

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1106	Date: NOVEMBER 9, 2006
	Change Request 5271

This CR is being re-communicated to change the effective and implementation dates for non-systems changes to December 9, 2006 and for system changes the effective date is January 1, 2007 and the implementation date is January 2, 2007. All other material remains the same.

SUBJECT: Outpatient Therapy Cap Clarifications

I. SUMMARY OF CHANGES: Clarifies and expands descriptions of the process for therapy cap exceptions. Corrects errors on the list of conditions and complexities for which exceptions are allowed. Announces the therapy cap amount for calendar year 2007. Some of the business requirements require system changes that shall be effective and implemented January 1, 2007. The business requirements that do not require system changes should be implemented ASAP.

CLARIFICATION

EFFECTIVE DATE*: December 9, 2006, for non-systems changes, January 1, 2007, for systems changes

IMPLEMENTATION DATE: December 9, 2006, for non-systems changes, January 2, 2007, for systems changes

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	5/10.2/The Financial Limitation
R	21/Table of Contents
R	21/50.17/Nonphysician Services
R	21/50.38/General Information Section
R	21/90.17/Servicios Que No Fueron Prestados Por Doctores
R	21/90.18/Cuidado Preventivo
R	21/90.38/Sección De Información General

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within

their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
5271.1	The contractor shall grant exceptions for any number of medically necessary services that meet the outpatient therapy automatic process exception criteria, if the beneficiary meets the conditions described in IOM Pub. 100-04, chapter 5, for 2006.	X	X	X						A/B MAC
5271.2	The contractor shall utilize clinical judgment in approving or disapproving requests for additional treatment days in the exceptional circumstance where a provider fails to submit all required documentation with the exception request in 2006.	X	X	X						A/B MAC
5271.3	The contractor shall grant an exception to the therapy cap, by way of approving any number of additional therapy treatment days, when those additional treatment days are deemed medically necessary based on documentation submitted by the provider in 2006.	X	X	X						A/B MAC
5271.4	The contractor shall grant an exception to the therapy cap, approving the number of treatment days requested by the provider/supplier/beneficiary, not to exceed 15 future treatment days, if the contractor does not make a decision within 10 business days of receipt of any request and appropriate documentation in 2006.	X	X	X						A/B MAC
5271.5	When reviewing claims for services excepted from therapy caps where there is evidence of potential provider fraud, the contractor shall follow the instructions in Pub. 100-08, chapter 4, on how to treat the claim in 2006.	X	X	X						A/B MAC
5271.6	When reviewing claims for services excepted from therapy caps the contractor shall deny the claim where there is evidence of misrepresentation of facts presented to the contractor by that provider in 2006.	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
5271.7	When reviewing claims for services excepted from therapy caps due to a pattern of aberrant billing the contractor shall deny the services that are not reasonable and necessary.	X	X	X						A/B MAC
5271.8	When replying to a request for exception, the contractor must reply as soon as practicable in 2006.	X	X	X						A/B MAC
5271.9	When replying to a request for exception, the contractor shall send the letter in Pub. 100-08, chapter 3 most appropriate to the circumstance in 2006.	X	X	X						A/B MAC
5271.10	The contractor shall develop a mechanism to track workload associated with the Therapy Cap process in 2006.	X	X	X						A/B MAC
5271.11	The contractor shall develop a mechanism to track costs associated with the Therapy Cap process in 2006.	X	X	X						A/B MAC
5271.12	For CY 2006, carriers and fiscal intermediaries shall report the therapy cap costs and workload on a monthly basis in activity code 27021 (not 21221). Note that if cap exceptions are extended beyond 2006, further instructions will be sent.	X	X	X						A/B MAC
5271.13	Contractors shall continue to report automatic and manual process exceptions separately on a monthly basis using the format and fields in the attachments to JSM/TDL-06427, 05-01-06 in 2006.	X	X	X						A/B MAC
5271.14	Contractors shall continue to enforce LCDs, since the presence of a KX does not supersede an LCD in 2006.	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
5271.15	Contractors shall note that the MSN messages in Pub. 100-04, chapter 21, have been modified to match the correct MSN messages in chapter 5.	X	X	X						A/B MAC
5271.15.1	Contractors shall modify MSN messages to match the MSN language in chapter 5, section 10.2D.	X	X	X						A/B MAC
5271.15.2	Modified MSN messages, as described in Pub. 100-04, chapter 5, section 10.2D shall be issued on all claims for outpatient therapy services until this instruction is changed.	X	X	X						A/B MAC
5271.16	Contractors shall note that the total amount paid for outpatient therapy services before the cap is reached, including deductible and coinsurance paid by the beneficiary, is \$1740 for calendar year 2006.	X	X	X						A/B MAC
5271.17	Contractors shall note that the total amount paid for outpatient therapy services before the cap is reached, including deductible and coinsurance paid by the beneficiary, is \$1780 for calendar year 2007.	X	X	X						A/B MAC
5271.17.1	CWF shall change the dollar amount for the limitation on outpatient physical therapy and speech-language pathology services combined to \$1780 for dates of service from January 1, 2007 through December 31, 2007.	X	X	X		X			X	A/B MAC
5271.17.2	CWF shall change the dollar amount for the limitation on outpatient occupational services combined to \$1780 for dates of service from January 1, 2007 through December 31, 2007.	X	X	X		X			X	A/B MAC
5271.18	Contractor shall, in <u>future</u> articles and publications that reference exceptions to therapy caps in 2006, refer to the automatic process and the manual process for exception as opposed to automatic exceptions and manual	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
F I S S	M C S					V M S	C W F			
	exceptions.									
