustment reason code: **16 Referral absent or** **5 exceeded.**	X			X						
7785.8.4.2	When returning claims returned as unprocessable per BR 7785.8.4, contractors shall use the following remittance advice remark codes: **N28 Missing/incomplete/invalid referring** **5 provider name.** **N28 Missing/incomplete/invalid referring** **6 provider primary identifier.**	X			X						

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	
7785.9	A provider education article related to this instruction will be available at http://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 one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. 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.	X		X	X	X					

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
7785.3.2	Current requirements regarding co-insurance, multiple procedure payment reductions or other payment adjustments will be applied to the new thresholds.
7785.6	Currently, CWF displays amounts up to the current therapy cap amount of $1880 and does not display amounts over $1880. This limitation on the displayed amount is removed by this requirement.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Institutional Claims: Wil Gehne, 410-786-6148, wilfried.gehne@cms.hhs.gov , Yvonne Young, 410-786-1886, yvonne.young@cms.hhs.gov

Professional Claims: Claudette Sikora, 410-786-5618, claudette.sikora@cms.hhs.gov

Policy Contact: Pamela West, 410-786-2302, pamela.west@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *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),* include the following statement:

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.

10.3 - Application of Financial Limitations

(Rev. 2615, Issued: 12/14/12, Effective: 10/01/12, Implementation: 10/01/12)

Financial limitations on outpatient therapy services, as described above, began for therapy services rendered on or after on January 1, 2006. References and polices relevant to the exceptions process in this chapter apply only when exceptions to therapy caps are in effect. *For dates of service before October 1, 2012,* limits apply to outpatient Part B therapy services furnished in all settings except outpatient hospitals, including hospital emergency departments. These excluded hospital services are reported on bill types 12x or 13x, or 85x. *Effective for dates of service on or after October 1, 2012, the limits also apply to outpatient Part B therapy services furnished in outpatient hospitals other than Critical Access Hospitals. During this period, only 12x claims with a CMS certification number in the CAH range and 85x claims are excluded.*

Contractors apply the financial limitations to the 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. Medicare will pay the remaining 80 percent of the limit after the deductible is met. These amounts will change each calendar year.

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.

A. Exceptions to Therapy Caps - General

The following policies concerning exceptions to caps due to medical necessity apply only when the exceptions process is in effect. With the exception of the use of the KX modifier, the guidance in this section concerning medical necessity applies as well to services provided before caps are reached.

Provider and supplier information concerning exceptions is in this chapter and in Pub. 100-02, chapter 15, section 220.3. Exceptions shall be identified by a modifier on the claim and supported by documentation.

The beneficiary may qualify for use of the cap exceptions at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps. All requests for exception are in the form of a KX modifier added to claim lines. (See subsection D. for use of the KX modifier.)

Use of the exception *process* does not exempt services from manual or other medical review processes as described in Pub. 100-08. 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 for services which are maintenance rather than rehabilitative treatment (see Pub. 100-02, chapter 15, sections 220.2, 220.3, and 230).

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

B. Exceptions *Process*

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 special documentation is submitted to the contractor for 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 exception because 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.

Documentation 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 exception, clinicians shall consider, for example, whether services are appropriate to--

- The patient's condition, including the diagnosis, complexities, and severity;
- The services provided, including their type, frequency, and duration;
- 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 exception process:

1. Exceptions for Evaluation Services

Evaluation. The CMS will except therapy evaluations from caps after 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 CPT codes for evaluation procedures may be appropriate:

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 listed in the Annual Therapy Update for the current year at:
http://www.cms.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage.
They are not diagnostic tests. Definitions of evaluations and documentation are found in Pub. 100-02, sections 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 - Therapy Cap Report, 3/21/2008, and CSC – Therapy Edits Tables 4/14/2008 at www.cms.hhs.gov/TherapyServices (Studies and Reports), or more recent utilization 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.

2. Exceptions for Medically Necessary Services

Clinicians may utilize the process for exception for any diagnosis or condition for which they can justify services exceeding the cap. Regardless of the diagnosis or condition, the patient must also meet other requirements for coverage.

