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MEDICARE THERAPY CAPS – EXPIRATION OF EXCEPTION PROCESSES AND APPLICABILITY TO HOSPITAL OUTPATIENT SERVICES

Due to an expiration of certain provisions in the Social Security Act, there are several changes to the Medicare therapy caps effective for dates of service on or after January 1, 2018. Hospitals and other therapy providers should review these changes to determine their impact on current operations.

Therapy providers should also monitor legislation because revisions to the therapy caps have been proposed as recently as October 2017. The proposed legislation has not passed for various reasons, but we understand that there is bipartisan support for revisions to the caps.

Summary of Therapy Caps. Medicare has two separate therapy caps: one for outpatient physical therapy and speech-language pathology services (i.e., a combined therapy cap for these services); and a second for outpatient occupational therapy services. The therapy caps are applied on a per beneficiary, per calendar year basis and increased from $1,980 in 2017 to $2,010 in 2018.

Exception Processes. Prior to January 1, therapy services above the caps were subject to the automatic exception process. Then, once therapy services exceeded $3,700 for a beneficiary, services were subject to a manual review exception process. However, both the automatic exception process and the manual review exception process expired on December 31, 2017. This means that beginning with dates of service on or after January 1, 2018, the therapy caps are a set limit on the amount of services for which CMS will pay.

There are currently mixed messages from CMS and others in the industry on how providers that are subject to the therapy caps should bill after January 1, 2018. CMS manual guidance states that providers that are subject to the cap should add the KX modifier **when exceptions are in effect** and the beneficiary qualifies for an exception. This indicates that providers should not use the KX modifier until Congress reinstates the exception processes.

However, on January 26, CMS posted instructions on its website stating that it has been holding claims with the KX modifier and will be releasing those claims on a first-in, first-out basis. In addition, CMS implemented a “rolling hold” for claims subject to the therapy caps to minimize the impact if the exceptions are subsequently extended. Specifically, CMS stated:

> At the same time, CMS will hold all newly received therapy claims with the KX modifier and implement a “rolling hold” of 20 days of claims to help minimize the number of claims requiring reprocessing and minimize the impact on beneficiaries if legislation regarding therapy caps is enacted. For example, on January 31, 2018, CMS will hold all therapy claims with the KX modifier received that day and release for processing the held claims received on January 11. Similarly, on February 1, CMS will hold all therapy claims with the KX modifier received that day and release for processing the held claims received on January 12 and so on.

Based on this instruction, providers that are subject to the therapy caps should continue to add the KX modifier to services that would qualify for an exception if they were in effect. Providers should also follow appropriate Advance Beneficiary Notice procedures.

Application of Therapy Caps to Hospital Outpatient Services. Prior to 2012, therapy services furnished to a hospital outpatient were not subject to the therapy caps, but the same legislation that created the exception processes also made the therapy caps applicable to hospital outpatient departments. When Congress made the therapy caps apply to hospital outpatient departments, it also gave this provision the same sunset date, i.e., December 31, 2017. This means that beginning with dates of services on or after January 1, 2018, therapy services furnished by a hospital outpatient department will not count against the therapy caps.

Importantly, it also means that the provider-based regulations are now applicable to facilities that furnish outpatient therapy services since there is a payment difference compared to freestanding facilities. Prior to January 1, 2018, CMS had been declining determination of provider-based status for therapy-only locations due to the lack of a payment differential. This will no longer be the case if the payment differential remains. Hospitals should begin reviewing these locations for compliance with Medicare's provider-based requirements.

Application of Therapy Caps to CAHs. Historically, CMS did not apply the therapy caps to services at critical access hospitals ("CAHs"). However, in 2014, after reviewing the statutory language, CMS concluded that the therapy caps should be applied to outpatient therapy

services furnished by CAHs. To apply the therapy caps, CMS applies the amount that would be paid under the Medicare Physician Fee Schedule toward the therapy caps rather than the actual amount that a CAH is reimbursed for the services since CAHs are reimbursed based on reasonable costs subject to cost report reconciliation and settlement.

It is important to note that while the application of the therapy caps to hospital services expired on December 31, 2017, the application of the therapy caps to CAHs is set by regulation and does not expire. In other words, any Congressional action to extend the exception processes likely will not impact the application of the therapy caps to outpatient CAH services.

Potential Fixes. Congress has proposed permanent revisions to the therapy caps over the years, but so far Congress has decided to extend these provisions temporarily. More recently, there have been discussions that Congress may include a permanent extension of the exception process with the repeal of the therapy caps, but lawmakers must find a way to "pay for" the change. So there could be cuts to other areas.

PRACTICAL TAKEAWAYS

- Providers that are subject to the therapy caps should note that there are currently no exception processes for services furnished above the cap. These providers should continue to use the KX modifier, however, for any services that are above the caps and would have qualified for an exception. In addition, these providers should follow appropriate Advance Beneficiary Notice procedures.
- The therapy caps do not apply to services furnished to hospital outpatients on or after January 1, 2018. Hospitals should not be using the KX modifier unless Congress extends the applicability of the therapy caps to hospital outpatient departments.
- Hospitals should begin reviewing therapy locations for compliance with Medicare's provider-based requirements.
- There are no changes with respect to the applicability of the therapy caps to services provided at CAHs.
- It is anticipated that Congress will attempt to include a fix to the therapy cap in its next budget bill but that would likely coincide with cuts to other areas. All therapy providers (including hospitals) should closely monitor any changes and the impact on their facilities.

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