Modifier KX and Outpatient Therapy Services

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Railroad Retirement Board

Specialty Medicare Administrative Contractor (RRB SMAC)

Provider Outreach and Education

September 26, 2019

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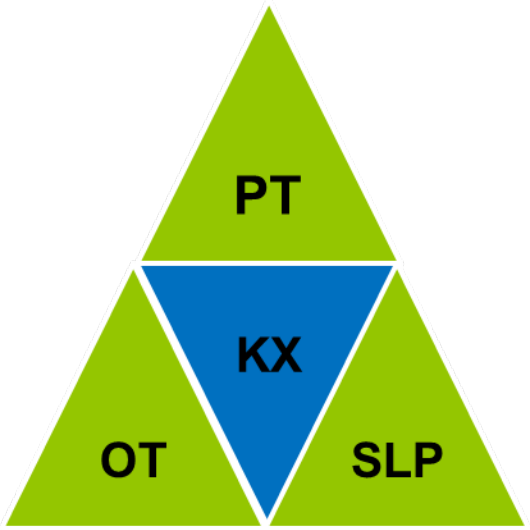
Modifier KX and Outpatient Therapy Services



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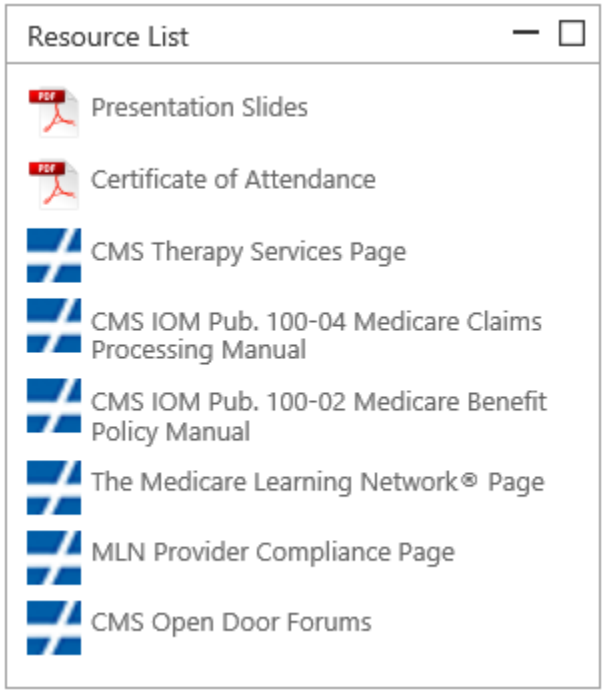


Disclaimer

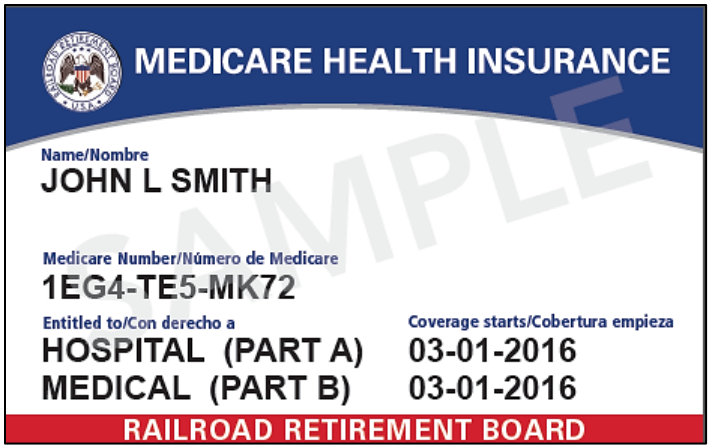
- The information provided in this presentation was current as of September 26, 2019. Any changes or new information superseding the information in this presentation will be provided in articles and resources with publication dates after the date of this live presentation, posted on our website at www.PalmettoGBA.com/RR. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.
- This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.
- The Centers for Medicare & Medicaid Services (CMS) and the Railroad Retirement Board (RRB) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.
- This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

