CMS Manual System

Pub 100-08 Medicare Program Integrity

Transmittal 140

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: FEBRUARY 15, 2006

Change Request 4364

NOTE: Transmittal 139, dated February 13, 2006 is rescinded and replaced by Transmittal 140, dated February 15, 2006. This instruction is being re-communicated to correct the funding statement. The funding statement has been revised. All other information remains the same.

SUBJECT: Therapy Caps Exception Process

I. SUMMARY OF CHANGES: Contractors shall, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, grant an exception to the therapy cap in certain circumstances. There are different categories of exceptions described in the instruction.

NEW/REVISED MATERIAL
EFFECTIVE DATE: January 1, 2006
IMPLEMENTATION DATE: No Later Than March 13, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Table of Contents
N	3/4/1.2 /Exception from the Uniform Dollar Limitation ("Therapy Cap")
R	11/1.3.9/Prepay Complex Review Workload and Cost (Activity Code 21221)

III. FUNDING:

Funding for implementation activities will be provided to contractors through the regular budget process.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-08	Transmittal: 140	Date: February 15 , 2006	Change Request 4364

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SUBJECT: Therapy Caps Exception Process

I. GENERAL INFORMATION

A. Background: Financial limitations on Medicare covered therapy services (therapy caps) were initiated by the Balanced Budget Act of 1997 and were implemented in 1999 and for a short time in 2003. Congress placed moratoria on the limits for 2004 and 2005. The moratoria are no longer in place, and caps were implemented on January 1, 2006. Congress has provided that exceptions to this dollar limitation may be made when provision of additional therapy services is determined to be medically necessary.

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B. Policy: Section 1833(g)(5) of the Deficit Reduction Act of 2005 provides that, for services provided during calendar year 2006, contractors shall, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, grant an exception to the therapy cap in certain circumstances. Claims for services above the cap for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable. Providers do not need to issue an ABN for these benefit category denials

