



## Outpatient Therapy Caps with Exceptions in Calendar Year (CY) 2009 – JA6321

**Note:** MLN Matters article MM6321 was revised to clarify the Advance Beneficiary Notice language on page 2.

Related CR Release Date: February 13, 2008 **Revised**

Date Job Aid Revised: March 12, 2009

Effective Date: January 1, 2009

Implementation Date: April 6, 2009

<b>Key Words</b>	MM6321, CR6321, R1678CP, Outpatient, Therapy, Caps, Exceptions
<b>Contractors Affected</b>	<ul style="list-style-type: none"> <li>• Medicare Carriers</li> <li>• Fiscal Intermediaries (FIs)</li> <li>• Part A/B Medicare Administrative Contractors (A/B MACs)</li> <li>• Regional Home Health Intermediaries (RHHIs)</li> </ul>
<b>Provider Types Affected</b>	Physicians, providers, and suppliers submitting claims to Medicare Carriers, A/B MACs, FIs, and/or RHHIs for therapy services provided to Medicare beneficiaries



Change Request (CR) 6321 describes the Centers for Medicare & Medicaid Services (CMS) policy for outpatient therapy cap exceptions for 2009 and updates the dollar amount of the therapy caps for 2009. **CR6321 makes no change to the exceptions process.**

**Provider Needs to Know...**

- CR6321 revises the *Medicare Claims Processing Manual*, Chapter 5, Section 10.2 (The Financial Limitation) to include the outpatient therapy cap exceptions for 2009.
- Financial limitations on outpatient therapy services, as described in the *Medicare Claims Processing Manual* (Chapter 5, Section 10.2) were as follows:
  - For 2006, it was \$1740;
  - For 2007, it was \$1780; and
  - For 2008, it was \$1810.

- For 2009, the annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is \$1840.
- For 2009, the separate limit for occupational therapy is \$1840.
- An Advance Beneficiary Notice of Noncoverage (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 before the cap is reached.
  - The ABN informs the beneficiary of their potential financial obligation to the provider and provides guidance regarding appeal rights.
  - Since therapy that exceeds the cap is statutorily excluded from Medicare coverage, the ABN is not required.
  - However, the ABN may be used on a voluntary basis to inform the beneficiary of potential liability for therapy that exceeds the cap.

**Note:** The ABN-G is no longer effective as of March 1, 2009. The revised ABN (CMS-R-131) must now be used. The revised ABN is available for download at <http://www.cms.hhs.gov/BNI/Downloads/ABNFormInstructions.zip> on the CMS website.

**Background**

- The Balanced Budget Act of 1997 established limits on outpatient therapy services. These limits change annually.
- The Deficit Reduction Act of 2005 allowed CMS to establish an exceptions process, which began January 1, 2006, and was extended by later legislation.
- The Medicare Improvements for Patients and Providers Act of 2008 extended the exceptions process for therapy caps through December 31, 2009.

**Operational Impact**

Contractors will not search their files to retract payment for claims already paid or retroactively pay claims. However, contractors will adjust claims brought to their attention.

**Reference Materials**

The related MLN Matters article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6321.pdf> on the CMS website.

The official instruction (CR6321) issued regarding this change may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1678CP.pdf> on the CMS website. The revised manual chapter (Chapter 5, Section 10.2) is included as an attachment to CR6321.