

Therapy Cap Fact Sheet

Medicare Part B Outpatient Therapy Cap and Exceptions Process

The Middle Class Tax Relief and Job Creation Act of 2012 (H.R. 3630) was signed into law on February 22, 2012. The law extends the Medicare Part B Outpatient Therapy Cap Exceptions Process through December 31, 2012.

Background

The statutory Medicare Part B outpatient therapy cap for Occupational Therapy (OT) is \$1,880 for 2012, and the combined cap for Physical Therapy (PT) and Speech-Language Pathology Services (SLP) is also \$1,880 for 2012. This is an annual per beneficiary therapy cap amount determined for each calendar year. Medicare allowable charges, which includes both Medicare payments to providers and beneficiary coinsurance, are counted toward the therapy cap. In outpatient settings, Medicare will pay for 80 percent of allowable charges and the beneficiary is responsible for the remaining 20 percent of the amount.

The therapy cap applies to all Part B outpatient therapy settings and providers including:

- private practices,
- skilled nursing facilities,
- home health agencies,
- outpatient rehabilitation facilities, and
- comprehensive outpatient rehabilitation facilities.

Beginning this year, the therapy cap will also apply to therapy services furnished in hospital outpatient departments (HOPDs) until December 31, 2012. Before 2012, therapy provided in hospital outpatient departments did not count towards the therapy cap.

The law requires an exceptions process to the therapy cap that allows providers to receive payment from Medicare for services above of the therapy cap amount. Therapy furnished by providers must always be reasonable and medically necessary, require the specialized skills of medical professional, and be justified by supporting documentation in the patient's medical record. When these conditions are met for care exceeding the therapy cap in a calendar year, which is \$1,880 for 2012, a provider may submit claims for a beneficiary with a KX modifier included on the claim form. The KX modifier on the claim indicates that the requirements for an exception to the therapy cap have been met. Claims that exceed the cap and do not include the KX modifier will be denied.

Manual Medical Review Process

- Beginning on the date of the phase-in indicated below, certain providers will be required to submit a request for an exception for therapy services above the threshold of \$3,700. Similar to the therapy cap, there is a threshold of \$3,700 for PT and SLP services combined and another threshold of \$3,700 for OT services. Such requests for exceptions will be manually medically reviewed.
- To ensure a timely and orderly implementation, providers within a Medicare Administrative Contractor (MAC) jurisdiction will be divided into three Phases. Each specific provider will be notified of their status in the phase-in process. Providers will be required to submit requests for exceptions to the threshold in advance of furnishing therapy services above the threshold. The phases are as follows:
 - Phase I Oct 1, 2012 to December 31, 2012
 - Phase II Nov 1, 2012 to December 31, 2012
 - Phase III Dec 1, 2012 to December 31, 2012
 - The Phase for a provider is based on CMS analysis taking into account the billing practices of the provider as well as the workload of the MAC.
- There will be no automatic exceptions granted for the requests for exceptions above the threshold solely on the basis of a specific diagnosis.
- The contractors will use the coverage and payment policy requirements in Section 220 of the Medicare Benefit Policy manual and any applicable local coverage decision policies when making determinations for approving therapy services above the threshold.
- Claims received for therapy services above the threshold which have not been approved for a provider assigned within a specific phase, shall be subject to prepayment review upon receipt for payment.
- Requests for exceptions can be made in increments of 20 treatment days.
- Contractors will have 10 business days to review the request for exception to the threshold using the manual medical review process. The 10-day timeframe starts when the contractor has obtained all necessary documentation from the provider. If a contractor fails to make a decision within 10 business days of receiving a request containing all the required documentation the request will be automatically approved.
- Each MAC will have detailed instructions posted to their websites on how to submit a request for an exception to the threshold before September 1, 2012.
- Providers will be notified via US Mail before September 1, 2012 about the process to request an exception to the threshold and manual medical review process on the CMS website and which Phase the provider is assigned.

Outreach and Education

- Letters will be sent to beneficiaries who have received \$1,700 or more in therapy services in CY 2012. The letter will inform them that if services are furnished above the therapy cap of \$1,880 in 2012, and the requirements for an exception are not met, then the beneficiary would be financially responsible for these services.
- The letters sent to beneficiaries will also inform that if services furnished above the \$3,700 threshold have not been approved by the manual medical review process in response to submission of a request for an exception (or through prepayment medical review) then the beneficiary would also be financially responsible for these services.
- Notification letters and other outreach activities will be undertaken to inform beneficiaries and providers of the manual medical review process for therapy services above the threshold.
 - CMS will host an Open Door Forum on Tuesday, August 7th, 2012 at 2 pm, to provide additional information and answer any questions had on the implementation of the medical review of therapy services to begin October 1-December 31, 2012.

Further questions?

You can contact CMS with questions about the therapy cap and new threshold via a designated email box, at therapycapreview@cms.hhs.gov.