CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3367	**Date: October 7, 2015**
	Change Request 9223

Transmittal 3309, dated August 6, 2015, is being rescinded and replaced by Transmittal 3367 to remove State code 80 from all requirements. All other information remains the same.

SUBJECT: Applying Therapy Caps to Maryland Hospitals

I. SUMMARY OF CHANGES: This Change Request (CR) revises Original Medicare systems to ensure therapy services provided in Maryland hospitals are subject to the outpatient therapy per-beneficiary caps.

EFFECTIVE DATE: January 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2016

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5/10/Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General
R	5/10.3/Application of Financial Limitations
N	5/10.3.1/Exceptions to Therapy Caps – General
N	5/10.3.2/Exceptions Process
N	5/10.3.3/Use of the KX Modifier for Therapy Cap Exceptions
N	5/10.3.4/Therapy Cap Manual Review Threshold
N	5/10.3.5/Identifying the Certifying Physician
N	5/10.3.6/MSN Messages Regarding the Therapy Cap
R	5/40.1/Determining Payment Amounts – Institutional Claims

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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3367	Date: October 7, 2015	Change Request: 9223

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I. GENERAL INFORMATION

A. Background: Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) required Original Medicare to temporarily apply the therapy caps (and related provisions) to the therapy services furnished in an outpatient hospital. These provisions have been extended several times by additional legislation. They were implemented by Change Request (CR) 7785, effective October 1, 2012. To account for future extensions of the effective dates, in January 2013, CR 7881 created a mechanism that Medicare Administrative Contractors (MACs) use to update a screen of 'legislation effective' indicators in their claims processing systems.

In those earlier CRs, the therapy cap provisions were inadvertently not applied to Maryland hospitals when MCTRJCA applied them to other outpatient hospitals described in section 1833(a)(8)(B) of the Social Security Act. This CR corrects the oversight. It also includes corrections and clarifications to various sections of Chapter 5 of Pub. 100-04.

B. Policy: This CR implements the following policies:

- Original Medicare pays outpatient therapy services furnished in Maryland hospitals at rates established under the Maryland All-Payer Model.
- The therapy caps and related provisions described in §1833(g) apply to hospitals paid under the Maryland All-Payer Model.
- Medicare will use the rates established under the All-Payer Model to count the therapy services of Maryland hospitals towards beneficiary's therapy caps and threshold total.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9223.1	The contractor shall ensure the therapy caps apply to claims with Type of Bill 012x and 013x when the CCN begins with '21' (Maryland).					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9223.1.1	The contractor shall apply the submitted charge amount on covered outpatient therapy service lines, before applying coinsurance or deductible, to the therapy financial limitation amount on claims with Type of Bill 012x and 013x when the CCN begins with '21.' '					X				
9223.2	The contractor shall add a "legislation effective" indicator of A as described in BR 7881.4.1 to outpatient therapy service line items on claims when the CCN begins with '21.'					X				
9223.3	The contractor shall add a "legislation effective" indicator of C as described in BR 7881.6.1 to outpatient therapy service line items on claims when the CCN begins with '21.'					X				
9223.4	The contractor shall add a "legislation effective" indicator of D as described in BR 7881.7.1 to outpatient therapy service line items on claims when the CCN begins with '21.'					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9223.5	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
9223.1	Therapy cap logic currently in place in the Common Working File is triggered by the presence of dollar amounts in the 'Therapy Financial Limitation' field. Previously, this field was not populated on Maryland hospital claims. The intent of this BR is for the FISS system to begin to populate the 'Therapy Financial Limitation' field on Maryland hospital claims.
9223.2	The hospital is expected to submit their approved amount under the Maryland All-Payer Model as their submitted charge on these claims.

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

V. CONTACTS

Pre-Implementation Contact(s): Isaac Burrows, isaac.burrows@cms.hhs.gov (Maryland All-Payer Model) , Pam West, pamela.west@cms.hhs.gov (Therapy payment policy) , Wil Gehne, wilfried.gehne@cms.hhs.gov (Claims processing)

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

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services

Table of Contents
(Rev.3367, 10-07-15)

10 - Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General

(Rev. 3367 Issued: 10-07-2015, Effective: 01-01-2016, Implementation: 01-04-2016)

Language in this section is defined or described in Pub. 100-02, chapter 15, sections 220 and 230.

