2011 Medicare Documentation and Therapy Cap Training

BMS Client Training Series

John Wallace PT, OCS

Training Objectives

- Review basic compliance definitions
- Understand the basic requirements of Medicare medical necessity certification
- Understand the therapy cap program
- Understand what constitutes an automatic exception
- Know what documentation is required to appropriately use the –KX modifier
- Appropriate use of ABNs

Deductible

- 2011 Medicare deductible = $162
  - *You may not collect money from Medicare patients for covered services at the time of service*
  - For other payers, you can and should collect copays, deductibles, supplies at the time of service *unless prohibited by your contract*
- Therapy cap amounts
  - PT + Speech: $1,870
  - OT: $1,870

Multiple Procedure Payment Reduction

- For 2011, CMS is reducing the Practice Expense component of the RVUs in the PMR fee schedule. The reduction is 25% for hospitals and 20% for clinician offices.
- The highest valued service will be paid at 100% PE RVU, the remaining services will be paid at 80% or 75% (depending on clinician vs. hospital setting)
- The overall affect will be a 5-8+% decrease in payment. The % determined by the number of units billed in a visit.

PQRS Update

- In 2011, Congress passed the Patient Protection and Affordable Care Act that further modified the participation incentives.
  - 2011 incentive payment 1.0%
  - 2012-2014 incentive payment is 0.5%
  - 2015 begins a 1.5% penalty for not participating
  - 2016 continues with a 2% penalty for not participating

Eligibility

- The provisions of the PQRI program apply to covered professional services:
  - Physical Therapists/PTPP
  - Occupational Therapists/OTPP
  - Speech Therapists/STPP
  - Physicians
  - Other qualified non-physician providers

Part B providers paid by Part A payers are not eligible:

- ***Outpatient Rehab Agencies (OFRs) and CORFs and HOPT***

Determination of Measures

- Minimal changes have occurred in the individual measures for 2011
  - 8 apply for PT
  - 6 apply for OT
- Groups Measure for Back Pain for PT
- Measures apply for SLP through NOMS registry through ASHA

Payment

- Lump-sum payment of 1.0% of allowed charges will be made in Q3 2012.
- Payments will be made to the holder of record of the TIN associated with the practice
- MAC payers post participation information and reports that are available to providers on their web sites.

Reporting

- There are 2 options for reporting:
  - Individual Measures: To qualify, you must report successfully on at least 3 individual measures on $\geq$ 50% (Claims method) or 80% (Registry method) of the eligible patients.
    - Not necessarily 3 measures on the same patient

$$\% = \frac{\text{Clinical Action described by measure}}{\text{Eligible Patients as identified by measure \#}}$$

Reporting

Or,

- Group Measure for Back Pain (applies to PT only)

Note: you can report more than 3 measures and/or the group measure if you like and want to better increase your odds of making the success criteria/

Establishing Medical Necessity

Establishing medical necessity for services revolves around four basic components:

1. Overview of Medicare documentation
2. ICD-9/CPT code matching: LCD requirements
3. Certification/Recertification: MD Signature requirements

Medicare Documentation Requirements

- Policy Manual Pub. 100-02 Medicare Benefit : National standard for patient care documentation http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf
- APTA Summary: Exceptions Process Transmittals Summary at www.apta.org

Documentation Highlights

- Definitions
  - **Assessment**:
    - Separate from evaluation/re-evaluation
    - Provided only by clinicians (therapists)
    - Part of each CPT code E/M service (as part of pre- and post- service time)
    - Not separately billable

Definitions continued

- **Clinician**: refers only to Therapists (PT, OT, SLP), nonphysician practioner, or physician
- **Complexities**: complicating factors that may influence treatment e.g. may influence the type, frequency, intensity, &/or duration of treatment. They may be represented by diagnoses, or by patient factors such as age, severity, acuity, multiple conditions, and motivation, or by social circumstances such as the support of significant other or the availability of transportation to therapy.

Definitions continued

- **Date**: can be stamped, written, or electronic. May be added to the record in any manner and at any time. As long as the dates are accurate. If the dates are different, refer to both the date the service was performed and the date of entry. For example, if the physician certifies the Plan of Care (POC) and fails to date it, staff may add “Received Date” in writing or with a stamp. The “Received Date” is valid for certification/re-certification purposes. If the document is faxed, the date that prints out on the fax is valid.

Definitions continued

- **Re-evaluation**: Separately payable and periodically indicated when professional assessment indicates a significant improvement or decline or change in the patient's condition or functional status that was not anticipated in the POC.

Definitions continued

- **NONPHYSICIAN PRACTITIONERS (NPP)**: means physician assistants, clinical nurse specialists, and nurse practitioners, who may, if state and local laws permit it, and when appropriate rules are followed, provide, certify or supervise therapy services.
- **Physician**: for outpatient therapy services means:
  - Doctor of Medicine
  - Doctor of Osteopathy
  - Doctor of Podiatric Medicine
  - Doctor of Optometry (for low vision services only)
  - Chiropractors and Dentists are not considered physicians

Definitions continued

- **Signature**: Legible identifier of any type (e.g. hand written, electronic, *stamped signatures no longer permitted*) See Pub. 100-08, chapter 3, §3.4.1.1B for specifics
- **Visits** or treatment sessions: Begin at the time the patient enters the treatment area and continues until all services (activities, procedures, services) have been completed and the patient leaves the treatment area to participate in non-therapy activities.
- **Unskilled services**: are palliative procedures that are repetitive or reinforce previously learned skills or maintain function after a maintenance program as been developed.

Reasonable and Necessary Services

- Services shall be of a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively preformed only by a therapist. Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable and necessary even if performed by a qualified professional.

