

## **FAQ About the Medicare Therapy Cap Implementation and Exception Process**

AOTA's responses to the following questions reflect our interpretation and recommendations to date, based on the information presently available from CMS. At the same time CMS issued memoranda about the cap exception process, it issued another memorandum that has implications for the cap and broader coverage and documentation issues; AOTA will post a separate FAQ about those changes. Watch this site for additional policy clarifications, as updates will be published as they are received from CMS.

- I. General Questions About the Cap Implementation/Exception Process**
- II. Questions About the Automatic Exception Process**
- III. Questions About the Manual Exception Process**

### **I. General Questions:**

#### **Q1: What is the amount payable for occupational therapy services under the 2006 Medicare therapy cap?**

A: \$1,740 per beneficiary per calendar year. (Payment amount is 80% to the provider/practitioner.)

#### **Q2: When can I submit my claim for an automatic or manual exception to Medicare?**

A: CMS has advised in teleconferences and Open Door Forums that claims eligible for "automatic process" exceptions should not be sent in before March 13—or by a prior date if the contractor announces one. However, CMS also recommends faxing, as soon as possible, the letter of request for the "manual process" exceptions you believe are necessary to the contractor. Check your contractor Web site for additional information on exception processing. If you have not been able to locate a fax number, call your Medicare Regional Office.

#### **Q3: From what date of service does the therapy cap exception process begin?**

The exceptions process is effective retroactively to January 1, 2006. Providers whose claims have already been denied because of the caps should review their documentation to determine if services received after the cap was reached during this time qualify for an exception. You may submit retroactive requests for this time period if the patient meets the exception criteria. In addition, providers who have not yet submitted claims for services on or after January 1, 2006 that qualify for the exception, should submit these claims for payment with the KX modifier. If the exception is approved, either through notice from the contractor or because the 10-day window has passed, all private payments collected from the beneficiary because of the cap should be refunded.

**Q4: How and in what order do therapists and providers report all the modifiers (e.g., CCI [59], exception [KX], OT [GO]) that may be required on one claim form?**

A: You may report modifiers in any order.

For professional claims (OTPP or physician office) sent to the carrier, refer to:

Pub.100-04 *Medicare Claims Processing Manual*, Chapter 26, for more detail regarding completing the CMS-1500 claim form, including the placement of HCPCS modifiers. Note that the CMS-1500 claim form currently has space for providing two modifiers in block 24D, but if you have more than two to report, you can do so by placing the -99 modifier (which indicates multiple modifiers) in block 24D and placing the additional modifiers in block 19.

- To access the *Medicare Claims Processing Manual*, go to <http://www.cms.hhs.gov/Manuals/>. From this site, click the links to **Internet-Only Manuals (IOMs)**, then **Pub. 100-04** to reach the *Medicare Claims Processing Manual*.

(AOTA has requested additional information from CMS on modifier use when billing with the electronic UB-92 form. In the interim, seek guidance from you contractor.)

**Q5: Can my Medicare contractor go back and deny services and recoup monies after they have approved my request for an exception to the cap?**

A: Yes. If contractors believe that there has been an overuse of services, abuse of billing, misrepresentation, or fraud in reporting a beneficiary's need for therapy services, they have the authority to request a review of all claims and deny services after they have been previously approved under a therapy cap exception.

**Q6: Is there a limit to the number of exceptions a client can have in 1 year? For example, what if the client has four or five separate incidents in 1 year?**

A: It is our understanding that there is not a limit on the number of exceptions that a client can have in 1 year if he/she meets the exception criteria separately for each episode (e.g. has a different diagnosis or condition for each of the separate episodes requiring therapy). We would caution you to be very thorough in your documentation for the care of this client, however, to ensure that you demonstrate the repeated need for skilled therapy in order to avoid any problems with medical review.

**Q7: Do the therapy caps also apply to occupational therapy private practices and physicians' offices?**

A: Yes, the therapy caps apply to all Medicare Part B outpatient therapy services except hospital outpatient departments.

**Q8: Is there a limit on the number of additional treatment days that I can request?**

A: A contractor may allow **up to 15** additional treatment days per exception request **before** services are rendered and may allow any number of medically necessary treatment

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days retroactively. You may apply for additional exceptions if necessary, but keep in mind that the medical record documentation must clearly support the medical necessity of the services. AOTA recommends that providers limit the number of retroactive requests.

**Q9: If my Medicare contractor denies my request for an exception to the therapy cap, can I appeal this unfavorable decision?**

A: No, the contractor's decision as to whether or not an exception to the cap has been approved does not come with appeal rights.