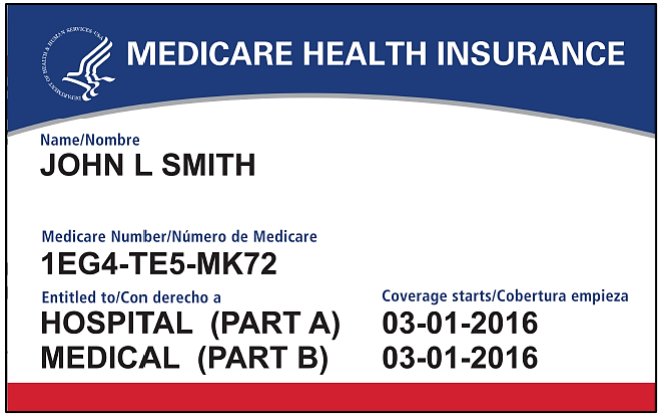
Frequently Used Acronyms

Acronym	Description
RRB SMAC	Railroad Retirement Board Specialty Medicare Administrative Contractor
CMS	Centers for Medicare & Medicaid Services
MBI	Medicare Beneficiary Identifier
CPT	Current Procedural Terminology®
HCPCS	Healthcare Common Procedure Coding System
IOM	Internet-Only Manual
CERT	Comprehensive Error Rate Testing
PT	Physical Therapy
OT	Occupational Therapy
SLP	Speech Language Pathology

Medicare Beneficiary Identifier (MBI)

Transition Period – April 2018 through December 2019 – Use either HICN or MBI





- Railroad Medicare HICNs, which were 6-9 numbers preceded by 1-3 letters, were replaced with MBIs
- Railroad Medicare MBIs are not distinguishable from other MBIs
- Railroad Medicare cards are distinct with Railroad Retirement Board name and seal
- Electronic eligibility transaction responses will identify Railroad Medicare patients

CMS New Medicare Card Overview Page
https://tinyurl.com/CMSNMCOverview

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How do I get a patient's MBI?

PALMETTO GBA eServices

- Ask your patients for their new Medicare cards
- Check your remittance advice
  - Through 12/31/19, the MBI will be returned on remittance advice for claims submitted with valid and active HICNs
- Use the secure MBI Lookup Tool
  - Available in Palmetto GBA eServices portal
  - Verify patient's MBI using name, date of birth and SSN
  - Will remain available after the transition period ends

Transition Period Ends December 31, 2019 – Start Using MBIs Now!

Objectives

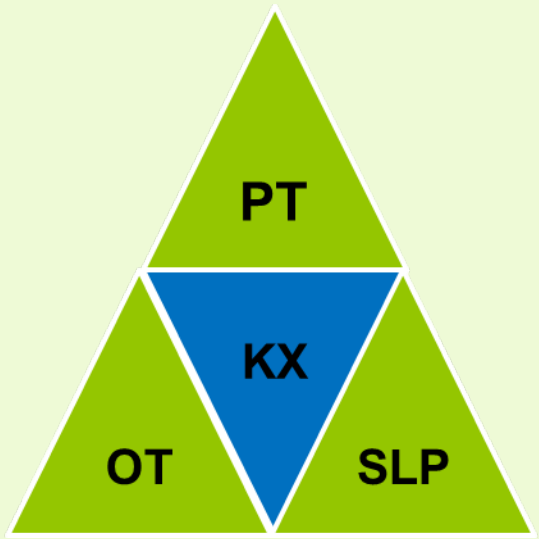
At the end of this presentation you will be familiar with:

- Medicare coverage guidelines of outpatient therapy services
- The proper use of modifiers for outpatient therapy services
- KX modifier thresholds for outpatient therapy services
- Documentation requirements for therapy services
- Resources for these services

Agenda

- Outpatient Therapy Coverage Guidelines
- Therapy Coding and Modifiers
- Documentation Requirements
- Resources
- Your Questions

OUTPATIENT THERAPY SERVICES



Medicare Coverage - Medical Necessity

"Medically necessary" is defined as "health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine."

Medical Necessity of Skilled Therapy

The services shall be of such a level of complexity and sophistication, or the condition of the patient shall be such, that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a therapist.

Coverage for Therapy Services

- Medicare coverage for outpatient therapy services does not depend on a patient's "potential for improvement from the therapy but rather on the beneficiary's need for skilled care"
- Skilled therapy services may be necessary to improve or to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition

Outpatient Therapy Service Types

Outpatient therapy includes service related to:

- Physical therapy (PT)
- Occupational therapy (OT)
- Speech-Language Pathology (SLP)

Physical Therapy (PT)

Physical therapy services are:

- Provided within the scope of practice of physical therapists
- Necessary for the diagnosis and treatment of:
  - Impairments
  - Functional limitations
  - Disabilities
  - Changes in physical function and health status

Occupational Therapy (OT)