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.1	Contractors shall only apply the exceptions to services provided to Medicare eligible beneficiaries in CY 2006.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.2	The contractor shall presume the beneficiary to be excepted from the therapy cap without submission of request for exception or supporting documentation if the beneficiary meets the conditions described in CMS IOM Pub. 100-04.	X	X	X						
4364.3	The contractor should automatically except beneficiaries with specific conditions or complexities in addition to those described in CMS IOM Pub. 100-04, where the contractor believes, based on the strongest evidence available, that those beneficiaries will require additional therapy treatment days beyond those payable under the therapy cap.	X	X	X						
4364.4	The contractor shall post an article on their Web site related to therapy caps.	X	X	X						
4364.4.1	The article shall detail any circumstances, in addition to those described in CMS IOM Pub. 100-4, under which the contractor will grant beneficiaries an automatic exception to the therapy cap, on the contractor Web site. **NOTE:** We plan to provide some additional information to you via e-mail as a guide in the future.	X	X	X						
4364.5	The contractor shall presume the beneficiary to be excepted from the therapy cap if the beneficiary meets the specific conditions for exception in a contractor's article, posted on the contractor Web site.	X	X	X						
4364.6	The contractor shall require the provider to submit a request for a specific number of additional treatment days after the cap has been reached, not to exceed 15 future treatment days for each discipline (OT, PT, and SLP), when the provider believes the beneficiary will require	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	therapy treatment days in excess of those payable under the therapy cap and the beneficiary does not meet criteria in CMS IOM Pub. 100-04 or the contractor's article for a automatic exception from the therapy cap.									
4364.7	For prospective and retrospective requests, the contractor shall approve any appropriate number of additional treatment days if determined to be medically necessary, for occupational therapy, physical therapy, and speech- language pathology regardless of the number of treatment days requested.	X	X	X						
4364.8	The contractor shall require the provider to document services in accordance with CMS IOM Pub. 100-02, chapter 15, section 220.3 and CMS OIM Pub. 100-04, chapter 5, sections 10.2 and 20.	X	X	X						
4364.9	The contractor shall require the provider to submit the These types of documentation of therapy services are expected to be submitted with any requests for documentation, unless the contractor requests less information: • Evaluation /and certified Plan of Care • Certification • Progress Reports • Treatment Encounter Notes • Justification	X	X	X						
4364.10	The contractor shall utilize clinical judgment in approving or disapproving requests for additional treatment days in the exceptional circumstance where a provider fails to submit all required documentation	X	X	X						
4364.11	The contractor shall consider any additional information the provider chooses to submit with the initial request in addition to the information described above.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.12	The contractor shall require the provider to submit separate requests for exception from the combined physical therapy and speech-language pathology cap and from the occupational therapy cap.	X	X	X						
4364.13	The contractor shall encourage that most requests for exception from the therapy cap be received before the cap is exceeded.	X	X	X						
4364.14	The contractor shall approve any number of additional therapy treatment days retroactively, if they are deemed medically necessary, in the exceptional circumstance where a provider fails to submit a timely request for exception from the therapy cap before it is surpassed.	X	X	X						
4364.15	The contractor shall approve additional therapy treatment days already provided when the request is accompanied by documentation supporting medical necessity of the services.	X	X	X						
4364.16	The contractor shall require the provider/supplier/beneficiary to submit a request for approval of a specific number of additional therapy treatment days, not to exceed 15 per discipline, each time the beneficiary is expected to require more therapy treatment days than previously approved.	X	X	X						
4364.17	The contractor shall grant an exception to the therapy cap, by way of approving additional therapy treatment days, when those additional treatment days are deemed medically necessary based on documentation submitted by the provider.	X	X	X						
4364.18	The contractor shall make the decision within 10 business days of receipt of request and appropriate documentation as to whether an exception to the cap has been made.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364. 19	For all letters, notify the provider what the determination is as practicable.	X	X	X						
4364.20	The contractor shall make the decision within 10 business days of receipt of request and appropriate documentation as to how many retrospective treatment days and how many additional future treatment days, are approved.	X	X	X						
4364.21	The contractor shall make the decision within 10 business days of receipt of request and appropriate documentation that additional therapy treatment days are disapproved if not found to be medically necessary.	X	X	X						
4364.22	The contractor shall inform the provider/supplier/beneficiary, using the standard letter found in CMS IOM Pub. 100-08, section 3.3.1.2, that the decision on the exception request is not an initial determination, and therefore does not carry with it administrative appeal rights.	X	X	X						
4364.23	The contractor shall inform the provider that claims for therapy services where no prior authorization was approved are denied as benefit category denials.	X	X	X						
4364.24	The contractor shall deem additional therapy services requested to be medically necessary when the contractor fails to make a decision within 10 business days of receipt of any request and appropriate documentation.	X	X	X						
4364.25	The contractor shall grant an exception to the therapy cap, approving the number of treatment days requested by the provider/supplier/beneficiary, not to exceed 15 future treatment days, if the contractor does not issue a decision within 10 business days of receipt of any request and appropriate documentation.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.26	The contractor shall allow providers to submit, an additional request for exception from the therapy cap after the first request is denied, only if the patient has undergone a significant change in condition.	X	X	X						
4364.27	The contractor shall not apply the 10-day determination and pre-approval processes to any provider where there is evidence of fraud.	X	X	X						
4364.28	The contractor shall not apply the 10-day determination and exception processes to any provider where there is evidence of misrepresentation of facts presented to the contractor by that provider.	X	X	X						
4364.29	The contractor shall not apply the 10-day determination and exception processes to any provider where a pattern of aberrant billing by that provider is found.	X	X	X						
4364.30	The contractor should develop a process by which requests for exceptions from the therapy caps may be received and logged expeditiously by the medical review department.	X	X	X						