The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by non-skilled personnel.

Reasonable and Necessary Services

- There must be an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time, or must be necessary for the establishment of a safe and effective maintenance program. In the presence of progressive degenerative disease, services may be intermittently necessary to determine the need for assistive equipment &/or establish a program to maximize function.

Reasonable and Necessary Services

- The amount, frequency, and duration of the services must be reasonable under acceptable standards of practice. The payer shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.

Rehabilitative Therapy

- Description: Includes recovery or improvement in function and, when possible, restoration to a previous level of function. Therefore, evaluation, re-evaluation and assessment documented in the Progress Report should describe objective measurements which demonstrate improvements in function or decrease in severity, or rationalization for optimistic outlook to justify continued treatment.

Skilled Therapy

- Requires the skills necessary to safely and effectively furnish a recognized therapy service whose goal is improvement of impairments or functional limitations.
- In the cases of progressive degenerative or terminal disease, services may be intermittently necessary to determine the need for assistive equipment &/or establish a program to maximize function.

Deciding factor: could services have been delivered or supervised by non-skilled personnel

Documentation Requirements for Therapy Services

Medicare required documentation: *Consider a similar approach with all payers*

- **Evaluation/and Plan of Care (POC)** (may be 1 or 2 documents)
  - Certification (physician/NPP approval of POC)
- **Progress Reports:**
  - Due every 10 visits/30 days and at discharge
  - Are not required to be sent to physician
  - Are not required to be signed by physician

(it will all be in one report in Revflow)

Documentation Requirements for Therapy Services

- **Treatment Notes** for each day of service
  - Use of flow sheets: ***No check marks, must be signed***
  - Daily notes must incorporate justification of skilled care delivery
  - Should give the reviewer a real sense of the time it took to deliver the care.
- Justification statement for exceeding the cap may be included as a separate document or within the above documents

Medicare Documentation Requirements

- Evaluations
  - Results of one of the following four measurement instruments ***are recommended but not required***:
    - OPTIMAL (APTA tool available on APTA web site to members who can also request permission to use for free)
    - Patient Inquiry by FOTO
    - Activity Measure—Post Acute Care (AM-PAC)
    - National Outcomes Measurement System (NOMS) from ASHA

Medicare Documentation Requirements

- Evaluations
  - If one of the measurement tools on previous slide is not used, **the following documentation is *required* to indicate objective, measurable patient physical function including:**
    - **Functional assessment individual item and summary scores from commercially available therapy instruments including comparisons from sequential use over the episode of care**
    - **Functional assessment scores from tests and measures validated in the professional literature including comparisons to prior assessments**
    - **Other measurable progress towards identifiable goals for function during the episode of care and at the conclusion of therapy.**

Medicare Documentation Requirements

- Examples from the Test and Measures section of *The Guide to Physical Therapist Practice* pub. by APTA and available to members:
  - Lysholm Knee Score
  - Oswestry Low Back Pain Disability Questionnaire
  - Shoulder Pain and Disability Index
  - Stroke Rehabilitation Assessment of Movement Measures

Documentation Information to Meet Requirements

- Evaluation, Re-evaluation, and Plan of Care
  - Evaluation or Eval including the POC should document the necessity for a course of therapy through objective findings and subjective patient self-reporting.
  - Can be done only by a therapist
  - May include objective measurements or observations made by assistants within their scope of practice but clinical assessment and judgment is the responsibility of the therapist.
  - Should include a list of conditions and complexities, and, when not obvious, describe their impact on the prognosis and plan for treatment.

you should ALWAYS do this!

Documentation Information to Meet Requirements

- Evaluation continued
  - Include the body part and all conditions and complexities that may impact treatment
  - Complexities may include:
    - **Comorbidities**
    - **Premorbid functional levels**
    - **Date of onset**
    - **Current functional levels**

Documentation Information to Meet Requirements

- When the Evaluation serves as the Plan of Care
  - Applies when the only service provided is the evaluation—no treatment provided
  - Must contain a diagnosis or a description of the condition from which a diagnosis may be determined by the physician/NPP
  - Referral or order for the evaluation and the evaluation itself are the only required documentation.
  - A referral or order may be signed and dated by the physician after the evaluation and shall be interpreted as certification of the Evaluation/POC

Medicare Documentation Requirements

Plan of Care should contain:

- Summary of patient problems, prior level of function, and pertinent medical history
- Diagnosis(s) that require physical therapy
- Therapeutic interventions to be used
- Frequency of treatment ("tapering" is allowed)
- Duration of treatment in weeks
- Long term treatment goals (*these must be specific and measurable)*
- Prognosis or Rehabilitation Potential
- **Must be signed and dated by therapist and physician**

POC Recertification

- CMS mandate to change from 30 days to 90 days
- Reporting period for Progress Report is 30 days
- Effective 1/1/2008
- Implementation 6/9/2008

Medicare Documentation Requirements

POC 90-day certification period:

- Certification good ***UP TO*** 90-days
- Duration must be reasonable for Diagnosis and patient problems
- Most POCs will be written for < 90-days
- Frequency and duration cannot be ranges (e.g. 2-3 x per week for 6-8 weeks)
- Duration can be tapered (e.g. 3x/wk x 4 wks, 2x/wk x 4 weeks, 1x/wk x 3 wks)

90-day Certification

Patient presents 2 weeks post TKR

- Referral: 2-3 times per week for 4-6 weeks

- During evaluation you discover hx of COPD
- Your POC frequency and duration:
  - 3 times per week for 4 weeks
  - 2 times per week for 2 weeks

Total of 6 weeks or 42 days

Medicare Documentation Requirements

- Changes to the POC
  - Must be signed by Therapist or Physician
  - Significant changes must be certified by the physician
    - Specifically, changes in Long Term Goals
  - Insignificant changes need not be certified
    - Decreased frequency or duration of treatment
    - Achievement of a goal
    - Discontinuing an intervention

Medicare Documentation Requirements

Progress Report:

- Is a periodic summary of patient progress
- Information must be provided every 10 visits or once every 30-days.
- Absences due to illness or holidays do not affect the requirement for Progress Reports.
- If delayed it must be completed within 7 days or the end of the reporting period and should explain the reason for the delay.
- Include documentation of therapist active participation within the reporting period by signing treatment notes.

