CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4178	**Date: November 30, 2018**
	Change Request 11055

SUBJECT: Annual Update to the Per-Beneficiary Therapy Amounts

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to describe the annual per-beneficiary incurred expenses amounts now called the KX modifier thresholds and related policy for CY 2019. These amounts were previously associated with the financial limitation amounts that were more commonly referred to as “therapy caps” before the application of the therapy limits/caps was repealed when the Bipartisan Budget Act of 2018 was signed into law. Information related to this Recurring Update Notification can be found in Pub. 100-04, Chapter 5, Section 10.

EFFECTIVE DATE: January 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 7, 2019

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 4178	Date: November 30, 2018	Change Request: 11055

SUBJECT: Annual Update to the Per-Beneficiary Therapy Amounts

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I. GENERAL INFORMATION

A. Background: Effective for January 1, 2018, section 50202 of the Bipartisan Budget Act of 2018, P.L. 115-123 (BBA of 2018) amended section 1833(g) of the Social Security Act (the Act) to repeal the application of the therapy caps and the therapy caps exceptions process while also retaining and adding limitations to ensure appropriate therapy. The therapy caps or financial limitations originally applied through section 4541(c) of the Balanced Budget Act of 1997, P.L. 105-33 (1997 BBA) are no longer applicable to beneficiaries.

A separate provision of section 50202 of the BBA of 2018 adds section 1833(g)(7)(A) of the Act to preserve the former therapy cap amounts as thresholds above which claims must include the KX modifier to confirm that services are medically necessary as justified by appropriate documentation in the medical record. Claims from suppliers or providers for therapy services above these amounts without the KX modifier are denied. These amounts are now known as the KX modifier thresholds.

Just as with the incurred expenses for the therapy cap amounts, there is one KX modifier threshold amount for physical therapy (PT) and speech-language pathology (SLP) services combined and a separate amount for occupational therapy (OT) services. These per-beneficiary amounts under section 1833(g) of the Act (as amended by 1997 BBA) are updated each year by the Medicare Economic Index (MEI).

For CY 2019, the KX modifier threshold amounts are: (a) $2,040 for PT and SLP services combined, and (b) $2,040 for OT services.

Another provision of section 50202 of the BBA of 2018 adds section 1833(g)(7)(B) of the Act which maintains the targeted medical review process (first established through section 202 of the Medicare Access and CHIP Reauthorization Act of 2015), but at a lower threshold than the $3,700 amount established as part of the therapy caps exceptions process via section 3005 of the Middle Class Tax Relief and Jobs Creation Act of 2012. For CY 2018 (and each successive calendar year until 2028, at which time it is indexed annually by the MEI), this now-termed Medical Review (MR) threshold amount is $3,000 for PT and SLP services combined and $3,000 for OT services.

For more information, please see the pages for Therapy Services (section II.M.) of CMS-1693-F on the CMS web page at the following link for PFS Federal Regulation Notices: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html

B. Policy: The CY 2019 KX modifier threshold amounts are: (a) $2,040 for PT and SLP services combined, and (b) $2,040 for OT services.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11055.1	Medicare contractors shall update the allowed dollar amount for CY 2019 outpatient per-beneficiary therapy amounts to $2,040 for physical therapy and speech-language pathology combined and $2,040 for occupational therapy.		X			X	X		X	
11055.2	Medicare contractors shall update the dollar amounts shown in the existing MSN message 17.18 and 17.19 with $2,040. Note: A future CR will revise Medicare systems to no longer send these MSN messages since the therapy caps have been repealed and no longer apply to beneficiaries.		X			X	X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11055.3	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X	X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Pamela West, 410-786-2302 or pamela.west@cms.hhs.gov (Policy questions) , Wilfried Gehne, 410-786-6148 or wilfried.gehne@cms.hhs.gov (Institutional claims questions) , Brian Reitz, 410-786-5001 or brian.reitz@cms.hhs.gov (Professional claims questions)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0