5271.19	Contractors shall follow the instructions in Pub. 100-04, chapter 5 for allowing outpatient therapy cap exceptions when the same patient has two conditions or complexities in the same year, one of which qualifies the beneficiary for use of the automatic exception process in 2006.	X	X	X						A/B MAC
5271.20	Contractors shall allow automatic process exceptions when complexities occur in combination with conditions that <u>may or may not be on the list</u> in Pub. 100-04, chapter 5 in 2006.	X	X	X						A/B MAC
5271.21	Contractors shall update the list of exceptions in 2006 according to the changes provided in this transmittal. Note that contractors may expand, but not remove ICD-9s from the list if their manual process exception decisions lead them to believe further exceptions should be allowed.	X	X	X						A/B MAC
5271.22	Contractors shall allow automatic process exceptions when medically necessary services are provided for two or more separate, billable, conditions in the same calendar year in 2006.	X	X	X						A/B MAC
5271.23	Contractors shall not utilize the KX modifier in data analysis as the sole indicator of services that DO exceed caps in 2006. For all claims, but especially for intermediary claims, there may be services with appropriately used KX modifiers that do not represent services that exceed the cap.	X	X	X						A/B MAC
5271.24	Contractors shall utilize consistently the new definitions and examples provided in this transmittal for Pub. 100-02, chapter 15.	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
5271.25	When a patient is being treated under the care of two physicians for separate conditions, contractors shall accept as appropriate documentation either a combined plan of care certified by one of the physicians/NPPs or two separate plans of care certified by separate physicians/NPPs.	X	X	X						A/B MAC
5271.26	Contractors shall not require the additional documentation that is encouraged but not required in Pub. 100-02, chapter 15.	X	X	X						A/B MAC
5271.26.1	In the event provider/suppliers fail to submit all requested documentation for the manual process therapy cap exception in 2006, contractors shall make determinations using clinical judgment based on all documentation received before the 10 th day after submission of the request.	X	X	X						A/B MAC
5271.27	Contractors shall interpret a referral or an order or a plan of care dated after an evaluation as certification of the plan to evaluate the patient when only an evaluation was performed. It is not required that a plan, order or referral be written prior to evaluation.	X	X	X						A/B MAC
5271.28	Contractors shall not deny payment for re-evaluation <u>only</u> because an evaluation or re-evaluation was recently done. For example: 1) re-evaluation is covered and payable if documentation supports the need for re-evaluation; 2) re-evaluation may be appropriate prior to planned discharge for the purposes of a) determining whether goals have been met, or b) to provide further information, beyond that required to be included in the discharge summary, for the use of the physician or the treatment site at which treatment will be continued.	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
5271.29	Contractors shall, on pre or postpay medical review, require Progress Reports to be written by clinicians once during each Progress Report Period.	X	X	X						A/B MAC
5271.29.1	When required elements of the Progress Report are written into the Treatment Notes or in a Plan of Care, the contractors shall accept it as fulfilling the requirement for a Progress Report; a separate Progress Report shall not be required.	X	X	X						A/B MAC
5271.29.2	When therapists are not providing all of the treatment, contractors shall, if performing pre or postpay medical review, require a clinician’s active participation in treatment at least during each Progress Report Period, except as noted in 5271.29.3.	X	X	X						A/B MAC
5271.29.3	When a clinician has not actively participated in treatment during the Progress Report Period due to the patient’s unexpected absence, the contractor shall, if performing pre or postpay review, make a clinical judgment based on each individual case whether continued treatment after the Progress Reporting Period is medically necessary.	X	X	X						A/B MAC
5271.29.3.1	When a clinician has not actively participated in treatment during the Progress Report Period due to an unanticipated and unusual occurrence, the contractor shall, if performing pre or postpay review, make a clinical judgment based on each individual case whether continued treatment after the Progress Reporting Period is medically necessary.	X	X	X						A/B MAC
5271.29.3.2	When a clinician has not actively participated in treatment during the Progress Report Period, the contractor shall, if performing prepay or postpay medical review, include in their consideration of medical necessity whether documentation indicates the clinicians active guidance of treatment during the reporting	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
F I S S	M C S					V M S	C W F			
5271.33	Contractors shall deny claims for outpatient therapy services exceeding the financial limits described in Pub. 100-04, chapter 5 section 10.2 as indicated by CWF and as appropriate according to Medicare policy.	X	X	X						A/B MAC
5271.34	Contractors shall modify Medicare Summary Notices (MSNs) 17.13, 17.18, and 17.19 such that when the calendar year is 2007, the (\$) limit is \$1780 effective January 1, 2007.	X	X	X						A/B MAC
5271.35	Contractors shall change any reference in their educational materials to reflect therapy limits for CY 2007 as \$1780 for physical therapy and speech-language pathology combined and \$1780 for occupational therapy.	X	X	X						A/B MAC
5271.36	The CWF shall display the therapy cap amount applied per beneficiary on all CWF inquiry screens (HIMR, HIQA, HUQA, HIQH, ELGA, ELGB, and ELGH)								X	
5271.37	In processing claims where Medicare is the secondary payer, the shared system takes the lowest secondary payment amount from MSPPAY and sends this amount to CWF as the amount applied to therapy limits.					X	X			

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
F I S S	M C S					V M S	C W F			
5271.38	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)							
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers			
F I S S	M C S					V M S	C W F		
	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 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. 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.								

