

# EXECUTIVE Summary



## Therapy Caps Exception Process

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**S**ubject to moratoria, essentially since their inception, the therapy caps required by the Balanced Budget Act of 1997 were implemented effective January 1, 2006. However, concern over the caps' limitations and the effect they may have on the availability of needed rehabilitation services to Medicare beneficiaries have prompted Congress to include a therapy caps exception process in Section 1833 (g)(5) of the Deficit Reduction Act (DRA) of 2005.

Therapy caps limits were established at \$1,740 for Medicare Part B occupational therapy (OT) services and \$1,740 for combined Medicare Part B physical therapy (PT) and/or speech and language pathology (SLP) services. Under the new therapy caps exception process, the Part B beneficiary or a person acting on his or her behalf may, when qualified, request an exception to the caps. Meeting the provisions of the DRA, the Centers for Medicare & Medicaid Services (CMS) developed automatic and manual processes in which one may qualify and be granted an exception to therapy caps.

Medicare beneficiaries will be automatically excepted from the therapy caps if the beneficiary meets specific criteria. CMS is quick to point out that the automatic exception process does not mean that all Medicare beneficiaries receive an automatic exception to the caps. The term "automatic" is used to distinguish between the processes (ie, automatic versus manual).

Under the automatic exception, the contractor (fiscal intermediary or carrier) shall presume the beneficiary to be excepted from the therapy cap without submission of a request for exception or supporting documentation if any of the following conditions is met:

1. The beneficiary meets specific conditions and or complexities (to see the list of "Therapy Caps Exceptions Conditions and Complexities," visit CMS online at [www.cms.hhs.gov/transmittals/downloads/R855CP.pdf](http://www.cms.hhs.gov/transmittals/downloads/R855CP.pdf))
2. The beneficiary meets specific criteria for exception where the contractor believes, based on the strongest evidence available, that those beneficiaries will require additional therapy treatment days beyond those payable under the therapy cap.

### CONDITIONS AND COMPLEXITIES

CMS has established a list of conditions and/or complexities identified by ICD-9 codes that will be excepted by the caps. The conditions are represented on the list without asterisks, while the conditions are listed with asterisks. A resident may qualify for an automatic exception when a condition is the reason for the exception; the condition must also relate to the therapy goals and directly and significantly impact the rate of recovery, which necessitates exceeding the cap.

The complexities listed are comorbidities or complicating circumstances and do not alone justify an exception from the caps. A complexity must be reported with another condition when both are concurrently influencing the length or intensity of treatment. CMS has also developed clinical complexities that can justify an automatic exception to the therapy caps for any condition that necessitates skilled thera-

py services, regardless of whether they are present on the list of conditions and complexities. CMS identifies these additional clinical complexities as:

1. The beneficiary was discharged from a hospital or skilled nursing facility (SNF) within 30 treatment days of starting the outpatient therapy.
2. The beneficiary has, in addition to another disease or condition being treated, generalized musculoskeletal conditions or conditions affecting multiple sites not listed as automatically excepted, which will directly and significantly impact the rate of recovery.
3. The beneficiary has a mental or cognitive disorder in addition to the condition being treated that will directly and significantly impact the rate of recovery.
4. The beneficiary requires PT and SLP services concurrently. (There is no impact on the OT cap.)
5. The beneficiary had a prior episode of outpatient therapy during this calendar year for a different condition. The second condition treated in the year does not need to appear on the list of excepted conditions or complexities. In cases where the beneficiary was treated in the same year for the same condition, contractor approval (for the manual process) is required.
6. The beneficiary requires this treatment in order to return to a pre-morbid living environment.
7. The beneficiary requires this treatment plan in order to reduce activities of daily living (ADL) assistance or instrumental activities of daily living (IADL) assistance to pre-morbid levels.
8. The beneficiary indicates he or she does not have access to outpatient hospital therapy services (excluded from therapy caps).

If your beneficiary does not qualify for an exception to the therapy caps based on the automatic exception process, he or she may still qualify for an exception using the manual exception process.

#### **THERAPY CAPS EXCEPTION REQUESTS**

Using the manual exception process, the beneficiary, representative, or provider of the rehabilitation services may submit a request for a cap exception to their contractor for review at any time during the episode of treatment.

CMS recommends for this request to be submitted as soon as the clinician determines that the beneficiary may need services beyond the cap limits. The letter of request should include the number of treatment days requested (not to exceed 15 days) and the justification for the medically necessary services and be faxed or mailed to the contractor with all available supportive documentation. CMS requires the supportive documen-

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*CMS predicts  
that roughly  
80% of the  
beneficiaries who  
require services  
in excess of the  
therapy caps will  
qualify for the  
automatic  
exemptions.*

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tation to include the current evaluation or reevaluation, current plan of care, treatment notes, and interval progress reports sufficient to explain the beneficiary's current functional status and need for continued therapy with the request for therapy treatment days in excess of the cap. The agency also encourages providers to contact their contractor for the preferred method of submitting these manual exception requests.

Once received, the Medicare contractor will have 10 business days to respond to the exception request. If approved as medically necessary, the contractor shall grant an exception to the therapy cap. The contractor may approve fewer than the number of additional days requested by the provider. The contractor may also approve any number of additional days that the contractor deems medically

necessary based on the submitted documentation.

