

## The Caps Are Back: January 2010

As of January 1st 2010 the amount of the Medicare therapy cap is \$1860 for each of the two caps AND the automatic exception process has expired. Currently both of the Healthcare Reform Bills from the House and the Senate contain a provision to extend the exception process, one bill for two years, the other for one. Although it is expected that when the Healthcare Reform Bill becomes law it will address this issue and it is anticipated that, as in other bills, the process will be made retroactive to January 1st, some practices will find themselves meeting the therapy cap prior to that time. So what does that mean for you at this time?

**First:** All of your patients, either new or current have the total amount of the caps monies available to them as of January 1st provided, as always, they meet the Medically Necessary Guidelines.

**Second:** You do not continue to add the KX modifier to the January claims for the patients that were utilizing the exception process in 2009..

**What you need to do:** With all of your patients, current and new, you need to inform them of the cap, its limitations and their options for care.

**Educate them** on the \$1860 financial limit and that it includes the 80% Medicare pays, their 20% co-pay and the annual deductible if this has not already been met. You can also tell them about the options that they will have if the current treatment exceeds the cap amount.

[There are some that are recommending that you issue the ABN (Advance Beneficiary Notice of Noncoverage) at this time but CMS has previously discouraged automatic use of the ABN for all patients as part of the admission process. We have included a copy of the ABN at the end of this report]

**When** they are close to meeting the cap and they continue to need medically necessary services past the cap that is when you provide them with the ABN. The ABN provides them with three options. 1

1. They can continue their treatment at a hospital outpatient department as the hospital is the only Part B provider setting not under the caps. {Option 3 on the ABN}
2. They can continue to receive services from you but will have to pay privately. However, because therapy is no longer a Medicare benefit, you are free to charge whatever you decide is appropriate for your services. {Option 2 on the ABN}
3. They can decide not to continue with therapy services. {Option 3 on the ABN}

**Note:** Option 1 on the ABN is not available to them under the caps as, once the cap is met, therapy services are no longer a covered benefit.

### **Special Considerations for SNF Residents:**

Residents of the distinct part unit of the SNF {Inpatient Part B residents residing in the part of the SNF certified as skilled and having services billed with the 22x billing code} come under consolidated billing and do not have the option of receiving services in a hospital. Therefore their options are of continuing under a private payment system or declining further services. Again, the SNF can determine its appropriate charge

For the LTC residents, they do have the option of going to the hospital thus receiving the same options as all other Part B outpatients.

NOTE: The ABN can be downloaded from the CMS website and customized for use as a word document. Instructions for use are included in the zip file. [www.cms.hhs.gov/BNI/02\\_ABN.asp](http://www.cms.hhs.gov/BNI/02_ABN.asp)

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<sup>1</sup> The amount of monies reimbursed under Part B is available through the common working file (CWF) available to the billing department/service or by contacting your contractor. However, it is only as current as the information added and will only include paid claims (not pending claims.) Therefore consider issuing the ABN when you are close to \$1400 of the total cap amount.

(A) Notifier(s):

(B) Patient Name:

(C) Identification Number:

### ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

**NOTE:** If Medicare doesn't pay for (D) \_\_\_\_\_ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) \_\_\_\_\_ below.

(D) _____	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D) \_\_\_\_\_ listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS:                      Check only one box. We cannot choose a box for you.
<input type="checkbox"/> <b>OPTION 1.</b> I want the (D) _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but <b>I can appeal to Medicare</b> by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
<input type="checkbox"/> <b>OPTION 2.</b> I want the (D) _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. <b>I cannot appeal if Medicare is not billed.</b>
<input type="checkbox"/> <b>OPTION 3.</b> I don't want the (D) _____ listed above. I understand with this choice I am <b>not</b> responsible for payment, and <b>I cannot appeal to see if Medicare would pay.</b>

**(H) Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

<b>(I) Signature:</b>	<b>(J) Date:</b>
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