Section §1834(k)(5) to the Social Security Act (the Act), *requires* that all claims for outpatient rehabilitation services and comprehensive outpatient rehabilitation facility (CORF) services, be reported using a uniform coding system. The CMS chose HCPCS (Healthcare Common Procedure Coding System) as the coding system to be used for the reporting of these services. This coding requirement is effective for all claims for outpatient rehabilitation services and CORF services submitted on or after April 1, 1998.

The *Act* also *requires* payment under a prospective payment system for outpatient rehabilitation services including CORF services. Effective for claims with dates of service on or after January 1, 1999, the Medicare Physician Fee Schedule (MPFS) became the method of payment for outpatient therapy services furnished by:

- Comprehensive outpatient rehabilitation facilities (CORFs);
- Outpatient physical therapy providers (OPTs), *also known as rehabilitation agencies*;
- Hospitals (to outpatients and inpatients who are not in a covered Part A stay);
- Skilled nursing facilities (SNFs) (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF); and
- Home health agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care (POC)).

NOTE: No provider or supplier other than the SNF will be paid for therapy services during the time the beneficiary is in a covered SNF Part A stay. For information regarding SNF consolidated billing see chapter 6, section 10 of this manual.

Similarly, under the HH prospective payment system, HHAs are responsible to provide, either directly or under arrangements, all outpatient rehabilitation therapy services to beneficiaries receiving services under a home health POC. No other provider or supplier will be paid for these services during the time the beneficiary is in a covered Part A stay. For information regarding HH consolidated billing see chapter10, section 20 of this manual.

Section 143 of the Medicare Improvements for Patients and Provider's Act of 2008 (MIPPA) authorizes the Centers for Medicare & Medicaid Services (CMS) to enroll speech-language pathologists (SLP) as suppliers of Medicare services and for SLPs to begin billing Medicare for outpatient speech-language pathology services furnished in private practice beginning July 1, 2009. Enrollment will allow SLPs in private practice to bill Medicare and receive direct payment for their services. Previously, the Medicare program could only pay SLP services if an institution, physician or nonphysician practitioner billed them.

In Chapter 23, as part of the CY 2009 Medicare Physician Fee Schedule Database, the descriptor for PC/TC indicator "7", as applied to certain HCPCS/CPT codes, is described as specific to the services of privately practicing therapists. Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice.

The MPFS is used as a method of payment for outpatient rehabilitation services furnished under arrangement with any of these providers.

In addition, the MPFS is used as the payment system for CORF services identified by the HCPCS codes in §20. Assignment is mandatory.

The Medicare **allowed charge** for the services is the lower of the actual charge or the MPFS amount. The Medicare payment for the services is 80 percent of the allowed charge after the Part B deductible is met. Coinsurance is made at 20 percent of the lower of the actual charge or the MPFS amount. The general coinsurance rule (20 percent of the actual charges) does not apply when making payment under the MPFS. This is a final payment.

The MPFS does **not** apply to outpatient rehabilitation services furnished by critical access hospitals (CAHs) *or hospitals in Maryland*. CAHs are to be paid on a reasonable cost basis. *Maryland hospitals are paid under the Maryland All-Payer Model.*

Contractors process outpatient rehabilitation claims from hospitals, including CAHs, SNFs, HHAs, CORFs, outpatient rehabilitation agencies, and outpatient physical therapy providers for which they have received a tie in notice from the *Regional Office* (RO). These provider types submit their claims to the contractors using the ASC X12 837 institutional claim format or the CMS-1450 paper form when permissible. Contractors also process claims from physicians, certain nonphysician practitioners (NPPs), therapists in private practices (TPPs), (which are limited to physical and occupational therapists, and speech-language pathologists in private practices), and physician-directed clinics that bill for services furnished incident to a physician's service (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, for a definition of "incident to"). These provider types submit their claims to the contractor using the ASC X 12 837 professional claim format or the CMS-1500 paper form when permissible.

