CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 181	**Date: December 29, 2006**
	Change Request 5478

SUBJECT: Outpatient Therapy Cap Exceptions Process for Calendar Year (CY) 2007

I. SUMMARY OF CHANGES: This instruction provides information for contractors to implement the therapy cap exception process for Calendar Year (CY) 2007. Deleted text related to manual process exceptions

New / Revised Material
Effective Date: January 1, 2007
Implementation Date: On or before January 29, 2007.

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	3/3.4.1.1.1 - Exception From the Uniform Dollar Limitation (Therapy Caps)

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 181	Date: December 29, 2006	Change Request: 5478

SUBJECT: Outpatient Therapy Cap Exceptions Process for Calendar Year (CY) 2007

Effective Date: January 1, 2007

Implementation Date: On or before January 29, 2007.

I. GENERAL INFORMATION

A. Background: Financial limitations on Medicare covered therapy services (therapy caps) were implemented on January 1, 2006. In the Deficit Reduction Act, Congress provided that exceptions to this dollar limitation may be made when provision of additional therapy services is determined to be medically necessary. This exceptions process was initially effective only for services provided in CY2006. Recent legislation, the Tax Relief and Health Care Act of 2006, has extended the application of this exceptions process for 1 year, CY2007.

This Change Request provides instructions to contractors regarding the short term implementation of this legislation. During calendar year 2006, local contractor controlled processes implemented the exceptions to the therapy cap. A nationally consistent systematic process to implement the exceptions is preferable to local processes. In order to meet legislated timeframes, local processes will be continued in the short term. These processes will be replaced by national system changes as soon as is practicable. The national process will be described in a subsequent instruction.

B. Policy: Section 1833(g)(5) of the Social Security Act, as amended by the Tax Relief and Health Care Act of 2006, provides that, for services provided during CY2007 contractors shall, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, grant an exception to the therapy cap in certain circumstances. Claims for services above the cap for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable. Providers do not need to issue an Advance Beneficiary Notice for these benefit category denials.

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	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5478.1	Contractors shall apply exceptions in this CR to the therapy financial limitations to services provided to Medicare eligible beneficiaries in CY2007.	X		X	X		X					
5478.1.1	Contractors shall continue to follow previous instructions for claims with dates of service in CY2006.	X		X	X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5478.1.2	The contractor shall grant exceptions for any number of medically necessary services if the beneficiary meets the conditions described in IOM Pub. 100-04, chapter 5, Section 10.2, forCY2007.											
5478.2	Contractors shall inform providers regarding theCY2007 process to request exceptions to the therapy financial limitations using the KX modifier, as described in Medicare manuals 100-02, 100-04, and 100-08.	X		X	X		X					
5478.3	Contractors shall continue in CY2007 to override CWF rejects indicating that a therapy service has exceeded the financial limitation and shall pay for the service if otherwise covered and payable when the claim contains a KX modifier.	X		X	X		X					
5478.4	Contractors shall discontinue the tracking and reporting requirements regarding the therapy financial limitation exceptions created in CR 4364 (Transmittal R52BP, R140PI, and R855CP).	X		X	X		X					
5478.5	Contractors shall subject therapy claims reporting the KX modifier to pre- or post-payment medical review as is consistent with their medical review strategy.	X		X	X		X					
5478.6	When reviewing claims for services excepted from therapy caps where there is evidence of potential provider fraud, the contractor shall follow the instructions in 100-08, chapter 4, on how to treat the claim in CY2007.	X		X	X		X					
5478.7	When reviewing claims for services excepted from therapy caps the contractor shall deny the claim where there is evidence of misrepresentation of facts presented	X		X	X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	to the contractor by that provider in CY2007.											
5478.8	When reviewing claims for services excepted from therapy caps due to a pattern of aberrant billing the contractor shall deny the services that are not reasonable and necessary.	X		X	X		X					
5478.9	Contractors shall not accept requests for manual process exceptions for services provided in CY2007.	x		x	x		x					
5478.9.1	Contractors have discretion as to whether and how to respond to a request for manual process exception for services provided in CY 2007.	X		X	X		X					
5478.10	The contractor shall track workload associated with the Therapy Cap process inCY2007 only to the extent they would normally track workload as part of an activity (e.g., claims processing).	X		X	X		X					
5478.11	The contractor shall track costs associated with the Therapy Cap process in CY2007 only to the extent they would normally track workload as part of an activity (e.g., claims processing_.	X		X	X		X					
5478.12	If unexpected costs related to the exceptions process occur, contractors shall report costs and workload in the line that best reflects the work being performed per the activity dictionary.	X		X	X		X					
5478.13	For CY2007, carriers and fiscal intermediaries shall not report the therapy cap costs and workload.	X		X	X		X					
5478.14	Contractors shall continue to enforce LCDs, since the presence of a KX does not supersede a Local Coverage Determination (LCD) in CY2007.	X		X	X		X					
5478.15	Contractors shall allow automatic	X		X	X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	process exceptions for documented medically necessary services when any condition or complexity occurs regardless of whether it is represented on the list in Pub. 100-04, chapter 5, section 10.2 in CY2007.											
5478.16	Contractors shall update the list of exceptions inCY2007 according to the changes provided in this CR. Note that contractors may expand, but not remove ICD-9s from the where they believe further exceptions should be allowed.	X		X	X		X					
5478.17	Contractors shall allow automatic process exceptions when medically necessary services are provided for two or more separate, billable, conditions in the same calendar year inCY2007.	X		X	X		X					
5478.18	Contractors shall NOT utilize the KX modifier in data analysis as the sole indicator of services that do exceed caps inCY2007. For all claims, there may be services with appropriately used KX modifiers that do not represent services that exceed the cap.	X		X	X		X					
5478.19	Contractors shall utilize consistently the new definitions and examples provided in this transmittal for Pub. 100-02, chapter 15, section 10.2.	X		X	X		X					
5478.20	Contractors shall not require the additional documentation that is encouraged but not required in Pub. 100-02, chapter 15, section 10.2.	X		X	X		X					
5478.21	Contractors shall require that documentation for outpatient therapy services include objective, measurable patient function information, either by using one of the four recommended (but not required) measurement tools, or	X		X	X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	other information as described in Pub 100-02, chapter 15 section 220.3C.											
5478.22	Contractors need not search their files to either retract payment for claims already paid or to retroactively pay CY2007 claims between 1/1/2007 and the implementation date of this Change Request However, contractors shall reopen and/or adjust CY2007 claims between 1/1/2007 and the implementation date of this CR when they are brought to their attention.	X		X	X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5478.23	A provider education article related to this instruction will be available at 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 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next	X		X	X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.											