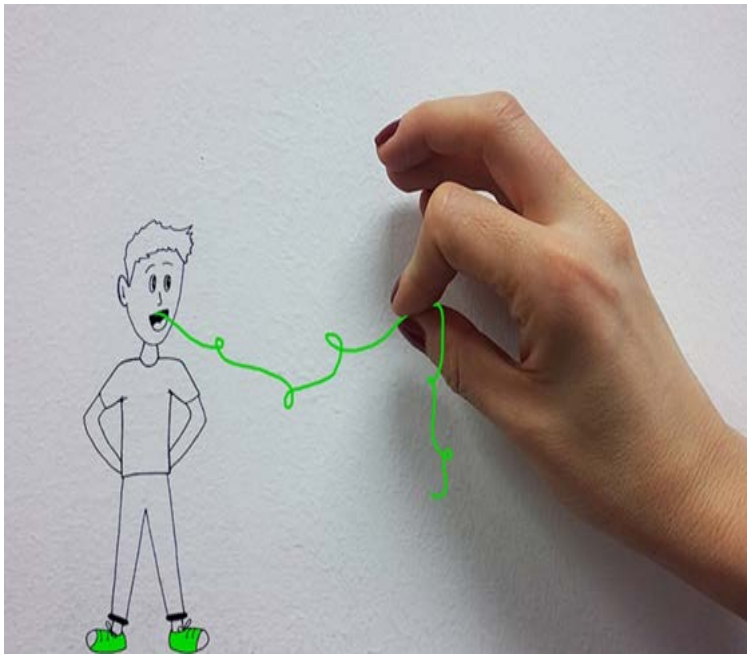
Occupational therapy services are provided within the scope of practice of occupational therapists and are necessary for:

- Treatment to maintain or increase an individual's level independent functioning
- Restoring sensory-integrative functions
- Addressing limitations in performing daily living activities

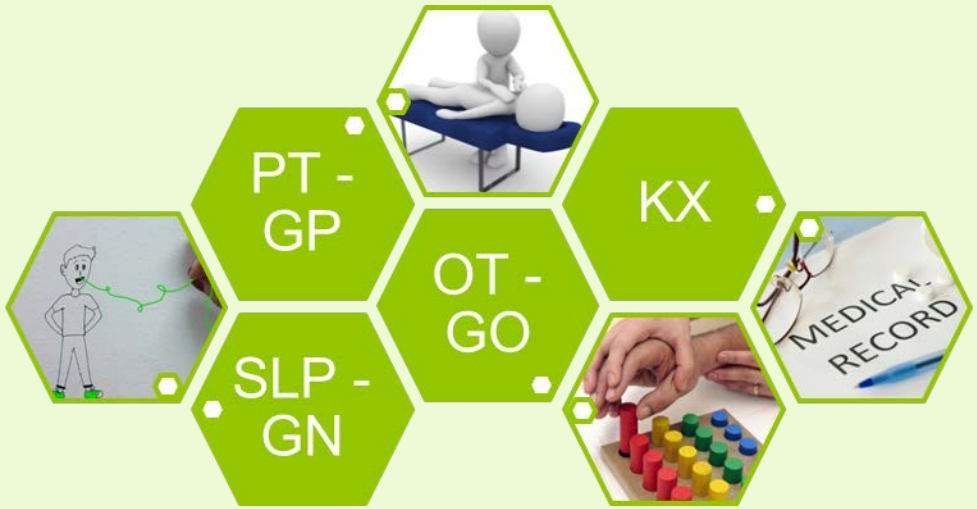
Speech-Language Pathology (SLP)

Speech-language pathology services are:

- Provided within the scope of practice of speech-language pathologists
- Necessary for the diagnosis and treatment of:
  - Speech/Language disorders
  - Communication disabilities
  - Swallowing disorders



CODES AND MODIFIERS



Commonly Billed Therapy Codes

CPT/ HCPCS Codesc	Short Descriptions
97035	Ultrasound therapy
97110	Therapeutic exercises (each 15 minutes)
97112	Neuromuscular re-education (each 15 minutes)
97113	Aquatic therapy/exercises (each 15 minutes)
97116	Gait training therapy (each 15 minutes)
97140	Manual therapy 1/> regions (each 15 minutes)
97150	Group therapeutic procedures
97530	Therapeutic activities (each 15 minutes)
97535	Self-care management training (each 15 minutes)
G0515	Cognitive skills development (each 15 minutes)

Therapy Discipline Modifiers

Modifier	Description
GP	Services delivered under an outpatient physical therapy plan of care
GO	Services delivered under an outpatient occupational therapy plan of care
GN	Services delivered under an outpatient speech-language pathology plan of care

- Outpatient physical and occupational therapy services, and speech-language pathology services must be submitted with the appropriate HCPCS modifiers when these services are provided as part of a therapy plan of care
- Therapy services that are submitted without the required modifier are rejected and must be corrected and resubmitted as new claims

