CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2537	**Date: August 31, 2012**
	Change Request 7881

SUBJECT: Expiration of 2012 Therapy Cap Revisions and User-Controlled Mechanism to Identify Legislative Effective Dates

I. SUMMARY OF CHANGES: The purpose of the Change Request is to create the new mechanism.

EFFECTIVE DATE: January 1, 2013
IMPLEMENTATION DATE: January 7, 2013

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	5/10.3/Application of Financial Limitations

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 with 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 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:

Business Requirements

Manual Instructions

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 2537	Date: August 31, 2012	Change Request: 7881

SUBJECT: **Expiration of 2012 Therapy Cap Revisions and User-Controlled Mechanism to Identify Legislative Effective Dates**

Effective Date: **January 1, 2013**

Implementation Date: January 7, 2013

I. GENERAL INFORMATION

A. Background: 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. Therapy services furnished in an outpatient hospital setting had previously been exempt from the application of the therapy caps; however, MCTRJCA required Original Medicare to temporarily apply the therapy caps (and related provisions) to the therapy services furnished in an outpatient hospital on/after October 1, 2012, and on/before December 31, 2012. Although claims processing requirements associated with the cap are only applicable to hospitals on/after October 1, 2012, claims paid for hospital outpatient therapy services since January 1, 2012, are included in calculating the cap beginning October 1, 2012.

MCTRJCA also required a manual review process for those exceptions where the beneficiary therapy services for the year reach a threshold of $3,700. The separate thresholds triggering manual medical reviews build upon the separate therapy caps -- one for PT and SLP services combined and one for OT services. The count of services to which these thresholds apply begins on January 1, 2012.

Absent Congressional action, all of these provisions expire for dates of service after December 31, 2012. Provisions relating to the therapy caps are among a number of legislative changes that may be extended from year to year, or for portions of a year. Medicare systems currently lack flexibility to apply policies to claims based on frequently changing effective dates. These changes may currently require a non-recurring Change Request (CR) to change hard coded edits in Medicare systems. Often, these CRs cannot be implemented timely to meet the changing effective dates.

The business requirements below seek to create a mechanism that Medicare Administrative Contractors (MACs) can use to extend the effective dates of certain policies based on the receipt of non-systems CRs or, in urgent situations, Technical Direction Letters (TDLs). This mechanism will be first used to set the expiration dates of the MCTRJCA 3005 therapy provisions.

Specifically, the mechanism will cause the Medicare Shared Systems to send differing indicators to Common Working File (CWF) to alert CWF of which policies are in effect for a given service. Each indicator will have a different meaning:

Indicator	Meaning
A	Hospital outpatient claims are subject to the therapy cap for this date of service. (This indicator will be used on institutional claims only.)
B	Critical Access Hospital outpatient claims are subject to the therapy cap for this date of service. (This indicator will be used on institutional claims only.)
C	The therapy cap exceptions process, as indicated by the submission of the KX modifier, no longer applies for this date of service. (This indicator will be used on both institutional and professional claims.)
D	The $3700 threshold for review of therapy services no longer applies for this date of service. (This indicator will be used on both institutional and professional claims.)

More than one of these indicators may apply to the same service.

Since the therapy caps themselves are not time-limited in legislation, no indicator is needed to show whether the original therapy cap edits are in effect. These edits are in effect at all times.

Currently, Critical Access Hospital claims are not subject to any therapy cap policies. Indicator B is created here to prepare for possible future legislation to include these claims.

B. Policy: N/A

II. BUSINESS REQUIREMENTS 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	
	INSTITUTIONAL AND PROFESSIONAL CLAIMS PROCESSING INSTRUCTIONS										
7881.1	Medicare contractors shall add fields for 5 one-position indicators to the claim record to indicate that a legislative requirement is effective for the dates of service of the claim.						X	X		X	NCH FPS
7881.1.1	Medicare contractors shall put the one-position indicator(s) on the line-level.						X	X			
7881.1.2	Medicare contractors shall create a process to transmit the new indicators between the contractors/MACs, through the Standard Systems to CWF.						X	X		X	NCH FPS
7881.2	Medicare contractors shall have the capacity to make	X		X	X	X	X	X			