4364.31	The contractor shall submit a Supplemental Budget Request (SBR) that identifies the additional funding that is anticipated to fulfill the above requirements.	X	X	X						
4364.32	The SBR shall only contain the funding and anticipated workload associated with the Therapy Cap Exception process.	X	X	X						
4364.33	The carriers and fiscal intermediaries shall report the therapy cap workload in activity code 21221 under miscellaneous code 01.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.34	Any other funding or workload shifts in the Medical Review line shall be submitted in a separate SBR.	X	X	X						
4364.35	The contractor shall develop a mechanism to track workload and costs associated with the Therapy Cap process and are to provide CMS with that information on a weekly basis.	X	X	X						
4364.36	The weekly report will be due the following Wednesday to CMS_MRStrategies@cms.hhs.gov.	X	X	X						
4364.37	The contractor shall also include the frequency of specific diagnoses that are being submitted to a manual exception.	X	X	X						
4364.38	The contractor shall track the number of requests disapproved by ICD-9 code and report the results to CMS weekly	X	X	X						
4364.39	The contractor shall adjust claims received between January 1, 2006 and such time as this DRA is implemented to apply the therapy cap exception provisions when such services are brought to the attention of the contractor by the provider/supplier/beneficiary.	X	X	X						
4364.40	Contractors shall pay otherwise covered and payable claims, if they are medically necessary, for therapy services when they exceed the therapy limitation and an exception has been granted.	X	X	X						
4364.41	Contractors shall override CWF rejects indicating that a therapy service has exceeded the financial limitation and pay for the service if otherwise covered and payable when the claim contains a KX modifier.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.42	Contractors shall inform providers to include a KX modifier on the claim identified as a therapy service with a GN, GO, GP modifier when an exception has been approved.	X	X	X						
4364.43	Contractors shall consider an episode of outpatient therapy as the time in treatment days from the initial patient encounter for the current condition(s) being treated till the last date of service for that plan of care.	X	X	X						
4364.44	Contractors shall not require more specific documentation than that required in manuals unless other Medicare policies (regulation or statute) require it. However, contractors may request information concerning cases under review when that information is required by policy but unclear or absent in the record.	X	X	X						
4364.45	Contractors shall publish CMS OIM examples of acceptable and unacceptable documentation in educational articles.	X	X	X						
4364.46	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.	X	X	X						
4364.47	If a claim is submitted and the cap is exceeded, those services will be denied. The provider/supplier/beneficiary may request and the contractor may retroactively approve an exception to the cap for any number of medically necessary services. Contractors may reopen and adjust the claim if brought to their attention.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.48	Contractors shall recoup funds in accordance with their routine procedures for doing so when they have paid claims in excess of the financial limitation where an exception to the limitation is inapplicable or has been disapproved or was approved based on fraud, misrepresentation or abuse.	X	X	X						
4364.49	Contractors shall revise MSN message 17.13, which appears on all claims containing outpatient rehabilitation services, to now read: 17.13 - Medicare approves a limited dollar amount each year for physical therapy and speech-language pathology services and a separate limit each year for occupational therapy services when billed by providers, physical and occupational therapists, physicians, and other non-physician practitioners. Medically necessary therapy over these limits is covered when received at a hospital outpatient department or when approved by Medicare. <u>Spanish Translation</u> Cada año, Medicare aprueba una cantidad límite por servicios de terapia física y patología del lenguaje. Anualmente también aprueba otra cantidad límite por servicios de terapia ocupacional cuando son facturados por proveedores, terapistas físicos y ocupacionales, médicos y otros practicantes no médicos. La terapia que es medicamente necesaria y que sobrepasa estas cantidades límites está cubierta cuando se recibe en una unidad de hospital ambulatorio o cuando está aproba por Medicare.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.50	Contractors shall revise MSN message 38.18, which appears on all MSNs, to now read: ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2006. The limits are $1,740 for PT and SLP combined and $1,740 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE. <u>Spanish Translation:</u> ALERTA: La cobertura de Medicare estará limitada para los servicios de terapia física ambulatoria (PT, por sus siglas en inglés), terapia de patología del habla (SLP, por sus siglas en inglés), y terapia ocupacional (OT) si son recibidos entre el 1 de enero de 2006 y el 31 de diciembre de 2006. Estos límites son $1,740 para PT y SLP combinados y $1,740 para OT. Medicare paga hasta 80 por ciento de los límites después que se haya pagado el deducible. Estos límites no se aplican a cierta terapia aprobada por Medicare ni a la terapia que usted obtenga en los departamentos de hospital para paciente ambulatorio, a menos que usted sea un residente y ocupe una cama certificada por Medicare en un centro de enfermería especializada. Si tiene preguntas, por favor llame GRATIS al 1-800-MEDICARE.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.51	The contractor shall require the provider to submit documentation, sufficient to support medical necessity, with the request for more therapy treatment days than previously approved.	X	X	X						
4364.52	Contractors shall consider a dictated document completed on the day it is dictated if the identity of the qualified professional is included in the dictation.	X	X	X						
4364.53	Contractors shall consider a document an evaluation or re-evaluation (for documentation purposes, but not necessarily for billing if it meets the new standards CMS IOM 100-02, chapter 15, section 220.3.	X	X	X						
4364.54	Contractors shall accept a referral/order and evaluation as complete documentation (certification and plan of care) when an evaluation is the only service provided by a provider/supplier in an episode of treatment.	X	X	X						
4364.55	Contractors shall pay for otherwise covered outpatient therapy services appropriately provided by assistants or qualified personnel only when the supervising clinician personally performs or participates actively in at least one treatment session during an interval of treatment.	X	X	X						
4364.56	Contractors shall not require a qualified professional's interval report for the incomplete interval when unexpected discontinuation of treatment occurs. Determine the necessity of services based on the delivery of services as anticipated in the plan and encounter notes.	X	X	X						
4364.57	Contractors shall not require the contents of interval progress notes to be provided daily in treatment encounter notes. The Treatment Encounter Note is acceptable if it records the date, name of the treatment, intervention, or activity provided, the time spent in services	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	represented by timed codes and the name and professional identity of the individual providing the intervention.									

