



Office of External Affairs

FACT SHEET

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OUTPATIENT THERAPY CAPS: EXCEPTIONS PROCESS REQUIRED BY THE DRA

Background: Section 4541 of the Balanced Budget Act of 1997 (BBA) required the Centers for Medicare & Medicaid Services (CMS) to impose financial limitations or caps on outpatient physical, speech-language and occupational therapy services by all providers, other than hospital outpatient departments. The law required a combined cap for physical therapy and speech-language pathology, and a separate cap for occupational therapy. Due to a series of moratoria enacted subsequently to the BBA, the caps were only in effect in 1999 and for a few months in 2003. With the expiration of the most recent moratorium, the caps were reinstated on January 1, 2006 at \$1,740 for each cap.

The President signed the Deficit Reduction Act of 2005 (DRA) into law on February 8, 2006. The DRA directs CMS to create a process to allow exceptions to therapy caps for certain medically necessary services provided on or after January 1, 2006. The law mandates that if CMS does not make a decision within 10 days, the services will be deemed to be medically necessary. This fact sheet describes the exceptions process which will be implemented by our claims processing contractors. Until contractors are able to implement the exceptions process, they are required to accept requests for adjustment of claims for services in 2006 that were denied for exceeding the caps.

Exceptions Process: CMS has established an exceptions process that is effective retroactively to January 1, 2006. Providers, whose claims have already been denied because of the caps, should contact their carrier to request that the claim be reopened and reviewed to determine if the beneficiary would have qualified for the exception. In addition, providers who have not yet submitted claims for services on or after January 1, 2006 that qualify for the exception, should submit these claims for payment, and refund to the beneficiary any private payments collected because of the cap.

The exceptions process allows for two types of exceptions to caps for medically necessary services:

- **Automatic Exceptions.** Automatic exceptions for certain conditions or complexities are allowed without a written request. A request to the contractor for an exception is not required when services related to these conditions and complexities, which are described below, are appropriately provided and documented. We anticipate that the majority of beneficiaries who require services in excess of the caps will qualify for automatic exceptions.

- **Manual Exceptions.** Manual exceptions require submission of a written request by the beneficiary or provider and medical review by the contractor responsible for processing the claims. If the patient does not have a condition or complexity that allows automatic exception, but is believed to require medically necessary services exceeding the caps--the provider/supplier or beneficiary may fax a letter requesting up to 15 treatment days of service beyond the cap. A treatment day is a day on which one or more services are provided. The request must include certain documentation, including a justification for the request. Contractors will make a decision on the number of treatment days they determine are medically necessary within 10 business days. These requests for cap exceptions should be submitted prior to the date the cap is expected to be surpassed to avoid placing the beneficiary at risk of incurring the costs of treatment if the request is denied.

Automatic Exceptions to the Therapy Caps: Certain diagnoses qualify for an automatic exception to the therapy caps, if the condition or complexity has a direct and significant impact on the need for course of therapy being provided and the additional treatment is medically necessary. A list of these diagnoses is attached. For a condition or complexity to qualify the beneficiary for an exception to the caps, the therapy must be related to one of the listed conditions.

In addition to conditions, there are clinically complex situations that can justify an automatic exception to the therapy caps for any condition that necessitates skilled therapy services. As in all exceptions, the services rendered above the caps must be documented, covered by Medicare, and medically necessary services. Those complex situations include:

- The beneficiary was discharged from a hospital or skilled nursing facility (SNF) within 30 treatment days of starting this episode of outpatient therapy. The claim should indicate the date of discharge and name of hospital or SNF.
- The beneficiary has, in addition to another disease or condition being treated, generalized musculoskeletal conditions or a condition affecting multiple sites that is not listed as qualifying for an automatic exception that will have a direct and significant impact on the rate of recovery.
- The beneficiary has a mental or cognitive disorder in addition to the condition being treated that will have a direct and significant impact the rate of recovery.

