Eli's Rehab Report

THERAPY CAPS: CMS Offers 3 Key Changes to the Therapy Cap for Outpatients

With only a $40 raise, experts weigh in on what will affect you most

The therapy cap will go from $1,740 to $1,780 in 2007 for both PT/SLP and OT, CMS says in Transmittal 1106 issued Nov. 9. But that's not where the changes stop. Get to know these important highlights from the latest exceptions process procedures.

1. Cap Amount Bumps Up

Same as last year, the transmittal outlines two therapy cap categories: one for physical therapy and speech language pathology, and another for occupational therapy. But CMS raised the therapy cap amount for both categories from $1,740 in 2006 to $1,780 in 2007.

Details: The 20 percent coinsurance still applies, requiring you to bill the 20 percent balance to secondary insurance or hold the beneficiary responsible for it, says **Joanne Byron, LPB, BSNH, CPC, CHA,** president of Health Care Consulting Services Inc. in Hickory, N.C.

The beneficiary exhausts the cap when the physician fee schedule's allowed amounts are applied to all therapy claims submitted for each respective cap. "This is an annual financial limitation assigned to each beneficiary," Byron adds. "Once the limitation is reached, it is exhausted until the beginning of the next calendar year."Once the limitation is reached, however, you have the option of an automatic or manual exceptions process, says **Rick Gawenda, PT,** director of physical medicine and rehabilitation at Detroit Receiving Hospital.

Remember: For claims with dates of service from Jan. 1 through Dec. 31, 2007, "Medicare shall apply these financial limitation in order, according to the dates when the claims were received," the transmittal notes.

2. Multiple Conditions Clarified

The original transmittal (855) said that one qualifier for an automatic exception was if a therapy patient was discharged and returned the same year with a second, separate condition. "But it didn't say what to do if a therapist is treating the patient for one condition while a second condition arises during the treatment for the first condition," Gawenda says.

Now, as long as both services are medically necessary, the beneficiary will qualify for an automatic exception, according to the latest transmittal. And "it is not required that any of these conditions be on the list of automatic process exceptions," CMS says.

Clarification: You would need to include the new condition or complexity in the patient's current plan of care "and become part of the same episode of care." That means if a patient is receiving treatment for a condition that does not qualify for an automatic exception but develops a second condition that may or may not qualify, "the presence of the second condition" added to the same plan of care allows you to use the automatic exception for both conditions, the transmittal clarifies.

In addition, even if at the initial evaluation the patient does not have a diagnosis on the exceptions list, she is not excluded from qualifying for exceptions when the cap exhausts, as long as she has a change in status that now qualifies under the cap, Byron says. If this occurs, "the therapist can use modifier KX (Specific required documentation on file) and apply the appropriate ICD-9 codes from the exceptions list or file for a manual request for exception," she says.

Documentation should support any ICD-9 code used as well as the medical necessity of the skilled intervention(s).

3. SNF Discharges Added to Complexity List

You may remember that a patient can receive an automatic exception for a "complexity" other than a listed ICD-9 code. One example of a complexity is when apatient has a mental or cognitive disorder in addition to the condition for which he's receiving therapy that will directly impact his rate of recovery.

Important: Regarding the complexity named last year of being discharged from a hospital within 30 days of beginning outpatient therapy, CMS has now clarified what type of hospital stay this is referring to: "any hospital or inpatient stay, or any episode of any duration paid under Part A within 30 calendar days."

"This means a patient discharged from a SNF setting in Part A may now qualify for an automatic exception since that is considered an inpatient stay under Part A," Gawenda says.