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4364.58	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: Listed in business requirements

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** No Later Than March 13, 2006 **Pre-Implementation Contact(s):** Exceptions Process and Medical Review: Dan Schwartz (daniel.schwartz@cms.hhs.gov) or Kim Spalding (kimberly.spalding@cms.hhs.gov); Clinical and Documentation Issues: Dr. Dorothy Shannon (dorothy.shannon@cms.hhs.gov); Claims Processing: Claudette Sikora (claudette.sikora@cms.hhs.gov) or Yvonne Young (yvonne.young@cms.hhs.gov) Appeals: David Danek (david.danek@cms.hhs.gov) **Post-Implementation Contact(s):** Regional offices	**Funding for implementation activities will be provided to contractors through the regular budget process.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Program Integrity Manual

Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

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Table of Contents
(Rev.140, 02-15-06)

3.4.1.2.1 - Exception From the Uniform Dollar Limitation ("Therapy Cap")

(Rev.140, Issued: 02-15-06, Effective: 01-01-06, Implementation: 03-13-06)

Section 1833(g)(5) of the Deficit Reduction Act of 2005 (DRA) provides that, for services provided during calendar year 2006, contractors shall, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, grant an exception to the therapy cap in certain circumstances.

Automatic Exceptions from Therapy Caps

The contractor shall presume the beneficiary to be excepted from the therapy cap without submission of request for exception or supporting documentation if:

- *The beneficiary meets specific conditions listed in CMS IOM Pub. 100-04 ch. 5 for exception from the therapy cap, or*

- *The beneficiary meets specific criteria for exception, in addition to those listed in CMS IOM Pub. 100-4, chapter 5, where the contractor believes, based on the strongest evidence available, that those beneficiaries will require additional therapy treatment days beyond those payable under the therapy cap.*

When the contractor develops therapy cap exception criteria, in addition to those described in CMS IOM Pub. 100-4, chapter 5, those criteria must be published, in the form of an article, on the contractor's Web site. Documentation requirements are in CMS IOM Pub. 100-02, chapter 15, section 230.3

Initial Request for Exception from Therapy Caps

For beneficiaries who the provider believes will require therapy treatment days in excess of those payable under the therapy cap, and who do not meet at least one of the above bulleted criteria for automatic exception, the Medicare contractor shall require the provider to submit a request for a specific number of additional therapy treatment days, not to exceed 15. Separate requests will be required for exception from the occupational therapy cap and from the combined physical therapy/speech language pathology caps.

The contractor shall require that documentation, sufficient to support medical necessity of those additional treatment days, be submitted with the request. The contractor shall require the provider to submit documentation in accordance with CMS IOM Pub. 100-02, chapter 15, section 220.3 and CMS IOM Pub. 100-04, chapter 5, sections 102 and 20 with the request for treatment days in excess of those payable under the therapy cap. Required documentation must include the current evaluation or reevaluation and current plan of care, treatment encounter notes, and interval progress reports sufficient to explain the beneficiary's current functional status and need for continued therapy with the request for therapy treatment days in excess of those payable under the therapy cap

Contractors shall encourage that most requests for exception from the therapy cap be received before the cap is exceeded. In those exceptional circumstances where a provider does not submit a timely request for exception from the therapy cap, the contractor shall approve any number of treatment days retroactively, if they were medically necessary.

Subsequent Requests for Continued Therapy During the Same Episode of Care

For beneficiaries who the provider believes will require therapy treatment days in excess of those previously approved, the contractor shall require the provider to submit a new request for approval of a specific number of additional future therapy treatment days, not to exceed 15, each time the beneficiary is expected to require more therapy treatment days.

The contractor shall require that documentation sufficient to support medical necessity of those additional treatment days be submitted with the request. Required documentation must include current evaluation or reevaluation and current plan of care, treatment encounter notes, and interval progress reports sufficient to explain the beneficiary's current functional status and need for continued therapy.