Medicare Documentation Requirements

Progress Report

- Discharge Progress report required for each episode
  - Covers the last reporting period up to the discharge date
  - If discharge is unanticipated, the therapist may base judgment on the Treatment Notes and other available documentation or verbal reports.
  - Does not have to be "certified" or signed by the physician.

Medicare Documentation Requirements

Contents of Progress Report

- Assessment of improvement, extent of progress (or lack thereof) toward each goal
- Reference to any re-evaluation data
- Plans for continuing treatment
- Changes to goals (would trigger new POC)
- discharge plans
- Re-evaluation should not be required before every Progress Note but may be appropriate when assessment indicates changes not anticipated in the current POC

Medicare Documentation Requirements

Progress Report

- The report must justify necessity of services. Justification must include objective evidence or a clinically supportable statement of expectation that:
  - The patient's condition has the potential to improve or is improving with therapy
  - Maximum improvement is not yet attained
  - There is an expectation that anticipated improvement is attainable in a reasonable period of time
- Must contain objective evidence of standardized patient assessment instruments, outcome measurement tools or measurable assessments of functional outcomes.

Medicare Documentation Requirements

Treatment Encounter note:

- Documentation required every treatment
- Date of treatment
- Identification of each specific intervention in language that can be compared with the billing on the claim
- Total treatment time **and** total 1-on-1 time in minutes required in every daily note
  - Total treatment time does not include time for services not billable (e.g. rest periods)
  - Unbilled services that are not part of total treatment time may be included in the note to show consistency with the POC or if requires by law or regulation
  - Time of each specific intervention may be include but may not be required by payers.

Medicare Documentation Requirements

Treatment Notes

- Signature and professional identification of the qualified professional who furnished or supervised the service and a list of those who participated
- Signature and identification of the supervisor of Assistants are not required on each note unless that person actively participated in the treatment that day but the supervisor must be clear in the POC and Progress Report
- When the supervisor is absent, the presence of a qualified supervisor on that day is sufficient.
- Flow Sheets: Provider of care must be clear, demonstrate skilled care was delivered: NEVER USE CHECK MARKS!

Treatment Notes

- Flow Sheets:
  - Provider of care must be clearly identified,
  - Provider must demonstrate skilled care was delivered:
    - NEVER USE CHECK MARKS!
    - Record exercise/activity dosing
    - Drop exercises off when skilled care no longer necessary and replace with more complex/higher level activities

Medical Necessity

- Services must relate to a written Plan of Care that was ***established*** by a therapist before treatment began.
- Services performed under a Plan of Care must be ***certified*** by a physician at least every 90 days to be covered unless the physician requires it sooner.
- A qualified non-physician provider (Physician Assistant, Nurse Practioner) can ***certify/recertify*** the POC as long as they are working for the patient's physician
- ***Delayed certification*** is allowed as long as the patient was under the physician's care at the time PT services were rendered.

Medical Necessity

- A physician prescription or referral is not sufficient to justify care and ***CANNOT*** replace the POC
- If patients are allowed Direct Access to PT in your state, no physician visit is required prior to the start of care.
- Once care begins, no other MD visit is required by Medicare ***UNLESS*** required by the MD.
- Services performed by PT/OT Aides, PT/PTA/OT/OTA students, license applicants are not covered
- Services can be furnished in the therapist's office or in the patient's home
- Patients covered under a Home Health Agency POC are not covered

Medical Necessity

Coverage guidelines and establishing medical necessity in PT/OTPP practices:

- In a PT/OTPP, Claims submitted by anyone other that a Medicare-certified therapist are not covered
- In PTPP/OTPP, assistants require in the office suite supervision, treatment notes need not be co-signed by supervising therapist, all changes in treatment plan/POC must be signed by the therapist.
- Services performed by persons who are not employees of the PT/OTPP are not covered unless they have made arrangements with the Carrier to have a UPIN that can be reassigned using the 855R

Medical Necessity: CPT / ICD-9

ICD-9 code/CPT code matching

- Contractor LCD lists the ICD-9 codes by CPT code that makes the CPT code *medically necessary*
- On POC, list the referral diagnosis(s) first, followed by any diagnoses you need to establish medical necessity
- Once it is certified, you have what you need
- DO NOT add diagnoses you need to the bill without getting them signed off on your POC
- If Exceptions DX is not on the list: use the ICD-9 you need for medical necessity as 1° followed by the exception's ICD-9 as 2°.

Therapy Caps

- Therapy cap amount changed 1/1/2011 Caps are based on Medicare "allowable"
- $1,870 combined cap for PT and Speech
- $1,870 cap for OT
- Patients receive "one cap" per year
  - Caps "reset" on January 1
- If your patient exceeds the caps, use the exceptions process criteria and rules to use the –KX modifier for coverage.

