

Therapy Cap Exceptions

Effective January 1, 2006, a financial limitation (therapy cap) was placed on outpatient rehabilitation services received by Medicare beneficiaries. These limits apply to outpatient Part B therapy services from all settings except the outpatient hospital (place of service code 22 on carrier claims) and the hospital emergency room (place of services code 23 on carrier claims). For more information about this therapy cap, please [click here](#).

Due to the passage of the Deficit Reduction Act (DRA) of 2005 in February 2006, the Centers for Medicare & Medicaid Services (CMS) released Change Request (CR) 4364, which offers exceptions to therapy caps for services provided during calendar year 2006 if the services meet certain qualifications as medically necessary services. (Section 1833(g)(5) of the Social Security Act). [Click here](#) to read the CMS Medlearn Matters article related to CR 4364.

The information in [CR 4364](#) describes the circumstances under which beneficiaries can receive automatic exceptions to the therapy caps. CR 4364 also includes an exception process for contractor approval.

Providers choosing to use the automatic exception process will need to include the KX modifier, *Specific required documentation on file*, on their claims. They will also need to include one of the ICD-9 diagnosis codes listed as conditions within CR 4364 (these are the ICD-9s listed without an *). If providers submit any of the complexity ICD-9s (ICD-9s listed with an *), an ICD-9 for a condition must also be reported. Complexity ICD-9 codes billed alone do not justify an exception to the therapy caps.

When providers choose to go through the exception process, they should mail or fax additional documentation to WPS Medicare. When mailing documentation to WPS Medicare, use the [mail documentation cover](#). If you choose to fax the documentation to WPS Medicare, please use the [fax documentation cover](#). These cover sheets, whether for mail or fax, are required in order for WPS Medicare to identify the beneficiary whose records are being submitted for review.

NOTE: Do not mail or fax to any address or fax number other than the ones listed on the mail or fax documentation covers. Doing so may result in incorrect denials or delays in payment of your services. Sending to the wrong address or fax can also result in information protected under the Health Insurance Portability and Accountability Act (HIPAA), i.e., HICN (Health Insurance Claim Number), being seen by people without the proper authorization.

[Click here](#) for information about what is considered acceptable and non-acceptable documentation. Italicized language in the article is directly from the CMS CR. Providers should familiarize themselves with the documentation requirements for the Therapy Cap exception process in order to prevent denials or delays in their claim(s) processing.

NOTE: Watch the WPS Website and future e-News Listserv messages for updates relating to the Therapy Cap exception process. [Click here](#) to subscribe to the free and secure WPS Medicare e-News Listserv.