**Q10: Where can I get the CMS documents that explain the exception process in detail?**

A: There are three different sets of instructions (transmittals) outlining the cap exception process and documentation requirements. These transmittals can be found at:

- Medicare Benefit Policy Manual changes at:  
<http://www.cms.gov/transmittals/downloads/R47BP.pdf>
- Medicare Claims Processing Manual changes at:  
<http://www.cms.gov/transmittals/downloads/R855CP.pdf>
- Medicare Program Integrity Manual changes at:  
<http://www.cms.gov/transmittals/downloads/R140PI.pdf>

**II. Questions about the Automatic Exception Process**

**Q1: What is an automatic exception?**

A: An automatic exception can be used when the client requires therapy beyond the amount payable under the therapy cap for one of two following reasons:

- The client's current diagnosis or comorbidity is specifically included in the CMS list of ICD-9 diagnostic codes for conditions and complexities.
- The client has a "complex situation."

**Q2: Where can I get the listing of ICD-9 diagnostic codes that qualify for the automatic cap exception based on condition or complexity?**

A: This listing is available on **page 22** of the transmittal on the CMS Web site at <http://www.cms.gov/transmittals/downloads/R855CP.pdf>.

**Q3: What are examples of "complex situations"?**

A: Each of the following situations allow for use of the automatic exception process and are described in detail in the transmittal listed in Q2 above.

- The beneficiary was discharged from a hospital or SNF within 30 treatment days of the start of the outpatient episode of treatment.
- The beneficiary has, in addition to the treated condition, generalized musculoskeletal conditions or conditions affecting multiple sites that directly and significantly impact the rate of recovery.
- The beneficiary has a mental or cognitive disorder in addition to the condition treated.

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- The beneficiary had a prior episode of outpatient therapy this calendar year for a **different** condition.
- The beneficiary requires treatment in order to return to a previous (more independent) living environment.
- The patient needs additional treatment in order to return to pre-morbid levels of ADL or IADL functioning.

**Q3: How do I indicate on a claim that the patient is allowed the automatic exception to the cap?**

A: You must add the **KX modifier** to each line of the claim that contains a service which exceeds the cap and that is a required skilled treatment meeting all other Medicare coverage criteria. This modifier represents the provider's attestation of medical necessity. While no other specific documentation is required at the time of submission of the claim, the documentation in the medical record should clearly and definitively show the existence of a condition or complexity that meets the automatic exception rules. Contractors may request additional information. Use of the modifier is likely to be closely monitored for overuse. Retroactive medical review of claims is allowed. See also III.Q5.

**III. Questions about the Manual Exception Process**

**Q1: What is a manual exception?**

A: A manual exception can be applied for when the client requires therapy beyond the amount payable under the therapy cap for therapy that otherwise meets the Medicare coverage criteria due to the complexities/severity/comorbidities of the condition but the condition(s) is **not** one which qualifies for the automatic cap exception based on the listing of ICD-9 diagnostic codes in the CMS transmittal or the other "complex situations" listed.

**Q2: How do I submit a request for a manual exception to the cap?**

A: You must submit a letter plus supporting documentation requesting an exception to your contractor as soon as you determine the client requires services beyond the cap amount (the contractor should have a designated fax line for these requests). Requests for cap exceptions should be submitted prior to the date the cap is expected to be surpassed to avoid placing the beneficiary at risk of incurring the costs of treatment if the request is denied. To be safe, AOTA recommends you include the following supporting documentation with your letter:

- Evaluation and certified plan of care
- Physician certification
- Progress notes
- Treatment encounter notes
- Justification for the clients need for continued therapy, specifying the number of additional treatment days needed

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**Q3: Does one request for a manual exception cover all current and future beneficiary services?**

A: No. Each condition or illness exceeding the beneficiary's outpatient therapy cap limit needs to be authorized by the contractor. Once the required documentation is received and approved, the specified number of treatment days for the beneficiary will be covered. If additional services for the same condition or illness are required beyond the allowed number of visits, you must submit a request for approval **each time** along with supporting documentation for additional treatment days.

**Q4: Can a client see both an occupational therapist and a physical therapist in the same treatment day, or have two different OT visits in one treatment day?**

A: Yes, the treatment days are separately approved by your contractor for OT and for PT and SLP. Any number of visits (also called treatment encounters) can be performed on the same day but that day is viewed as one treatment day.

**Q5: If CMS approves my request for an exception, how do I bill for additional services for the approved client?**

A: You would submit your claims with a **KX modifier** indicating that a manual exception was approved by your contractor. (Recall that the KX modifier is also used to indicate qualification for an automatic exception.) You add the KX modifier to each line of the claim that contains a service that exceeds the cap, when the complexity of the client's condition meets the exception requirements. This modifier also represents the provider's attestation of medical necessity.

**Q6: How do I know if my contractor approves my request for a manual exception?**

A: Medicare contractors are required to respond with a decision to a request for a manual exception within 10 business days of receiving the request. If your Medicare contractor does **not** make a decision within 10 business days of receipt of the request and documentation, the decision for therapy cap exception is deemed **approved** as medically necessary for the number of future visits requested, which cannot exceed 15 visits.