HCPCS Modifier KX

- The Bipartisan Budget Act of 2018 repealed application of the Medicare outpatient therapy caps and its exceptions process while adding limitations to ensure appropriate therapy
- Former “therapy cap” amounts were preserved as KX modifier thresholds
- Claims above these thresholds must include the KX modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record
- Claims for therapy services above these amounts billed without the KX modifier are denied

KX Modifier Thresholds

- One KX modifier threshold amount for physical therapy (PT) and speech-language pathology (SLP) services combined
- One KX modifier threshold amount for occupational therapy (OT) services
- These per beneficiary amounts are updated each year
- Verify the amount applied to a patient's KX modifier threshold on IVR and eServices eligibility transactions

2019 KX Modifier Threshold Amounts	
PT and SLP services combined	$2,040
OT services	$2,040

Supporting the Use of KX Modifier

- The patient medical record must include justification for continued therapy provided by a skilled therapist
- Services must be provided by the qualified professional (or qualified personnel under the supervision of the professional)
- The patient must require the expertise, knowledge, clinical judgment, decision making and abilities of a licensed therapist because the patient needs services that cannot be provided sufficiently by assistants, caretakers or the patient independently

Missing KX Modifier

Claims from suppliers or providers for therapy services above the threshold amounts, submitted without the KX modifier, are denied as:

'*Benefit maximum for this time period or occurrence has been met*'

- The therapist, or therapy provider, is financially liable for the cost of therapy services provided to a beneficiary above the threshold amount when Medicare denies payment for failure to use the −KX modifier
- In order for a therapy provider to transfer liability to the beneficiary, the patient must have signed a valid Advance Beneficiary Notification (ABN)

Billing with an ABN

- Have a patient sign an ABN for therapy services that are not medically reasonable and necessary
- To indicate therapy services billed with ABN, add the modifier GA to the claim line
- Do not use an ABN for services above the KX threshold that are medically reasonable and necessary
- Never bill a claim line with both the KX and the GA modifier

The current ABN form and form instructions can be downloaded from the CMS Beneficiary Notices Initiative (BNI) Homepage

http://cms.gov/Medicare/Medicare-General-Information/BNI/index.html

Modifier 59 Definition

Distinct Procedural Service

- Use to indicate that a procedure or service was distinct or independent from other non-E/M (evaluation and management) services performed on the same day which are not normally reported together.
- National Correct Coding Initiative (NCCI) Procedure-to-Procedure edits

MLN Article SE1418 - Proper Use of Modifier 59

Modifier 59: Therapy Service Example

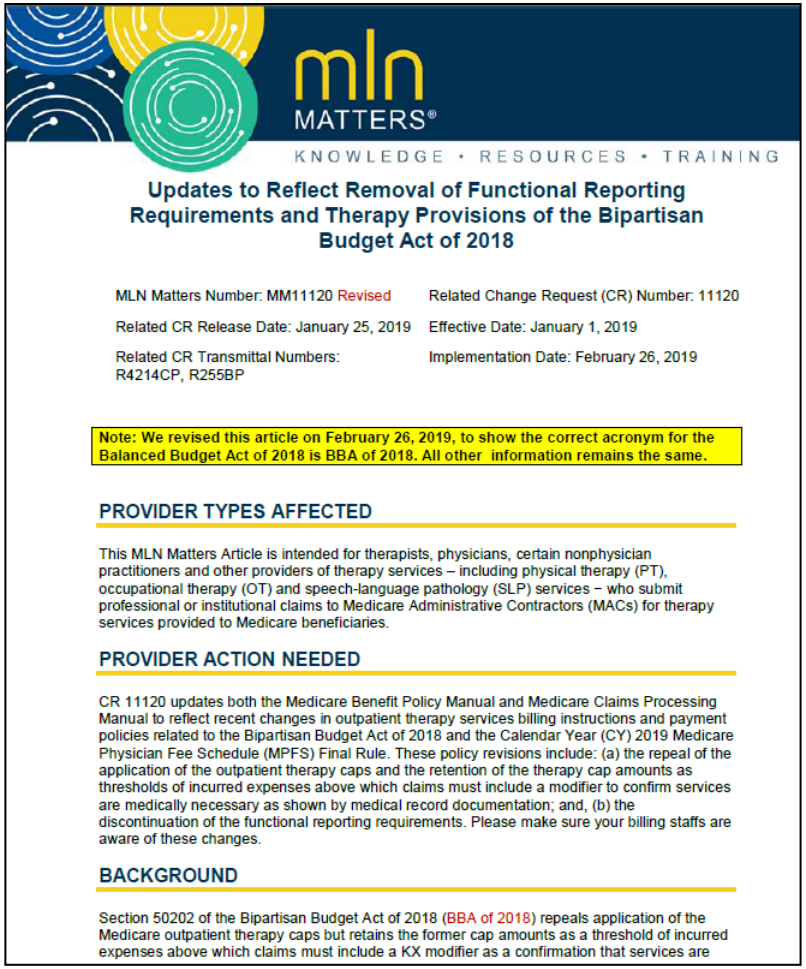
CPT 97140	Manual therapy 1/> regions (each 15 minutes)
CPT 97530	Therapeutic activities (each 15 minutes)