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	
	user-controlled updates to the claims processing system to change the effective dates of time-limited legislation.										
7881.2.1	Medicare contractors shall have the capacity to define the effective periods that shall cause a 'legislation effective' indicator to be set on claim records.	X		X		X	X	X			
7881.2.2	Medicare contractors shall enter 'legislation effective' updates into the claims processing system only when directed by CMS via CR or TDL.	X		X	X	X					
	INSTITUTIONAL CLAIMS PROCESSING REQUIREMENTS										
7881.3	Medicare contractors shall have the capacity to enter values for the following claim characteristics: • Effective "From" date • Effective "Through" date • Last Updated date (for audit trail purposes) **NOTE**: A sample screen table is shown in Attachment A.	X		X		X	X				
7881.3.1	Medicare contractors shall display the following information for each provision that is implemented using a 'legislation effective' indicator: • Legislation identifier • CMS instruction identifier • Legislation Effective Indicator **NOTE**: A sample screen table is shown in Attachment A.						X				
7881.4	Medicare contractors shall create a user-updated legislation effective period for applying therapy services on outpatient hospital claims toward the therapy cap.	X		X			X				
7881.4.1	Medicare contractors shall add a 'legislation effective' indictor of A to line items that meet the following conditions: • Type of bill 12X (excluding Critical Access Hospital CCNs in the range 1300-1399) or 13X • Revenue code 042X, 043X or 044X • Modifier GN, GO or GP and • Dates of service that fall within the effective dates set on the user-controlled 'legislation effective' screen.						X				
7881.4.2	Medicare contractors shall add therapy payment									X	

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	
	amounts to the therapy cap totals on types of bill 12X (excluding Critical Access Hospital CCNs in the range 1300-1399) or 13X only when a 'legislation effective' indicator of A is present on the line.										
7881.4.3	Medicare contractors shall edit claims for outpatient therapy services on outpatient hospital claims against the therapy cap only when a 'legislation effective' indicator of A is present on the line.									X	
7881.4.3.1	Medicare contractors shall remove the termination date of December 31, 2012 from editing of outpatient hospital claims against the therapy cap.									X	
7881.4.4	Medicare contractors shall display the following information on the 'legislation effective' screen: • Legislation identifier - MCTRJCA 3005(b) • CMS instruction identifier – CR 7881 • Legislation Effective Indicator – A						X				
7881.4.5	Medicare contractors shall set up the user-controlled portion of the 'legislation effective' screen for indicator A as follows: • Effective "From" date – 01/01/2012 • Effective "Through" date – 12/31/2012	X		X		X					
7881.5	Medicare contractors shall create a user-updated legislation effective period for applying therapy services on outpatient Critical Access Hospital claims toward the therapy cap.	X		X			X				
7881.5.1	Medicare contractors shall add a 'legislation effective' indictor of B to line items that meet the following conditions: • Type of bill 12X with Critical Access Hospital CCNs in the range 1300-1399 or 85X • Revenue code 042X, 043X or 044X • Modifier GN, GO or GP and • Dates of service that fall within the effective dates set on the user-controlled 'legislation effective' screen.						X				
7881.5.2	Medicare contractors shall add therapy payment amounts to the therapy cap totals on types of bill 12X with Critical Access Hospital CCNs in the range 1300-1399 or 85X only when a 'legislation effective' indicator of B is present on the line.									X	
7881.5.2.1	Medicare contractors shall pass the MPFS amounts for therapy services provided in a CAH (Hospital CCNs in						X				

