

HIGHLIGHTS OF THERAPY CAP EXCEPTIONS PROCESS

Background

Beginning January 2006, Medicare beneficiaries are subject to a \$1740 per beneficiary annual financial limitation on physical therapy services and speech language pathology services and a separate \$1740 per beneficiary limitation on occupational therapy services. The limits apply to outpatient Part B therapy services provided in all settings except outpatient hospitals.

In February 2006, Congress passed the Deficit Reduction Act which included a provision (section 1833(g)(5)) directing CMS to develop a process during calendar year 2006 to allow for exceptions to the caps in cases where therapy services are medically necessary.

On February 13, CMS issued Transmittal [853](#), Transmittal [139](#), and Transmittal [46](#) outlining the exceptions process. In addition to explaining the exceptions process, Transmittal 46 also identifies minimal expectations of documentation by providers or suppliers submitting claims for payment of therapy services to the Medicare program. The contractors must implement the exceptions process and the documentation requirements by March 13, 2006. Although the implementation date is March 13, exceptions from the therapy cap will be granted retroactively to January 1, 2006 if requested by the provider. Contractors may reopen and adjust the claim if it is brought to their attention.

These transmittals may be downloaded from the 2006 Transmittal page on the CMS website (<http://new.cms.hhs.gov/Transmittals/2006Trans/list.asp#TopOfPage>). Go to "Show items containing only the following key words" and type in "therapy." Click on the appropriate transmittal numbers.

This document provides highlights of the exceptions process and the documentation requirements. We strongly urge therapists to review the Transmittals in their entirety.

Qualifying for an Exception

Providers, suppliers and beneficiaries may request exceptions from therapy caps if services beyond the cap are medically necessary. CMS establishes two categories of exceptions: automatic exceptions and manual exceptions. If a beneficiary qualifies for an automatic exception, no specific request or documentation is submitted to the contractor.

For those beneficiaries who do not qualify for an automatic exception, the provider or beneficiary may submit a request for a cap exception to the contractor at any time during the episode. In all cases, documentation must support the medical necessity of the services. A KX modifier must be submitted with the claim indicating that either an automatic exception applies or that a manual exception has been granted by the contractor. The two categories of exceptions are described in further detail below.

Automatically Excepted Services

- Evaluation services: After the therapy caps are reached, an exception for certain evaluation services is permitted to allow the provider to determine if the beneficiary requires more therapy services. CMS identifies the following evaluation procedures (92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, **97001, 97002**, 97003, 97004).
- Certain conditions and complexities when supported by documentation. CMS includes a list of conditions and complexities (comorbidities) identified by ICD-9 codes that would qualify for an automatic exception. When a condition is the reason for the exception, that condition must be related to the therapy goals and must directly and significantly impact the rate of recovery. In order to qualify for the exception, comorbidities specified on the list must be reported with another condition (which itself may or may not be listed as an excepted condition) and **both** concurrently influence the length or intensity of treatment such that the caps would be exceeded. The list of these ICD-9 codes is included in **Attachment A** (complexities (comorbidities) are denoted by an *).

Although these conditions and complexities are justification for an automatic exception if the required services would exceed the cap, CMS also expects that many beneficiaries with these conditions will not need services beyond the cap. A KX modifier should be submitted with the claim indicating the need for an automatic exception **only** in instances where the complexity is such that the cap would be exceeded. Routine use of the KX modifier for patients with these conditions will likely show up as an aberrant billing practice and result in further review and inquiry.

- Additional complexities or circumstances. CMS includes a list of additional complexities that would allow for an exception (e.g. patient requires PT and SLP concurrently, multiple episodes for different conditions during the calendar year, no access to hospital outpatient departments, and others). The mere existence of one of these complexities does not assure that the services were medically necessary. The clinician's documentation must justify the use of the modifier. A more complete list of these exceptions is included in **Attachment A**.
- Contractors may add additional automatic exceptions through articles.