Example:

- One service may be performed during the initial 15 minutes of therapy and the other service performed during a second 15 minutes of therapy
- Alternatively, the therapy time blocks may be split. For example, manual therapy might be performed for 10 minutes, followed by 15 minutes of therapeutic activities, followed by another 5 minutes of manual therapy

Functional Reporting

- Effective for dates of service on or after January 1, 2019, Medicare no longer requires the functional reporting HCPCS G-codes and severity modifiers on claims for therapy services
- For details about these payment policies, see MLN Matters article MM11120



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Updates to Reflect Removal of Functional Reporting Requirements and Therapy Provisions of the Bipartisan Budget Act of 2018

MLN Matters Number: MM11120 Revised | Related Change Request (CR) Number: 11120

Related CR Release Date: January 25, 2019 | Effective Date: January 1, 2019

Related CR Transmittal Numbers: R4214CP, R255BP | Implementation Date: February 26, 2019

Note: We revised this article on February 26, 2019, to show the correct acronym for the Balanced Budget Act of 2018 is BBA of 2018. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for therapists, physicians, certain nonphysician practitioners and other providers of therapy services – including physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services – who submit professional or institutional claims to Medicare Administrative Contractors (MACs) for therapy services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11120 updates both the Medicare Benefit Policy Manual and Medicare Claims Processing Manual to reflect recent changes in outpatient therapy services billing instructions and payment policies related to the Bipartisan Budget Act of 2018 and the Calendar Year (CY) 2019 Medicare Physician Fee Schedule (MPFS) Final Rule. These policy revisions include: (a) the repeal of the application of the outpatient therapy caps and the retention of the therapy cap amounts as thresholds of incurred expenses above which claims must include a modifier to confirm services are medically necessary as shown by medical record documentation; and, (b) the discontinuation of the functional reporting requirements. Please make sure your billing staffs are aware of these changes.

BACKGROUND

Section 50202 of the Bipartisan Budget Act of 2018 (BBA of 2018) repeals application of the Medicare outpatient therapy caps but retains the former cap amounts as a threshold of incurred expenses above which claims must include a KX modifier as a confirmation that services are

DOCUMENTATION REQUIREMENTS

MEDICAL RECORD DOCUMENTATION

"If it is not documented,
it has not been done."

Clear and concise medical record documentation is:

- Critical to providing patients with quality care
- Utilized to report the care a patient receives
- Necessary for a provider or providers to evaluate and plan the patient's immediate treatment and monitor the patient's health care over time

Therapy Services: Required Documentation

Documentation elements required for therapy services include:

- Initial evaluation
- Plan of care (POC) - prior to treatment
- Provider Certification and/or Recertification
- Treatment Encounter Notes
- Interval Progress Reports
- Re-evaluations - and additional assessments when appropriate

Evaluation

The initial evaluation should document the necessity for a course of therapy through objective findings and subjective patient self-reporting

Documentation of the evaluation should:

- List the conditions and complexities
- Describe the impact the conditions and complexities have on the prognosis and/or the plan for treatment
- Make it clear to the reviewer of the record that the services planned are appropriate for the individual

Evaluation Documentation Elements

An Evaluation should include:

- Objective and subjective findings
- The patient's impairment-based diagnosis
- A description of the patient's problems that require treatment
- Identification the patient's affected body part
- Conditions, co-morbidities, and complications that may impact the patient's course of treatment
- Goals based on the objective measures, when the evaluation also serves as the plan of care

Plan of Care Required for Coverage

Medicare covers outpatient PT, OT, and SLP services when a physician or non-physician practitioner (NPP) clinically certifies the treatment plan/plan of care (POC), ensuring:

1. The patient needs the therapy services
2. A treatment plan/POC is:
   - Established by a physician/NPP, or a qualified therapist providing such services, and
   - Reviewed periodically by a physician/NPP
3. The patient is under physician/NPP care while receiving services

Plan of Care Requirements

At a minimum, the POC must contain:

- Diagnoses
- Long-term treatment goals
- Type of rehabilitation therapy services (PT, OT, or SLP) – where appropriate; the type may be a description of a specific treatment or intervention
- Therapy amount – number of treatment sessions in a day
- Therapy frequency – number of treatment sessions in a week
- Therapy duration – total number of weeks or number of treatment sessions

