Outpatient Therapy Caps Exceptions Process Refinement

An introduction to the revised policy and new claims coding requirements

Disclaimer

Contents of this presentation are for educational purposes only. Clinicians should refer to Medicare manuals and contractor instructions for current policies.

Medicare outpatient therapy benefit

- Medicare Part B covers ambulatory outpatients or inpatients who have exhausted or are not eligible for Part A benefits.
- Outpatient therapy includes;
  - Physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services furnished (as permitted by state law) by:

Provider Facilities	**Office-Based Professionals**
Hospitals	Physical therapists in private practice (PTPP)
Skilled nursing facilities (SNF)	Occupational therapists in private practice (OTPP)
Comprehensive outpatient rehabilitation facilities (CORF)	Speech-language pathologists in private practice (SLPP)
Outpatient rehabilitation facilities (ORF)	Physicians
Home health agencies (HHA)	Non-physician practitioners (NPP)

Medicare outpatient therapy benefit

- Coverage requirements;
  - Such services were required because the individual needed therapy services, and
  - A plan for furnishing such services (containing at a minimum: diagnosis(es); long term treatment goals; and type, amount, duration, and frequency of therapy services) was established by a clinician which was also periodically reviewed by a physician or NPP, and
  - Such services were furnished while the beneficiary was under the care of a physician or NPP, and
  - Such services were furnished on an outpatient basis, and
  - The physician or NPP certified the plan of care for the applicable payment period.

Medicare outpatient therapy benefit

- Related claim processing requirements
  - Provider facilities submit CMS 1450 (UB-04) claims (or electronic equivalent).
  - Professional offices submit CMS 1500 claims (or electronic equivalent).
  - Outpatient therapy services are identified at the claim line by the 5-digit Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes for each procedure furnished on each date of service.
  - The outpatient therapy discipline furnishing the services is identified at the claim line by the GP, GO, or GN modifier representing PT, OT, or SLP services respectively.

Outpatient therapy caps

- Annual per-beneficiary limitation on allowed outpatient therapy services (regardless of need).
  - Extended to all outpatient therapy settings/professionals (except hospitals) effective in 1999.
  - Two caps exist: 1) a PT/SLP services combined cap, and 2) a separate OT services cap.
  - Cap limits are adjusted annually per Congressional formula.
  - For most of 2000-2006, the caps were not enforced as a result of legislation.
  - Since 2006, there has been an exceptions process permitted by Congress that allows beneficiaries to receive services beyond the cap limits in non-hospital settings, if the clinician attests the services are medically necessary, and places a KX modifier on claim lines for services furnished beyond the annual cap limits.
    - Since 2007 only automatic process exceptions procedures have applied

Automatic process exceptions

- Indicates that the claims processing for the exception is automatic, not that the exception is automatic.
- The clinician is responsible for justifying medical necessity.
- No special documentation is submitted to the contractor with the claim.
  - Documentation shall be submitted in response to any Additional Documentation Request (ADR) for claims selected for medical review.
- The Medicare contractor makes the final determination concerning whether the claim is payable.
- The exceptions process refinement does not affect the above requirements.

Exceptions process since 2007

- All covered and medically necessary services qualify for exceptions to caps.
- All services that require exceptions to caps are processed using ‘automatic process exceptions’.
- *The KX modifier is added to claim lines to indicate that the clinician attests that services are medically necessary and justification is documented in the medical record.*
- *Medicare issues payments for claim lines containing the KX modifier.*
  - *Claim lines for services furnished beyond the cap limits without the KX modifier are denied payment.*
- Use of automatic process exceptions does not exempt services from manual or other medical review processes.

Note: Steps in *italicized text* above are being eliminated with the exceptions process refinement in 20XX.

Exceptions process refinement for 20XX

- All covered and medically necessary services qualify for exceptions to caps.
- All services that require exceptions to caps are processed using ‘automatic process exceptions’.
- *New nonpayable HCPCS and modifier codes (next 3 slides) are submitted at episode onset and at periodic intervals that reflect current and treatment goal function.*
  - *The new codes serve as an attestation that services are medically necessary and justification is documented in the medical record.*
- *Medicare issues payments for claim lines as long as the provider submitted the new nonpayable HCPCS and modifier codes for services furnished within the periodic interval requirement.*
  - *Claim lines for services furnished beyond the cap limits without the new nonpayment HCPCS and modifier codes within the periodic interval requirement are denied payment.*
- Use of automatic process exceptions does not exempt services from manual or other medical review processes.

Note: Steps in *italicized text* above are new with the exceptions process refinement in 20XX.