Manual Exceptions (Process for Contractor Approval)

- In the judgment of the Medicare contractor, an exception for conditions or complexities other than those that are automatic may be justified by specific documentation indicating the beneficiary requires therapy beyond the cap amount for continued safe and effective rehabilitation of health status and/or function within a reasonable amount of time.
- A letter with supporting documentation requesting an exception should be submitted to the contractor by fax as early as the therapist determines that the beneficiary may need services beyond the cap (the contractor could choose to specifically allow phone or mail requests). Unless the contractor requests less information, the documentation submitted should include: evaluation/and certified plan of care, certification, progress reports, treatment encounter notes, and justification sufficient to explain the beneficiary's current functional status and need for continued therapy.
- The provider's request should specify the number of additional treatment days after the cap has been reached, but may not exceed 15 future treatment days for each discipline (PT, OT, and SLP). The contractor may approve fewer days than the number requested by the provider. If the provider determines that the episode of treatment extends beyond the amount that has been approved, the provider can submit a request for further cap exception.
- Medicare contractors have 10 business days from receipt of the request with required documentation to make a decision. If a decision is not made within 10 business days of receipt, the services are deemed medically necessary. The contractor shall notify the provider of the decision as soon as practicable.
- Providers are discouraged from routine submission of requests.

Use of the KX Modifier to Indicate Exception

When the beneficiary qualifies for a therapy cap exception (automatic or manual), the provider shall add the KX modifier to the therapy HCPCS code subject to the limits. By adding this modifier, the provider is attesting that the services billed qualified for the cap exception either automatically or by contractor approval, are reasonable and necessary, and are justified by appropriate documentation. If this attestation is inaccurate the provider will be subject to sanctions for putting inaccurate information on the claim.

Appeals

If a contractor decides not to grant a therapy cap exception, a provider or beneficiary **may not** appeal this decision. If the first request is denied, an additional request for exception from the therapy cap may be allowed only if the patient has undergone a significant change in condition. However, if an exception request is not approved and the beneficiary elects to continue to receive services exceeding the cap, a claim may be submitted and if denied, that denial may be appealed using the standard process already in place for appealing Medicare denials.

Medical Review

If the contractor makes the determination that the requested services are medically necessary, that determination is binding on the contractor in the absence of

- Fraud
- Evidence of misrepresentation of facts presented to the contractor, or
- A pattern of aberrant billing by a provider.

If there is evidence of fraud, misrepresentation, or aberrant billing patterns, claims are subject to medical review regardless of whether the request for an exception was approved.

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 the services are otherwise covered and appropriately provided. Examples of inappropriate use of the exceptions process are routine use of the KX modifier on every claim that meets the automatic exception criteria, or routine application for exceptions only after the cap has been exceeded.

New Documentation Requirements for Therapy Services

In Transmittal 46, CMS includes new documentation requirements for all therapy services billed to Medicare. CMS clarifies that contractors shall not require more specific documentation than that required in the manuals unless other Medicare policies (regulation or statute) require it. These guidelines identify minimal expectations for documentation under Medicare. State or local laws may require more extensive documentation. Below are highlights of the new documentation requirements. It is strongly recommended that physical therapists and physical therapist assistants read the full transmittal for further details regarding documentation.

The following types and description of documentation of therapy services are expected to be submitted in response to any requests for documentation, unless the contractor requests otherwise:

Evaluation and Certified Plan of Care (may be either one or two documents): Include the initial evaluation and any re-evaluations relevant to the episode being reviewed.