Initial Certification of the Plan of Care

Certification of POC

- The physician's/NPP's signature and date on a correctly written POC satisfies the certification requirement for the duration of the POC or 90 calendar days from the date of the initial treatment, whichever is less
- Include the initial evaluation indicating the treatment need in the POC

Signature Dates

- The physician/NPP must certify the initial POC with a dated signature or verbal order within 30 days following the first day of treatment (including evaluation)
- The physician/NPP must sign and date verbal orders within 14 days

Recertification

- Sign the recertification:
  - Whenever a significant POC modification becomes evident
  - At least every 90 days after the treatment starts
    - Complete recertification sooner when the duration of the plan is less than 90 days
- Recertification is timely when dated during the duration of the initial POC or within 90 calendar days of the initial treatment under that plan, whichever is less

Progress Notes

- The progress report provides justification for the medical necessity of treatment.
- Progress reports must be written by a clinician or therapist, who provides the services and/or supervises services
- Must be completed for each interval of 10 treatment days (not calendar days)
- It must be written within 7 calendar days after the last treatment day of the reporting interval

Progress Report Due Date Example

Initial Date of Reporting Period	Date Progress Note Due	Date Progress Note Created	Interval Progress Report Covers
9/09/2019	9/20/2019	9/13/2019	9/09/2019 – 9/13/2019
9/16/2019	9/27/2019	May create from 9/27/2019 - 10/04/2019	9/16/2019 – 9/27/2019

For a patient evaluated on Monday, September 9th and being treated five times a week, on weekdays:

- On September 13th, (before it is required), the clinician chose to write a progress report for the last week's treatment (from September 9 to September 13). September 13 ends the reporting period
- The next treatment on Monday, September 16th, begins the next reporting period. The next report is required to cover September 16 through September 27, which would be 10 treatment days

Progress Notes Documentation Elements

The progress note should contain:

- Date of current progress note
- Dates of the interval reporting period (the beginning and ending of the interval of the 10 treatment days)
- Objective reports/measurements
- Assessment of progress
- Plans for continued treatment
- Changes or updates to POC
- Signature and credentials

Treatment Encounter Note

- Must be documented for each therapy session
- Should include:
  - Date of treatment
  - Description of modality/ therapy intervention
  - Total minutes of direct service
  - Total minutes of timed-based codes
  - Signature and credentials of each person involved

Reporting Untimed Services

- CPT Codes for Evaluation or Re-evaluation
- CPT Codes for Application of modalities for therapeutic changes to tissue, including:
  - Thermal – hot/ cold packs
  - Light – infrared
  - Mechanical – traction

Time Units

- When counting units for therapy codes, 1 unit = 15 mins
- Services provided for less than eight minutes should not be billed

Units	Minutes
1	≥ 8 minutes through 22 minutes
2	≥ 23 minutes through 37 minutes
3	≥ 38 minutes through 52 minutes
4	> 53 minutes through 67 minutes

Time Units Examples

Example A

CPT Code	Timed Minutes	Billable Units
97110	8	1
97112	8	0
97116	8	0
97140	8	1
Total	32	2

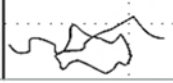
Example B

CPT Code	Timed Minutes	Billable Units
97110	7	1
97112	7	0
97140	7	0
Total	21	1

For more information on calculating units billed by time, see IOM Pub. 100-04, Medicare Claims Processing Manual, Chapter 5, Section 20.2

Valid Signatures

- Documentation must contain a valid provider signature
- Must include a legible form of the name and credentials
- Printed or typed names must be accompanied by initials or signature of provider
- Electronic signatures must indicate it is an electronic signature
- Signature examples

Name and Credentials	Signature	Initials
Victor Frankenstein, D.O.	Dr. Victor Frankenstein	VF
Doogie Howser, M.D.	DOOGIE	DH
Dr. John Doolittle		

Summary of Therapy Services: Required Documentation

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- Initial evaluation
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- Treatment Encounter Notes
- Interval Progress Reports
- Re-evaluations - and additional assessments when appropriate

RESOURCES AND CONTACTS

CMS Home Page Resources

CMS.gov
Centers for Medicare & Medicaid Services

Home | About CMS | Newsroom | Archive | Share Help

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Medicare | Medicaid/CHIP | Medicare-Medicaid Coordination | Private Insurance | Innovation Center | Regulations & Guidance | Research, Statistics, Data & Systems | Outreach Educatio

Home > Medicare > Therapy Services > Therapy Services

Therapy Services

- Functional Reporting
- 11 Part B Billing Scenarios for PTs and OTs (Individual vs. Group Treatment)
- Annual Therapy Update
- Studies and Reports
- Transmittals
- Spotlight Archive
- Jimmo Settlement

Therapy Services

Spotlight

CY 2019 Therapy Services Updates

The Therapy Services webpage is being updated, in the "Latest Applicable Law" section on the landing page, to: (a) Reflect the KX modifier amounts for CY 2019 and (b) Note that the Beneficiary Fact Sheet has been updated.