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: December 9, 2006, for non-systems changes, January 1, 2007 for systems changes	No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating
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<p>Implementation Date: December 9, 2006, for non-systems changes, January 2, 2007 for systems changes</p> <p>Pre-Implementation Contact(s): Exceptions Process and Medical Review: Dan Schwartz (daniel.schwartz@cms.hhs.gov) or Kim Spalding (kimberly.spalding@cms.hhs.gov);</p> <p>Clinical and Documentation Issues: Dr. Dorothy Shannon (dorothy.shannon@cms.hhs.gov);</p> <p>Claims Processing: Claudette Sikora (claudette.sikora@cms.hhs.gov) or Wil Gehne (Wilfred.gehne@cms.hhs.gov)</p> <p>Appeals: David Danek (david.danek@cms.hhs.gov)</p> <p>Post-Implementation Contact(s): Regional offices</p>	<p>budgets.</p>
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10.2 - The Financial Limitation

(Rev. 1106, Issued: 11-09-06; Effective: 01-01-07; Implementation: 01-02-07)

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, *and only for calendar year 2006*, Congress passed the Deficit Reduction Act that allowed 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 *only for calendar year 2006*.

C. Application of Financial Limitation *After* January 1, 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 *of this section when* exceptions to therapy caps *apply*. *The limits were \$1740 in 2006*. For 2007, the annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is \$1780; the limit for occupational therapy is \$1780. 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). *These excluded hospital services are reported on types of bill 12x or 13x on intermediary claims*.

Contractors apply the financial limitations to the *Medicare Physician Fee Schedule (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. For example, in 2007, if the deductible has been met prior to submission of a claim for \$1780 of therapy services, Medicare will pay 80 percent, which is \$1424. The beneficiary will pay the 20 percent coinsurance, which is \$356. If the deductible has not been met, the beneficiary will also pay the deductible amount of \$131 and 20 percent of the amount remaining after the deductible is met (20% of \$1649), or \$329.80 for a total of \$460.80. Medicare will pay the remaining 80 percent after the deductible is met or \$1319.20. These amounts are for calendar year 2007 and will change each calendar year. Medicare Contractors shall publish the financial limitation amount in educational articles. It is also available at 1-800-Medicare.

For claims with dates of service from January 1, 2006, through December 31, 2007, 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 *2006* exceptions to the caps in cases where continued therapy services are medically necessary. *The exceptions apply only during 2006.*

Instructions for contractors to manage requests for *the* automatic *process for* 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 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.

The beneficiary may qualify for use of the cap exceptions at any time during the episode when documented medically necessary services exceed caps. For example, if a beneficiary is being treated for a condition that does not qualify for an exception, should a change in status result in the beneficiary satisfying the requirements for a cap exception, the provider or supplier would either utilize the modifier for automatic process exceptions or apply for contractor approval using the manual process, depending on which applies.

Exception *Processes* fall into two categories:

- Automatic *Process Exceptions*-
 - 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 *automatic process exceptions*.)
 - Contractor articles may describe other exceptions.
- Manual *Process 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 *continued skilled* 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. (See C5.)

All exceptions, *including those allowed using the automatic process and the manual process*, 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 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.

Medical Review of Claims with Exceptions. 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 *by the automatic process* or by manual *process* 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.

2. Automatic *Process* Exceptions

No specific documentation is submitted to the contractor if the beneficiary qualifies for the automatic *process* 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 *medical* record *that justifies* the clinician's decision that the beneficiary qualified for the automatic *process* cap exception for medically necessary services. This documentation shall be submitted in response to any subsequent claim review. The providers/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 10.2 C3.

a. Exceptions for Evaluation Services

Evaluation permits the *clinician* 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.

The CMS will except therapy evaluation procedures from caps after the therapy caps are reached. *For example, the following are evaluation procedures appropriate in 2006. Contact the Medicare contractor for instruction if the evaluation codes change in later years:*

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.” *Definition of evaluations and documentation is found in Pub 100-02, section 220 and 230.*

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.

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 *10.2 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.

Exception from caps using the automatic process for exception requires that a beneficiary currently has a condition or complexity that is on the list (below) of conditions or complexities. NOT ALL patients who have a condition or complexity on the list are excepted from therapy caps. The patient must also meet other requirements for coverage. For example, the patient must require skilled treatment for a covered, medically necessary service; the services must be appropriate in type, frequency and duration for the patient's condition and service must be documented appropriately. Guidelines for utilization of therapy services may be found in Medicare manuals, Local Coverage Determinations of Medicare contractors, and professional guidelines issued by associations and states.

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. For example, when a patient with diabetes is being treated 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 code in the primary position. In that case, the relevant 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 on the claim 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.