Evaluation shall include:

- A diagnosis (where allowed) and description of the specific problem to be evaluated and/or treated. Include all conditions and complexities that may impact treatment.
- Objective measurements, preferably standardized patient assessment instruments and/or outcomes measurement tools related to current functional status, when these are available and appropriate to the condition being evaluated;
- Clinician's clinical judgments or subjective impressions that describe the current functional status of the condition being evaluated, when they provide further information to supplement measurement tools;

- A determination that treatment is not needed, or, if treatment is needed a prognosis for return to pre-morbid condition or maximum expected condition with expected time frame and a plan of care.
- When an evaluation is the only service provided by a provider/supplier in an episode of treatment, the evaluation serves as the plan of care if it contains a diagnosis, or in states where a therapist may not diagnose, a description of the condition from which a diagnosis may be determined by the referring physician/NPP. In order to document that the therapist has met Medicare's requirement that the patient is under the care of a physician, **one** of the following is required:
 - a referral/order and evaluation (without an additional plan of care), **or**
 - a plan of care to evaluate and discharge certified by the physician.

Certification: Physician/NPP approval of the plan required within 30 treatment days after initial treatment, or delayed certification.

Progress Reports:

- Information required in Progress Reports should be provided at least once every 10 treatment days or once during the interval (30 calendar treatment day or one month), whichever is less.
- If each element required in a Progress Report is included at least once during the interval in the encounter notes, then a separate Progress Report is not required.
- A clinician must personally perform or actively participate in at least one treatment session during the interval of treatment.
- A physical therapist must complete a Progress Report at least once during each interval of treatment.
- When unexpected discontinuation of treatment occurs, contractors shall not require a report from the physical therapist or physical therapist assistant for the incomplete interval. Determine the necessity of services based on the delivery of services as anticipated in the plan and encounter notes.
- When discontinuation of treatment is expected during an interval, a discharge note is required. The discharge note shall be an interval note covering the period from the last interval note to the date of discharge.
- Physical therapist assistants (as well as certified occupational therapist assistants, as appropriate) may supplement the reports of clinicians and shall include:
 - Date of beginning of the interval
 - Date report was written
 - Signature or identification of the physical therapist or physical therapist assistant who wrote report and date on which report was written
 - Objective reports of patient's subjective statements, if they are relevant.
 - Objective measurements or description of changes in status relative to each goal currently being addressed in treatment, if they occur. NOTE: physical therapist assistants may not make clinical judgments about why progress was or was not made but may report the progress objectively.
- In addition to the requirements above for notes written by physical therapist assistants, the interval report of a clinician shall also include:
 - Assessment of improvement, extent of progress (or lack thereof) toward each goal;

- Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions should be documented in the clinician's Progress Report;
- Changes to long or short term goals, discharge or an updated plan of care that is sent to the clinician for certification of the next interval of treatment.

Treatment Encounter Notes (may also serve as Progress Reports when required information is included in the notes):

- Documentation is required for every treatment day, and every therapy service.
- Documentation of each treatment encounter will include the following required elements:
 1. Date of treatment;
 2. Total timed code treatment minutes and total treatment time. The amount of time for each specific intervention/modality provided to the patient is **not** required as it is indicated in the billing, but the billing and the total timed code treatment minutes must be consistent (see CMS IOM, Pub. 100-04, chapter 5, section 20.3 for description of billing timed codes);
 3. Identification of each specific intervention/modality provided and billed, for both timed and untimed codes. Frequency and intensity of treatment and other details may be included in the plan of care and need not be repeated in the treatment encounter notes unless they are changed from the plan; and
 4. Signature and professional identification of the qualified professional who furnished or supervised and list of each person who contributed to treatment during that encounter (i.e., the signature of Kathleen Smith, PT, supervisor, with notation of the assistance).
- Justification for treatment must include objective evidence or a clinically supportable statement of expectation that:
 1. The patient's condition has the potential to improve or is improving in response to therapy;
 2. Maximum improvement is yet to be attained; and
 3. There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- Documentation of each treatment encounter may also include the following optional elements to be mentioned **only** if the physical therapist or physical therapist assistant recording the note determines they are **appropriate and relevant**. If these are not recorded daily, any relevant information should be included in the Progress Report:
 - Patient self-report;
 - Adverse reaction to intervention;
 - Communication/consultation with other providers (e.g., supervising clinician, attending physician, nurse, another therapist, etc.);
 - Significant, unusual or unexpected changes in clinical status;
 - Equipment provided; and/or
 - Any additional relevant information the qualified professional finds appropriate.

