| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-20 One-Time Notification | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 1124** | **Date: September 25, 2012** |
| | **Change Request 8036** |

**Transmittal 1117, dated August 31, 2012, is being rescinded and replaced by Transmittal 1124, dated September 25, 2012, to delete business requirement 8036.26.1. All other information remains the same.**

**SUBJECT: Manual Medical Review of Therapy Services**

**I. SUMMARY OF CHANGES:** All requests for Physical Therapy/Speech-Language Pathology or Occupational Therapy services above $3,700 provided under Medicare Part B shall be approved in advance.

**EFFECTIVE DATE: October 1, 2012**
**IMPLEMENTATION DATE: October 1, 2012**

***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 |
|---|---|
| | |

**III. FUNDING:**
**For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:**
Funding or implementation activities will be provided to contractors through the regular budget process

**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 obliged 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:**
**One-Time Notification**
***Unless otherwise specified, the effective date is the date of service.***

# Attachment - One-Time Notification

| Pub. 100-20 | Transmittal: 1124 | Date: September 25, 2012 | Change Request: 8036 |
|---|---|---|---|

**Transmittal 1117, dated August 31, 2012, is being rescinded and replaced by Transmittal 1124, dated September 25, 2012, to delete business requirement 8036.26.1. All other information remains the same.**

**SUBJECT: Manual Medical Review of Therapy Services**

**EFFECTIVE DATE: October 1, 2012**
**IMPLEMENTATION DATE: October 1, 2012**

## I. GENERAL INFORMATION

**A. Background:** The Balanced Budget Act of 1997 enacted financial limitations on outpatient physical therapy, occupational therapy, and speech-language pathology services in all settings except outpatient hospital. Exceptions to the limits were enacted by the Deficit Reduction Act, and have been extended by legislation several times. Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) extended the therapy caps exceptions process through December 31, 2012, and made several changes affecting the processing of claims for therapy services.

See attachment.

**B. Policy:** All requests for therapy services above $3,700 provided by speech language therapists, physical therapists, and physicians shall be approved or disapproved in advance. Settings include Part B SNF, CORF, rehabilitation agencies (ORFs), private practices, HHAs (TOB 34X) and hospital outpatient departments. Occupational therapy provided above $3,700 shall also be approved in advance.

There are no automatic exceptions. The provider shall send a request for approval to the MAC or legacy contractor in advance of providing service.

See attachment.

## II. BUSINESS REQUIREMENTS TABLE

*Use "Shall" to denote a mandatory requirement.*

| Number | Requirement | Responsibility | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | Part A | Part B | | | | | FISS | MCS | VMS | CWF | |
| 8036.1 | Requests for therapy services above $3,700 furnished by occupational therapists, speech language therapists, physical therapists, physicians, other practitioners, and | X | X | | X | X | X | | | | | |

| Number | Requirement | Responsibility | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | Part A | Part B | | | | | FISS | MCS | VMS | CWF | |
| | certain provider settings shall be approved or disapproved in advance of services furnished over the threshold. The settings include Part B SNF, CORF, rehabilitation agencies (ORFs), private practices, HHAs (TOB 34X), and hospital outpatient departments. This also applies to physicians billing incident to for therapy services. This applies to therapy services with dates of service October 1, 2012 - December 31, 2012, according to the phase each provider is assigned. | | | | | | | | | | | |
| 8036.2 | No automatic exceptions apply to claims above $3,700 for claims submitted by providers in their respective phase. | X | X | | X | X | X | | | | | |
| 8036.3 | Contractors shall provide a mailing address where requests for pre-claim review can be submitted. Contractors have the discretion to provide a fax number. | X | X | | X | X | X | | | | | |
| 8036.4 | Contractors shall allow providers to submit additional requests for preapproval only if they have additional information to supply and the original request was denied. | X | X | | X | X | X | | | | | |
| 8036.5 | Contractors shall make a decision (number of days approved and/or denied) and inform (by telephone, fax, or letter; if by letter the letter must be postmarked by the 10th day) the provider and beneficiary within 10 business days of receipt of all requested documentation. Failure to make a decision within 10 business days will lead to an automatic approval of the request. | X | X | | X | X | X | | | | | |
| 8036.6 | If approved due to time constraints, the contractor shall inform the provider and beneficiary within 10 business days that the documentation was not reviewed. | X | X | | X | X | X | | | | | |
| 8036.7 | If denied the contractor shall provide a letter of denial to the provider and beneficiary. The provider letter must have detailed reasons (e.g., not enough evidence of skilled care is not enough detail). Contractors shall aim to get reading levels of letters as low as possible (target readability is a 6th - 9th grade reading level) without losing important content or distorting the meaning and without sounding condescending to the reader. Contractors can also provide this information | X | X | | X | X | X | | | | | |

