

OUTPATIENT THERAPY SERVICES - Limits 2007

Limits of \$1780 apply.

Slides 10-23 show 2007 policies.

See Change Request 5478 or

Pub. 100-04, chapter 5, section 10.2

Pub. 100-02, chapter 15, section 220

Pub. 100-08, chapter 3, Sec. 3.4.1.1.1



Background on Limits

- Prior to 1999, there was a \$900 limit on physical therapy (PT) and occupational therapy (OT) services rendered in the offices of privately practicing physical and occupational therapists.
- Balanced Budget Act of 1997:
 - increased the dollar amount of therapy services Medicare would cover
 - increased the therapy services included in the limits
 - expanded the settings in which the limits would apply.
- The new limits of \$1500 were in effect in 1999



Moratorium on Therapy Caps

- The limits on Outpatient Therapy Services were implemented in 1999 and from September 1 to December 7, 2003.
- Congress put a “hold” on the limits for 2000-2002, part of 2003 and all of 2004 and 2005.
- Caps were applied in calendar years 2006 and 2007, but Congress allowed exceptions to caps. There were exceptions in both years, but the exceptions process is different.



Limited Services

- “Therapy services” include only physical therapy, occupational therapy and speech-language pathology in outpatient settings paid under the Physician Fee Schedule.
- These services are identified by the plan of care and the codes that the therapy service provider or supplier uses in billing*.
- * See Pub 100-04 Ch 5, Sec. 20 for codes.



Outpatient Therapy Service Providers and Suppliers Included in Limits

● Outpatient Therapy Services from:

- Physicians,
- Physical therapists,
- Occupational therapists,
- Speech-language pathologists,
- Nurse practitioners,
- Clinical nurse specialists, and
- Physician assistants



Outpatient Therapy Services Settings Included in Limits

- Outpatient therapy services provided, for example, at:
 - Private practices of therapists, physicians and non-physician practitioners,
 - Outpatient rehabilitation facilities/rehabilitation agencies,
 - Comprehensive outpatient rehabilitation facilities,
 - Skilled nursing facilities (SNF) providing service to outpatients or residents who are not in covered stays, and
 - Home for outpatients who are not receiving Medicare-covered home health care (HHA-PPS).



Exceptions to Caps - Hospitals

- Outpatient therapy services billed by hospitals are not included in the limits. Still, all hospital services must be documented as medically necessary.
- Prior to the exceptions to therapy caps in 2006, only hospitals could bill for outpatient services that exceeded caps. Exceptions in 2006 and 2007 allow medically necessary outpatient services billed in any setting to exceed caps if they meet criteria for exception.



Exceptions for 2006

- In 2006, services above caps could be paid when the clinician documented medical necessity and applied a KX modifier to the claim line with the GN, GO, or GP modifier attesting the service was appropriate.
- The clinician could use the KX modifier without contractor approval in an “automatic process” when certain conditions or complexities were documented, but a request and approval from the contractor were required for the “manual process” exceptions.



2006 Policies Apply to 2006 Services

- For services furnished in 2006, the policies applicable to 2006 apply.
- Policies for exceptions to therapy caps in 2006 were provided in change requests 4364 (R855CP, R140PI, R47BP) and 5271 (R60BP, R1106CP, R171PI)

<https://www.cms.hhs.gov/Transmittals/2006Trans/list.asp>



Caps in 2007

- The dollar amount of each cap in 2007 is \$1780.
- One cap is for PT and speech-language pathology (SLP) together and the other is for OT separately.
- Limits apply to each beneficiary's services.

Example of Payments 2007

- The following example will help you understand what Medicare pays and what beneficiaries might pay for services subject to caps and provided from 1-1-07 to 12-31-07.
- This example applies to beneficiaries who obtained outpatient therapy services from settings that are limited. It does not apply to services from a hospital.
- If the deductible was not already met, the beneficiary would pay the deductible for therapy services that also count toward caps.

Example: 1/1/2007-12/31/2007

Part B Deductible Already Met

- Beneficiary has Medicare B and already paid the deductible (\$131 in 2007). After meeting the deductible, s/he received both PT and SLP services.
- The allowed amount for PT and SLP services totaled \$1780 (the maximum allowed without exceptions).
- Medicare paid \$1424 (80% of \$1780).
- Beneficiary paid \$356 (20% of \$1780).