* MAKE SURE YOU ALWAYS PULL FROM THE LIST OF ICD9/10 CODES THAT JUSTIFY MEDICAL NECESSITY! *
These were provided to you when you initially signed on with PIC.
Please let PIC know if you need these again.
**PLEASE also let PIC know if you are having trouble adding the above medically necessary ICD 10 codes in to Revflow

Revflow will keep track of the Therapy Cap money for us, but you will have to :
(a) - check to see if your client has one of the diagnoses listed on the last few pages of this handout
(b) - if they do, you can continue to see the client, but you HAVE to do the below steps in Revflow:
1 - click Yes on the KX modifier when Revflow asks you,
2 - click the checkmark by "Therapy Cap Exception Justification" on the A : Evaluation > Assessment tab,
3 - fill in the justification for why you are seeing them longer for treatment than a "typical outpatient," and exceeding the cap - e.g., list the diagnoses the client has that are on exceptions list, along with contraindications,

Therapy Caps

- Exception process does is not in effect for 2010 pending action of the House and Senate conference committee work on putting together the final version of Healthcare Reform.
- We expect it to be included and retroactive to 1/1.
- We'll keep you informed.
- CMS recommends holding 2010 –KX claims until approved then dropping claims.

Tracking the Cap

- Services rendered by PTPPs, OTPPs, Outpatient Rehab Facilities (Rehab Agency), CORFs, MDs ("incident to" services) and rendered to non-certified bed SNF patients apply to the caps
- All services for all diagnoses in 2011 count toward the cap regardless of where they were rendered, except:
- Services rendered in Outpatient Hospital departments and emergency rooms are exempt from the cap

All in-patient hosp., HHA/Hospice rehab, and SNF Part A services do not count toward the caps.

Exceptions Process: Core Documents

- Publication 100-04 Medicare Claims Manual: National standard for the exceptions process program
  http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf
- Publication 100-08 Medicare Program Integrity Manual: Communications processes to therapists and patients regarding the exceptions process and therapy caps.
  http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf

Tracking the Cap

Estimate the number of visits per Medicare patient based on your treatment of Medicare patients in 2010 or completed months for 2011

- For services in your office: Track the cap amounts using Medicare payment from prior time period to estimate number of visits it takes to use the cap
- For PT/SLP outside your office:
  - Call Medicare for the amount of cap processed
  - All EOMBs have cap data on them

Tracking the Cap

Estimated visits per Medicare Patient

In RevFlow:

- Under "Reports" > "Practice and Location"
- >"Paid Claims by Financial Class by Visit"
- Enter date range for the months you want to check
- Shows Charge/visit and Payment/visit by insurance class
- Go to Medicare line
- Divide $1870/MC Pay per visit = average number of MC visits per patient available under the cap based on paid claims you checked

Tracking the Cap

Identifying Patient over the cap

Identifying MC patient accounts over the cap:

- Under "Reports" > "Therapy Cap Reports" >
- "Exceeds Medicare Allowable" to see patients over the cap
- Or, to find patients approaching the cap, > "Under Cap Summary", put in the allowable amount used that you want to see (e.g. $1500) and the year to get a report of patient that have used at least $1500 of the cap but are under $1870

*Note: **Estimates** Medicare allowable based on entered charges only. MPPR will be added as a percentage adjustment.*

- To find charges over the cap and held for potential application of –KX: "Unresolved Medicare Cap Charges"

Exceptions Process: Core Documents

- Publication 100-04 Medicare Claims Manual: National standard for the exceptions process program http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf
- Policy Manual Pub. 100-02 Medicare Benefit : National standard for patient care documentation http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf
- Publication 100-08 Medicare Program Integrity Manual: Communications processes to therapists and patients regarding the exceptions process and therapy caps. http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf

Exceptions Process

- The patient may qualify for an exception any time during the episode of care when documentation supports the medical necessity for exceeding the cap.
- Deletion of the manual process for exceptions increases the responsibility of the therapist for determining and documenting that services exceeding the cap are appropriate.
- No specific documentation is submitted to the payer for automatic process exceptions.

Automatic Exceptions

- An exception may be made when the patient's condition is justified by documentation indicating that the patient requires continued skilled therapy.
- Therapy is payable beyond the therapy cap to achieve the patient's prior level of function or maximum expected function within a reasonable amount of time.
- Documentation justifying services shall be submitted in response to an Additional Documentation Request (ADR) for claims selected for review.

Automatic Exceptions

- The minimum documentation requirements enumerated in in Pub. 100-02, Chapter 15, section 220.3 should be followed.
  - Make **Justification Statement** for exceeding the cap: may be included in POC or Progress report
- If medical records are requested for review, clinicians may include, at their discretion, a summary that specifically addresses the justification for exceeding the therapy cap exception.

Exceptions for Services

Evaluations:

- Excepted after the cap is reached when necessary to determine if the current status of the patient requires therapy services.
- Qualifying codes:
  - 97001, 97002, 97003, 97004
  - 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105

Exceptions for Services

Exceptions for conditions or complexities identified by ICD-9 codes:

- Condition/Complexity list (see at end of handout)
- **These diagnoses will be appropriate for patients who require therapy services that exceed the cap but must be justified in the medical record**
- ~~Clinicians may use the exceptions process for patients who do not have a condition or complexity on the list, but they must *justify carefully* the therapy services that exceed the cap~~
- Guidelines for utilization: MIO Manuals, NCDs, LCDs, professional associations.

Sent these NCDs & LCDs to you earlier in the year - will send again if you don't have them!

Exceptions for Services

- When the patient's condition is the reason for the exception it must be related to the therapy goals and must be the condition that is being treated
- If the complexity is the reason for the exception, it must directly and significantly impact the rate of recovery of the condition being treated.
  - ICD-9 complexities are unlikely to cause treatment in excess of the cap unless they occur in a patient who has a primary condition (either listed or not)
  - Documentation should indicate how the complexity(ies) directly and significantly affects treatment.