For Therapy Cap Exceptions, records justifying services in excess of the cap amount. A separate justification statement may be included either as a separate document or within

the other documents if the provider/supplier wishes to assure that the contractor understands the reasoning for use of the KX modifier.

Additional Clarification Regarding Documentation

In the past, certain contractors have required therapists to document specifically to the minute the time spent performing each procedure. APTA has opposed this level of specificity related to recording of time because it is overly burdensome in practice. CMS notes that “contractors shall not count each minute for each therapy service relative to each billed treatment code, but shall ascertain that the total number of minutes of treatment for services represented by time codes is consistent with the number of units billed for those services and that the total number of minutes of treatment including untimed codes is consistent with the documentation that the services were provided for a reasonable amount of time.”

Contractors are required to publish examples of acceptable and unacceptable documentation in educational articles.

Attachment A

ICD-9 Codes That Qualify for the Automatic Therapy Cap Exception Process
 (* indicates a comorbidity)

ICD-9	DESCRIPTION
V43.64	JOINT REPLACEMENT,HIP
V43.65	JOINT REPLACEMENT,KNEE
V43.61	JOINT REPLACEMENT,SHOULDER
V49.63-49.67	UPPER LIMB AMPUTATION STATUS
V49.73-49.77	LOWER LIMB AMPUTATION STATUS
250 – 250.93	DIABETES MELLITUS*
278.01-278.02	OVERWEIGHT,OBESITY,AND OTHER HYPERALIMENTATION *
290.0-290.4	DEMENTIAS*
294.0-294.9	PERSISTENT MENTAL DISORDERS DUE TO CONTIONS CLASSIFIED ELSEWHERE*
311	DEPRESSIVE DISORDER NEC*
323.0-323.0	ENCEPHALITIS,MYELITIS,AND ENCEPHALOMYELITIS*
331.0-331.9	OTHER CEREBRAL DEGENERATIONS
332.0-332.1	PARKINSON'S DISEASE
333.0-333.99	OTHER EXTRAPYRAMIDAL DISEASES AND ABNORMAL MOVEMENT DISORDERS
334.0-334.9	SPINOCEREBELLAR DISEASE
335.0-335.9	ANTERIOR HORN CELL DISEASE
336.0-336.9	OTHER DISEASES OF SPINAL CORD
337.20-337.29	REFLEX SYMPATHETIC DYSTROPHY
340	MULTIPLE SCLEROSIS
342.00-342.9	HEMIPLEGIA AND HEMIPARESIS
343.0-343.9	INFANTILE CEREBRAL PALSY
344.00-344.9	OTHER PARALYTIC SYNDROMES
348.9-348.9	OTHER CONDITIONS OF BRAIN
349.0-349.9	OTHER AND UNSPECIFIED DISORDERS OF THE NERVOUS SYSTEM
353-357	NEUROPATHIES
359.0-359.9	MUSCULAR DYSTROPHIES AND OTHER MYOPATHIES
386.0-386.9	VERTIGINOUS SYNDROMES AND OTHER DISORDERS OF VESTIBULAR SYSTEM*
401.0-401.9	ESSENTIAL HYPERTENSION*
402.00-402.91	HYPERTENSIVE HEART DISEASE*
414.00-414.9	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE*
415.0-415.19	ACUTE PULMONARY HEART DISEASE*
416.0-416.9	CHRONIC PULMONARY HEART DISEASE*