The section on "Functional Reporting" is also being updated to: Clarify the ending of the Functional Reporting requirements, effective for dates of service on and after January 1, 2019.

Latest Applicable Law

This section was last revised in December 2018 to reflect the CY 2019 KX modifier thresholds. On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018 (BBA of 2018) (Public Law 115-123). This new law includes two provisions related to Medicare payment for outpatient therapy services including physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services:

- Section 50202 of the BBA of 2018 repeals application of the Medicare outpatient therapy caps and its exceptions process while adding limitations to ensure appropriate therapy. For related information see the CMS link to "Medicare Expired Legislative Provisions Extended and Other Bipartisan Budget Act of 2018 Provisions."
- Section 53107 of the BBA of 2018 relates to the payment of OT and PT services furnished by an assistant.

The new law, through section 50202 of the BBA of 2018, preserves the former therapy cap amounts as thresholds above which claims must include the KX modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record. Just as with the incurred expenses for the therapy cap amounts, there

https://www.cms.gov/Medicare/Billing/TherapyServices/index.html

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CMS Internet-Only Manual Resources

- CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 5, Part B Outpatient Rehabilitation and CORF/OPT Services

  https://tinyurl.com/CP100-04CH5

- CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Sections 220 and 230

  https://tinyurl.com/BP100-02CH15

- Code of Federal Regulations: § 410.59, 410.60, 410.61

  https://tinyurl.com/42CFR-IV-B-410

Medicare Learning Network® Resources

- The Medicare Learning Network® Page
  https://tinyurl.com/MLNPage
  - MLN National Provider Calls
- MLN Provider Compliance Page
  https://tinyurl.com/MLNProvCompliance
  - Provider Compliance MLN Educational Products
  - Provider Compliance MLN Matters® Articles
  - Quarterly Provider Compliance Newsletter Archive

Provider MLN Resources

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go.cms.gov/mln

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Annual Update to the Per-Beneficiary Therapy Amounts

MLN Matters Number: MM11055 | Related Change Request (CR) Number: CR 11055
Related CR Release Date: November 30, 2018 | Effective Date: January 1, 2019
Related CR Transmittal Number: R4178CP | Implementation Date: January 7, 2019

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for physicians, therapists, and other providers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

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Updates to Reflect Removal of Functional Reporting Requirements and Therapy Provisions of the Bipartisan Budget Act of 2018

MLN Matters Number: MM11120 Revised | Related Change Request (CR) Number: 11120
Related CR Release Date: January 25, 2019 | Effective Date: January 1, 2019
Related CR Transmittal Numbers: R4214CP, R255BP | Implementation Date: February 26, 2019

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PROVIDER ACTION NEEDED

mln FACT SHEET
PRINT-FRIENDLY VERSION
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COMPLYING WITH MEDICARE SIGNATURE REQUIREMENTS

Target Audience: Medicare Fee-For-S
The Hyperlink Table, at the end of this document, provides t

INTRODUCTION

This fact sheet describes common Medicare Comprehensive E errors related to signature requirements. It helps providers and t the documentation needed to support a claim submitted to Medi

The Medicare Learning Network® (MLN), along with the CERT Medical Equipment (DME) Medicare Administrative Contractor Forces, developed this fact sheet to provide nationally consiste health care professionals. Visit the Centers for Medicare & Me to learn about the CERT Program and review CERT Improper

