CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1985	Date: June 11, 2010
	Change Request 6980

SUBJECT: Clarifications and Updates of Therapy Services Policies

I. SUMMARY OF CHANGES: This change request manualizes previous instructions to contractors as required by the PPACA, signed March 23, 2010. It simplifies manual language, but does not change manual policy concerning therapy caps and exceptions.

EFFECTIVE DATE: July 11, 2010

IMPLEMENTATION DATE: July 11, 2010

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

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1985	Date: June 11, 2010	Change Request: 6980

SUBJECT: Clarifications and Updates of Therapy Services Policies

EFFECTIVE DATE: July 11, 2010
IMPLEMENTATION DATE: July 11, 2010

I. GENERAL INFORMATION This change request manualizes changes required by JSM/TDL-10207, issued March 29, 2010, and the PPACA, signed March 23, 2010. It simplifies manual language, but does not change manual policy concerning therapy caps and exceptions.

A. Background: The Patient Protection and Affordable Care Act, signed March 23, 2010, contained Section 3103, which extended the exceptions for outpatient therapy caps for all of CY 2010. On March 29, 2010, CMS issued JSM/TDL-10207, instructing contractors that the date for exceptions had changed. A message was sent on the Contractor Provider Education Resources Listserv, learnresource-L, containing provider education language. In accordance with Change Request 3445, messages sent on this listserv were distributed on the contractors' provider listserv and posted to the contractors' Web site.

B. Policy: The outpatient therapy caps exception process is in effect for CY 2010.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6980.1	Contractors shall note that the manual language at Pub. 100-04, chapter 5, section 10.2, has been modified to conform to instructions previously received in JSM/TDL-10207.	X		X	X						
6980.2	Contractors shall note that the obsolete list of diagnoses that applied to manual process exceptions has been removed. It is no longer relevant and should not be used to limit therapy services.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Dorothy Shannon, Dorothy.Shannon@cms.gov
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VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

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.

10.2 - The Financial Limitation

(Rev.1985, Issued: 06-11-10, Effective: 7-11-10, Implemention: 07-11-10)

A. Balanced Budget Act (BBA)

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 annual limit is announced in the final rule of the Medicare Physician Fee Schedule, released on or about November 1 of each year. It is also available in MedLearn Matters articles, contractor Web sites and at www.cms.hhs.gov/therapyservices.*

The limitation is based on therapy services the Medicare beneficiary receives, not the type of practitioner who provides the service. Physical therapists, speech-language pathologists, occupational therapists as well as physicians and certain nonphysician practitioners could render a therapy service.

B. Moratoria and Exceptions for Therapy Claims

Since the creation of therapy caps, Congress has enacted several moratoria and an exceptions process, which has been extended periodically. The cap exception for therapy services billed by outpatient hospitals was part of the original legislation and applies as long as caps are in effect. Exceptions to caps based on the medical necessity of the service are in effect only when Congress legislates the exceptions. References to the exceptions process in subsection C of this section apply only when the exceptions are in effect.

C. Application of Financial Limitations

Financial limitations on outpatient therapy services, as described above, began for therapy services rendered on or after on January 1, 2006. See C1 to C7 of this section when exceptions to therapy caps apply. Limits apply to outpatient Part B therapy services from all settings except outpatient hospital and hospital emergency room. These excluded hospital services are reported on types of bill 12x or 13x, or 85x.

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. Medicare will pay the remaining 80 percent of the limit after the deductible is met. These amounts will change each calendar year. Medicare Contractors shall publish the financial limitation amount in educational articles. It is also available at 1-800-Medicare.

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 2005 directed CMS to develop exceptions to therapy caps for calendar year 2006 and those exceptions have been extended several times by subsequent legislation. The following policies concerning exceptions to caps due to medical necessity apply only when the exceptions process is in effect. With the exception of the use of the KX modifier, the guidance in this section concerning medical necessity applies as well to services provided before caps are reached.

Instructions for contractors to manage automatic process for exceptions will be found in the Program Integrity Manual, chapter 3, section 3.4.1.2. Provider and supplier information concerning exceptions is in this manual 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 at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps.

In 2006, the Exception Processes fell into two categories, Automatic Process Exceptions, and Manual Process Exceptions. Beginning January 1, 2007, there is no manual process for exceptions. All services that require exceptions to caps shall be processed using the automatic process. All requests for exception are in the form of a KX modifier added to claim lines. (See subsection C6 for use of the KX modifier.)

*U*se of the automatic process for exception does not exempt services from manual or other medical review processes as described in Pub. 100-08, chapter 3, section 3.4.1.1.1. Rather, atypical use of the automatic exception process may invite contractor scrutiny. Particular care should be taken to document improvement and avoid billing for services that do not meet the

requirements for skilled services, or for services which are maintenance rather than rehabilitative treatment (see Pub. 100-02, chapter 15, sections 220.2, 220.3, and 230).

The KX modifier, described in subsection C6, is added to claim lines to indicate that the clinician attests that services are medically necessary and justification is documented in the medical record.