There are different fee rates for nonfacility and facility services. Chapter 23 describes the differences in these two rates. (See fields 28 and 29 of the record therein described). Facility rates apply to professional services performed in a facility other than the professional's office. Nonfacility rates apply when the service is performed in the professional's office. The nonfacility rate (that is paid when the provider performs the services in its own facility) accommodates overhead and indirect expenses the provider incurs by operating its own facility. Thus it is somewhat higher than the facility rate.

Contractors pay the nonfacility rate on institutional claims for services performed in the provider's facility. Contractors may pay professional claims using the facility or nonfacility rate depending upon where the service is performed (place of service on the claim), and the provider specialty.

Contractors pay the codes in §20 under the MPFS on professional claims regardless of whether they may be considered rehabilitation services. However, contractors must use this list for institutional claims to determine whether to pay under outpatient rehabilitation rules or whether payment rules for other types of service may apply, e.g., OPPS for hospitals, reasonable costs for CAHs.

Note that because a service is considered an outpatient rehabilitation service does not automatically imply payment for that service. Additional criteria, including coverage, plan of care and physician certification must also be met. These criteria are described in Pub. 100-02, Medicare Benefit Policy Manual, chapters 1 and 15.

Payment for rehabilitation services provided to Part A inpatients of hospitals or SNFs is included in the respective PPS rate. Also, for SNFs (but not hospitals), if the beneficiary has Part B, but not Part A coverage (e.g., Part A benefits are exhausted), the SNF must bill for any rehabilitation service.

Payment for rehabilitation therapy services provided by home health agencies under a home health plan of care is included in the home health PPS rate. HHAs may submit bill type 34X and be paid under the MPFS if there are no home health services billed under a home health plan of care at the same time, and there is a valid rehabilitation POC (e.g., the patient is not homebound).

An institutional employer (other than a SNF) of the TPPs, or physician performing outpatient services, (e.g., hospital, CORF, etc.), or a clinic billing on behalf of the physician or therapist may bill the contractor on a professional claim.

The MPFS is the basis of payment for outpatient rehabilitation services furnished by TPPs, physicians, and certain nonphysician practitioners or for diagnostic tests provided incident to the services of such physicians or nonphysician practitioners. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, for a definition of "incident to, therapist, therapy and related instructions.") Such services are billed to the contractor on the professional claim format. Assignment is mandatory.

The following table identifies the provider and supplier types, and identifies which claim format they may use to submit *claims for outpatient therapy services* to the contractor.

"Provider/Supplier Service" Type	**Format**	**Bill Type**	**Comment**
Inpatient SNF Part A	Institutional	21X	Included in PPS
Inpatient hospital Part B	Institutional	12X	Hospital may obtain services under arrangements and bill, or rendering provider may bill.
Inpatient SNF Part B (audiology tests are not included)	Institutional	22X	SNF must provide and bill, or obtain under arrangements and bill.
Outpatient hospital	Institutional	13X	Hospital may provide and bill or obtain under arrangements and bill.
Outpatient SNF	Institutional	23X	SNF must provide and bill or obtain under arrangements and bill.
HHA billing for services not rendered under a Part A or Part B home health plan of care, but rendered under a therapy plan of care.	Institutional	34X	Service not under home health plan of care.
Outpatient physical therapy providers (OPTs), also known as rehabilitation agencies	Institutional	74X	Paid MPFS for outpatient rehabilitation services.
Comprehensive Outpatient Rehabilitation Facility (CORF)	Institutional	75X	Paid MPFS for outpatient rehabilitation services and all other services except drugs. *D*rugs are paid 95% of the AWP.
Physician, NPPs, TPPs, (*therapy services* in hospital or SNF)	Professional	See Chapter 26 for place of service coding.	Payment may not be made for therapy services to Part A inpatients of hospitals or SNFs, or for Part B SNF residents. ***NOTE:*** *Payment may be made to physicians and NPPs for their professional services defined as "sometimes therapy" (not part of a therapy plan) in certain situations; for*

"Provider/Supplier Service" Type	Format	Bill Type	Comment
			example, when furnished to a beneficiary registered as an outpatient of a hospital.
Physician/NPP/TPPs office, or patient's home	Professional	See Chapter 26 for place of service coding.	Paid via MPFS.
Critical Access Hospital - inpatient Part B	Institutional	*12X*	Rehabilitation services are paid at cost.
Critical Access Hospital – outpatient Part B	Institutional	85X	Rehabilitation services are paid at cost.