| Number | Requirement | Responsibility | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | Part A | Part B | | | | | FISS | MCS | VMS | CWF | |
| | by fax or phone. | | | | | | | | | | | |
| 8036.8 | Contractors shall use the coverage and payment policy requirements contained within Pub. 100-02, Medicare Benefit Policy Manual, section 220 as well as any Local Coverage Decisions when making decisions as to whether a service shall be preapproved. | X | X | | X | X | X | | | | | |
| 8036.9 | The requirement for pre-approval of therapy services shall apply to specifically identified providers on the effective date determined by CMS for the phase. Contractors shall prioritize reviews as follows:<br><br>Phase I: October 1, 2012 – December 31, 2012<br><br>Phase II: November 1, 2012 – December 31, 2012<br><br>Phase III: December 1, 2012 – December 31, 2012 | X | X | | X | X | X | | | | | |
| 8036.10 | Pre-approval re-requests shall not be reviewed any sooner than 15 calendar days before the start of each Phase. The pre-approval requests reviews shall start no sooner than September 16, 2012. | X | X | | X | X | X | | | | | |
| 8036.11 | A provider may render the services that are unapproved and submit the claim, which shall be denied by the contractor. At that time an appeal may be requested. If the provider chooses to not render the unapproved services, they may send in a new preapproval request only if they have additional information to supply and the original request was denied. | X | X | | X | X | X | | | | | |
| 8036.12 | Claims rejected because of the threshold shall be automatically released from suspension for processing unless the provider is being reviewed in Phase I, Phase II, or Phase III if the KX modifier is appended to the claim according to current CMS billing guidelines. Contractors shall follow the current MR prepayment review guidelines. | X | X | | X | X | X | | | | | |
| 8036.13 | Claims submitted by a provider in their respective phase without a request for preapproval having been submitted shall be subject to prepayment medical review. | X | X | | X | X | X | | | | | |
| 8036.14 | Contractors shall develop a methodology to identify preapproval requests that have been submitted for pre- | X | X | | X | X | X | | | | | |

| Number | Requirement | Responsibility | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | Part A | Part B | | | | | FISS | MCS | VMS | CWF | |
| | approval and match them to submitted claims for specific periods of time. | | | | | | | | | | | |
| 8036.15 | Contractors shall inform the provider of the tracking mechanism being used for preapproval requests (either approved or denied) and instructions on how to submit the claim and preapproval requests. | X | X | | X | X | X | | | | | |
| 8036.16 | When a claim is submitted, contractors shall check to see if the claim has been preapproved or denied. If the contractor can match the claim to a request for preapproval, the contractor shall either approve or deny the claim based on the outcome of the request for preapproval. | X | X | | X | X | X | | | | | |
| 8036.17 | For all other time periods prior to October 1, 2012, the contractor shall treat the claims as if the claims were claims received under the usual procedures for the medical review threshold of $3,700. | X | X | | X | X | X | | | | | |
| 8036.18 | Contractors shall not routinely subject claims to prepayment medical review if prior approval was given for the claims unless you believe there is potential fraud or abuse involved. | X | X | | X | X | X | | | | | |
| 8036.19 | Contractors may perform retrospective review of claims receiving pre-approval. | X | X | | X | X | X | | | | | |
| 8036.20 | Recovery auditors shall not review therapy claims above the $1,880 cap because the beneficiary is liable. | | | | | | | | | | | Recovery Auditors |
| 8036.21 | Contractors shall report weekly the following information to the COR and the following mailbox - therapycapreview@cms.hhs.gov - the number of preapproval requests received, number of preapproval requests approved, treatment days requested, treatment days approved, number of claims approved, number of claims denied. A partial approval/denial shall be counted as an approval. This information shall be reported in Excel format every Friday. The report shall contain the information for the preceding week for the jurisdiction (does not have to be broken down by state). | X | X | | X | X | X | | | | | |
| 8036.22 | The contractor shall utilize clinical review judgment in approving or disapproving requests for additional treatment days in the exceptional circumstance where a provider fails to submit all required documentation. | X | X | | X | X | X | | | | | |