Justification Statement

- In order to qualify for the use of automatic exceptions process the condition or complexity must ***directly and significantly affect*** one or more of the
  - type
  - frequency
  - intensity
  - duration

  of required, medically necessary, skilled services
- This needs to be recorded in the MR: POC or Progress Report or Daily Notes

ICD-9 codes that qualify for the automatic process therapy cap exception based upon clinical condition or complexity

- When LCDs do not allow a listed ICD-9 code in the primary position:
  - Use the LCD required ICD-9 code as 1°
  - Use the diagnosis from the list as the 2° dx on the claim and in the medical record or as the payer directs.
- In most cases, the severity of conditions, comorbidities or complexities will contribute to the necessity of services exceeding the cap and should be documented.
- See the list at the end of the handout.

Additional Considerations for Exceptions

- The "automatic" exceptions related to hospitalization from 2006 are no longer specifically listed. Make the case based on medical complexities related to hospitalization.
- The key non-ICD-9 complexities related to returning the patient to their premorbid living arrangements and ADL abilities or maximizing their ADL and independent living abilities.

Use of the –KX modifier

- Once you know, believe or expect to exceed the therapy cap, the –KX modifier should be associated with each CPT code for each date of service.
- This must be done for each date of service for the remainder of the calendar year.
- The application of the –KX modifier in RevFlow cannot be automated because of the attestations associated with the use of the modifier.

While Revflow cannot just automatically assign the KX modifier for you, it WILL ask you if you want to apply it - you should ALWAYS CHOOSE YES, to apply the KX modifier, AND make sure the below attestations are accurate!!

Use of the –KX modifier

By attaching the –KX modifier, the provider is attesting that the services billed:

- Are reasonable and necessary that require the skills of a therapist (Pub. 100-02, Ch. 15, section 220.2 B),
- Are justifiable by appropriate documentation in the medical record (Pub, 100-02, Ch. 15, section 220.3),
- Qualify for an exception using the automatic process exception.

If this attestation is determined to be inaccurate, the provider is subject to sanctions resulting from providing inaccurate information on a claim.

Use of the –KX modifier

- Claims denied for exceeding are marked with the group code **PR** and adjustment reason code **119**
- When the provider knows that the limit has been reached no further billing should occur
  - Use the –GX modifier to bill the Medicare payer for services over the cap for which you need a denial to bill another insurance payer.
  - No other use of ABN modifiers are appropriate in regards to the cap or the exceptions process.

Going Over the Caps

If your patient does not qualify for an exception…

- Once you believe that treatment for the year will exceed the cap, you should:
  - Advise them that they can receive Medicare covered services at a hospital department

    or
  - Have the patient sign the ABN form
  - Discuss payment arrangements: *See next slide*

Overuse of the –KX Modifier

- National statistical analysis shows the cap is exceeded 10-20% of the time (the percentage increases with age with older beneficiaries requiring more therapy).
- Indicators of possible inappropriate use:
  - Routine use of the –KX for every case after the cap is exceeded
  - Routine use of –KX on every patient that has a diagnosis on the condition/complexity list regardless of impact of the condition or complexity on the need for service

Going Over the Caps

- Services received by the patient that exceed the cap are "patient responsibility"
- Medicare states: *"If the beneficiary chooses to continue treatment at a setting other than the outpatient hospital where medically necessary services may be covered, the services may be billed at the rate the provider/supplier determines."*
- Services that exceed the cap are not covered by Medicare policy

Going Over the Caps

- If you want to "discount" the patient portion to less than Medicare rates…

  You have to let your account representative know…

Advanced Beneficiary Notice

New ABN Forms

- It is the provider's responsibility to present the patient with accurate information about therapy limits and that appropriate care can be obtained at a HOP department.
- Medicare recommends the use of the ABN form when your patient exceeds the cap.
  - NEMB form was replaced by a new version of the ABN in March 2008
  - See sample (attached)

Advance Beneficiary Notification

- Used for particular situations to notify Medicare beneficiary about their possible financial responsibility for services they receive:
  - Possibly not medically necessary
  - Not covered but need a denial
  - Not covered and voluntarily issuing notice to beneficiary

Advance Beneficiary Notification

- Modifiers
  - -GA: Wavier of Liability Statement Issued, as required by payer policy—ABN on file—claim will be denied; if denied, patient responsible
  - -GX: Notice of Liability Issued, voluntary under payment policy—ABN on file—will be denied; non-covered service, patient responsible
  - -GY: Item or service statutorily non-covered or is not a Medicare benefit; patient responsible
  - -GZ: Item or service may not medically necessary, MC may deny—No ABN on file; patient not responsible

Advance Beneficiary Notification

Important points:

- Have the patient sign when you believe or suspect services may not be covered
- You only have to have them sign it once if the services and costs are the same from that time forward
- **DO NOT** have patients sign them routinely at the stat of care

Advance Beneficiary Notification

- Sample ABN form (attached)
- More info on ABNs:
  - See payer web site, or
  - CMS web site: Information on ABN-G
    http://www.cms.hhs.gov/bni

For more information...

- John Wallace, PT, OCS 800 478-2778
  jwallace@BMSemail.com

Medicare Learning Network
MLN Matters
CMS
Information for Medicare Fee-for-Service Health Care Professionals

Flu Shot Reminder

It's Not Too Late to Get the Flu Shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. But re-vaccination is necessary each year because the flu viruses change each year. Encourage your Medicare patients who haven't already done so to get their annual flu shot and don't forget to immunize yourself and your staff. **Protect yourself, your patients, and your family and friends. Get Your Flu Shot. It's Not Too Late!** Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS's website: **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf** .

