

FREQUENTLY ASKED QUESTIONS: MEDICARE THERAPY CAP

Update: On January 2, 2013, President Obama signed H.R. 8, the American Taxpayer Relief Act of 2012, which included a 12-month extension to the Medicare therapy cap exceptions process.

WHAT IS THE THERAPY CAP AMOUNT FOR 2013?

The therapy cap amount for 2013 is \$1,900 for outpatient physical therapy and speech- language pathology services combined. There is a separate \$1,900 cap for outpatient occupational therapy services. The cap is applicable to services provided to a Medicare beneficiary until December 31, 2013.

IS THERE AN EXCEPTIONS PROCESS IN 2013?

Yes. The exceptions process is applicable for therapy services in excess of the cap amount delivered during the 2013 calendar year. In 2013 there are 2 exceptions processes: (1) an automatic exceptions process at \$1,900 in which the therapist applies a KX modifier to the claim form to designate that continued care is medically necessary and (2) a manual medical review exceptions process. The manual medical review exceptions process applies to patients who meet or exceed \$3,700 in therapy expenditures for physical therapy/speech-language pathology combined and a separate \$3,700 in occupational therapy expenditures.

WHICH PROVIDERS ARE SUBJECT TO THE \$1,900 CAP?

In 2013, the \$1,900 therapy cap with an exceptions process applies to services furnished in the following outpatient therapy settings: physical therapists in private practice, physician offices, skilled nursing facilities (Part B), rehabilitation agencies (or ORFs), comprehensive outpatient rehabilitation facilities (CORFs), and outpatient hospital departments. Legislation included outpatient hospitals under the cap for calendar years 2012 and 2013. The therapy cap will no longer apply to outpatient hospital departments on January 1, 2014, unless Congress passes legislation continuing the application to this setting.

WHO IS IMPACTED BY THE PHYSICAL THERAPY CAP?

If the therapy cap is in effect with no exceptions process, approximately 1,170,000 beneficiaries will be unable to receive Medicare coverage for medically necessary services. Patients receiving physical therapy due to a serious injury or illness, including stroke, Parkinson disease, joint replacement, or amputation, are the most likely to be adversely impacted by the therapy cap. Also, individuals who need physical therapy more than once during a year for different conditions also are likely to be negatively impacted because the cap is based on an annual monetary amount, not a condition or episode of care.

WHAT IS "MANUAL MEDICAL REVIEW?"

Congress revised the therapy cap exceptions process under the Middle Class Tax Relief and Job Creation Act of 2012. This legislation directed the continued use of the KX modifier at the cap level of \$1,900 and further directed the Centers for Medicare and Medicaid Services (CMS) to develop a manual medical review process for therapy claims that exceed \$3,700 in therapy services for the combined PT/SLP cap and the separate OT cap. Congress also tasked GAO to study the manual medical review process and report back to Congress by May 1, 2013.

HOW WILL “MANUAL MEDICAL REVIEW” BE PERFORMED IN 2013?

For 2013, CMS has replaced the prior approval process used in 2012. Effective April 1, 2013, Recovery Audit Contractors (RACs) will conduct 2 types of reviews for claims processed on or after April 1, 2013: prepayment review for states within the Recovery Audit Prepayment Review Demonstration, and immediate postpayment review for the remaining states.

- **Prepayment Review:** States participating in the prepayment review demonstration are Florida, California, Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina, and Missouri. The Medicare Administrative Contractor (MAC) will send an Additional Development Request (ADR) to the provider requesting that additional documentation be sent to the RAC. The RAC will conduct prepayment review within 10 business days of receiving the additional documentation and will notify the MAC of the payment decision.
- **Postpayment Review:** In the remaining states, the RACs will conduct immediate postpayment review. The MAC will flag claims that exceed \$3,700, request additional documentation, and pay the claim. The MAC will send an ADR to the provider requesting that the additional documentation be sent to the RAC. The RAC will conduct postpayment review and will notify the MAC of its decision.