| Number | Requirement | Responsibility | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | Part A | Part B | | | | | FISS | MCS | VMS | CWF | |
| | Clinical review judgment does not replace poor or inadequate medical records. Refer to Pub. 100-08, Medicare Program Integrity Manual, chapter 3, section 3.3.1.3 for instructions on the Basis of Clinical Review Judgment. | | | | | | | | | | | |
| 8036.23 | The contractor shall consider any additional information the provider chooses to submit with the initial request in addition to the information described in the policy section of this CR and any additional documentation requested by the contractor. | X | X | | X | X | X | | | | | |
| 8036.24 | The contractor shall educate the provider/supplier to submit a request for preapproval of a specific number of additional therapy treatment days, not to exceed 20 per discipline, each time the beneficiary is expected to require more therapy treatment days than previously approved. | X | X | | X | X | X | | | | | |
| 8036.25 | The contractor should develop a process by which requests for preapproval may be received and logged expeditiously by the medical review department. | X | X | | X | X | X | | | | | |
| 8036.26 | Therapy Cap review activities described in this CR shall be charged to program management (PM) funds not Medicare integrity program (MIP) funds. Contractors shall report as a separate submission to the Monthly Status Report an accounting of all workload performed in relation to the Manual Medical Review effort for Therapy Cap exceptions. | X | X | | X | X | X | | | | | |
| 8036.27 | Contractors shall stop doing preapproval and prepayment for therapy services when the funds have been exhausted. Direction will be given to each A/B MAC related to a "not to exceed" limit of expenditure. | X | X | | X | X | X | | | | | |
| 8036.28 | Contractors shall post on their Website information about the Therapy Cap Exception process. This information shall include, at a minimum, the 3 Phases and associated NPIs, HETS and ELGA screen information, and instructions to providers on how to submit a preapproval request (include cover/transmittal sheet information). This information should be posted no later than September 9, 2012. | X | X | | X | X | X | | | | | |
| 8036.29 | Contractors shall notify providers, at a minimum, by posting on their Website when they have stopped doing the reviews. | X | X | | X | X | X | | | | | |

| Number | Requirement | Responsibility | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | Part A | Part B | | | | | FISS | MCS | VMS | CWF | |
| 8036.30 | Contractors shall override the CWF edit for rejection of therapy claims when the contractor has stopped the manual medical review of therapy cap exceptions process. | X | X | | X | X | X | | | | | |
| 8036.31 | **NOTE:** Beneficiary notification letters informing beneficiaries that they are close to or over the Therapy Cap, and the Provider Notification Letter describing the new therapy cap procedures will be sent out by CMS. Contractors shall not send out these letters. | | | | | | | | | | | CMS |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Other |
| | | Part A | Part B | | | | | |
| 8036.32 | A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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 one week of the availability of the provider education 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. | | | | | | | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements: N/A**
*Use "Should" to denote a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|
| | |

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

## V. CONTACTS

**Pre-Implementation Contact(s):** Charlene Harven, 410-786-8228 or charlene.harven@cms.hhs.gov, Debbie Skinner, 410-786-7480 or debbie.skinner@cms.hhs.gov, Therapy Cap Review Mailbox, therapycapreview@cms.hhs.gov

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

## VI. FUNDING

**Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:**
Funding or implementation activities will be provided to contractors through the regular budget process

**Section B: For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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.

