MEDICARE THERAPY CAPS: CHANGES EFFECTIVE OCTOBER 1, 2012 AND THE IMPACT ON HOSPITAL OUTPATIENTS AND OTHERS

Recently, there have been several significant changes to Medicare’s therapy caps that will be effective on October 1, 2012. Many of these changes are due to the enactment of the Middle Class Tax Relief and Job Creation Act of 2012 (the “Act”). This article summarizes these changes to the therapy caps and the exception processes.

SUMMARY OF THERAPY CAPS - SERVICES AND APPLICATION

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 for 2012 the therapy caps are set at $1,880 each. Currently, the therapy caps apply to all outpatient therapy services except those furnished by a hospital or another entity under an arrangement with a hospital.

Until October 1, 2012, therapy services furnished by a hospital to an outpatient, or by another entity under an arrangement with a hospital, do not count toward the therapy caps. However, effective October 1, 2012, outpatient therapy services furnished by a hospital (except critical access hospitals) from October 1 through December 31, 2012 will be subject to the 2012 therapy caps. In other words, unless changed, Medicare is only temporarily applying the therapy caps to therapy services furnished to a hospital outpatient. On January 1, 2013, therapy services provided to a hospital outpatient, either directly or under arrangements, will not count toward the therapy caps.

Importantly, when CMS calculates the therapy caps beginning October 1, 2012, claims paid for hospital outpatient therapy services since January 1, 2012 will be applied toward the therapy caps.

When applying the therapy caps, CMS applies services toward the therapy caps in the order of the dates that the claims are received and tracks the therapy caps using the Common Working File. The amount applied toward the therapy cap is the lesser of the Medicare physician fee schedule amount or the actual charges (deductible and coinsurance amounts count toward the therapy caps). Medicare will not pay for therapy services that exceed the therapy caps unless they qualify for an exception. CMS indicated that it planned to notify beneficiaries by letter beginning in September when they reach $1,700.

CMS recommends that providers notify beneficiaries at the time the services are provided if the beneficiary will be responsible for payment of the therapy services above the therapy caps (unless the services qualify for an exception). Although the provider may use its own form for this notice, the provider can also use the Advanced Beneficiary Notice of Noncoverage (“ABN, Form CMS-R-131”). CMS recommends including the following language on the notice: “Services do not qualify for exception to therapy caps. Medicare will not pay for [insert: physical therapy and speech-language pathology or occupational therapy] services over $1,880 in 2012 unless the beneficiary qualifies for a cap exception.” An estimate of the patient’s payment amount may also be included in the notice.

EXCEPTION PROCESSES

Beginning October 1, 2012, there will be two levels of exception processes: one at $1,880 - the automatic exception process, and another at $3,700 - the manual review exception process.

Automatic Exception Process. Currently, Medicare will pay for services in excess of the $1,880 therapy cap (for calendar year 2012) if the services qualify for the automatic exception process. An automatic exception means that the claims processing for the exception is automatic, not that the exception is automatically granted. Evaluation services are not subject to the therapy caps when these services are necessary to determine if the beneficiary requires further medically necessary services. Other therapy services may be excepted from the cap if the services are medically necessary.

Providers should append the modifier “KX” to therapy services that exceed the therapy cap if medical necessity is supported by documentation in the medical record that indicates that the beneficiary requires the services to achieve prior functional status or maximum expected functional status within a reasonable amount of time. The KX modifier indicates that the clinician attests that the services are
medically necessary. Supporting documentation does not need to be submitted unless the contractor makes an Additional Documentation Request.

Use of the automatic exceptions process does not exempt claims from further review, and excess or atypical use of the process may invite additional contractor scrutiny. Providers and suppliers must be sure that the services are medically necessary and sufficient documentation exists prior to using the "KX" modifier for automatic exceptions because they could be subject to sanctions for providing inaccurate information on a claim.

**Manual Review Exception Process.** Beginning October 1, 2012, requests for exceptions for medically necessary outpatient therapy services that exceed $3,700 per calendar year will be subject to a manual review process. Providers will be phased into this manual review process by being placed in one of three phases. Providers in Phase I will be subject to the process beginning October 1, 2012, providers in Phase II will be subject to the process beginning November 1, 2012 and providers in Phase III will be subject to the process beginning December 1, 2012. The manual exception process does not apply to a provider until its designated phase has begun. CMS will send a mailing to providers to inform them of which phase they have been placed into. This manual review process will be in addition to the automatic exception process for the $1,880 cap already in place and will act as a second level of the exception process.

Under the manual review process, hospital outpatient therapy services also apply toward the $3,700 limitation. Under the new manual review process, providers are required to submit a request for an exception to the therapy cap prior to providing the services, and the Medicare contractor is required to respond to the request within ten days of receipt of the request. If the contractor cannot or does not make a decision within ten days, the request will be deemed to be approved. The request must contain detailed information about the beneficiary and the treatment, including the number of treatment days requested. Providers may request preapproval for up to 20 treatment days of services. Contractors will not review requests for preapproval more than 15 days prior to the beginning of the phase the provider is placed within.

It is important to note that both the automatic exception process and the manual review process are set to expire on December 31, 2012. The automatic exception process has been set to expire numerous times over the years but has been extended. Unless Congress extends the exception processes, providers will not have a method of obtaining payment from Medicare for medically necessary services in excess of the therapy cap, which will result in the beneficiary being liable for these services.

**PRACTICAL TAKEAWAYS**

1. Therapy providers should monitor beneficiaries' therapy caps because services provided by hospital outpatient departments provided since January 1 will be included, effective October 1, 2012;

2. Therapy providers should watch for CMS’s letter regarding what “Phase” they, as a provider, are placed in to know and understand which Manual Exception phase applies to its facility after October 1, 2012, and be ready to comply with the Manual Exception process when applicable; and

3. Therapy providers should monitor legislative and regulatory changes during the last quarter (and even early next year) because the rules on the therapy caps are continuously changing.

**CONCLUSION**

Hospitals need to be prepared for these upcoming changes as claims for outpatient therapy services could be denied for exceeding the therapy caps. Providers of therapy services should continue to monitor legislation and CMS guidance regarding the therapy caps since both exceptions processes and the inclusion of hospital outpatient services toward the therapy cap are set to expire on December 31, 2012.

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