2. Automatic Process Exceptions

The term "automatic process exceptions" indicates that the claims processing for the exception is automatic, and not that the exception is automatic. 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 automatic process 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 automatic process 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 automatic process 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 automatic exception process:

a. Exceptions for 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 evaluation procedures may be appropriate:

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 Pub. 100-04, chapter 5, section 20(B) "Applicable Outpatient Rehabilitation HCPCS Codes." They are not diagnostic tests. Definition of evaluations and documentation is found in Pub. 100-02, 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.

b. Exceptions for Conditions or Complexities.

Clinicians may utilize the automatic 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 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 *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. *D*ocumentation 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 th*o*se 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 automatic process 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/common sense. See Pub. 100-02, chapter 15, section 230.3 subsections related to documentation of the evaluation, and section 220.2 on medical necessity for some factors that complicate treatment.

Note that the patient's lack of access to outpatient hospital therapy services alone 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 for continued services above the caps. The patient's condition and complexities might justify extended services, but their location does not.

3. Appeals Related to Disapproval of Cap Exceptions

Disapproval of Exception from Caps. *W*hen 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. Contractors may review claims with KX modifiers to determine whether the services are medically necessary, or for other reasons. Services that exceed therapy caps but do not meet Medicare criteria for medically necessary services are not payable even when clinicians recommend and furnish and these services.

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 Pub. 100-04, chapter 1, section 60 for appropriate use of modifiers.

APPEALS –If a beneficiary whose excepted services do not meet the Medicare criteria for medical necessity elects to receive such services and a claim is submitted for such services, the resulting determination would be subject to the administrative appeals process. Further details concerning appeals are found in Pub. 100-04, chapter 29.

4. Use of the KX Modifier for Therapy Cap Exceptions

When exceptions are in effect and when 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 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 or A/B M*AC*, refer to:
    - Medicare Claims Processing Manual, *Pub.100-04,* chapter 26, for more detail regarding completing the CMS-Form 1500 claim form, including the placement of HCPCS modifiers. Note that the CMS-Form1500 claim form currently has space for providing two modifiers in block 24D, but, if *the provider has* more than two 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, Version 4010A1, 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, data elements SV101-3, SV101-4, SV101-5, and SV101-6. *C*opies of the

ASC X12N 837 implementation guides *may be obtained* from the Washington Publishing Company.

- For claims paid *by a* carrier or A/B M*AC*, 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 FI *or A/B MAC*:

- 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 Medicare Claims Processing Manual, *Pub.100-04,* chapter 25, for more detail.
- 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 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 attached 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 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. 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.

D. MSN Messages

Existing MSN messages 17.13, 17.18 and 17.19 shall be issued on all claims containing outpatient rehabilitation services as noted in this manual. Add applied amount for individual beneficiaries and the generic limit amount 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, terapistas 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 lenguage 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.

Contractors 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. *Institutional Claims Processing* 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. *Contractors e*dit 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 *or A/B MACs* 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 or A/B Mac 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 or A/B M*ACs* 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.

G. FI *or A/B MAC* Action Based on CWF Trailer During the Time Therapy Limits are in Effect

Upon receipt of the CWF error code/trailer, FIs *or A/B MACs* 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 *or A/B MAC* 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 2009 limit of $1840 for a beneficiary who has paid the deductible and the coinsurance:

Services received to date $1825 ($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 *or A/B MAC* reports in the "Financial Limitation" field of the CWF record "$25.00 along with the CWF override code. The FI *or A/B MAC* 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 Contractors 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 contractors 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, *and exceptions are either not appropriate or not available,* 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 C6 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.

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.

Prior to March 1, 2009, providers could use the Notice of Exclusion from Medicare Benefits (NEMB Form No. CMS 20007) to inform a beneficiary of financial liability for therapy above the cap, where no exception applied; however, the NEMB form has been discontinued. In its place, providers may now use a form of their own design, or the Advanced Beneficiary Notice of Noncoverage (ABN, Form CMS-R-131) may be used as a voluntary notice. When using the ABN form as a voluntary notice, the form requirements specified for its mandatory use do not apply. The beneficiary should not be asked to choose an option or sign the form. The provider should include the beneficiary's name on the form and the reason that Medicare may not pay in the space provided within the form's table. Insertion of 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) in (add the year or the dates of service to which it applies) 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, if appropriate. A cost estimate for the services may be included but is not required.

After the cap is exceeded, voluntary notice via a provider's own form or the ABN is appropriate, even when services are excepted from the cap. The ABN is also used **BEFORE** the cap is exceeded when notice about noncovered services is mandatory. For example, 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, an ABN must be issued before the beneficiary receives that service. 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, *beneficiaries should be informed* that Medicare most likely will not provide additional coverage, and *the* ABN *should be issued prior to* delivering any services. The ABN informs the beneficiary of his/her potential financial obligation to the provider and provides guidance regarding appeal rights. When the ABN is used as a mandatory notice, providers must adhere to the form requirements set forth in this manual in chapter 30, section 50.6.3.

The ABN can be found at: http://www.cms.hhs.gov/BNI/Downloads/ABNFormInstructions.zip

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 *or A/B MACs* will also find the amount a beneficiary has accrued toward the financial limitations on the HIQA. Some suppliers and providers billing to carrier or A/B M*AC* 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.