Attachment

# Manual Medical Review of Therapy Services

## Background

The Balanced Budget Act of 1997 enacted financial limitations on outpatient physical therapy, occupational therapy, and speech-language pathology services in all settings except outpatient hospital. Exceptions to the limits were enacted by the Deficit Reduction Act, and have been extended by legislation several times. Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) extended the therapy caps exceptions process through December 31, 2012, and made several changes affecting the processing of claims for therapy services. Suppliers and providers will continue to use the KX modifier to request an exception to the therapy cap on claims that are over the 2012 cap amounts -- $1,880 for occupational therapy services and $1,880 for the combined services for physical therapy and speech-language pathology. Use of the KX modifier indicates that the services are reasonable and necessary and that there is documentation of medical necessity in the patient's medical record. The MCTRJCA also established a requirement for manual medical review of claims over $3,700 with dates of service October 1, 2012 – December 31, 2012. To implement this law, providers shall be assigned to specific phases by CMS. There will be three phases. The requirement for pre-approval of all therapy services shall apply to specifically identified providers on the effective date determined by CMS for the phase. CMS will publish a list of providers and the respective phases in which they are placed. In addition, CMS shall send a mailing to every provider subject to the therapy manual medical review threshold notifying them of the respective phase they have been placed into. CMS is implementing this process in phases in order to ensure a smooth transition to the new process. Effective dates for the phases are:

Phase I: October 1, 2012 – December 31, 2012

Phase II: November 1, 2012 – December 31, 2012

Phase III: December 1, 2012 – December 31, 2012

In mid-September 2012, CMS shall mail a letter to beneficiaries who have received therapy services in CY 2012 over $1,700. The CMS letter will inform them of the $1,880 therapy cap, the exceptions process and that if services over the cap do not qualify as medically necessary, that they will be responsible for the charges.

## Policy:

All requests for therapy services above $3,700 provided by speech language therapists, physical therapists, and physicians shall be approved or disapproved in advance. Settings include Part B SNF, CORF, rehabilitation agencies (ORFs), private practices, HHAs (TOB 34X) and Hospital Outpatient Departments. Occupational therapy provided above $3,700 shall also be approved in advance.

There are no automatic exceptions. The provider (or beneficiary) shall send a request for approval to the MAC or legacy contractor in advance of providing service (similar to the procedure in 2006).

The MAC or legacy contractor shall provide a mailing address where requests for pre-claim review can be submitted. Contractors have the discretion to provide a fax number. Pre-claim reviews shall not be reviewed any sooner than 15 days before the start of each Phase for providers within that phase.

**The request shall contain the following information:**

- Beneficiary Last Name:
- Beneficiary First Name:
- Beneficiary Middle Initial:
- Beneficiary Medicare Claim Number (HICN):
- Beneficiary Date of Birth:
- Beneficiary Address and Telephone Number:
- Name of Provider Certifying Plan of Care:
- Address of Provider Certifying Plan of Care:
- Telephone and Fax Number of Provider Certifying Plan of Care:
- Provider Number of Physician/NPP Certifying Plan of Care:
- Name of Performing Provider:
- Address of Performing Provider:
- Performing Provider Number:
- Telephone and Fax Number of Performing Provider:
- Number of treatment days requested:
- Expected date range of services:
- Date of Submission:

**A cover/transmittal sheet containing the following information and documentation:**

- Cover sheet;
- Justification;
- Evaluation and/or reevaluation(s) for Plan(s) of Care;
- Certification(s) of the plan(s) of care, where available;
- Objectives and measurable goals and any other documentation requirements of the LCD;
- Progress reports;
- Treatment notes;
- Any orders, if applicable, for the additional therapy services requested; and
- Any additional information requested by the contractor.

The provider may request preapproval of up to 20 treatment days of services.