Exceptions 2007

- For 2007, there is no “manual process” for exceptions. Do not submit requests.
- All covered (e.g., medically necessary) outpatient therapy services that are justified by documentation on file may be submitted for payment with a KX modifier.
- Use of the KX modifier will allow payment of services billed above the caps.

Special Note for SNFs

- For residents occupying a bed in a nursing home (or a portion of a nursing home) that Medicare certifies as a skilled nursing facility (SNF), Medicare will not cover services billed by a hospital outpatient department. *Note Consolidated Billing rules in SNFs make this statement true regardless of caps, or exceptions to caps.*
- By contrast, residents in a portion of the nursing home that is not certified as a SNF may receive medically necessary covered services billed by an outpatient hospital department even after reaching the limits.

Exceptions in SNFs

- In 2007, we note that that location of the patient is not relevant. All services exceeding caps must be medically necessary, and all medically necessary services qualify for exceptions.

Covered Services

- Clinicians must document carefully to assure the services billed with a KX modifier conform to the requirements for covered services. (e.g., see Pub. 100-02, chapter 15, sections 220 and 230, and also Pub. 100-04, chapter 5, section 10.2).
- Contractors may review claims with KX modifiers where there is potential fraud, misrepresentation or aberrant billing patterns.

Typical Services

- Services that are typical or average may be either more or less than is needed by an individual.
- Good therapeutic outcomes are identified by better than typical improvement (effectiveness) with less than typical treatment (efficiency) compared to patients with similar conditions.

Examples of Unusual Services

- Except in unusual circumstances, most services should not exceed caps. Examples:
 - Multiple comorbidities or complexities that affect treatment.
 - Published research indicates that patients with similar conditions obtain good therapeutic outcomes with treatment of similar type, frequency and duration to that provided.

Identify Typical Services

- To determine if a patient's needs are typical and services provided are appropriate, see professional guidelines and literature.
- www.cms.hhs.gov/therapyservices (Studies and Reports, especially the latest Utilization Reports). Note utilization of services as analyzed nationally may not be consistent with appropriate utilization of services for an individual place of service, or, especially, for an individual patient. Document each patient's needs.

Document Carefully

- Wherever services are provided, there is a variety of patients, some who need more and some less than is typical for their condition.
- Document carefully both for patients whose services are below the caps, and those above to assure that treatment type, frequency intensity and duration are not excessive to the patient's actual needs.

Objective Measurements

- Although progress may result from healing or treatment other than therapy, one strong indicator of need is response to treatment.
- Objective measurements are required to document the patient's condition and progress during treatment.

Objective Measures Required

- Indicate a measurable physical function in all records.
- Certain tools are recommended but not required (NOMS, OPTIMAL, FOTO, AMPAC).
- Other measurement tools, both commercial and clinic generated, may be appropriate.

Other Recommended Records

- These help justify medical necessity and should be in the evaluation/reevaluation:
 - Severity
 - Complexity
 - Previous medical care
 - Beneficiary's opinion of health status
 - Social support available to beneficiary

More Information for Provider/Suppliers

- If total claims for outpatient therapy are greater than the limits, and they are not billed by an outpatient hospital, or with a KX modifier indicating an exception applies, they are denied.
- If the beneficiary continues to receive services above the limit that were not billed by an outpatient hospital, the provider could bill the beneficiary for the cost of the services.
- Other insurers may cover services Medicare denies.



How Much of the Caps are USED?

- Medicare Contractors and providers can access the accrued amount of therapy services from the ELGA screen inquiries into CWF.
- Provider/suppliers may access therapy service amount remaining through the 270/271 eligibility inquiry transaction.
- Providers who bill to intermediaries may also access HIQA.
- Some suppliers and providers billing to carriers may, in addition, use the ELGB screen inquiries into CWF.
- Those without computer access should call your contractor.

More Information

- A beneficiary may always appeal a Medicare denial. However, the limitation is statutory and a Medicare Contractor may not pay a claim after the limit is reached unless medical necessity has been documented.
- When the beneficiary has other insurance and Medicare is the secondary payer, the Medicare systems will apply to the therapy limit no more than the amount Medicare actually pays as the secondary payer on the claim.

QUESTIONS???

- Beneficiaries: Call 1-800-MEDICARE, or the office where services were furnished.
- Those who furnish services: Call the Medicare contractor (carrier or intermediary) who pays your claims.
- Contractors and others who have no Medicare contractor: Call the nearest Medicare Regional Office.
- Regional Offices may contact the Central Office if they cannot resolve the question.