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Related Change Request (CR) #: 4364

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Effective Date: January 1, 2006

Related CR Transmittal #: R52BP, R140PI, R855CP

Implementation Date: No later than March 13, 2006

**Note:** This article was updated on November 1, 2012, to reflect current Web addresses. All other information remains unchanged.

## Therapy Caps Exception Process

**Important Note:** Recent legislation extended the therapy cap exceptions for calendar year 2007. For details on the 2007 exceptions and process, see the MLN Matters article MM5478 at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5478.pdf> on the CMS site.

## Provider Types Affected

Providers, physicians, and non-physician practitioners (NPPs) who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers) under the Part B benefit for therapy services

## Key Points

- Effective January 1, 2006, a financial limitation (therapy cap) was placed on outpatient rehabilitation services received by Medicare beneficiaries. These limits apply to outpatient Part B therapy services from all settings except the outpatient hospital (place of service code 22 on carrier claims) and the hospital emergency room (place of service code 23 on carrier claims). Outpatient rehabilitation services include:
  - **Physical therapy** - including outpatient speech-language pathology: Combined annual limit for 2006 is \$1,740; and
  - **Occupational therapy** - annual limit for 2006 is \$1,740.
- In 2006 Congress passed the Deficit Reduction Act (DRA), which allows the Centers for Medicare & Medicaid Services (CMS) to grant, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, **exceptions to therapy caps for services provided during calendar year 2006**, if these services meet certain qualifications as medically necessary services (Section 1833(g) (5) of the Social Security Act).

### Disclaimer

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- The exception process may be accomplished automatically for certain services, and by request for exception, with the accompanied submission of supporting documentation, for certain other services.
- Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if those beneficiaries:
  - Meet specific conditions and complexities listed in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, (as revised by CR4364) for exception from the therapy cap; or
  - Meet specific criteria for exception, in addition to those listed in the *Medicare Claims Processing Manual*, Pub. 100-4, Chapter 5, where the Medicare contractor has published additional exceptions, when the contractor believes, based on the strongest evidence available, that the beneficiary will require additional therapy visits beyond those payable under the therapy cap.
- Medicare beneficiaries may be manually excepted from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the above bulleted criteria for automatic exceptions.
- You may submit a request, with supporting documentation, for a specific number (not to exceed 15 future treatment days for each discipline of occupational therapy, physical therapy, and speech language pathology services) of additional therapy visits.
- Please refer to the *Additional Information* section of this article for more detailed information about the therapy caps exception process.

## Background

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Financial limitations on Medicare-covered therapy services (therapy caps) were initiated by the Balanced Budget Act of 1997. These caps were implemented in 1999 and for a short time in 2003. Congress placed moratoria on the limits for 2004 and 2005.

The moratoria are no longer in place, and caps were implemented on January 1, 2006. Congress has provided that exceptions to these dollar limitations of \$1,740 for each cap in 2006 may be made when provision of additional therapy services is determined to be medically necessary.

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## Additional Information

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### *Billing Guidelines*

- **KX Modifier:** You must include a KX modifier on the claim identified as a therapy service with a GN, GO, GP modifier when a therapy cap exception has been approved, or it meets all the guidelines for an automatic exception. This allows the approved therapy services to be paid, even though they are above the therapy cap financial limits.
- **Separate requests:** You must submit separate requests for exception from the combined physical therapy and speech language pathology cap and from the occupational therapy cap. In general, requests for exception from the therapy cap should be received **before** the cap is exceeded because the patient is liable for denied services based on caps.
- **Subsequent requests during the same episode of care:** To request therapy services in addition to those previously approved, you must submit a request for approval along with supporting documentation for a specific number of additional therapy treatment days, not to exceed 15, **each time** the beneficiary is expected to require more therapy days than previously approved. It is appropriate to send documentation for the entire planned episode of care if the episode exceeds the 15 treatment days allowed.
- When those additional visits are approved as reasonable and necessary based on the documentation you submit, an exception to the therapy cap will be approved and bills may be submitted using the KX modifier. If the contractors have reason to believe that fraud, misrepresentation, or abusive billing has occurred, they have the authority to review claims and may deny claims even though prior approval was granted.

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

The CR4364 transmittal that contains these codes is the one that revises the *Medicare Claims Processing Manual*, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R855CP.pdf> on the CMS website. You may wish to bookmark that link so you may easily reference these codes.

### *Documentation*

Providers who believe that it is medically necessary for their patient to receive therapy services in excess of the therapy cap limitations (and the patient does not fall into the automatically excepted categories mentioned above) must submit documentation, sufficient to support medical necessity, in accordance with the revised *Medicare Benefit Policy Manual*, Pub.100-02, Chapter 15, Section 220.3;

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and the revised *Medicare Claims Processing Manual*, 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.

