MLN Matters
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 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: January 29, 2007

Outpatient Therapy Cap Exception Process for 2007

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

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2006 American Medical Association. All rights reserved.

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**

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2006 American Medical Association. All rights reserved.

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	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 348.0-349.9	Other Disorders of the Central Nervous System	X	X	X

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2006 American Medical Association. All rights reserved.

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	*	*	*

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2006 American Medical Association. All rights reserved.

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	*	*	--

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2006 American Medical Association. All rights reserved.

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	*	*	--

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2006 American Medical Association. All rights reserved.

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	*	*	--

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2006 American Medical Association. All rights reserved.

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

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2006 American Medical Association. All rights reserved.

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.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2006 American Medical Association. All rights reserved.

- 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.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2006 American Medical Association. All rights reserved.

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 website 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 on the CMS website.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2006 American Medical Association. All rights reserved.