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 to report another diagnosis code. For example, when a patient with diabetes is being treated with therapy 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 diagnosis code in the primary position. In that case, the relevant diagnosis 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.

The condition or complexity that caused treatment to exceed caps 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. Documentation for an exception should indicate how the complexity (or combination of complexities) directly and significantly affects treatment for a therapy condition.

If the contractor has determined that certain codes do not characterize patients who require medically necessary services, providers/suppliers may not use those codes, but must utilize a billable diagnosis code allowed by their contractor to describe the patient's condition. Contractors shall not apply therapy caps to services based on the patient's condition, but only on the medical necessity of the service for the condition. If a service would be payable before the cap is reached and is still medically necessary after the cap is reached, that service is excepted.

Contact your contractor for interpretation if you are not sure that a service is applicable for exception.

It is very important to recognize that most conditions 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. 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.

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 (such as the availability of a caregiver at home) 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 or common sense. See Pub. 100-02, chapter 15, section 220.3 for information related to documentation of the evaluation, and section 220.2 on medical necessity for some factors that complicate treatment.

Note that the patient's lack of access to outpatient hospital therapy services alone, *when outpatient hospital therapy services are excluded from the limitation,* 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 as justification for continued services above the caps. The patient's condition and complexities might justify extended services, but their location does not. *For dates of service on or after October 1, 2012, therapy services furnished in an outpatient hospital are not excluded from the limitation.*

C. Appeals Related to Disapproval of Cap Exceptions

Disapproval of Exception from Caps. 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 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 Pub. 100-04, chapter 1, section 60.4 for appropriate use of modifiers.

APPEALS –If a beneficiary whose excepted services do not meet 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 Pub. 100-04, chapter 29.

D. Use of the KX Modifier for Therapy Cap Exceptions

When exceptions are in effect and the beneficiary qualifies for a therapy cap exception, the provider shall add a KX modifier to the therapy HCPCS code 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 for a given calendar year are listed at: http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage.

The GN, GO, or GP therapy modifiers are currently required to be appended to therapy services. 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 or A/B MAC, 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 currently has space for providing two modifiers in block 24D, but, if the provider has more than two to report, he/she can do so by placing the -99 modifier (which indicates multiple modifiers) in block 24D and placing the additional modifiers in block 19.

- The ASC X12N 837 Health Care Claim: Professional Implementation Guide 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, and data elements SV101-3, SV101-4, SV101-5, and SV101-6. Copies of the ASC X12N 837 implementation guides may be obtained from the Washington Publishing Company.

- For claims paid by a carrier or A/B MAC, it is only appropriate to append the KX modifier to 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 or A/B MAC:

  - 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 modifier 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 modifier 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 modifier is appropriately used on all of the PT lines. Refer to Pub.100-04, Medicare Claims Processing Manual, chapter 25, for more detail.

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

- Are reasonable and necessary services that require the skills of a therapist; (See Pub. 100-02, chapter 15, section 220.2); and

- Are justified by appropriate documentation in the medical record, (See 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 appended to a therapy HCPCS code, 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 append 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 appending the KX modifier would have been appropriate, contractors 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.

E. Therapy Cap Manual Review Threshold

For calendar year 2012, there shall be two total therapy service thresholds of $3700 per year: one annual threshold each for

(1) Occupational therapy services.

(2) Physical therapy services and speech-language pathology services combined.

Services shall accrue toward the thresholds beginning with claims with dates of service on and after January 1, 2012. The thresholds shall apply to both services showing the KX modifier and those without the modifier. Beginning with claims with dates of service on and after October 1, 2012, contractors shall apply the thresholds to claims exceeding it by suspending the claim for manual review. Instructions regarding the manual review process may be found in the Program Integrity Manual.

F. Identifying the Certifying Physician

Therapy plans of care must be certified by a physician or non-physician practitioner (NPP), per the requirements in the Medicare Benefit Policy Manual, Pub.100-02, chapter 15, section 220.1.3. Further, the National Provider Identifier (NPI) of the certifying physician/NPP identified for a therapy plan of care must be included on the therapy claim.