New nonpayment HCPCS coding

- Submitted on the date of the episode onset (first encounter for the therapy discipline) and at periodic intervals (12 sessions or 30 calendar days – whichever is less)
- Up to six nonpayment HCPCS G-codes and seven modifiers would report clinical information on the claim at these intervals.
- The G-codes identify whether certain factors are being addressed in the plan of care, such as:
  - 1) Impairments to body structures and functions,
  - 2) Activity limitations or participation restrictions (difficulty), and
  - 3) Environmental barriers.
- Separate G-codes will differentiate current function from functional outcome goals in the plan of care.
- The modifiers attached to these new HCPCS codes would rate the severity within each of the function G-codes.

New nonpayment HCPCS codes

Impairments to body functions and/or structures codes

- GXXXU – Impairments to body functions and/or structures – current
- GXXXV – Impairments to body functions and/or structures – goal

Activity limitations and/or participation restrictions codes

- GXXXW – Activity limitations and/or participation restrictions – current
- GXXXX – Activity limitations and/or participation restrictions – goal
- Environmental barriers codes
- GXXXY – Environmental barriers – current
- GXXXY – Environmental barriers – goal

New nonpayment modifier codes

- XA – 0% impairment, difficulty or barrier
- XB – 1-19% impairment, difficulty or barrier
- XC – 20-39% impairment, difficulty or barrier
- XD – 40-59% impairment, difficulty or barrier
- XE – 60-79% impairment, difficulty or barrier
- XF – 80-99% impairment, difficulty or barrier
- XG – 100% impairment, difficulty or barrier

Coding example for exceptions process refinement – Episode Initial Encounter

Initial encounter

- PT evaluated patient and initiated treatment
  - Patient has back pain when moving about that limits function by about 50 %

HCPCS codes submitted

- 97001 – PT evaluation – 1 unit, and GP modifier
- 97110 – Therapeutic exercise – 1 unit, and GP modifier
- GXXXU – Impairments to body functions and/or structures – current, and XD modifier – 40-59% impairment, and GP modifier
  - Modifier demonstrates impairment severity at episode start.
- GXXXV – Impairments to body functions and/or structures – goal, and XA modifier – 0% impairment, and GP modifier
  - Modifier indicates treatment goal for impairment.

Coding example for exceptions process refinement – 5th Session

5th session (12 calendar days later)

- PT continued treatment
  - Patient has back pain when moving about that limits function by about 25%

HCPCS codes submitted

- 97110 – Therapeutic exercise – 2 units, and GP modifier
- 97140 – Manual therapy – 1 unit, and GP modifier
- New nonpayment HCPCS and modifiers are not required since 5th session is less than 12 treatment days and occurred less than 30 calendar days since new codes were submitted.
  - If re-assessment or re-evaluation identifies unplanned changes in function or plan of care goals, the clinician may consider submitting the nonpayment HCPCS codes to indicate to contractor that a change has occurred and is documented.

Coding example for exceptions process refinement – 30 Calendar Days

11th session

- PT continued treatment
  - Patient has back pain when moving about that limits function by about 10%

HCPCS codes submitted

- 97110 – Therapeutic exercise – 1 unit, and GP modifier
- 97140 – Manual therapy – 1 unit, and GP modifier
- GXXXU – Impairments to body functions and/or structures – current, and XB modifier – 1-19% impairment modifier, and GP modifier
  - Modifier demonstrates reduced impairment severity compared to previously submitted code at episode start
- GXXXV – Impairments to body functions and/or structures – goal, and XA modifier – 0% impairment, and GP modifier
  - Modifier indicates treatment goal not fully achieved yet

Benefits of enhanced exceptions process

- Clinicians will be able to submit high level clinical information on the claim regarding patient function and goals to support medical necessity of outpatient therapy services.
- Contractors will be able to use new codes to monitor general clinical progress at approximately monthly intervals (or less) to support medical review and fraud detection efforts.
- CMS will be able to use new codes in efforts to monitor outpatient therapy utilization and to develop episode-based payment models.
- Enhanced exceptions process reduces provider burden in long run (next slide).

Provider burden is offset

- Initial increased burden to learn new codes and update billing systems.
- Reduced burden with no further need to submit KX modifier with each claim line once cap limit is approached or exceeded.
- Reduced burden as the need to track cap limits is eliminated as long as clinicians submit new nonpayment HCPCS codes indicating current functional impairments, difficulties or barriers, and related intervention goal codes, within the periodic interval requirement of 12 sessions or 30 calendar days (whichever is less).