POLARIS PULSE®

A Bi-monthly Informational Bulletin Brought To You By Polaris Group

Therapy Cap Exception Process

The Deficit Reduction Act (DRA) of 2005 required the Center for Medicare & Medicaid Services (CMS) to create an **exceptions process** that permits payment for medically justified therapy services in excess of the Uniform Dollar Limitation (Caps) required by the Balanced Budget Act.

On February 13, CMS issued Program Transmittals to the contractors (Fiscal Intermediaries, Regional Home Health Intermediaries and Carriers) regarding the exception process and applicable restrictions. The transmittals instruct the contractors to implement the exception process no later than March 13, 2006.

The below highlights key points included in the Transmittals.

Automatic Exceptions from Therapy Caps

Treatment days beyond the cap may be provided without a request for exception or supporting documentation if:

- The beneficiary meets specific conditions listed in CMS Internet Only Manual (IOM) Publication 100-04 Chapter 5
  - » Examples of automatic exceptions include, but not limited to:
    - ◊ V43.64 Joint Replacement, Hip
    - ◊ 250 – 250.93 Diabetes Mellitus*
    - ◊ 332.0 – 332.1 Parkinson's Disease
    - ◊ 719.7 Difficulty Walking*
    - ◊ **Conditions** are represented on the list without an asterisk (*)
    - ◊ **Complexities** are represented on the list with an asterisk (*)
    - ◊ Clinical complexities may justify an automatic exception to the caps for any condition that necessitates skilled therapy services regardless of whether the condition is also on the list, however the mere existence of a complexity does not assure services were medically necessary.
  - » The codes apply to all therapy disciplines, but may be used only when the code is applicable to the condition being actively treated.
    - ◊ For example, an exception should not be claimed for a diagnosis of hip replacement when the service provided is for an unrelated dysphagia.
- Contractors may develop therapy cap exception criteria (based on the strongest evidence available), in addition to those described in CMS IOM Publication 100-4, Chapter 5. The criteria must be published on the contractors Web site.
- Clinical record documentation requirements are located in CMS IOM Publication 100-02, Chapter 15, Section 230.3

Automatic Exception Criteria Not Met

Initial Request

If the provider believes a beneficiary does not meet at least one of the "automatic exception" criteria, but will require therapy treatment days in excess of the cap, a request for a specific number of additional therapy treatment days may be requested. The request may not exceed 15 treatment days. Separate requests are required for an OT cap exception and for the combined PT/SLP cap exception.

The provider is required to submit documentation with the exception request. At a minimum, the documentation must include the current evaluation or reevaluation, 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.

For more information, please contact your Polaris Group representative.

Providers are encouraged to submit requests for an exception before the cap is exceeded. When a provider does not submit a timely request for exception, the contractor may approve any number of treatment days retroactively, if they were medically necessary.

Subsequent Requests for Continued Therapy During the Same Episode of Care

The provider is required to submit a new request for approval of additional therapy treatment days, again not to exceed 15, each time the beneficiary is expected to require days beyond the prior approval. Minimal documentation requirements are the same as for initial exception requests.

If an initial or subsequent request for an exception is denied, the FI will accept another request only if the beneficiary's condition has significantly changed.

Contractor Response to Therapy Cap Exception Requests

The contractor will make a decision as to whether to approve the exception request and how many additional therapy treatment days are medically necessary within 10 business days of receipt of the request. The contractor may approve fewer than the number of days requested if the requested number is not deemed medically necessary. Conversely, the contractor may approve additional days if deemed medically necessary based on the documentation provided.

The contractor will notify the provider of their decision via one of the standard letters developed by CMS. The letter will include whether an exception to the cap has been deemed medically necessary, how many unlimited retroactive treatment days are approved and how many additional future days, not to exceed 15 per discipline, are approved.

If the exception is not approved, The contractor will notify the provider "*as soon as practicable"* via the appropriate standard letter. If the contractor does not issue a decision within 10 business days, the contractor shall be deemed to have found the requested additional treatment days to be medically necessary.

The decision on the exception request is not an initial determination; therefore, **administrative appeal rights do not apply**. Subsequent claims for additional treatment days that are denied are denied as benefit category denials.

If the contractor makes the determination that the requested services are medically necessary, that determination is binding on the contractor in the absence of fraud, evidence of misrepresentation of facts presented to the contractor, or a pattern of aberrant billing by a provider.

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.

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 (see below) 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.

Use of KX Modifier for Therapy Cap Exceptions

When the beneficiary qualifies for a therapy cap exception, the provider shall add a KX modifier to the therapy HCPCS subject to the cap limits.

- The GN, GO, or GP therapy modifiers are currently required. in addition to the KX modifier, the GN, GP and GO modifiers shall continue to be used.
- By attaching the KX modifier, the provider is attesting that the services billed:
  - ≈ Qualified for the cap exception either automatically or by contractor approval
  - ≈ Are reasonable and necessary services that require the skills of a therapist; and
  - ≈ Are justified by appropriate documentation in the medical record
- *Routine use of the KX modifier for all beneficiaries with automatic exception ICD-9 conditions/complexities will likely show up on data analysis as aberrant and invite inquiry.*

Submitting Letters of Request for Cap Exceptions

- The letter of request, including the number of

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treatment days requested and the justification for the medically necessary services **must** be submitted to the contractor by FAX with supporting documentation, unless the contractor specifically requests or allows phone or mail requests.

- The request and all documentation required for medical review must be sent in together.
- Keep the fax receipt in the record.
- If mailed requests are allowed, certified mail will document receipt at the contractor.
- If phone requests are allowed, both the contractor and the provider shall document the request and the contractor's response.
- Include any documentation beyond that required if believed it may be helpful to the contractor in determining that the services are necessary and were or will be appropriately provided. For example, outcome measurements that indicate the beneficiary is progressing, has good prognosis, but has not reached expected outcomes for the condition, or research that indicates the length of treatment for the condition is appropriate.
- If the contractor approves the cap exception a copy of the approval should be maintained in the beneficiary's clinical record. A copy of the approval should be included in documentation provided to the contractor during any subsequent claim review.

CMS will publish a Medlearn Article to assist with implementation of the Therapy Cap Exception Process.

SOLUTION CENTER Q&A

"Where No Question Goes Unanswered"

Q: Is the Notice of Medicare Provider Non Coverage (QIO Expedited Review Notice) required for residents in a Medicare Certified bed when they reach a Therapy Cap and an exception is not appropriate?

A: No. Once the therapy cap is met, a resident in a Medicare Certified bed is no longer eligible for Medicare benefits; therefore, an expedited review is not an option. The facility would notify the beneficiary of financial liability for continued therapy services via the Notice of Exclusion of Medicare Benefits.

TELECONFERENCE TRAININGS

Polaris Group is pleased to present the following ***CEU approved*** teleconference trainings

Live Teleconference Trainings

Topic	Date
Sections K, P, and T	2/16
Quality Indicators/Measures	2/21
Part B Caps	2/22
Sections I, J, O, and W	2/23
Managing 53 RUGs for Reimbursement	2/28
Pain Management in LTC	3/2
Part B Caps	3/8
Case Management for PPS	3/14
Medicare Billing Introduction	3/16
Managed Risk	3/21
Medicare Billing Practicum	3/23
Medical Director Survey Protocol	3/28
Consolidated Billing	3/30

Please join us in our Teleconferences . For further information regarding these seminars, please contact the Seminar Department at: 800-275-6252 ext. 233

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