The contractor shall make a decision (number of days approved and/or denied) and inform (by telephone, fax, or letter; if by letter the letter must be postmarked by the 10th day) the provider and beneficiary within 10 business days of receipt of all requested documentation. All decisions shall be in writing. If the contractor cannot make a decision with 10 days, the therapy will be considered approved. The letter shall indicate that the approval was made because of time constraints and not on the information provided to the contractor.

The contractors shall use the coverage and payment policy requirements contained within Pub. 100-02, Medicare Benefit Policy Manual, section 220 and any applicable local coverage decision policies when making decisions as to whether a service shall be preapproved.

If the decision is non-affirmative, the letter communicating the decision must be detailed. The notice shall indicate that if the beneficiary wants to receive the services from the provider even though Medicare will not pay for the service, the provider may charge the beneficiary. If the request was non-approved, a provider may submit additional requests and provide additional information for consideration. Contractors shall develop a methodology to identify preapproval requests that have been submitted for pre-approval and match them to submitted claims for specific periods of time. Contractors shall inform the provider of the tracking mechanism

being used for preapproval requests (either approved or denied) and instructions on how to submit the claim. Contractors shall use the tracking mechanism to identify that the claims were preapproved or non-approved.

For all other time periods the contractors shall treat the claims as if the claims were claims received under the manual medical review threshold of $3,700.

If the provider or beneficiary wishes to appeal a decision the provider can provide the service, the MAC or legacy contractor shall, upon receipt of the claim, deny the claim and then the provider or beneficiary may file an appeal. CMS strongly encourages providers to provide the beneficiary a voluntary Advanced Beneficiary Notice of no-coverage in these situations. If a decision of non-coverage is reached on initial review or appeal, it shall be considered beneficiary liability.

Contractors shall develop a methodology to identify those claims that have been received for pre-approval and to match them to the decision when the claims for specific periods of time are submitted. Pre-authorization itself is not a guarantee of payment. Retrospective reviews of claims receiving pre-approval may still be performed. Contractors shall not routinely subject claims to prepayment medical review if prior approval was given for the claims, unless you believe there is potential fraud or abuse involved.

Contractors shall prepare and submit a weekly report on the status of workload related to this project including number of preapproval requests received, the number of preapproval requests approved, treatment days requested, treatment days approved, number of claims approved and number of claims denied. A partial approval/denial shall be counted as an approval.

CMS shall publish the list of providers (by NPI number only) and the Phase to which they are assigned. If CMS publishes a list and a provider is not on the list, then that provider shall be deemed to be in Phase III. Contractors shall post the list of NPI numbers CMS provides on their Website.

Claims suspended because of the cap shall be automatically approved unless the provider is being reviewed in Phase I, Phase II, or Phase III.

**Out of Sequence Claims – Post Pay Review Not Required**

Medicare has a 12 month claims filing limitation. Therefore, claims may be received and processed in a sequence different than that of the services provided. When this occurs, a contractor is not required to conduct post payment review on claims that would have been subjected to the $3,700 manual medical review threshold had the claims been received and processed in the order provided. For example:

A beneficiary was in a skilled nursing facility (SNF) and exhausted their SNF benefit days under Part A. The beneficiary continued to receive therapy services under Part B totaling $3,600 (all dates of service before 10/1/2012). The beneficiary was then discharged from the SNF and received therapy services from an independently practicing PT totaling $1,800. The independent PT billed in November 2012 for services provided after 10/1/2012. The MAC received the claims and processed them. After these claims were processed the MAC received the SNF Part B claims totaling $3,600 and processed them. Had these claims been received in advance of the independent PT services the independent PT would have been required to have the services approved in advance. In circumstances such as the example above the contractor is not required to perform post payment review on the $1,800 provided by the independent therapist.

CMS will inform the contractors of the budget they are to use for this project. When the funds have been exhausted, contractors shall stop doing preapproval for therapy services. Contractors shall notify providers by posting on their Websites when they have stopped doing the reviews.