For the purposes of processing professional claims, the certifying physician/NPP is considered a referring provider. At the time the certifying physician/NPP is identified for a therapy plan of care, private practice therapists (PPTs), physicians or NPPs, as appropriate, submitting therapy claims, are to treat it as if a referral has occurred for purposes of completing the claim and to follow the instructions in the appropriate ASC X12 837 Professional Health Care Claim Technical Report 3 (TR3) for reporting a referring provider (for paper claims, they are to follow

the instructions for identifying referring providers per Chapter 26 of this IOM) . These instructions include requirements for reporting NPIs.

Currently, in the 5010 version of the ASC X12 837 Professional Health Care Claim TR3, referring providers are first reported at the claim level; additional referring providers are reported at the line level only when they are different from that identified at the claim level. Therefore, there will be at least one referring provider identified at the claim level on the ASC X12 837 Professional claim for therapy services. However, because of the hierarchical nature of the ASC X12 837 health care claim transaction, and the possibility of other types of referrals applying to the claim, the number of referring providers identified on a professional claim may vary. For example, on a claim where one physician/NPP has certified all the therapy plans of care, and there are no other referrals, there would be only one referring provider identified at the claim level and none at the line levels. Conversely, on a claim also containing a non-therapy referral made by a different physician/NPP than the one certifying the therapy plan of care, the billing provider may elect to identify either the nontherapy or the therapy referral at the claim level, with the other referral(s) at the line levels. Similarly, on a claim having different certifying physician/NPPs for different therapy plans of care, only one of these physician/NPPs will be identified at the claim level, with the remainder identified at the line levels. These scenarios are only examples: there may be other patterns of representing referring providers at the claim and line levels depending upon the circumstances of the care and the manner in which the provider applies the requirements of the ASC X12 837 Professional Health Care Claim TR3.

For situations where the physician/NPP is both the certifier of the plan of care and furnishes the therapy service, he/she supplies his/her own information, including the NPI, in the appropriate referring provider loop (or, appropriate block on the 1500 form). This is applicable to those therapy services that are personally furnished by the physician/NPP as well as to those services that are furnished incident to their own and delivered by "qualified personnel" (see section 230.5 of this manual for qualifications for incident to personnel).

Contractors shall edit to ensure that there is at least one claim-level referring provider identified on professional therapy claims, and shall use the presence of the therapy modifiers (GN, GP, GO) to identify those claims subject to this requirement.

For the purposes of processing institutional claims, the certifying physician/NPP and their NPI are reported in the Attending Provider fields on institutional claim formats. Since the physician/NPP is certifying the therapy plan of care for the services on the claim, this is consistent with the National Uniform Billing Committee definition of the Attending Provider as "the individual who has overall responsibility for the patient's medical care and treatment" that is reported on the claim. In cases where a patient is receiving care under more than one therapy plan of care (OT, PT, or SLP) with different certifying physicians/NPPs, the second certifying physicians/NPP and their NPI are reported in the Referring Physician fields on institutional claim formats.

G. MSN Messages

Existing MSN messages 38.18, 17.13, 17.18 and 17.19 shall be issued on all claims containing outpatient rehabilitation services as noted in this manual. Contractors add the applied amount for individual beneficiaries and the generic limit amount to all MSNs that require them. For details of these MSNs, see: http://www.cms.gov/MSN/02_MSN%20Messages.asp

10.4 - Claims Processing Requirements for Financial Limitations

(Rev. 2615, Issued: 12/14/12, Effective: 10/01/12, Implementation: 10/01/12)

A. Requirements – Institutional Claims

Regardless of financial limits on therapy services, CMS requires modifiers (See section 20.1 of this chapter) on specific codes for the purpose of data analysis. Beneficiaries may not be simultaneously covered by Medicare as an outpatient of a hospital and as a patient in another facility. *When outpatient hospital therapy services are excluded from the limitation, the beneficiary* 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 as hospital outpatient services, even if the CORF is owned by the hospital. Only services billed by the hospital on bill types 12X or 13X are exempt from limitations on therapy services, *when outpatient hospital therapy services are excluded from the limitation*.