Page 1 of 5 ICN 905364 May 2018

mln BOOKLET
PRINT-FRIENDLY VERSION
KNOWLEDGE • RESOURCES • TRAINING

OUTPATIENT REHABILITATION THERAPY SERVICES: COMPLYING WITH DOCUMENTATION REQUIREMENTS

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

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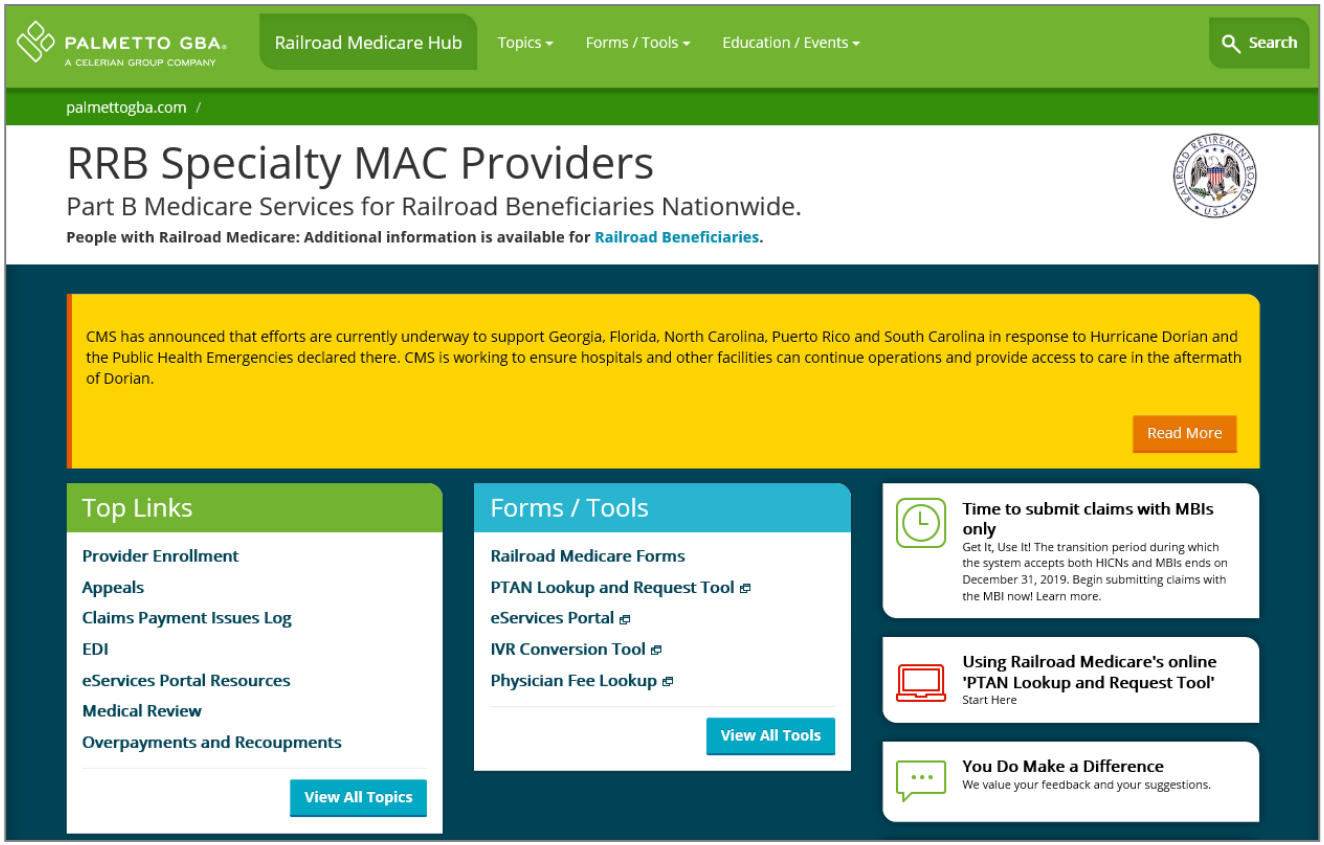
CMS Open Door Forums

- CMS sponsors regularly scheduled ‘Open Door Forums’ providing opportunities for live dialogue between CMS and the stakeholder community at large
- Subscribe to the Open Door Forum Mailing List to be notified when forums are scheduled or when new information is posted to the website
- CMS Open Door Forums page https://tinyurl.com/OpenDoorForums

RRB SMAC Resources



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eServices

Look Up

- Claim Status
- Patient Eligibility and Medicare Beneficiary Identifier (MBI)
- Remittance Advice
- Financial Data – Last 3 checks paid and Payment Floor Status

Submit

- First Level Appeals, Clerical Error Reopenings, General Inquiries
- Documentation for MR Additional Documentation Requests
- eCheck Overpayment Refunds and eOffset Requests
- Paperless eClaims

Receive

- Greenmail Notification of Pending Prepay MR ADR Requests
- Greenmail eDelivery of Appeals Decision Letters
- Greenmail eDelivery of Overpayment Demand Letters
- Greenmail eDelivery of General Inquiry Responses

www.PalmettoGBA.com/eServices

Railroad Medicare Contacts

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eServices Portal	www.PalmettoGBA.com/eServices
CMS Listserv	https://tinyurl.com/CMSEmailUpdates

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Interactive Voice Response (IVR) System

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Questions?

Q&A Widget

Survey Widget - Please take our short survey. We appreciate your feedback.

Resource Widget

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Questions about this webcast?

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