Multiple Requests for Exception for the Same Beneficiary

If an initial or subsequent request for exception from the therapy cap is denied, the contractor shall accept another request for exception for that beneficiary only if the beneficiary's condition has significantly changed.

Contractor Response to Requests for Exception From Therapy Caps

Upon receipt of the request for additional therapy treatment days, along with appropriate supporting documentation, the Medicare contractor shall, within 10 business days, make a decision as to whether and how many additional therapy treatment days are medically necessary and notify the provider whether an exception to the cap has been made. In the case where a provider fails to submit required documentation, the contractor shall use clinical judgment in deciding whether to approve or disapprove the request for additional therapy treatment days.

The contractor shall grant an exception to the therapy cap, by way of approving additional therapy treatment days, when those additional treatment days are deemed reasonable and necessary based on documentation submitted by the provider. The contractor may approve fewer than the number of additional therapy treatment days requested by the provider if the contractor believes that the requested number are not medically necessary. The contractor may approve any number of additional treatment days that the contractor determines are medically necessary, based on the documentation provided. The contractor shall make the decision within 10 business days of receipt of request and appropriate documentation, and notify the provider as soon as practicable

using the appropriate standard letter (See "Exhibit" below) as to whether an exception to the cap has been made, how many unlimited retroactive treatment days and how many additional future treatment days, not to exceed 15 per discipline, are approved. If additional therapy treatment days are not approved, the contractor shall make that decision within 10 business days of receipt of request and appropriate documentation, and notify the provider as soon as practicable using the appropriate standard letter that additional therapy treatment days are disapproved if not found to be medically necessary, that the decision on the exception request is not an initial determination, and therefore does not carry with it administrative appeal rights, and that subsequent claims for additional therapy treatment days which are denied are denied as benefit category denials.

In order to avoid delay in reviewing and processing claims, the contractor is encouraged to develop a process by which requests for exception to the therapy cap may be received and logged by the contractor's medical review department. An expeditious receipt of requests for exception from the therapy cap will lessen the potential for unintentional deeming of services to be medically necessary by exceeding the 10 business day time limit for decisions on requests for exception from the cap.

If the Medicare contractor does not issue a decision within those 10 business days, the contractor shall be deemed to have found the additional services requested to be medically necessary. In these cases, the contractor shall grant an exception to the therapy cap, approving the number of treatment days requested by the provider, not to exceed 15.

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; or*
- *evidence of misrepresentation of facts presented to the contractor, or*
- *A pattern of aberrant billing by a provider.*

Should such evidence of fraud, misrepresentation, or aberrant billing patterns by a provider be found, claims are subject to medical review regardless of whether the request was approved (either after manual review or 10 days after the request). The 10-day exception process shall not be applicable to that provider.

Progressive Corrective Action (PCA) and Medical review have a role in the therapy prior authorization exception process. 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 that the services are otherwise covered and appropriately provided. The exception is granted on the clinician's assertion that there is documentation in the record justifying that the services meet the criteria for reasonable and necessary services. For example, the documentation must accurately represent the facts, and there shall be no evidence of patterns of aberrant billing of the services by the provider/supplier. Services deemed medically necessary are still subject to review related to fraud or abuse. An

example of inappropriate use of the process is the routine application for exceptions only after the cap has been exceeded. Also, the routine use of the KX modifier on every claim for a patient that has an excepted condition or complexity, regardless of the impact of the condition on the need for services above the cap, is inappropriate.

Exhibit-Required Letter Format and Contents

Letter #1-Approved

XXXX
XXXX
XXXX

Date

Submitter Name
Submitter Address

Case Number:
Beneficiary Name:
Medicare Number:

SUBJECT: Request for Exception from the Therapy Cap-Approved

Dear Sir/Madam

We have received your [X/XX/XXXX] therapy cap exception request for the above named beneficiary. Based on the information submitted, we have determined that the beneficiary does meet the medical necessity requirements Medicare has established for granting an exception for a number of treatment days. We are granting exceptions to the cap for an additional [insert number] treatment days subject to the terms and conditions below.

This decision does not provide assurance that the beneficiary meets Medicare eligibility requirements nor does it assure that any other Medicare requirements (Medicare Secondary Payer, etc.) have been met. Only upon submission of a complete claim can the [Fiscal Intermediary/Payer] make a full and complete determination.

To ensure proper processing of the claim for these services append the KX modifier to your claim or it will deny. Do not append the modifier to claims not excepted by this letter or to services which are no longer medically necessary.

