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Eli's Rehab Report

Reader Questions: Know Your Therapy Cap Exceptions to a Tee

Question: I need clarification about therapy cap exceptions on different treatments done within the same calendar year. For example, in February (2008), I saw a patient for a shoulder problem, who used $1,400 of his Medicare limit. The same patient returned in October 2008 with a low back condition. Once the patient reaches his $1,810 limit I can use the KX modifier since this is a different diagnosis, right? Also, did CMS update any therapy cap policies for 2009?

Florida Subscriber

Answer: You're correct that you can bill with the KX modifier after the patient reaches his $1,810 limit on skilled treatment for his low back condition. By using the KX modifier, you are essentially telling your Medicare contractor that the Medicare beneficiary continues to require skilled therapy services above and beyond the therapy cap. Your documentation would support the medical necessity of your therapy services and support that the services were skilled and could have only been provided by a therapist or an assistant under the supervision of a therapist.

There is no limit for the KX modifier, regardless of whether the diagnosis has changed, as long as you can support medical necessity and skilled intervention in your documentation.

As far as CMS updates for 2009, the agency did not change anything in the latest transmittal it issued to contractors on Nov. 7, other than pointing out the newest date extension for the exceptions process. That is, now, exceptions are valid until Dec. 31, 2009, thanks to the Medicare Improvements for Patients and Providers Act of 2008. After that, the exceptions process expires unless Congress takes further action.

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