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 *either be the condition that is being treated or a condition that directly and significantly impacts the rate of recovery of the condition being treated* 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 (*), *or are identified in the following text as complexities.* Complexities, in combination with other conditions that *may or may not be* on the list, *qualify a beneficiary for use of the automatic process for exception if they directly and significantly impact the rate of recovery for the condition being treated, such that they cause the caps to be exceeded.* List in your documentation both the *condition being* 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. *In order to qualify the beneficiary for use of the automatic process for exception, the condition or complexity must directly and significantly affect the type, frequency, intensity and/or duration of required, medically necessary, skilled services such that it causes those services to exceed the cap.*

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

When using this table, refer to the ICD-9 code book for coding instructions. Exceptions *described by ICD-9 codes* apply only to the codes listed, *unless your Medicare contractor approves the use of additional codes. Some contractors' Local Coverage Determinations do not allow the use of some of the codes on this list in the primary diagnosis position on a claim. If the contractor has determined that these codes do not characterize patients who require medically necessary services, providers/suppliers may not use these codes, but must utilize a billable diagnosis code to describe the patient's condition. However, providers/suppliers may use the automatic process when the patient has a billable condition and the patient also has a related diagnosis on the list below that qualifies the patient for use of the automatic exception process. In that case, the diagnosis may be put in a secondary position on the claim and/or in the medical records, as the contractor directs.*

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 descriptions in the table are not always identical to those in the ICD-9 code book, but may be summaries. Contact your contractor for interpretation if you are not sure that a condition or complexity is applicable for automatic process exception.*

The severity of the condition or related therapy disorder for which that patient is treated (which may or may not be on the list) must be 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 *represented by ICD-9 codes* are comorbidities or complicating circumstances and do not, alone, justify an exception from caps. *Complexities represented by ICD-9 codes* must be reported with another condition (which may or may not be *on the list for automatic process exception*) 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 *process* 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
250.00 – 250.93	DIABETES MELLITUS*
278.01-278.02	OVERWEIGHT, OBESITY, AND OTHER HYPERALIMENTATION *
290.0-290.43	DEMENTIAS*
294.0-294.9	PERSISTENT MENTAL DISORDERS DUE TO CONTIONS CLASSIFIED ELSEWHERE*
311	DEPRESSIVE DISORDER NEC*
323.0-323.9	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
342.00-342.92	HEMIPLEGIA AND HEMIPARESIS
343.0-343.9	INFANTILE CEREBRAL PALSY

344.00-344.9	OTHER PARALYTIC SYNDROMES
348.0-348.9	OTHER CONDITIONS OF BRAIN
349.0-349.9	OTHER AND UNSPECIFIED DISORDERS OF THE NERVOUS SYSTEM
353.0-357.7	NEUROPATHIES. <i>SEE CODE BOOK FOR DETAILS</i>
359.0-359.9	MUSCULAR DYSTROPHIES AND OTHER MYOPATHIES
386.00-386.9	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*
427.0-427.9	CARDIAC DYSRHYTHMIAS*
428.0-428.9	CONGESTIVE HEART FAILURE*
430-432.9	INTRACRANIAL HEMORRHAGES
433.00-434.91	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	DISEASES OF VOCAL CORDS OR LARYNX
486	PNEUMONIA, ORGANISM UNSPECIFIED*
490-496	CHRONIC OBSTRUCTIVE PULMONARY DISEASES*
710.0-710.9	DIFFUSE DISEASES OF CONNECTIVE TISSUE
707.00-707.9	CHRONIC ULCER OF SKIN*
711.00-711.99	ARTHROPATHY ASSOCIATED WITH INFECTIONS*
713.0-713.8	ARTHROPATHY ASSOCIATED WITH OTHER DISORDERS CLASSIFIED ELSEWHERE*
714.0-714.9	RHEUMATOID ARTHRITIS AND OTHER INFLAMMATORY POLYARTHROPATHIES*
715.09	OSTEOARTHRITIS AND ALLIED DISORDERS, <i>MULTIPLE SITES</i>
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 <i>JOINT</i> , 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
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*
784.3-784.9	APHASIA AND OTHER SPEECH DISTURBANCES
787.2	DYSPHAGIA
806.00-806.9	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 OF RADIUS AND ULNA
820.00-820.9	FRACTURE OF NECK OF FEMUR
821.00-821.39	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
881.00-881.22	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)
941.00- 949.5	BURNS
<i>950.0-952.9</i>	<i>INJURY TO OPTIC AND OTHER CRANIAL NERVES, SPINAL CORD</i>
959.01	HEAD INJURY

4. Additional Exceptions for Complexity

While a beneficiary may not qualify for an *automatic process* exception solely based on one of the underlying medical conditions in the table in 10.2 C3, or conditions in combination with complexities in the table in 10.2 C3, the beneficiary may still qualify for an *automatic process* exception for other clinical complexities. Following are clinical complexities that can justify an *automatic process* exception *for any* condition that necessitates skilled therapy services, regardless of whether it is on the list in the table in 10.2 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 *any hospital inpatient stay, or any episode of any duration paid under Part A* within 30 *calendar* days of starting this episode of outpatient therapy. Indicate *in the medical record the* 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 conditions that qualify for use of the automatic process for exception in table in 10.2 C3 and these conditions* 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 *arm* 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. *Although such services might not exceed caps, if the dysfunctional arm caused necessary services that exceed caps the services would qualify for use of the automatic process for exception.*