427.0-427.0	CARDIAC DYSRHYTHMIAS*
428.0-428.9	CONGESTIVE HEART FAILURE*
430-432.9	INTRACRANIAL HEMORRHAGES
433.0-434.9	OCCLUSION AND STENOSIS OF PRECEREBRAL AND CEREBRAL ARTERIES (FOR OCCLUSION ONLY)
436	ACUTE,BUT ILL-DEFINED,CEREBROVASCULAR DISEASE
437.0-437.9	OTHER AND ILL-DEFINED CEREBROVASCULAR DISEASE
438.0-438.9	LATE EFFECTS OF CEREBROVASCULAR DISEASE
443.0-443.9	OTHER PERIPHERAL VASCULAR DISEASE*
453.0-453.9	OTHER VENOUS EMBOLISM AND THROMBOSIS*
457.0-457.1	POSTMASTECTOMY LYMPHEDEMA SYNDROME AND OTHER LYMPHEDEMA
478.30-478.5	DISEASES OF VOCAL CORDS OR LARYNX
486	PNEUMONIA,ORGANISM UNSPECIFIED*
490-496	CHRONIC OBSTRUCTIVE PULMONARY DISEASES*
710.0-710.9	DIFFUSE DISEASES OF CONNECTIVE TISSUE
707.99-707.9	CHRONIC ULCER OF SKIN*
711.00-711.99	ARTHROPATHY ASSOCIATED WITH INFECTIONS*
713.0-713.8	ARTHROPATHY ASSOCIATED WITH OTHER DISORDERS CLASSIFIED ELSEWHERE*
714.0-714.9	RHEUMATOID ARTHRITIS AND OTHER INFLAMMATORY POLYARTHROPATHIES*
715.09	OSTEOARTHRITIS AND ALLIED DISORDERS
715.11	OSTEOARTHRITIS,LOCALIZED,PRIMARY,SHOULDER REGION
715.15	OSTEOARTHRITIS,LOCALIZED,PRIMARY,PELVIC REGION AND THIGH
715.16	OSTEOARTHRITIS,LOCALIZED,PRIMARY,LOWER LEG
715.91	OSTEOARTHRITIS,UNSPECIFIED ID GEN.OR LOCAL,SHOULDER
715.96	OSTEOARTHRITIS,UNSPECIFIED IF GEN.OR LOCAL,LOWER LEG
718.44	CONTRACTURE OF HAND
718.49	CONTRACTURE OF JOINT,MULTIPLE SITES
719.7	DIFFICULTY WALKING*
721.91	SPONDYLOSIS WITH MYELOPATHY
723.4	OTHER DISORDERS OF THE CERVICAL REGION,BRACHIA NEURITIS OR RADICULITIS NOS
724.02	SPINAL STENOSIS,LUMBAR REGION
724.3	OTHER AND UNSPECIFIED DISORDERS OF THE BACK,SCIATICA*
724.4	OTHER AND UNSPECIFIED DISORDERS OF THE BACK,THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS,UNSPECIFIED*
726.10-726.19	ROTATOR CUFF DISORDER AND ALLIED SYNDROMES
727.61-727.62	RUPTURE OF TENDON,NONTRAUMATIC

