



Information Bulletin

American Physical Therapy Association

CMS Posts Therapy Cap Implementation Resources

Today, the Centers for Medicare and Medicaid Services (CMS) posted resources for providers and patients regarding the expiration of the therapy cap exceptions process on its website. Below is a summary of the CMS guidance including links to additional agency resources:

- Outpatient therapy service providers should not submit claims with the KX modifier for services furnished on or after July 1, 2008. To the extent possible, CMS is working with Congress, health care providers, and the beneficiary community to avoid disruption in the delivery of health care services and payment of outpatient physical therapy, occupational therapy and speech-language pathology claims for services furnished by physicians, non-physician practitioners, and therapists paid under the physician fee schedule, beginning July 1.
- For physical therapy and speech language pathology services combined, the limit on incurred expenses is \$1810. For occupational therapy services, the limit is \$1810. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached. **Therapy cap accruals began on January 1, 2008, and some patients may have reached the annual limits by June 30, 2008.**

Providers may access the accrued amount or remaining amount of therapy services from the Medicare beneficiary eligibility inquiry and response transactions.

- For CWF users, the system returns the “applied” amount. See CR4115 at <http://www.cms.hhs.gov/transmittals/downloads//R759CP.pdf>
- For users of the HETS 270/271, the system returns the “remaining” amount. See the page 18 of the 270/271 user guide at <http://www.cms.hhs.gov/HETSHelp/Downloads/HETS%20270-271%20User%20Companion%20Guide.pdf>
- The Medicare contractors’ Interactive Voice Response units (IVR) return either the remaining or applied amounts based upon contractor programming. For those few contractors that do not provide this information on their IVRs, providers can call the contractors’ customer service representatives.

For additional information, Providers and Suppliers should also read the Medicare Claims Processing Manual, chapter 5, section 10. 2 at

<http://www.cms.hhs.gov/manuals/downloads/clm104c05TXT.pdf>

Patients Who Have Reached Their Limit(s) on Outpatient Therapy Services:

Patients who have reached their limit(s) on outpatient therapy services, other than those who reside in a Medicare-certified part of a skilled nursing facility, may obtain medically necessary therapy services that

exceed the caps if the services are furnished and billed by the outpatient department of a hospital. In other settings, outpatient therapy services in excess of the caps are not covered, and the therapy provider may charge for those services.

An Advance Beneficiary Notice is recommended, but not required for services that exceed therapy caps.

- An ABN is available at the following link:
http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp#TopOfPage (click on ABN-CMS-R-131 Form).
In the box titled "Reason Medicare will not pay" the following language is suggested Medicare will not pay more than \$1810 for expenses incurred for physical therapy and speech-language pathology services combined or for occupational services in 2008.

Patients will be able to refer to this website for further information; Currently this link is inactive

<http://www.medicare.gov/Publications/Pubs/pdf/10988.pdf>

[APTA will forward to you additional information from CMS on implementation of the therapy caps as it becomes available.](#)