- *Two Disciplines.* The beneficiary requires PT and SLP services *in the same calendar year*. 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.
- *Two Conditions.* If services are medically necessary and would be payable *before the cap was reached*, an *automatic process* exception is allowed *when two or more separate and distinctly* different conditions caused the cap to be exceeded *either due to a prior episode or concurrently during the episode being billed. It is not required that any of these conditions be on the list of automatic process exceptions (denoted by ICD-9 codes in the table in 10.2 C3 above). That is, neither those conditions that require services currently, nor those conditions that required services that caused caps to be exceeded due to prior treatment, nor the condition causing concurrent services need be on the list in table 10.2 C3 above. In these cases, the automatic process exception applies*

regardless of whether or not the cap was exceeded during the first episode of treatment or after the initiation of treatment for the different condition.

A new condition or complexity, occurring during an 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 could not qualify for exception using the automatic process, but developed a second condition that was appropriate for use of the automatic process before discharge from treatment for the initial condition, and, if the medically necessary services exceeded the cap, then the presence of the second condition shall be added to the plan of care and would qualify the beneficiary to use the automatic process for exception to bill for both conditions even if the first condition would not. (See C.4. Additional Exceptions for complexity.)

- Unlisted Condition with Listed Complexity. The beneficiary may have an initial billable condition that could not qualify for use of the automatic process, but may develop a related complexity that qualifies the beneficiary to use the automatic process for exception and directly and significantly impacts the treatment. In these circumstances, if the cap is exceeded and treatment is medically necessary, the complexity would be included in the plan same of care and the KX modifier would be used in the automatic process for exception to bill for both the condition and (if billable) the complexity.*

In the situations described in the two bullets immediately above, the automatic process for exception would be used for medically necessary services over the cap while the patient was treated for either of the two the conditions or while the complexity impacted treatment during that episode in that calendar year.

However, in cases where the beneficiary was treated in the same year for different episodes of the same condition, manual process exception is required for use of the KX modifier if the cap is exceeded and other exceptions do not apply.

- The beneficiary requires this treatment in order to return to a pre-morbid 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 pre-morbid 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 hospitals 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. *Manual Process* Exception (Contractor Approval)

If the beneficiary does not qualify for *use of the automatic process* exception based upon clinical condition or clinical complexity at the onset of the treatment episode, the beneficiary or the representative *of the beneficiary* (including providers and suppliers) may submit a request for a cap exception to the contractor for review at any time. 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.

Submit Manual Process Requests Promptly. Providers and suppliers are encouraged to submit requests for treatment that may extend beyond the caps at least 10 days before the cap is exceeded, to allow time for the contractor's decision concerning extension of the treatment. Medicare contractors have 10 business days from contractor's receipt of the request to decide to approve or disapprove requests. If required documentation is not submitted with the manual request, the contractor shall use clinical judgment in deciding whether to approve the request. The contractor's response to the request shall be returned to the requestor as soon as is practicable, usually within a few days of the decision.

Exceptions Approved per Treatment Day. Manual Process 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.

Providers/suppliers/beneficiaries may request only up to and including 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 treatment days currently requested. (See approval of Necessary Treatment Days, below.)

Approval of Necessary Treatment Days. Although only 15 treatment days may be requested using the manual process, 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 5 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 beneficiary at risk for financial liability 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.*

Routine submission for manual process exceptions when patients are not receiving rehabilitative treatment is an abuse of the process. Routine submission of manual process exception requests after the cap has been met is also an abuse of the process.

Requests for Services Already Delivered. 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 number of treatment days of services rendered in the past, but providers/suppliers/beneficiaries are cautioned against abuse of the process by routinely requesting exceptions for past services.

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 and suppliers are discouraged from submitting routine or excessive manual process exception requests especially when services are appropriate for use of the automatic process exception. Also avoid excessive requests for services already rendered.

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. *Check the contractor's website and published articles for instructions on how to submit 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 required *to be sent to the contractor with the request for the manual process exception is* the same as the documentation required to be kept in the medical record for services that are excepted *using the automatic process. They are* described in *this* section 10.2 C2 through 10.2 C4 above *and in Pub. 100-02, chapter 15, section 220.3.* 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, *the provider/supplier may include* 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 *medical* 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 to all *approved* therapy procedures subject to the caps. *Note that for intermediary claims, this may require use of the KX modifier on some services that do not exceed caps on the same claim as approved services. See C1 above for details on use of the KX modifier. Contact the Medicare contractor if there is any doubt about which services should have KX modifiers.*

- 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 include the reason for the disapproval *in the notification letter*.