Complete claim form completion requirements are contained in chapters 25 and 26.

For a list of the outpatient rehabilitation HCPCS codes see §20.

If a contractor receives an institutional claim for one of these HCPCS codes with dates of service on or after July 1, 2003, that does not appear on the supplemental file it currently uses to pay the therapy claims, it contacts its professional claims area to obtain the non-facility price in order to pay the claim.

NOTE: The list of codes in §20 contains commonly utilized codes for outpatient rehabilitation services. Contractors may consider other codes on institutional claims for payment under the MPFS as outpatient rehabilitation services to the extent that such codes are determined to be medically reasonable and necessary and could be performed within the scope of practice of the therapist providing the service.

10.3 - Application of Financial Limitations

(Rev. 3367 Issued: 10-07-2015, Effective: 01-01-2016, Implementation: 01-04-2016)

(Additions, deletions or changes to the therapy code list are updated via a Recurring Update Notification)

Financial limitations on outpatient therapy services, as described above, began for therapy services rendered on or after on January 1, 2006. References and polices relevant to the exceptions process in this chapter apply only when exceptions to therapy caps are in effect. For dates of service before October 1, 2012, limits apply to outpatient Part B therapy services furnished in all settings except outpatient hospitals, including hospital emergency departments. These excluded hospital services are reported on types of bill 12x or 13x, or 85x. Effective for dates of service on or after October 1, 2012, the limits also apply to outpatient Part B therapy services furnished in outpatient hospitals other than CAHs *and hospitals in Maryland*. During this period, only type of bill 12x claims with a CMS certification number in the CAH range, *type of bill 12x and 13x claims with a CMS certification number beginning with the State code for Maryland,* and type of bill 85x claims are excluded. Effective for dates of service on or after January 1, 2014, the limits also apply to CAHs. *Effective for dates of service on or after January 1, 2016, the limits also apply to hospitals in Maryland.*

Contractors apply the financial limitations to the MPFS amount (or the amount charged if it is smaller) for therapy services for each beneficiary.

As with any Medicare payment, beneficiaries pay the coinsurance (20 percent) and any deductible that may apply. Medicare will pay the remaining 80 percent of the limit after the deductible is met. These amounts will change each calendar year.

Medicare shall apply these financial limitations in order, according to the dates when the claims were received. When limitations apply, the Common Working File (CWF) tracks the limits. Shared system

maintainers are not responsible for tracking the dollar amounts of incurred expenses of rehabilitation services for each therapy limit.

In processing claims where Medicare is the secondary payer, the shared system takes the lowest secondary payment amount from MSPPAY and sends this amount on to CWF as the amount applied to therapy limits.

10.3 1 - Exceptions to Therapy Caps – General

(Rev. 3367 Issued: 10-07-2015, Effective: 01-01-2016, Implementation: 01-04-2016)

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

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

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

Use of the exception process does not exempt services from manual or other medical review processes as described in Pub. 100-08. Rather, atypical use of the exception process may invite contractor scrutiny, for example, when the KX modifier is applied to all services on claims that are below the therapy caps or when the KX modifier is used for all beneficiaries of a therapy provider. To substantiate the medical necessity of the therapy services, document in the medical record (see Pub. 100-02, Chapter 15, sections 220.2, 220.3, and 230).

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

10.3.2 - Exceptions Process

(Rev. 3367 Issued: 10-07-2015, Effective: 01-01-2016, Implementation: 01-04-2016)

An exception may be made when the patient's condition is justified by documentation indicating that the beneficiary requires continued skilled therapy, i.e., therapy beyond the amount payable under the therapy cap, to achieve their prior functional status or maximum expected functional status within a reasonable amount of time.

No special documentation is submitted to the contractor for exceptions. The clinician is responsible for consulting guidance in the Medicare manuals and in the professional literature to determine if the beneficiary may qualify for the exception because documentation justifies medically necessary services above the caps. The clinician's opinion is not binding on the Medicare contractor who makes the final determination concerning whether the claim is payable.