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
5478.9	Contractors should note that the manual process for granting exceptions has been removed from the Medicare manuals.
5478.12	CMS does not anticipate any costs associated with the therapy caps process in CY2007.

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne (claims processing) 410-786-6148, Dorothy Shannon 410-786-3396 (payment policy) or Dan Schwartz (program integrity) 410-786-4197.

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. *For TITLE XVIII Contractors*, use only one of the following statements:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC)*, use only one of the following statements:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

3.4.1.1.1 - Exception From the Uniform Dollar Limitation ("Therapy Caps")

(Rev.181, Issued: 12-29-06, Effective: 01-01-07, Implementation: on or before 01-29-07)

Section 1833(g)(5) of the Social Security Act provides that, for services provided during calendar year 2006, contractors shall, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, grant an exception to the therapy cap in certain circumstances.

Automatic Exceptions from Therapy Caps

For CY 2007, the contractor shall presume the beneficiary to be excepted from the therapy cap without submission of request for exception or supporting documentation if:

- The beneficiary meets specific conditions listed in CMS Pub. IOM 100-04 chapter 5, *§10.2* for exception from the therapy cap, or

- *The beneficiary does not meet the specific criteria in CMS Pub. IOM 100-04 chapter 5, §10.2, but has a need for medically necessary therapy services above the therapy cap.*

In both of these situations, the contractor shall require that the therapist maintain on file, necessary documentation to support the medical necessity of therapy services. Documentation requirements are found in CMS IOM Pub. 100-02, chapter 15, section 230.3.

Request for Exception from Therapy Caps

Contractors shall not require providers to submit written requests for exception from the therapy cap. Instead, the placement of the KX modifier on the claim shall be interpreted as a request for exception from the cap. For beneficiaries who the *clinician* believes will require therapy treatment days in excess of those payable under the therapy cap, and who meet the above bulleted criteria for automatic exception, the Medicare contractor shall require the provider to *maintain sufficient documentation on file to support the medical necessity for this service. Use of the KX modifier shall be interpreted as the therapist's attestation that services provided above the cap are medically necessary.*

The contractor shall require the provider to *maintain on file* documentation in accordance with CMS IOM Pub. 100-02, chapter 15, section 220.3 and CMS IOM Pub. 100-04, chapter 5, sections 10.2 and 20 with the request for treatment days in excess of those payable under the therapy cap.

If the clinician attests that the requested services are medically necessary by using a KX modifier on the claim line, the contractor may make the determination that the claim is medically necessary. That determination is binding on the contractor in the absence of:

- potential fraud; or
- evidence of misrepresentation of facts presented to the contractor, or
- A pattern of aberrant billing by a provider.

Should such evidence of potential fraud, misrepresentation, or aberrant billing patterns by a provider be found, claims are subject to medical review regardless of whether the *KX modifier was used on the claim.*

Progressive Corrective Action (PCA) and Medical review have a role in the therapy exception process. Although the services may meet the criteria for exception from the cap due to condition or complexity, they are still subject to review to determine that the services are otherwise covered and appropriately provided. The exception is granted on the clinician's assertion that there is documentation in the record justifying that the services meet the criteria for reasonable and necessary services. For example, the documentation must accurately represent the facts, and there shall be no evidence of patterns of aberrant billing of the services by the provider/supplier. Services deemed medically necessary are still subject to review related to fraud or abuse. An example of inappropriate use of the process is the routine use of the KX modifier on every claim for a patient that has an excepted condition or complexity, regardless of the impact of the condition on the need for services above the cap.