If the beneficiary does not qualify for a cap exception *using the automatic process*, and *if the beneficiary's service* is not approved by the contractor *through the manual exception process*, then the therapy services furnished during that episode are subject to the caps. *The beneficiary is liable for services that exceed the caps unless furnished at the outpatient hospital.*

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 –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. 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. *Further details concerning appeals is found in CMS IOM Pub. 100-04, chapter 29.*

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 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 are listed in a table in the Claims Processing Manual, *Pub. 100-04*, 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. *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, refer to:*

- *Pub.100-04 Medicare Claims Processing Manual, Chapter 26, for more detail regarding completing the CMS-1500 claim form, including the placement of HCPCS modifiers. Note that the CMS-1500 claim form currently has space for providing two modifiers in block 24D, but, if you have more than two to report, you can do so by placing the -99 modifier (which indicates multiple modifiers) in block 24D and placing the additional modifiers in block 19.*

You may access the Medicare Claims Processing Manual at this web address <http://www.cms.hhs.gov/Manuals/>

From this site, click the links to [Internet-Only Manuals \(IOMs\)](#), then [Pub. 100-04](#) to reach the Medicare Claims Processing Manual.

- *The ASC X12N 837 Health Care Claim: Professional Implementation Guide, Version 4010AI, 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, SVI segment, data elements SV101-3, SV101-4, SV101-5, and SV101-6. You may obtain copies of the ASC X12N 837 implementation guides from the Washington Publishing Company.*

- *For claims paid to carriers, it is only appropriate to use a KX for 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:*

- *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 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 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 is appropriately used on all of the PT lines.

- *Refer to Pub.100-04 Medicare Claims Processing Manual, Chapter 25, for more detail regarding completing the CMS-1450 claim form, including the placement of HCPCS modifiers.*

You may access the Medicare Claims Processing Manual at this web address <http://www.cms.hhs.gov/Manuals/> From this site, click the links to Internet-Only Manuals (IOMs), then Pub. 100-04 to reach the Medicare Claims Processing Manual.

- By attaching the KX modifier, the provider is attesting that the services billed:
 - Are reasonable and necessary services that require the skills of a therapist; (See CMS Pub. 100-02, chapter 15, section 220.2 B); and
 - Are justified by appropriate documentation in the medical record, (See CMS Pub. 100-02, chapter 15, section 220.3); and
 - *Qualify for an exception using the automatic process exception or contractor approval is on record for use of the manual 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 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 *without KX modifiers* 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.

- *Do not add the KX modifier to line items that would not be eligible for exception if the service was provided after the cap is reached. That is, if the services would require a manual exception if the cap is exceeded and that exception has not yet been approved, do not bill for that service using the KX modifier.*

- *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.*

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, 2007. The limits are \$1,740 *in 2006 and \$1780 in 2007* for PT and SLP combined and \$1,740 *in 2006 and \$1780 in 2007* 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 2007. Estos límites son \$1,740 *en 2006 y \$1780 en 2007* para PT y SLP combinados y \$1,740 *en 2006 y \$1780 en 2007* 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 a 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 *and \$1780 in 2007*) 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, terapeutas físicos y ocupacionales, médicos y otros practicantes no médicos. La terapia que es médicamente necesaria y que sobrepasa estas cantidades límites está cubierta cuando se recibe en una unidad de hospital ambulatorio o cuando está aprobada 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 lenguaje 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 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 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 any 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 2007 limit of \$1780 for a beneficiary who has paid the deductible and the coinsurance:

Services received to date \$1765 (\$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 *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 FIs and carriers 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, 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.

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.6 of this section and Pub. 100-04, chapter 29.

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. *However, when therapy cap exceptions apply, SNF residents may qualify for exceptions that allow billing within the consolidated billing rules.*

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. *Although use of the NEMB form is not a Medicare requirement,* 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.

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

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., \$1780 in 2007) *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.

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. Provider/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.

Medicare Claims Processing Manual

Chapter 21 - Medicare Summary Notices

Table of Contents *(Rev. 1106, 11-09-06)*

90.18 - Cuidado Preventivo

50.17 - Nonphysician Services

(Rev. 1106, Issued: 11-09-06; Effective: 01-01-07; Implementation: 01-02-07)

- 17.1 - Services performed by a private duty nurse are not covered.
- 17.2 - This anesthesia service must be billed by a doctor.
- 17.3 - This service was denied because you did not receive it under the direct supervision of a doctor.
- 17.4 - Services performed by an audiologist are not covered except for diagnostic procedures.
- 17.5 - Your provider's employer must file this claim and agree to accept assignment.
- 17.6 - Full payment was not made for this service(s) because the yearly limit has been met.
- 17.7 - This service must be performed by a licensed clinical social worker.
- 17.8 - Payment was denied because the maximum benefit allowance has been reached.
- 17.9 - Medicare (Part A/Part B) pays for this service. The provider must bill the correct Medicare contractor. (NOTE: Insert appropriate program. Message is used for Part A claims received by Part B or Part B claims received by Part A.)
- 17.10 - The allowance has been reduced because the anesthesiologist medically directed concurrent procedures.
- 17.11 - This item or service cannot be paid as billed.
- 17.12 - This service is not covered when provided by an independent therapist.
- 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.*
- 17.14 - Charges for maintenance therapy are not covered.
- 17.15 - This service cannot be paid unless certified by your physician every (___) days. (NOTE: Insert appropriate number of days.)
- 17.16 - The hospital should file a claim for Medicare benefits because these services were performed in a hospital setting.
- 17.18 - (\$) has been applied during this calendar year (CCYY) towards the (\$) limit on outpatient physical therapy and speech-language pathology benefits.
- 17.19 - (\$) has been applied during this calendar year (CCYY) towards the (\$) limit on outpatient occupational therapy benefits

50.38 - General Information Section

(Rev. 1106, Issued: 11-09-06; Effective: 01-01-07; Implementation: 01-02-07)

38.3 - If you change your address, contact the Social Security Administration by calling 1-800-772-1213.