Documentation justifying the services shall be submitted in response to any Additional Documentation Request (ADR) for claims that are selected for medical review. Follow the documentation requirements in Pub. 100-02, chapter 15, section 220.3. If medical records are requested for review, clinicians may include, at their discretion, a summary that specifically addresses the justification for therapy cap exception.

In making a decision about whether to utilize the exception, clinicians shall consider, for example, whether services are appropriate to--

> *The patient's condition, including the diagnosis, complexities, and severity;*
> *The services provided, including their type, frequency, and duration;*
> *The interaction of current active conditions and complexities that directly and significantly influence the treatment such that it causes services to exceed caps.*

In addition, the following should be considered before using the exception process:

1. Exceptions for Evaluation Services

Evaluation. The CMS will except therapy evaluations from caps after the therapy caps are reached when evaluation is necessary, e.g., to determine if the current status of the beneficiary requires therapy services. For example, the following CPT codes for evaluation procedures may be appropriate:

> *92521, 92522, 92523, 92524, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004.*

These codes will continue to be reported as outpatient therapy procedures as listed in the Annual Therapy Update for the current year at:
http://www.cms.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage.
They are not diagnostic tests. Definitions of evaluations and documentation are found in Pub. 100-02, chapter 15, sections 220 and 230.

Other Services. There are a number of sources that suggest the amount of certain services that may be typical, either per service, per episode, per condition, or per discipline. For example, see the CSC - Therapy Cap Report, 3/21/2008, and CSC – Therapy Edits Tables 4/14/2008 at www.cms.hhs.gov/TherapyServices (Studies and Reports), or more recent utilization reports. Professional literature and guidelines from professional associations also provide a basis on which to estimate whether the type, frequency, and intensity of services are appropriate to an individual. Clinicians and contractors should utilize available evidence related to the patient's condition to justify provision of medically necessary services to individual beneficiaries, especially when they exceed caps. Contractors shall not limit medically necessary services that are justified by scientific research applicable to the beneficiary. Neither contractors nor clinicians shall utilize professional literature and scientific reports to justify payment for continued services after an individual's goals have been met earlier than is typical. Conversely, professional literature and scientific reports shall not be used as justification to deny payment to patients whose needs are greater than is typical or when the patient's condition is not represented by the literature.

2. Exceptions for Medically Necessary Services

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

Bill the most relevant diagnosis. As always, when billing for therapy services, the diagnosis code that best relates to the reason for the treatment shall be on the claim, unless there is a compelling reason to report another diagnosis code. For example, when a patient with diabetes is being treated with therapy for gait training due to amputation, the preferred diagnosis is abnormality of gait (which characterizes the treatment). Where it is possible in accordance with State and local laws and the contractors' local coverage determinations, avoid using vague or general diagnoses. When a claim includes several types of services, or where the physician/NPP must supply the diagnosis, it may not be possible to use the most relevant therapy diagnosis code in the primary position. In that case, the relevant diagnosis code should, if possible, be on the claim in another position.

Codes representing the medical condition that caused the treatment are used when there is no code representing the treatment. Complicating conditions are preferably used in non-primary positions on the claim and are billed in the primary position only in the rare circumstance that there is no more relevant code.

The condition or complexity that caused treatment to exceed caps must be related to the therapy goals and must either be the condition that is being treated or a complexity that directly and significantly impacts the rate of recovery of the condition being treated such that it is appropriate to exceed the caps. Documentation for an exception should indicate how the complexity (or combination of complexities) directly and significantly affects treatment for a therapy condition.

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

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

It is very important to recognize that most conditions would not ordinarily result in services exceeding the cap. *Use the KX modifier only in cases where the condition of the individual patient is such that services are APPROPRIATELY provided in an episode that exceeds the cap. Routine use of the KX modifier for all patients with these conditions will likely show up on data analysis as aberrant and invite inquiry. Be sure that documentation is sufficiently detailed to support the use of the modifier.*

In justifying exceptions for therapy caps, clinicians and contractors should not only consider the medical diagnoses and medical complications that might directly and significantly influence the amount of treatment required. Other variables (such as the availability of a caregiver at home) that affect appropriate treatment shall also be considered. Factors that influence the need for treatment should be supportable by published research, clinical guidelines from professional sources, and/or clinical or common sense. See Pub. 100-02, chapter 15, section 220.3 for information related to documentation of the evaluation, and section 220.2 on medical necessity for some factors that complicate treatment.