In the event that the Medicare contractor does not issue a decision within those 10 business days, the contractor shall be deemed to have found the additional services requested to be medically necessary and grant the exception approving the number of days requested (not to exceed 15 treatment days).

Upon this approval by the contractor, providers should maintain a copy of the approval in the beneficiary's clinical record and append the "KX" modifier to all therapy procedures subject to the cap. If the clinician determines that the episode of treatment appropriately extends beyond the original approved exception request, a subsequent request will be required.

CMS anticipates that the majority of beneficiaries who require services in excess of the caps will qualify for the automatic exceptions. On the "Therapy Cap Open Door Forum" held on March 27, 2006, it was stated that CMS anticipates an 80/20 split between those who qualify under the automatic exception and those qualifying under the manual exception processes.

When providing services that exceed the therapy cap, CMS instructs providers to add a KX modifier to the therapy HCPCS, which are subject to the therapy caps. This modifier would be used in conjunction with the "GN," "GO," or "GP" therapy modifiers currently in use. In addition, the "-59" modifier would also be required, if applicable.

By appending the KX modifier to the appropriate HCPCS code, the provider is attesting that the services billed:

1. Qualified for the cap exception either automatically or by contractor approval;
2. Are reasonable and necessary services that require the skills of a therapist; and
3. Are justified by appropriate documentation in the medical record.

Use of the KX modifier will allow the contractor to appropriately pay for the services delivered. The KX modifier will instruct the contractor to exclude these services from the appropriate therapy cap. Claims submitted that exceed the cap and do not have the KX modifier included will be denied by the contrac-

tor. CMS cautions the use of the KX modifier and states, "Routine use of the KX modifier for all patients with these conditions will likely show up on a data analysis as aberrant and invite inquiry."

CMS instructs providers not to use the KX modifier until the resident has exceeded the cap limits. In those circumstances for which the provider is unsure of how close to the cap the beneficiary may be, the provider may begin using the KX modifier near the end of limit. CMS strongly discourages the routine use of the KX modifier when the resident is still within his or her cap limit.

In addition to the automatic and manual exceptions, CMS also requires the KX modifier be appended to any therapy evaluation procedures that are provided after the therapy cap has been reached. CMS also provides exceptions for these evaluation services to allow providers to determine if the current status of the beneficiary requires therapy services. Any subsequent therapy services provided would mandate that the cap exception requirements be met. The following HCPCS codes for evaluation procedures will be excepted: 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 97001, 97002, 97003, 97004.

Documentation will be required when submitting these claims, which shall include the complaint or condition that indicated why the evaluation was necessary as well as description of any complexities that directly and substantially impact the beneficiary's treatment.

## CONCLUSION

It is important to note that CMS repeatedly reinforces that the underlying premise for approval of either the automatic or manual exception is the fact that the services being provided are medically reasonable and necessary; that the beneficiary is currently being treated for a condition or complexity on the list; and that the severity of the condition or related therapy disorder, for which the beneficiary is being treated, is such that the skills of a therapist are required for services to address the medical needs above the therapy caps. Documentation in the record must always justify the medical necessity of

the services both before and after the cap has been reached.

Many providers have asked what role the expedited determination and issuance of the generic notice plays in the outpatient therapy caps. CMS addressed this question in its March 2006 "Question and Answer" documents related to the expedited determination process. This document offers the following guidance:

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**Question:** When the annual dollar limit or "cap" for therapy services recently implemented by CMS is exceeded, can a beneficiary who does not qualify for one of the allowed exceptions request an expedited determination?

**Answer:** No, exceeding the therapy cap does not trigger the expedited right. This is true because the cap is set in law, and once it is exceeded, Quality Improvement Organizations (QIOs) contradict or reinterpret the law. Exceeding the therapy cap is similar to exhaustion of other benefits, such as when a beneficiary exceeds the limit of 100 days of coverage in a skilled nursing facility (SNF) Part A stay. Providers never issue generic notices based solely because benefits exhaust.

If reaching the cap, however, coincides with the end of other Medicare-covered care offered by the provider, the generic

notice should be given to allow the beneficiary to receive a QIO opinion on the other services being terminated. However, if the cap has been reached and therapy is the only remaining covered service, the generic notice is not given because the QIO cannot overturn the statutory limit, as stated above.

If the cap has been reached and therapy is the only remaining covered service, the provider should give the generic notice when these therapy services are ending. This is because the statutory limit for the benefit has not been reached, and the provider is making a medical-necessity decision to terminate covered therapy services, thus making it appropriate for a QIO to review at the beneficiary's request.

At the time the clinician determines that skilled services are no longer required, the beneficiary should be informed. An advance beneficiary notice (ABN) would be issued to the beneficiary whenever the treating clinician determines that the services being provided are no longer expected to be covered and the therapy caps have been met. A notice of exclusions to Medicare benefits (NEMB) would be issued once the caps have been met, regardless of whether the services were excepted from the cap.

While the therapy caps have been long in coming, the development of the therapy cap exception process will help ensure that the most vulnerable, our country's aging population, will still have access and benefits related to medically necessary rehabilitation services. ■

*Editor's note: Centers for Medicare & Medicaid Services (CMS) transmittals 47, 140, and 855 as well as the agency's "Medlearn Matters" article MM4364, all from February 15, 2006, were used as resources for this article and can be downloaded at [www.cms.hhs.gov/transmittals](http://www.cms.hhs.gov/transmittals).*

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