Outpatient Therapy Services and Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, August 2018

Q1: How did the Bipartisan Budget Act of 2018 (PL 115-123, February 9, 2018) affect liability provisions for outpatient therapy services, including physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP)?

A1: The Bipartisan Budget Act of 2018 (BBA of 2018) repeals the application of the Medicare outpatient therapy caps and its exceptions process. In place of the therapy caps, the new law:

- retains the former cap amounts as a threshold 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 – for CY 2018 the −KX modifier threshold is $2,010 for PT and SLP services combined and $2,010 for OT services; and
- retains the targeted medical review process, but at a lower annual threshold amount – in a calendar year before 2028: $3,000 for PT and SLP services combined and $3,000 for OT services in CY 2018.

Section 50202 of the BBA of 2018 didn't change provider liability procedures which first became effective January 1, 2013. Section 1833(g)(8) of the Social Security Act (as redesignated by the Bipartisan Budget Act of 2018) continues to provide limitation of liability (LOL) protections to beneficiaries receiving outpatient therapy services on or after January 1, 2013, when services are denied for certain reasons, including failure to include a necessary −KX modifier. (Section 1879 provides LOL protections for reasonable and necessary denials more generally.)

Under section §1833(g)(8), 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 to indicate that the services are medically necessary as justified by documentation in the medical record. In order for the therapist or therapy provider to transfer liability to the beneficiary, s/he must issue a valid ABN, Form CMS-R-131.

Q2: When are therapists or therapy providers required to issue the mandatory ABN for therapy services furnished on or after January 1, 2018?

A2: Therapists and therapy providers that intend to collect from beneficiaries directly are required to issue the ABN to original (fee-for–service) Medicare beneficiaries prior to providing therapy that is or may be denied as not medically reasonable and necessary regardless of the amount of incurred expenses.

- **Example #1 – The incurred expenses for PT services in CY 2018 is $630. An ABN is mandatory to switch liability to the patient for medically unnecessary services.**

Mr. XX has been receiving physical therapy (PT) two times per week, and currently, he has achieved all his PT goals established in the plan of care (POC). The total amount of incurred expenses for PT this year is $630 – he has not received any SLP services in 2018. Mr. XX requests continued services one time per week even though PT is no longer medically necessary. In this example:

The ABN must be issued prior to providing the services that won't be covered by Medicare because they are no longer medically necessary.

Rationale for ABN: "You have reached your therapy goals and have been discharged from your Medicare PT episode of care. You may elect to pay for services that Medicare doesn't consider medically reasonable and necessary."

Mr. XX may select Option 1, 2, or 3:

If the beneficiary selects option 1 on the ABN, the claim must be submitted to Medicare for review. The –GA modifier would be used on the claim.

If the beneficiary selects option 2, s/he agrees to pay for the services and no claim is submitted.

If the beneficiary selects option 3, s/he agrees to not receive the services and therefore, no claim.

Q3: When a therapist or therapy provider furnishes services that aren't medically reasonable and necessary and a valid ABN was issued, how is this indicated on the claim?

A3: The –GA modifier is added to the line of service on the claim to indicate that an ABN has been issued as required per payer policy. The –KX and –GA modifiers cannot be added to the same claim line of service because they convey opposing payer policy.

Q4: For services at or above the CY 2018 –KX modifier threshold – $2,010 for PT and SLP services combined and $2,010 for OT services in 2018 – that are medically reasonable and necessary, can a therapist or a therapy provider transfer liability to a beneficiary?

A4: No, Medicare covers therapy services above the –KX modifier thresholds for which the therapist or therapy provider attests are medically reasonable and necessary. When the incurred expenses for OT services or the combined PT and SLP services reach the CY 2018 $2,010 threshold, the therapist or therapy provider would apply the –KX modifier to the claim to confirm that the services are medically reasonable and necessary as justified by appropriate documentation in the medical record. The beneficiary would be liable for applicable co-pays and deductible for these covered therapy services.

Q5: Can a therapist or a therapy provider transfer liability to a beneficiary for medically necessary services just because the incurred expenses for CY 2018 have reached the $3,000 Medical Review (MR) threshold – that is, $3,000 for PT and SLP services combined and $3,000 for OT services?

A5: No, Medicare covers therapy services above the $3,000 MR thresholds that are medically reasonable and necessary. When the incurred expenses for OT services or the combined PT and SLP services reach the $3,000 MR threshold, the therapist or therapy provider would continue to apply the −KX modifier to the claim to reaffirm that the services are medically reasonable and necessary. The beneficiary would be liable for applicable co-pays and deductible for these covered therapy services.

Q6. How does a therapist or therapy provider handle services that Medicare would never cover? Is an ABN issued?

A6. An ABN is not needed for services that Medicare would never cover. If desired, a voluntary ABN can be issued to the patient.

- **Example #1: Mrs. QQ had received PT for low back pain and she'd reached her goals and was discharged from her PT episode of care.** The patient then opted to pay out-of-pocket for Tai Chi classes her PT offers as part of her Wellness Programs that are open to other community members.

Q7: Where can I get more information on the ABN or a copy of the ABN?

A7: Information on the ABN and the form and form instructions can be downloaded from http://cms.gov/Medicare/Medicare-General-Information/BNI/index.html

If you have any ABN specific questions that aren't answered by reviewing our webpage documents, you can send an email to: RevisedABN_ODF@cms.hhs.gov