Part B Insider (Multispecialty) Coding Alert

THERAPY: Overcome Therapy Caps With New Exceptions Process

What you don't know could cost your Part B therapy business $1,000s

The new Medicare reimbursement caps for outpatient therapy could drastically limit the therapy services you provide in your office--unless you know the ropes.

Congress originally passed the caps, which apply only to outpatient rehabilitation therapy provided under the Part B benefit, in the Balanced Budget Act of 1997. The caps do not apply to therapy furnished under the home care benefit.

But then Congress relented and repeatedly postponed the therapy caps. Finally, the caps took effect Jan. 1.

However, in the Deficit Reduction Act passed in January, Congress allowed for an exceptions process to the two caps. One $1,740 cap applies to combined physical therapy and speech-language pathology services for one patient in one year, while the other applies to occupational therapy services annually.

Heads up: The therapy cap is retroactive, so you can use the guidance below to reopen denied claims since Jan. 1.

Get To Know Automatic Exceptions

If you were dreading a bunch of paperwork, you're in luck because one way to get an exception is to send in a special claim with a KX modifier, which will indicate the need for an automatic exception. The automatic process covers many patient conditions, so find out first if your patient qualifies before resorting to a manual process.

What to do: Simply review CMS' list of qualifying ICD-9 codes to see if your patient matches any listed conditions, and verify that the therapy you want to provide is relevant and medically necessary.

Bonus: ICD-9 codes with asterisks indicate comorbidities that, when reported with another condition not on the list, will qualify for automatic exceptions, points out **Dave Mason,** VP of government affairs for the **American Physical Therapy Association** in Alexandria, VA. However, you must document that both the comorbidity and condition would cause the patient to exceed the therapy caps.

But the list doesn't stop there. CMS notes additional "complex situations" that warrant automatic exceptions. For example, patients who have been discharged from a hospital or skilled nursing facility (SNF) within 30 days or who have already had therapy for a separate condition that year would qualify for an automatic exception. Read the text below the ICD-9 chart in Transmittal 855 for a full list of qualifying complex situations.

Caution: The transmittal states that deviant billing patterns will be reasons for medical review, Mason warns. "So if the overwhelming majority of claims coming from a particular provider have a KX modifier, that's going to be a bright red flag for the carriers to review claims."

Follow Up With Manual Exceptions

If you've reviewed all your options and find out that your patient still doesn't qualify for the automatic process, you can try a manual process. This is where you submit a written request to your Medicare contractor explaining the need for an exception. Then, the contractor will decide to grant or deny the exception.

Your request must include specific documentation, including a justification for the request, instructs Transmittal 140.

Also, you may not request more than 15 treatment days of service beyond the cap, but you can send another request for an exception after you determine that the treatment will extend beyond your contractor's approved amount.

Good idea: Mark your calendar because Medicare contractors have 10 business days to respond to your letter with a grant or denial, or CMS will automatically deem your requested services medically necessary.
But you can't always count on Medicare putting you off for more than 10 days. Now, your documentation counts more than ever because unlike regular claims processing, you may not appeal a denied exception request, Mason reminds.

Tip: To avoid this trap, be sure you can justify the therapy in the medical record, advises **Leslie Stein Lloyd, Esq.,** director of reimbursement and regulatory policy for the **American Occupational Therapy Association** in Bethesda, MD.

Transmittal 47 goes into even further detail about new documentation requirements for all outpatient therapy. For instance you must use new methods for documenting your evaluation and certified plan of care: the physician certification, progress reports and treatment encounter notes.

Editor's Note: A summary of the exceptions process is at
www.cms.hhs.gov/apps/media/press/release.asp?Counter=1782.