38.4 - You are at high risk for complications from the flu and it is very important that you get vaccinated. Please contact your health care provider for the flu vaccine.

38.5 - If you have not received your flu vaccine it is not too late. Please contact your health care provider about getting the vaccine.

38.6 - January is cervical cancer prevention month.

38.7 - The Pap test is the most effective way to screen for cervical cancer.

38.8 - Medicare helps pay for screening Pap tests once every two years.

38.9 - Colorectal cancer is the second leading cancer killer in the United States. However, screening tests can find polyps before they become cancerous. They can also find cancer early when treatment works best. Medicare helps pay for screening tests. Talk to your doctor about the screening options that are right for you.

38.10 - Compare the services you receive with those that appear on your Medicare Summary Notice. If you have questions, call your doctor or provider. If you feel further investigation is needed due to possible fraud or abuse, call the phone number in the Customer Service Information Box.

38.12 - Your physician participates in the Competitive Acquisition Program for Medicare Part B drugs (CAP). The drug(s) you received in your physician's office were provided by an approved CAP vendor. You will receive two separate Medicare Summary Notices (MSNs). This MSN is from the Medicare carrier that processes claims for your drug that came from the approved CAP vendor. You will receive another MSN from the Medicare carrier that processes claims for your physician, for the administration of the drug(s). If you appeal the determination for this drug vendor claim, you must send your appeal to the Medicare carrier address listed on the physician administration MSN, and not this vendor claim MSN.

38.13 - If you are not due a payment check from Medicare, your Medicare Summary Notices (MSN) will now be mailed to you on a quarterly basis. You will no longer receive a monthly statement in the mail for these types of MSNs. You will now receive a statement every 90 days summarizing all of your Medicare claims. You may receive a bill from your provider before you receive an MSN. Compare the MSN with the bill from your provider to ensure you paid the appropriate amount for your services.

38.18 - 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, 2007. The limits are \$1,740

in 2006 and \$1780 in 2007 for PT and SLP combined and \$1,740 in 2006 and \$1780 in 2007 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.

90.17 - Servicios Que No Fueron Prestados Por Doctores

(Rev. 1106, Issued: 11-09-06; Effective: 01-01-07; Implementation: 01-02-07)

AB-03-057

- 17.1 - Servicios realizados por una enfermera privada no están cubiertos.
- 17.2 - Su médico debe facturar por este servicio de anestesia.
- 17.3 - Este servicio se denegó porque usted no lo recibió bajo la supervisión directa de un médico.
- 17.4 - Servicios realizados por un audiólogo no son cubiertos, excepto por procedimientos diagnósticos.
- 17.5 - El patrón de su proveedor debe enviar esta reclamación y estar de acuerdo en aceptar la asignación.
- 17.6 - Debido a que usted alcanzó su límite anual por este servicio, no se hará un pago completo.
- 17.7 - Este servicio debe ser realizado por un trabajador social clínico autorizado.
- 17.8 - El pago fue denegado debido a que usted alcanzó el pago máximo del beneficio.
- 17.9 - Este servicio es pagado por Medicare (Parte A/Parte B). El proveedor debe enviar la factura al contratista de Medicare correcto.
- 17.10 - La cantidad aprobada ha sido reducida porque el anesthesiólogo dirigió procedimientos médicos concurrentes.
- 17.11 - Este servicio no se puede pagar según facturado.
- 17.12 - Este servicio no es cubierto cuando es proporcionado por un terapeuta independiente.
- 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, terapeutas físicos y ocupacionales, médicos y otros practicantes no médicos. La terapia que es médicamente necesaria y que sobrepasa estas cantidades límites está cubierta cuando se recibe en una unidad de hospital ambulatorio *o cuando está aprobada por Medicare*.
- 17.14 - Los costos por terapia de mantenimiento no están cubiertos.
- 17.15 - Este servicio no puede ser pagado si no está certificado por su médico cada (___) días.
- 17.16 - El hospital debe radicar una reclamación por los beneficios de Medicare porque estos servicios fueron prestados en un hospital.
- 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 lenguaje hablado.
- 17.19 - En este año (CCYY), (\$) han sido deducidos de la cantidad límite de (\$) por los beneficios de terapia ocupacional ambulatoria.