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 or A/B MACs 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 *when outpatient hospital therapy services are excluded from the limitation*.

B. Requirements - Carrier or A/B Mac Claims

Claims containing any of the "always therapy" codes should have one of the therapy modifiers appended (GN, GO, GP). When any code on the list of therapy codes is submitted with specialty codes "65" (physical therapist in private practice), "67" (occupational therapist in private practice), or "15" (speech-language pathologist in private practice) they always represent therapy services, because they are provided by therapists. Carriers or A/B MACs shall return claims for these services when they do not contain therapy modifiers for the applicable HCPCS codes.

The CMS identifies certain codes listed at: http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage as "sometimes therapy" services, regardless of the presence of a financial limitation. Claims from physicians (all specialty codes) and nonphysician practitioners, including specialty codes "50" (Nurse Practitioner), "89," (Clinical Nurse Specialist), and "97," (Physician Assistant) may be processed without therapy modifiers when they are not therapy services. On review of these claims, "sometimes therapy" 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.

C. FI or A/B MAC Action Based on CWF Trailer

Upon receipt of the CWF error code/trailer, FIs or A/B MACs 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 or A/B MAC 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:

Services received to date are $15 under the limit. There is a $15 allowed amount remaining that Medicare will cover before the cap is reached.

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 or A/B MAC reports in the “Financial Limitation" field of the CWF record “$25.00 along with the CWF override code. The FI or A/B MAC 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.

D. Additional Information for Contractors 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 contractors 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, and exceptions are either not appropriate or not available, 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 *when outpatient hospital therapy services are excluded from the limitation* (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. of section 10.3 and Pub. 100-04, chapter 29.

10.5 - Notification for Beneficiaries Exceeding Financial Limitations

(Rev. 2615, Issued: 12/14/12, Effective: 10/01/12, Implementation: 10/01/12)

A. Notice to Beneficiaries

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 *when outpatient hospital therapy services are excluded from the limitation*. 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.

It is the provider's responsibility to present each beneficiary with accurate information about the therapy limits, and indicate that, where necessary, appropriate care above the limits can be obtained at a hospital outpatient therapy department *when outpatient hospital therapy services are excluded from the limitation*.

Prior to March 1, 2009, providers could use the Notice of Exclusion from Medicare Benefits (NEMB Form No. CMS 20007) to inform a beneficiary of financial liability for therapy above the cap, where no exception applied; however, the NEMB form has been discontinued. In its place, providers may now use a form of their own design, or the Advanced Beneficiary Notice of Noncoverage (ABN, Form CMS-R-131) may be used as a voluntary notice. When using the ABN form as a voluntary notice, the form requirements specified for its mandatory use do not apply. The beneficiary should not be asked to choose an option or sign the form. The provider should include the beneficiary's name on the form and the reason that Medicare may not pay in the space provided within the form's table. Insertion of 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) in (add the year or the dates of service to which it applies) 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, if appropriate. A cost estimate for the services may be included but is not required.

After the cap is exceeded, voluntary notice via a provider's own form or the ABN is appropriate, even when services are excepted from the cap. The ABN is also used **BEFORE** the cap is exceeded when notice about noncovered services is mandatory. For example, 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, an ABN must be issued before the beneficiary receives that service. At the time the clinician determines that skilled services are not necessary, the clinical goals have been met, or 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, beneficiaries should be informed that Medicare most likely will not provide additional coverage, and the ABN should be issued prior to delivering any services. The ABN informs the beneficiary of his/her potential financial obligation to the provider and provides guidance regarding appeal rights. When the ABN is used as a mandatory notice, providers must adhere to the form requirements set forth in this manual in chapter 30, section 50.6.3.

The ABN can be found at: http://www.cms.hhs.gov/BNI/Downloads/ABNFormInstructions.zip

B. 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 or A/B MACs will also find the amount a beneficiary has accrued toward the financial limitations on the HIQA. Some suppliers and providers billing to carriers or A/B MACs may, in addition, have access to 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.

Beneficiaries are provided with the most current amount accrued toward their caps on each MSN.