733.00	OSTEOPOROSIS WITH WEDGING OF VERTEBRA
780.93	MEMORY LOSS
781.2	ABNORMALITY OF GAIT
781.3	LACK OF COORDINATION
781.8	NEUROLOGIC NEGLECT SYNDROME
781.92	SYMPTOMS INVOLVING NERVOUS AND MUSCULOSKELETAL SYMPTOMS,ABNORMAL POSTURE*
784.3-784.69	APHASIA AND OTHER SPEECH DISTURBANCES
787.2	DYSPHASIA
806.00-806.99	FRACTURE OF VERTEBRAL COLUMN WITH SPINAL CORD INJURY
810.00-810.13	FRACTURE OF CLAVICLE
811.00-811.19	FRACTURE OF SCAPULA
812.00-812.59	FRACTURE OF HUMERUS
813.00-813.93	FRACTURE OF RADIUS AND ULNA
820.00-820.9	FRACTURE OF NECK OF FEMUR
821.0-821.39	FRACTURE OF OTHER AND UNSPECIFIED PARTS OF FEMUR
828.0-828.1	MULTIPLE FRACTURES INVOLVING BOTH LOWER LIMBS,LOWER WITH UPPER LIMB,AND LOWER LIMB(S)WITH RIB(S)AND STERNUM
852.00-852.59	SUBARACHNOID,SUBDURAL,AND EXTRADURAL HEMORRHAGE,FOLLOWING INJURY
853.00-853.19	OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE FOLLOWING INJURY
854.00-854.19	INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE
881.0-881.2	OPEN WOUND OF ELBOW,FOREARM,AND WRIST
882.0-882.2	OPEN WOUND OF HAND WITH TENDON INVOLVEMENT
884.0-884.2	MULTIPLE AND UNSPECIFIED OPEN WOUND OF UPPER LIMB WITH TENDON INVOLVEMENT
887.0 – 887.7	TRAUMATIC AMPUTATION OF ARM AND HAND (COMPLETE)(PARTIAL)
897.0-897.7	TRAUMATIC AMPUTATION OF LEG(S)(COMPLETE)(PARTIAL)
952.00-952.9	SPINAL CORD INJURY WITHOUT EVIDENCE OF SPINAL BONE INJURY
941.00-952.9	BURNS
959.01	HEAD INJURY

Clinically Complex Situations that Qualify for Automatic Exception

While a beneficiary may not automatically qualify for a cap exception solely based on one of the underlying medical conditions (ICD-9 codes) in the table above, or conditions in combination with complexities in the table above, the beneficiary may still qualify for an automatic cap exception for other clinical complexities. Following are clinical complexities that can justify an automatic exception to the therapy caps for **any** condition

that necessitates skilled therapy services, regardless of whether it is on the list in the table above. As in all exceptions, the services rendered above the caps must be documented, covered, medically necessary services. The mere existence of one of these complexities does not assure that the services were medically necessary. The clinician's documentation must justify the use of the modifier.

- The beneficiary was discharged from a hospital or SNF within 30 treatment days of starting this episode of outpatient therapy. Indicate date of discharge and name of hospital or SNF.
- 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 by condition that will directly and significantly impact the rate of recovery.
- 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.

For the above complexities, list in your documentation all relevant disorders or conditions and describe the impact. For example: A sprained ankle does not qualify for exception by condition, but if the patient also has a dysfunctional wrist on the opposite side that precludes the use of a cane, it would cause a direct and significant impact on the patient's need for skilled physical therapy, and might require services that exceed caps.

- The beneficiary requires PT and SLP services concurrently. If the combination of the two services causes the cap to be exceeded for necessary services, the services are excepted from the PT/SLP cap. There is no affect on the OT cap.
- The beneficiary had a prior episode of outpatient therapy during this calendar year for a different condition. The second condition treated in the year may not be on the list of excepted conditions. IF services are medically necessary and would be payable under the cap, an exception is allowed if prior use of services for a different condition caused the cap to be exceeded and the medically necessary services to be denied. In cases where the beneficiary was treated in the same year for the same condition, contractor approval is required for use of the KX modifier.
- The beneficiary requires this treatment in order to return to a pre morbid living environment. Document what environment and what is needed to return. For example: Patient is progressing (see FIM scores) and has good potential for completing goals for independent toileting which is required for discharge from the nursing home setting and return to the assisted living facility where she resided prior to the CVA.
- The beneficiary requires this treatment plan in order to reduce Activities of Daily Living assistance or Instrumental Activities of Daily Living assistance to pre morbid levels. Document prior level of independence and current assistance needs.
- The beneficiary indicates he/she does not have access to outpatient hospital therapy services. List reasons that justify why the patient cannot obtain excepted services from an outpatient hospital. Reasonable justifications include 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 hospital in the beneficiary's county. If there is any question that the justification may not be accepted as reasonable, submit a request to the contractor.