NOTE*: The patient's lack of access to outpatient hospital therapy services alone, when outpatient hospital therapy services are excluded from the limitation, does not justify excepted services. Residents of skilled nursing facilities prevented by consolidated billing from accessing hospital services, debilitated patients for whom transportation to the hospital is a physical hardship, or lack of therapy services at hospitals in the beneficiary's county may or may not qualify as justification for continued services above the caps. The patient's condition and complexities might justify extended services, but their location does not. For dates of service on or after October 1, 2012, therapy services furnished in an outpatient hospital are not excluded from the limitation.*

10.3.3 - Use of the KX Modifier for Therapy Cap Exceptions

(Rev. 3367 Issued: 10-07-2015, Effective: 01-01-2016, Implementation: 01-04-2016)

When exceptions are in effect and the beneficiary qualifies for a therapy cap exception, the provider shall add a KX modifier to the therapy HCPCS code subject to the cap limits. The KX modifier shall not be added to any line of service that is not a medically necessary service; this applies to services that, according to a local coverage determination by the contractor, are not medically necessary services.

The codes subject to the therapy cap tracking requirements for a given calendar year are listed at: http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage.

The GN, GO, or GP therapy modifiers are currently required to be appended to therapy services. In addition to the KX modifier, the GN, GP and GO modifiers shall continue to be used. Providers may report the modifiers on claims in any order. If there is insufficient room on a claim line for multiple modifiers, additional modifiers may be reported in the remarks field. Follow the routine procedure for placing HCPCS modifiers on a claim as described below.

- *For professional claims, sent to the A/B MAC(B), refer to:*
    - *Pub.100-04, Medicare Claims Processing Manual, chapter 26, for more detail regarding completing Form CMS 1500, including the placement of HCPCS modifiers.* ***NOTE****: The Form CMS 1500 currently has space for providing four modifiers in block 24D, but, if the provider has more than four to report, he/she can do so by placing the -99 modifier (which indicates multiple modifiers) in block 24D and placing the additional modifiers in block 19.*
    - *The ASC X12N 837 Health Care Claim: Professional Implementation Guide for more detail regarding how to electronically submit a health care claim transaction, including the placement of HCPCS modifiers. The ASC X12N 837 implementation guides are the standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for submitting health care claims electronically. The 837 professional transaction currently permits the placement of up to four modifiers, in the 2400 loop, SV1 segment, and data elements SV101-3, SV101-4, SV101-5, and SV101-6. Copies of the ASC X12N 837 implementation guides may be obtained from the Washington Publishing Company.*
    - *For claims paid by a carrier or an A/B MAC(B), it is only appropriate to append the KX modifier to a service that reasonably may exceed the cap. Use of the KX modifier when there is no indication that the cap is likely to be exceeded is abusive. For example, use of the KX modifier for low cost services early in an episode when there is no evidence of a previous episode that might have exceeded the cap is inappropriate.*
- *For institutional claims, sent to the A/B MAC(A):*
    - *When the cap is exceeded by at least one line on the claim, use the KX modifier on all of the lines on that institutional claim that refer to the same therapy cap (PT/SLP or OT), regardless of whether the other services exceed the cap. For example, if one PT service line exceeds the cap, use the KX modifier on all the PT and SLP service lines (also identified with the GP or GN modifier) for that claim. When the PT/SLP cap is exceeded by PT services, the SLP lines on the claim may meet the requirements for an exception due to the complexity of two episodes of service.*
    - *Use the KX modifier on either all or none of the SLP lines on the claim, as appropriate. In contrast, if all the OT lines on the claim are below the cap, do not use the KX modifier on any of the OT lines, even when the KX modifier is appropriately used on all of the PT lines. Refer to Pub.100-04, Medicare Claims Processing Manual, chapter 25, for more detail.*

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

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

Are justified by appropriate documentation in the medical record, (See Pub. 100-02, chapter 15, section 220.3); and

Qualify for an exception using the automatic process exception.