MLN Matters Number: MM5478 REVISED | **Related Change Request (CR) #: 5478**

Related CR Release Date: December 29, 2006 | **Effective Date: January 1, 2007**

Related CR Transmittal #: R1145CP, R181PI,R63BP | **Implementation Date: 30 days from issuance**

Outpatient Therapy Cap Exception Process for 2007

Note: This article was revised on January 11, 2007, to eliminate a reference to Cedaron. All other information remains the same.

Provider Types Affected

Providers, physicians, and non-physician practitioners (NPPs) who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), carriers, and Part A/B Medicare Administrative Contractors (A/B MACs) under the Part B benefit for therapy services.

Provider Action Needed

Be sure you are aware of the requirements for the therapy cap exceptions for calendar year 2007, especially the use of the KX modifier and the rules governing the exceptions.

Background

Section 1833(g)(5) of the Social Security Act provided that, for services rendered during calendar year 2006, FIs, RHHIs, and carriers could, in certain circumstances, grant an exception to the therapy cap when requested by the

individual enrolled under the Part B benefit (or by a person acting on behalf of that individual).

On January 1, 2006, Medicare implemented financial limitations on covered therapy services (therapy caps); however, the 2006 Deficit Reduction Act provided for exceptions to this dollar limitation) when the provision of additional therapy services is determined to be medically necessary. This exceptions process has been extended by recent legislation (the Tax Relief and Health Care Act of 2006) for one year (calendar year 2007).

Remember that a therapy cap exception may be made when a beneficiary requires continued skilled therapy, (in other words, therapy beyond the amount payable under the therapy cap) to achieve their prior functional status or maximum expected functional status within a reasonable amount of time. Documentation supporting the medical necessity of those therapy services must be kept on file by the provider.

Additionally, you should note that, in 2006, Exception Processes fell into two categories, Automatic, and Manual. Beginning January 1, 2007, there is no manual process for exceptions, and all services that require exceptions to caps will be processed using the automatic process.

Key Points

CR 5478, from which this article is taken, provides instructions to contractors regarding the short term implementation of this legislation.

Details about these instructions follow:

- Contractors will grant exceptions for any number of medically necessary services if the beneficiary meets the conditions described in the Medicare Claims Processing Manual (100-04), Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), section 10.2 (The Financial Limitation) for 2007, (displayed in Table 1, below). **The following ICD-9 codes describe the most typical conditions (etiology or underlying medical diagnoses) that may result in exceptions (marked X) and complexities that MIGHT cause medically necessary therapy services to qualify for the automatic process exception (marked *) for each discipline separately. When the cell in the table is marked with a dash (-), the diagnosis code in the corresponding row is not appropriate for services by the discipline in the corresponding column. Therefore, services provided by that discipline for that diagnosis do not qualify for exception to caps. Services may be appropriate when provided by that discipline for another diagnosis appropriate to the discipline, which may or may not be on this table, and that diagnosis should be documented on the claim, if possible, or in the medical record.**

Table 1

ICD-9 codes describing diagnoses that may result in excepted conditions (marked X) and complexities (marked *) that MIGHT cause medically necessary therapy services to qualify for the automatic process exception.

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
V43.61-V43.69	Joint Replacement	X	X	--
V45.4	Arthrodesis Status	*	*	--
V45.81-V45.82 and V45.89	Other Postprocedural Status	*	*	--
V49-61-V49.67	Upper Limb Amputation Status	X	X	--
V49.71-V49.77	Lower Limb Amputation Status	X	X	--
V54.10-V54.29	Aftercare for Healing Traumatic or Pathologic Fracture	X	X	--
V58.71-V58.78	Aftercare Following Surgery to Specified Body Systems, Not Elsewhere Classified	*	*	*
244.0-244.9	Acquired Hypothyroidism	*	*	*
250.00-251.9	Diabetes Mellitus and Other Disorders of Pancreatic Internal Secretion	*	*	*
276.0-276.9	Disorders of Fluid, Electrolyte, and Acid-Base Balance	*	*	*
278.00-278.01	Obesity and Morbid Obesity	*	*	*
280.0-289.9	Diseases of the blood and blood-forming organs	*	*	*
290.0-290.43	Dementias	*	*	*
294.0-294.9	Persistent Mental Disorders due to Conditions Classified Elsewhere	*	*	*
295.00-299.91	Other Psychoses	*	*	*
300.00-300.9	Anxiety, Disassociative and Somatoform Disorders	*	*	*
310.0-310.9	Specific Nonpsychotic Mental Disorders due to Brain Damage	*	*	*
311	Depressive Disorder, Not Elsewhere Classified	*	*	*
315.00-315.9	Specific delays in Development	*	*	*
317	Mild Mental Retardation	*	*	*
320.0-326	Inflammatory Diseases of the Central Nervous System	*	*	*
330.0-337.9	Hereditary and Degenerative Diseases of the Central Nervous System	X	X	X
340-345.91 and	Other Disorders of the Central Nervous System	X	X	X

348.0-349.9				
ICD-9 Cluster	**ICD-9 (Cluster) Description**	**PT**	**OT**	**SLP**
353.0-359.9	Disorders of the Peripheral Nervous system	X	X	--
365.00-365.9	Glaucoma	*	*	*
369.00-369.9	Blindness and Low Vision	*	*	*
386.00-386.9	Vertiginous Syndromes and Other Disorders of Vestibular System	*	*	*
389.00-389.9	Hearing Loss	*	*	*
401.0-405.99	Hypertensive Disease	*	*	*
410.00-414.9	Ischemic Heart Disease	*	*	*
415.0-417.9	Diseases of Pulmonary Circulation	*	*	*
420.0-429.9	Other Forms of Heart Disease	*	*	*
430-438.9	Cerebrovascular Disease	X	X	X
440.0-448.9	Diseases of Arteries, Arterioles, and Capillaries	*	*	*

ICD-9 codes describing diagnoses that may result in excepted conditions (marked X) and complexities (marked *) that MIGHT cause medically necessary therapy services to qualify for the automatic process exception.