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

- The beneficiary requires physical therapy (PT) and speech-language pathology (SLP) services concurrently. If the combination of the two services causes the cap to be exceeded for necessary

- services, the services are excepted from the PT/SLP cap. There is no effect on the occupational therapy cap.
- The beneficiary had a prior episode of outpatient therapy during this calendar year for a different condition. If services are medically necessary and would be payable under the cap, an exception is allowed if prior use of services for a different condition caused the cap to be exceeded and the medically necessary services to be denied. In cases where the beneficiary was treated in the same year for the same condition, a written request and contractor approval is required for use of the KX modifier if the condition does not qualify for an automatic exception.
- The beneficiary requires this treatment in order to return to a previous place of residence. Document that environment and what is needed to return. For example: “Patient is progressing (see initial and current objective measurement scores) and has a good potential for completing goals for independent use of the toilet which is required for discharge from the nursing home setting and return to the assisted living facility where she resided prior to the stroke.”
- The beneficiary requires this treatment plan in order to reduce Activities of Daily Living assistance or Instrumental Activities of Daily Living assistance to previous levels. Document prior level of independence and current assistance needs.
- The beneficiary indicates he/she does not have access to outpatient hospital therapy services. List reasons that justify why the patient cannot obtain necessary services from a hospital outpatient department. Reasonable justifications include residents of skilled nursing facilities prevented by consolidated billing from accessing hospital services, debilitated patients for whom transportation to the hospital is a physical hardship, or lack of therapy services at hospital in the beneficiary’s county.

Use of Modifier: When services qualify for either an automatic or manual exception, provider/suppliers should add a KX modifier to each line of the claim that contains a service that exceeds caps. This modifier represents the provider/supplier’s attestation of medical necessity. Medical records continue to be subject to review for possible misrepresentation, fraud or patterns of abuse. If the contractor determines that the provider/supplier has inappropriately used the modifier, the provider/supplier may be subject to sanctions resulting from providing inaccurate information on a claim.

Further Information: Further information regarding automatic exceptions and the process for requesting and documenting manual exceptions is published on the CMS website at:
www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage.

The therapy caps are discussed in Pub 100-04, chapter 5, section 10.2, Pub.100-8, chapter 3.4.1.2, and Pub 100-02, chapter 15, section 220.3. Other information concerning the process can be found in CR4364, at www.cms.hhs.gov/Transmittals/2006Trans/list.asp#TopOfPage.

Diagnosis Codes That Qualify for an Automatic Exception to the Caps

Note: On this table, conditions are represented in normal type and complexities are bold with asterisks.

ICD-9	DESCRIPTION
V43.64	JOINT REPLACEMENT, HIP
V43.65	JOINT REPLACEMENT, KNEE
V43.61	JOINT REPLACEMENT, SHOULDER
V49.63-49.67	UPPER LIMB AMPUTATION STATUS
V49.73-49.77	LOWER LIMB AMPUTATION STATUS
250 – 250.93	DIABETES MELLITUS*
278.01-278.02	OVERWEIGHT, OBESITY, AND OTHER HYPERALIMENTATION *
290.0-290.4	DEMENTIAS*
294.0-294.9	PERSISTENT MENTAL DISORDERS DUE TO CONTIONS CLASSIFIED ELSEWHERE*
311	DEPRESSIVE DISORDER NEC*
323.0-323.0	ENCEPHALITIS, MYELITIS, AND ENCEPHALOMYELITIS*
331.0-331.9	OTHER CEREBRAL DEGENERATIONS
332.0-332.1	PARKINSON'S DISEASE
333.0-333.99	OTHER EXTRAPYRAMIDAL DISEASES AND ABNORMAL MOVEMENT DISORDERS
334.0-334.9	SPINOCEREBELLAR DISEASE
335.0-335.9	ANTERIOR HORN CELL DISEASE
336.0-336.9	OTHER DISEASES OF SPINAL CORD
337.20-337.29	REFLEX SYMPATHETIC DYSTROPHY
340	MULTIPLE SCLEROSIS
342.00-342.9	HEMIPLEGIA AND HEMIPARESIS
343.0-343.9	INFANTILE CEREBRAL PALSY
344.00-344.9	OTHER PARALYTIC SYNDROMES
348.9-348.9	OTHER CONDITIONS OF BRAIN
349.0-349.9	OTHER AND UNSPECIFIED DISORDERS OF THE NERVOUS SYSTEM
353-357	NEUROPATHIES
359.0-359.9	MUSCULAR DYSTROPHIES AND OTHER MYOPATHIES
386.0-386.9	VERTIGINOUS SYNDROMES AND OTHER DISORDERS OF VESTIBULAR SYSTEM*
401.0-401.9	ESSENTIAL HYPERTENSION*
402.00-402.91	HYPERTENSIVE HEART DISEASE*
414.00-414.9	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE*
415.0-415.19	ACUTE PULMONARY HEART DISEASE*
416.0-416.9	CHRONIC PULMONARY HEART DISEASE*
427.0-427.9	CARDIAC DYSRHYTHMIAS*
428.0-428.9	CONGESTIVE HEART FAILURE*

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

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

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