These manual sections contain important definitions, as well as examples of acceptable documentation, and are attached to CR4364. CR4364 is in three parts, one each for the revised manuals, i.e.:

- The *Medicare Benefit Policy Manual*, located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R52BP.pdf> on the CMS website;
- The *Medicare Claims Processing Manual*, located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R855CP.pdf>; and
- The *Medicare Program Integrity Manual*, located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R140PI.pdf> on the CMS website.

The following types of documentation of therapy services are expected to be submitted in response to any requests for documentation, unless the contractor requests otherwise:

1. **Evaluation and Certified Plan of Care** - 1-2 documents.
2. **Certification** - Physician/NPP approval of the plan required 30 days after initial treatment-or delayed certification.
3. **Clinician-signed Interval Progress Reports** (when treatment exceeds 10 treatment days or 30 days) – These must be sufficient to explain the beneficiary's current functional status and need for continued therapy with the request for therapy visits in excess of those payable under the therapy cap. This is not required to be provided daily in treatment encounter notes or for an incomplete interval when unexpected discontinuation of treatment occurs.
4. **Treatment Encounter Notes** – The Treatment Encounter Note is acceptable if it records the name of the treatment; intervention, or activity provided; the time spent in services represented by timed codes; the total treatment time; and the identity of the individual providing the intervention. These may substitute for Progress Reports if they contain the requirements of interval progress reports at least once every 10 treatment days or once in the interval.
5. For therapy caps exceptions purposes, **records justifying services over the cap**, either included in the above or as a separate document.

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Please see the revised Section 220.3 of the *Medicare Claims Processing Manual* located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R855CP.pdf> for more details about the types of documentation required and explanations of what that documentation should contain.

When reviewing documentation, Medicare contractors will:

- Consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary;
- Consider a dictated document to be completed on the day it is dictated if the identity of the qualified professional is included in the dictation;
- Consider a document an evaluation or re-evaluation (for documentation purposes, but not necessarily for billing purposes) if it includes a diagnosis, subjective and/or objective condition, and prognosis. This information may be included in or attached to a plan. The inclusion of this information in the documentation does not necessarily constitute a billable evaluation or re-evaluation unless it represents a service; and
- Accept a referral/order and evaluation as complete documentation (certification and plan of care) when an evaluation is the only service provided by a provider/supplier in an episode of treatment.

### ***Medicare Contractor Decisions***

If determined to be medically necessary, your Medicare contractor will grant additional treatment days for occupational therapy, physical therapy, and speech language pathology.

It is preferable that the request for exception be received before the therapy cap is actually exceeded. However, your Medicare contractor will approve additional therapy treatment days retroactively if they are deemed medically necessary, in the exceptional circumstance where a timely request for exception from the therapy cap is not received before the therapy cap is surpassed.

Your Medicare contractor may also approve additional therapy visits already provided when the request is accompanied by documentation supporting medical necessity of the services.

Please note that outpatient therapy services appropriately provided by assistants or qualified personnel will be considered covered services only when the supervising clinician personally performs or participates actively in at least one treatment session during an interval of treatment. Claims for services above the cap that are not deemed medically necessary will be denied as a benefit category denial.

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If your Medicare contractor does *not* make a decision within 10 business days of receipt of the request and documentation, then the decision for therapy cap exception is considered to be deemed **approved** as medically necessary for the number of future visits requested (not to exceed 15).

### ***Notification***

You will be notified as to whether or not an exception to the cap has been made (and if so, for how many additional future visits) as soon as practicable once the contractor has made its decision.

This notification is not an initial determination and, therefore, does not carry with it administrative appeal rights. For examples of the standard letters from the *Medicare Program Integrity Manual*, 100-8, Section 3.3.1.2, please refer to the Attachments to CR4364. The examples include:

- Letter #1 - Approved
- Letter #2 - Negative Decision-Medical Necessity
- Letter #3 - Denied-Insufficient Documentation

### ***Revised Medicare Summary Notice (MSN) Messages***

The MSN messages (17.13; 38.18) are revised to inform beneficiaries about the therapy caps and approved medically necessary exceptions. These notices are also part of CR4364.

Once again, there are three transmittals that comprise CR4364. They are:

- The *Medicare Benefit Policy Manual* revision at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R52BP.pdf> on the CMS website;
- The Medicare Claims Processing Manual revision, located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R855CP.pdf> on the CMS website;
- The Medicare Program Integrity Manual revision, located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R140PI.pdf> on the CMS website.

If you have any questions, contact your Medicare contractor at their toll free number, which is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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