If this attestation is determined to be inaccurate, the provider/supplier is subject to sanctions resulting from providing inaccurate information on a claim.

When the KX modifier is appended to a therapy HCPCS code, the contractor will override the CWF system reject for services that exceed the caps and pay the claim if it is otherwise payable.

Providers and suppliers shall continue to append correct coding initiative (CCI) HCPCS modifiers under current instructions.

If a claim is submitted without KX modifiers and the cap is exceeded, those services will be denied. In cases where appending the KX modifier would have been appropriate, contractors may reopen and/or adjust the claim, if it is brought to their attention.

Services billed after the cap has been exceeded which are not eligible for exceptions may be billed for the purpose of obtaining a denial using condition code 21.

10.3.4 - Therapy Cap Manual Review Threshold

(Rev. 3367 Issued: 10-07-2015, Effective: 01-01-2016, Implementation: 01-04-2016)

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

(1) Occupational therapy services.

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

Services shall accrue annually toward the thresholds beginning with claims with dates of service on and after January 1, 2012. The thresholds shall apply to both services showing the KX modifier and those without the modifier. Contractors shall apply the thresholds to claims exceeding it by suspending the claim for manual review. Instructions regarding the manual review process may be found in Pub. 100-08, Medicare Program Integrity Manual.

10.3.5 - Identifying the Certifying Physician

(Rev. 3367 Issued: 10-07-2015, Effective: 01-01-2016, Implementation: 01-04-2016)

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

For the purposes of processing professional claims, the certifying physician/NPP is considered a referring provider. At the time the certifying physician/NPP is identified for a therapy plan of care, private practice therapists (PPTs), physicians or NPPs, as appropriate, submitting therapy claims, are to treat it as if a referral has occurred for purposes of completing the claim and to follow the instructions in the appropriate ASC X12 837 Professional Health Care Claim Technical Report 3 (TR3) for reporting a referring provider (for paper claims, they are to follow the instructions for identifying referring providers per Chapter 26 of this manual) . These instructions include requirements for reporting NPIs.

Currently, in the 5010 version of the ASC X12 837 Professional Health Care Claim TR3, referring providers are first reported at the claim level; additional referring providers are reported at the line level only when they are different from that identified at the claim level. Therefore, there will be at least one referring provider identified at the claim level on the ASC X12 837 Professional claim for therapy services. However, because of the hierarchical nature of the ASC X12 837 health care claim transaction, and the possibility of other types of referrals applying to the claim, the number of referring providers identified on a professional claim may vary. For example, on a claim where one physician/NPP has certified all the therapy plans of

care, and there are no other referrals, there would be only one referring provider identified at the claim level and none at the line levels. Conversely, on a claim also containing a non-therapy referral made by a different physician/NPP than the one certifying the therapy plan of care, the billing provider may elect to identify either the nontherapy or the therapy referral at the claim level, with the other referral(s) at the line levels. Similarly, on a claim having different certifying physician/NPPs for different therapy plans of care, only one of these physician/NPPs will be identified at the claim level, with the remainder identified at the line levels. These scenarios are only examples: there may be other patterns of representing referring providers at the claim and line levels depending upon the circumstances of the care and the manner in which the provider applies the requirements of the ASC X12 837 Professional Health Care Claim TR3.

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

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

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

10.3.6 - MSN Messages Regarding the Therapy Cap

(Rev. 3367 Issued: 10-07-2015, Effective: 01-01-2016, Implementation: 01-04-2016)

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

40.1 - Determining Payment Amounts – Institutional Claims

(Rev. 3367 Issued: 10-07-2015, Effective: 01-01-2016, Implementation: 01-04-2016)

Institutional outpatient rehabilitation claims are paid under the Medicare Physician Fee Schedule (MPFS), except for claims from CAHs and hospitals in Maryland. Medicare contractors should see §100.2 for details on obtaining the correct fee amounts.