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	
	the range of 1300-1399) on TOB 12X or 85X with Revenue codes 042X, 043X, or 044X and modifiers GN, GO, or GP to CWF for applying the therapy cap and threshold.										
7881.5.3	Medicare contractors shall edit claims for outpatient therapy services on outpatient hospital claims against the therapy cap only when a 'legislation effective' indicator of B is present on the line.									X	
7881.5.4	Medicare contractors shall display the following information on the 'legislation effective' screen: • Legislation identifier - MCTRJCA 3005(b) • CMS instruction identifier – CR 7881 • Legislation Effective Indicator – B						X				
7881.5.5	Medicare contractors shall not enter any information in the user-controlled portion of the 'legislation effective' screen for indicator B.	X		X		X					
7881.6	Medicare contractors shall create a user-updated legislation effective period for bypassing the therapy cap on claims for outpatient therapy services when the KX modifier is present.	X		X		X	X				
7881.6.1	Medicare contractors shall add a 'legislation effective' indictor of C to line items that meet the following conditions: • Revenue code 042X, 043X or 044X • Modifier GN, GO or GP • Modifier KX and • Dates of service that fall outside the effective dates set on the user-controlled 'legislation effective' screen.						X				
7881.6.2	Medicare contractors shall bypass therapy cap edits when the KX modifier is present only when a 'legislation effective' indicator of C is not present on the line.									X	
7881.6.3	Medicare contractors shall display the following information on the 'legislation effective' screen: • Legislation identifier - MCTRJCA 3005(a)(2) • CMS instruction identifier – CR 7881 • Legislation Effective Indicator – C						X				
7881.6.4	Medicare contractors shall set up the user-controlled portion of the 'legislation effective' screen for indicator C as follows:	X		X		X					

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	
	• Effective "From" date – 01/01/2012 • Effective "Through" date – 12/31/2012										
7881.7	Medicare contractors shall create a user-updated legislation effective period to suspend institutional claims for outpatient therapy services when a beneficiary exceeds $3700 in therapy services in a year.	X		X		X	X				
7881.7.1	Medicare contractors shall add a 'legislation effective' indictor of D to claims that meet the following conditions: • CWF rejects institutional therapy claims that exceeds the current legislation threshold and • Dates of service that fall outside the effective dates set on the user-controlled 'legislation effective' screen. The claim shall then be resubmitted to CWF.						X				
7881.7.2	Medicare contractors shall edit claims for outpatient therapy services when a beneficiary exceeds $3700 in therapy services in a year only when a 'legislation effective' indicator of D is not present on the claim.									X	
7881.7.3	Medicare contractors shall display the following information on the 'legislation effective' screen: • Legislation identifier - MCTRJCA 3005(a)(5) • CMS instruction identifier – CR 7881 • Legislation Effective Indicator – D						X				
7881.7.4	Medicare contractors shall set up the user-controlled portion of the 'legislation effective' screen for indicator D as follows: • Effective "From" date – 01/01/2012 • Effective "Through" date – 12/31/2012	X		X		X					
	PROFESSIONAL CLAIMS PROCESSING INSTRUCTIONS										
7881.8	Medicare contractors shall create a mechanism in the claims processing system to allow the carriers/Part B MACs to enter the new legislation periods with appropriate dates.							X			
7881.8.1	The Standard System shall design this mechanism in a manner that allows the carriers/Part B MACs to enter new legislation periods without Standard System intervention.							X			
7881.9	Medicare contractors shall create a 'legislation effective' period for bypassing the therapy cap on	X			X						

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	
	claims for outpatient therapy services when the KX modifier is present.										
7881.9.1	Medicare contractors shall add a 'legislation effective' indicator of C to claims that meet the following conditions: • Modifier GN, GO or GP • Modifier KX and • Dates of service that fall outside of the effective dates of the current legislation.							X			
7881.9.2	Medicare contractors shall bypass therapy cap edits when the KX modifier is present only when a 'legislation effective' indicator of C is **NOT** present on the claim.									X	
7881.10	Medicare contractors shall create a legislation effective period to suspend professional claims for therapy services when a beneficiary exceeds $3700 in therapy services in a year.	X			X						
7881.10.1	Medicare contractors shall add a 'legislation effective' indicator of D to claims that meet the following conditions: • CWF rejects professional therapy claims that exceeds the current legislation threshold and • Dates of service that fall outside of the effective dates of the current legislation. The claim shall then be resubmitted to CWF.							X			
7881.10.2	Medicare contractors shall edit claims for therapy services when a beneficiary exceeds the current legislation threshold only when a 'legislation effective' indicator of D is **NOT** present on the claim.									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	
7881.11	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 site 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 your 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	X	X					

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
7881.1	Shared system maintainers should determine whether new fields must be created for these indicators or existing fields can be used.