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
451.0-453.9 and 456.0-459.9	Diseases of Veins and Lymphatics, and Other Diseases of Circulatory System	*	*	*
465.0-466.19	Acute Respiratory Infections	*	*	*
478.30-478.5	Paralysis, Polyps, or Other Diseases of Vocal Cords	*	*	*
480.0-486	Pneumonia	*	*	*
490-496	Chronic Obstructive Pulmonary Disease and Allied Conditions	*	*	*
507.0-507.8	Pneumonitis due to solids and liquids	*	*	*
510.0-519.9	Other Diseases of Respiratory System	*	*	*
560.0-560.9	Intestinal Obstruction Without Mention of Hernia	*	*	*
578.0-578.9	Gastrointestinal Hemorrhage	*	*	*
584.5-586	Renal Failure and Chronic Kidney Disease	*	*	*
590.00-599.9	Other Diseases of Urinary System	*	*	*
682.0-682.8	Other Cellulitis and Abscess	*	*	--
707.00-707.9	Chronic Ulcer of Skin	*	*	--
710.0-710.9	Diffuse Diseases of Connective Tissue	*	*	*
711.00-711.99	Arthropathy Associated with Infections	*	*	--
712.10-713.8	Crystal Arthropathies and Arthropathy Associated with Other Disorders Classified Elsewhere	*	*	--
714.0-714.9	Rheumatoid Arthritis and Other Inflammatory Polyarthropathies	*	*	--
715.00-715.98	Osteoarthrosis and Allied Disorders (Complexity except as listed below)	*	*	--
715.09	Osteoarthritis and allied disorders, multiple sites	X	X	--
715.11	Osteoarthritis, localized, primary, shoulder region	X	X	--
715.15	Osteoarthritis, localized, primary, pelvic region and thigh	X	X	--
715.16	Osteoarthritis, localized, primary, lower leg	X	X	--
715.91	Osteoarthritis, unspecified id gen. or local, shoulder	X	X	--
715.96	Osteoarthritis, unspecified if gen. or local, lower leg	X	X	--
716.00-716.99	Other and Unspecified Arthropathies	*	*	--

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
717.0-717.9	Internal Derangement of Knee	*	*	--
718.00-718.99	Other Derangement of Joint (Complexity except as listed below)	*	*	--
718.49	Contracture of Joint, Multiple Sites	X	X	--
719.00-719.99	Other and Unspecified Disorders of Joint (Complexity except as listed below)	*	*	--
719.7	Difficulty Walking	X	X	--
720.0-724.9	Dorsopathies	*	*	--

ICD-9 codes describing diagnoses that may result in excepted conditions (marked X) and complexities (marked *) that MIGHT cause medically necessary therapy services to qualify for the automatic process exception.

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
725-729.9	Rheumatism, Excluding Back (Complexity except as listed below)	*	*	--
726.10-726.19	Rotator Cuff Disorder and Allied Syndromes	X	X	--
727.61-727.62	Rupture of Tendon, Nontraumatic	X	X	--
730.00-739.9	Osteopathies, Chondropathies, and Acquired Musculoskeletal Deformities (Complexity except as listed below)	*	*	--
733.00	Osteoporosis	X	X	--
741.00-742.9 and 745.0-748.9 and 754.0-756.9	Congenital Anomalies	*	*	*
780.31-780.39	Convulsions	*	*	*
780.71-780.79	Malaise and Fatigue	*	*	*
780.93	Memory Loss	*	*	*
781.0-781.99	Symptoms Involving Nervous and Musculoskeletal System (Complexity except as listed below)	*	*	*
781.2	Abnormality of Gait	X	X	--
781.3	Lack of Coordination	X	X	--
783.0-783.9	Symptoms Concerning Nutrition, Metabolism, and Development	*	*	*
784.3-784.69	Aphasia, Voice and Other Speech Disturbance, Other Symbolic Dysfunction	*	*	X
785.4	Gangrene	*	*	--

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
786.00-786.9	Symptoms involving Respiratory System and Other Chest Symptoms	*	*	*
787.2	Dysphagia	*	*	X
800.00-828.1	Fractures (Complexity except as listed below)	*	*	--
806.00-806.9	Fracture of Vertebral Column With Spinal Cord Injury	X	X	--
810.11-810.13	Fracture of Clavicle	X	X	--
811.00-811.19	Fracture of Scapula	X	X	--
812.00-812.59	Fracture of Humerus	X	X	--
813.00-813.93	Fracture of Radius and Ulna	X	X	--
820.00-820.9	Fracture of Neck of Femur	X	X	--
821.00-821.39	Fracture of Other and Unspecified Parts of Femur	X	X	--
828.0-828.1	Multiple Fractures Involving Both Lower Limbs, Lower with Upper Limb, and Lower Limb(s) with Rib(s) and Sternum	X	X	--
830.0-839.9	Dislocations	X	X	--
840.0-848.8	Sprains and Strains of Joints and Adjacent Muscles	*	*	--
851.00-854.19	Intracranial Injury, excluding those With Skull Fracture	X	X	X

ICD-9 codes describing diagnoses that may result in excepted conditions (marked X) and complexities (marked *) that MIGHT cause medically necessary therapy services to qualify for the automatic process exception.