90.18 - Cuidado Preventivo

(Rev. 1106, Issued: 11-09-06; Effective: 01-01-07; Implementation: 01-02-07)

- 18.1 - Exámenes rutinarios y servicios relacionados no están cubiertos por Medicare.
- 18.2 - Esta inmunización y/o servicios preventivos no están cubiertos.
- 18.3 - Las pruebas de mamografía para mujeres menores de 35 años no están cubiertas.
- 18.4 - Este servicio se denegó debido a que no han transcurrido (12-24) meses desde su último examen de este tipo.
- 18.5 - Medicare pagará por otra mamografía en (12-24) meses.
- 18.6 - Una mamografía de cernimiento es cubierta una vez solamente para mujeres entre las edades de 35-39.
- 18.7 - El examen Papanicolau es cubierto una vez cada tres años, a menos de que existan factores de alto riesgo.
- 18.8 - Una mamografía de cernimiento es cubierta una vez cada 24 meses a mujeres de 40-49 años de edad que no tengan factores de alto riesgo.
- 18.9 - Una mamografía de cernimiento es cubierta una vez cada 12 meses a mujeres de 40-49 años de edad que tengan factores de alto riesgo.
- 18.10 - Una mamografía de cernimiento es cubierta una vez cada 12 meses a mujeres de 50-64 años de edad.
- 18.11 - Una mamografía de cernimiento es cubierta una vez cada 24 meses a mujeres de 65 años o más de edad.
- 18.12 - El examen de mamografía de cernimiento se cubre una vez al año para mujeres de 40 años de edad o más.
- 18.13 - Este servicio no está cubierto para beneficiarios menores de 50 años de edad.
- 18.14 - Este servicio está siendo denegado ya que no han transcurrido (12,24,48) meses desde el último (examen/procedimiento) de esta clase.
- 18.15 - Medicare solamente cubre este procedimiento para beneficiarios con alto riesgo de contraer cáncer en el colon.
- 18.16 - Este servicio está siendo denegado ya que se ha hecho un pago por un procedimiento similar dentro del término de tiempo establecido.
- 18.17 - Medicare paga por el examen Papanicolau y/o examen pélvico (incluyendo un examen clínico del pecho) solamente una vez cada tres años, a menos que existan factores de alto riesgo.
- 18.18 - Medicare no paga por separado estos servicios, ya que el pago estaba incluido en nuestra asignación por otros servicios que usted recibió el mismo día.
- 18.19 - Este servicio no está cubierto hasta después de que el beneficiario cumpla 50 años.

90.38 - Sección De Información General

(Rev. 1106, Issued: 11-09-06; Effective: 01-01-07; Implementation: 01-02-07)

38.3 - Si usted cambia de dirección, por favor comuníquese con la Administración del Seguro Social al 1-800-772-1213.

38.4 - Usted está en alto riesgo para complicaciones de la influenza y es muy importante que usted se vacune. Favor de comunicarse con su proveedor del cuidado de la salud para la vacuna contra la influenza.

38.5 - Si usted no ha recibido su vacuna contra la influenza no es demasiado tarde. Favor de comunicarse con su proveedor del cuidado de la salud sobre recibir la vacuna contra la influenza.

38.6 - El cáncer colorectal es el segundo cáncer principal que ataca en los E.E.U.U. Sin embargo, pruebas de investigación pueden encontrar pólipos antes de que lleguen a ser cancerosos. También pueden encontrar el cáncer temprano cuando el tratamiento trabaja lo mejor posible. Medicare ayuda a pagar por pruebas de investigación. Comuníquese con su doctor sobre las opciones de pruebas de investigación que son apropiadas para usted.

38.7 - Medicare cubre las pruebas de investigación del cáncer colorectal que pueden encontrar pólipos precancerosos en el colon y recto. Los pólipos pueden ser removidos antes de que sean cancerosos. Comuníquese con su doctor sobre hacerse la prueba.

38.8 - Enero es el mes de la prevención del cáncer cervical.

38.9 - La prueba de papanicolao (o prueba pap) es la manera más efectiva de examinar el cáncer cervical.

38.10 - Compare los servicios que usted recibe con los que aparecen en su Resumen de Medicare. Si tiene preguntas, llame a su doctor o proveedor. Si usted cree que se necesita investigar más debido a un posible fraude o abuso, llame al teléfono que aparece en la sección Información de Servicios al Cliente.

38.12 – Su médico participa en el Programa de Adquisición Competitiva para las medicinas cubiertas por la Parte B de Medicare (CAP, por sus siglas en inglés). Las medicinas que usted recibió en la oficina de su médico fueron provistas por un suplidor autorizado del CAP. Usted recibirá dos Resúmenes de Medicare por separado. Este Resumen es de la empresa de seguros Medicare que procesa las reclamaciones de sus medicinas provistas por el suplidor autorizado del CAP. Usted recibirá otro Resumen de la empresa de seguros Medicare que procesa las reclamaciones de su médico, por el suministro de sus medicinas. Si usted apela la decisión de esta reclamación del suplidor de medicinas, debe enviar la apelación a la empresa de seguros Medicare que se menciona en el Resumen de la reclamación de su médico y no a la dirección que aparece en este Resumen.

38.13 - Si Medicare no le debe un pago por cheque, sus Resúmenes de Medicare (MSN, por sus siglas en inglés) serán enviados por correo cada tres meses. Usted no recibirá un resumen mensual en su correo si Medicare no le debe un pago por cheque. De ahora en adelante, usted recibirá un aviso como éste (que no incluye pago por cheque) cada 90 días resumiendo todas sus reclamaciones de Medicare. Usted puede recibir una factura de su proveedor antes de que reciba un aviso de MSN. Compare el MSN con la factura que le envió su proveedor para asegurarse de que pagó la cantidad correcta por sus servicios.

38.18 - 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 2007. Estos límites son \$1,740 en 2006 y \$1780 en 2007 para PT y SLP combinados y \$1,740 en 2006 y \$1780 en 2007 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 a 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.