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

V. CONTACTS

Pre-Implementation Contact(s):

Institutional Claims Processing: Wil Gehne, wilfried.gehne@cms.hhs.gov, 410-786-6148
Yvonne Young, yvonne.young@cms.hhs.gov, 410-786-1886
Professional Claims Processing: April Billingsley, april.billingsley@cms.hhs.gov, 410-786-0140
Payment Policy: Pam West, pamela.west@cms.hhs.gov, 410-786-2302

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,* 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.

Attachment

Attachment A: Screen Layout and Examples

The table below outlines the data elements needed to create a user-controlled capacity to set 'legislation effective' indicators on claims. The examples show sample input that could be used to implement the expiration of various provisions of MCTRJCA 3005. If one or more of these provisions is extended by law, the "Effective Through Date" can be changed by the MAC to reflect the new expiration date.

This attachment is not meant to suggest the exact appearance of a screen. Design decisions about the screen display and labels should be determined by the shared system maintainers and MACs during the CR walkthrough process.

Legislation Label	**CMS Instruction**	**Legislation Effective Indicator**	**Effective From Date**	**Effective Through Date**	**Last Updated Date**
MCTRJCA 3005(b)	CR XXXX	A	01/01/2012	12/30/2012	01/07/2013
MCTRJCA 3005(a)(2)	CR XXXX	B			01/07/2013
MCTRJCA 3005(a)(5)	CR XXXX	C	10/01/2012	12/30/2012	01/07/2013
MCTRJCA 3005(a)(5)	CR XXXX	D	10/01/2012	12/30/2012	01/07/2013

10.3 - Application of Financial Limitations

(Rev.2537, Issued: 08-31-12, Effective: 01-01-13, Implementation: 01-07-13)

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 *applied only* to outpatient Part B therapy services furnished in all settings except outpatient hospitals, including hospital emergency departments. These excluded hospital services *were* reported on bill types 12x or 13x, or 85x.

Effective for dates of service on or after October 1, 2012, the limits also applied to outpatient Part B therapy services furnished in outpatient hospitals other than Critical Access Hospitals. *These services are subject to the limits only when such legislation is in effect. When the legislation is in effect,* only 12x claims with a CMS certification number in the CAH range and 85x claims are excluded.

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.

A. Exceptions to Therapy Caps - General

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.

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 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 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 D., is added to claim lines to indicate that the clinician attests that services are medically necessary and justification is documented in the medical record.

B. Exceptions *Process*

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:

> 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 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, 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 ICD-9 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 *and any periods after that date when legislation is in effect,* therapy services furnished in an outpatient hospital are not excluded from the limitation.

C. Appeals Related to Disapproval of Cap Exceptions

Disapproval of Exception from Caps. When a service beyond the cap is determined to be medically necessary, it is covered and payable. But, when a service provided beyond the cap (outside the benefit) is determined to be NOT medically necessary, it is denied as a benefit category denial. 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 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 60.4 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.

D. Use of the KX Modifier for Therapy Cap Exceptions

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 carrier or A/B MAC, refer to:
  - Pub.100-04, Medicare Claims Processing Manual, chapter 26, for more detail regarding completing the CMS-Form 1500 claim form, including the placement of HCPCS modifiers.
    NOTE: The CMS-Form 1500 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 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 A/B MAC, 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 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.

E. Therapy Cap Manual Review Threshold

For 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 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. Beginning with claims with dates of service on and after October 1, 2012 *and any periods after that date when legislation is in effect,* 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 the Program Integrity Manual.

F. Identifying the Certifying Physician

Therapy plans of care must be certified by a physician or non-physician practitioner (NPP), per the requirements in the Medicare Benefit Policy Manual, Pub.100-02, 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 IOM) . 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 the 1500 form). 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.

G. MSN Messages

Existing MSN messages 38.18, 17.13, 17.18 and 17.19 shall be issued on all claims containing outpatient rehabilitation services as noted in this manual. 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