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
880.00-884.2	Open Wound of Upper Limb	*	*	--
885.0-887.7	Traumatic Amputation, Thumb(s), Finger(s), Arm and Hand (complete)(partial)	X	X	--
890.0-894.2	Open Wound Lower Limb	*	*	--
895.0-897.7	Traumatic Amputation, Toe(s), Foot/Feet, Leg(s) (complete)(partial)	X	X	--
905.0-905.9	Late Effects of Musculoskeletal and Connective Tissue Injuries	*	*	*
907.0-907.9	Late Effects of Injuries to the Nervous System	*	*	*
941.00-949.5	Burns	*	*	*
952.00-952.9	Spinal Cord Injury Without Evidence of Spinal Bone Injury	X	X	X
953.0-953.8	Injury to Nerve Roots and Spinal Plexus	X	X	*
959.01	Head Injury, Unspecified	X	X	X

- Medicare contractors will allow automatic process exceptions for diagnoses in the table above or any other diagnosis for which therapy services are appropriate when the beneficiary needs therapy services above the therapy cap (due to the occurrence of any condition or complexity that is appropriately documented).
- For the therapy HCPCS codes subject to the cap limits in your claims to be excepted, you must include the KX modifier to indicate that the clinician attests that services are medically necessary and justification is documented in the medical record. In CY 2007, when claims contain a KX modifier, contractors will override edits that indicate that a therapy service has exceeded the financial limitation, and will pay for the service if it is otherwise covered and payable.
- Contractors will not use the KX modifier as the sole indicator of services that do exceed caps in 2007, because, there will be services with appropriately used KX modifiers that do not represent services that exceed the cap.

- Contractors will require that the documentation for outpatient therapy services include objective, measurable patient function information, **either** by using one of the four recommended (but not required) measurement tools:
  - (*National Outcomes Measurement System (NOMS) by the American Speech-Language Hearing Association,*
  - *Patient Inquiry by Focus On Therapeutic Outcomes, Inc. (FOTO),*
  - *Activity Measure – Post Acute Care (AM-PAC), or*
  - *OPTIMAL by the American Physical Therapy Association),*

  or by including other information as described in the *Medicare Benefit Policy Manual* (Publication 100-02), chapter 15 (Covered Medical and Other Health Services), section 220.3C (Documentation Requirements for Therapy Services -- Evaluation/Re-Evaluation and Plan of Care).
- If one of these instruments is not in the patient's medical record, the record must contain documentation to indicate objective, measurable beneficiary physical function including, for example: 1) Functional assessment individual item and summary scores (and comparisons to prior assessment scores) from commercially available therapy outcomes instruments other than those listed above; or 2) Functional assessment scores (and comparisons to prior assessment scores) from tests and measurements validated in the professional literature that are appropriate for the condition/function being measured; or 3) Other measurable progress towards identified goals for functioning in the home environment at the conclusion of this therapy episode of care.

The automatic exceptions process for therapy claims reporting the KX modifier does not preclude these claims from being subject to review. The contractor may review claims when they are potentially fraudulent, where there is evidence of misrepresentation of facts, or where there is a pattern of aberrant billing.

Note: Claims for services above the cap, which are denied, are considered benefit category denials, and the beneficiary is liable. Further, providers do not need to issue an ABN for these benefit category denials.

Be aware that contractors do not have to search their files to either retract payment for claims already paid or to retroactively pay claims, but will reopen and/or adjust claims brought to their attention.

Final note: The CR5478 also relocates some information. Comprehensive Outpatient Rehabilitation Facilities (CORF) policies for 1) Group therapy services and 2) Therapy students, are the same as other Part B outpatient services policies for group therapy services and therapy students; and can now be found in the Medicare Benefit Policy Manual, chapter 15, section 230.

Additional Information

You can find more information about the outpatient therapy cap exception process for 2007 by going to CR 5478. CR5478 is actually issued in 3 separate transmittals, one for each manual being revised. The attachments to each of the transmittals include the updates to the *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), section 10.2 (The Financial Limitation) for 2007; the *Program Integrity Manual*, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 3.4.1.1.1 (Exception From the Uniform Dollar Limitation ("Therapy Cap")), and the *Medicare Benefit Policy Manual*, chapter 15 (Covered Medical and Other Health Services), Section 220.3C (Documentation Requirements for Therapy Services -- Evaluation/Re-Evaluation and Plan of Care). You are encouraged to be familiar with these important manual sections. You can find these transmittals on the CMS web site at:

- The *Medicare Claims Processing Manual* transmittal - http://www.cms.hhs.gov/transmittals/downloads/R1145CP.pdf;
- The *Medicare Benefit Policy Manual* transmittal - http://www.cms.hhs.gov/transmittals/downloads/R63BP.pdf and
- The *Medicare Program Integrity Manual* transmittal - http://www.cms.hhs.gov/transmittals/downloads/R181PI.pdf.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip.**

***(A)*Notifier(s): Stretch and Scream Physical Therapy**
***(B)* Patient Name:** Betty Smith ***(C)* Identification Number: 279348**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for ***(D)***Physical Therapy below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the ***(D)Physical Therapy*** below.

(D) Physical Therapy	***(E)* Reason Medicare May Not Pay:**	***(F)* Estimated Cost:**
Treatment for your low back pain	Medicare does not pay for PT services over $1840 per calendar year. You may be able to receive treatment at a hospital outpatient PT department if the therapist believe you will benefit from further treatment	$60 per visit

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the ***(D)*** Physical Therapy listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

***(G)* OPTIONS: Check only one box. We cannot choose a box for you.**

X OPTION 1. I want the ***(D)*** Physical Therapy listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the ***(D)*_____** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

OPTION 3. I don't want the ***(D)*_____**listed above. I understand with this choice I am **not** responsible for payment**,** and **I cannot appeal to see if Medicare would pay.**

***(H)* Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

***(I)* Signature:**	***(J)* Date:**