Also, this decision does not extend to the price Medicare will allow for the service(s). Payment amounts are determined upon receipt of the claim.

This therapy exception decision is valid for [XX] additional treatment days over the cap. Beneficiaries who require therapy are subject to rapid changes in medical condition. These changes may obviate the need for a particular service because the beneficiary's condition either improved or deteriorated. For this reason, if the condition of the patient changes and additional therapy is no longer required, you should not use the KX modifier nor expect payment from Medicare for these services.

We reserve the right to review claims on a pre-or postpayment basis, and may deny claims and take appropriate action when our approval was made based on fraud, misrepresentation, or we discover you are engaged in a pattern of aberrant billing.

For additional information, please see our Web site at www. ____.com

Sincerely,

[Insert Name and/or title]
Medical Review

Letter #2-Negative Decision-Medical Necessity

XXXX
XXXX
XXXX

Date

Submitter Name
Submitter Address

Case Number:
Beneficiary Name:
Medicare Number:

SUBJECT: Request for Exception from the Therapy Cap

Dear Sir/Madam

We have received your [X/XX/XXXX] therapy cap exception request for the above named beneficiary. Based on the information submitted, we have determined that the beneficiary does not meet the medical necessity requirements Medicare has established for granting an exception for these services for the following reasons:

Example: All requests for information must include information which documents the medical condition of the patient that necessitates additional therapy treatment days that will cause a beneficiary to exceed the cap. In our judgment, the documentation you provided is insufficient to support granting an exception.

This decision is not appealable. Medicare may not make payment for therapy services that exceed the current financial limitation. Such services are considered outside the scope of Medicare coverage, and the beneficiary may be charged for the services when

an exception from the cap is not pre-approved. No advance beneficiary notice need be issued.

You may still submit a claim for these services expected to exceed the cap, but you must not append the KX modifier to these services. If the service(s) exceed(s) the cap, the claim will be denied.

If the condition of the patient changes and additional therapy is required, you may submit a new request.

For additional information, please see our Web site at www. ____.com

Sincerely,

[Insert Name and/or title]
Medical Review

Letter #3-Denied-Insufficient Documentation
XXXX
XXXX
XXXX

Date

Submitter Name
Submitter Address

Case Number:
Beneficiary Name:
Medicare Number:

SUBJECT: Request for Exception from the Therapy Cap

Dear Sir/Madam

We have received your [X/XX/XXXX] therapy cap exception request for the above named beneficiary. Based on the information submitted, we have determined that the beneficiary does not meet the medical necessity requirements Medicare has established for granting an exception for these services for the following reasons:

Example: All requests for information must include a current plan of care, a narrative explanation/justification of the beneficiary's current functional status and need for continued therapy, or any other information you think would help support your request for exception. You failed to submit a current plan of care.

This decision is not appealable. Medicare may not make payment for therapy services that exceed the current financial limitation. Such services are considered outside the scope of Medicare coverage, and the beneficiary may be charged (for the services) when an exception from the cap is not pre-approved. No advance beneficiary notice need be issued."

You may still submit a claim for these services expected to exceed the CAP, but you must not append the KX modifier to these services. If the service(s) exceed(s) the cap, the claim will be denied.

If the condition of the patient changes and additional therapy is now required, you may submit a new request.

For additional information, please see our Web site at www. ____.com

Sincerely,

[Insert Name and/or title]
Medical Review

Tracking and Workload Reporting

The contractor shall develop a mechanism to track workload and costs associated with the Therapy Cap process and are to provide CMS with that information on a weekly basis. The weekly report will be due the following Wednesday to CMS_MRStrategies@cms.hhs.gov. The contractor shall also include the frequency of specific diagnoses that are being submitted for a manual exception. See Chapter 11 for CAFM reporting requirements.

11.1.3.9 - Prepay Complex Review Workload and Cost (Activity Code 21221)

(Rev.140, Issued: 02-15-06, Effective: 01-01-06, Implementation: 03-13-06)

Report all costs associated with prepay complex review in Activity Code 21221. In the workload section of CAFM II, Activity Code 21221, report the number of claims reviewed in Workload 1. Report the number of claims denied in whole or in part in Workload 2. Report the number of providers subject to prepay complex review in Workload 3.

The DMERCs shall report the number of Advanced Determinations of Medicare Coverage accepted (CMS IOM Pub.100-8, ch.5 §5.7) to miscellaneous code 21221/01.

The carriers and fiscal intermediaries shall report the therapy cap workload in activity code 21221 under miscellaneous code 01.