

THERAPY CAP FREQUENTLY ASKED QUESTIONS

Updated 1/22/2018

Update: On January 19, 2018, CMS issued updated guidance on the 2018 therapy cap and use of the KX modifier. CMS states it is holding claims with the KX modifier and indicates that providers may continue to use the KX modifier when services over the cap are medically necessary. CMS states that if claims are not submitted with the KX modifier and the beneficiary has exceeded the cap, the claim will be denied. CMS is not holding any other claims except those affected by the therapy cap. If legislation regarding the therapy cap is not enacted in the near future, CMS will release and process the therapy claims.

For more information, see: <https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html>.

WHAT IS THE THERAPY CAP FOR CALENDAR YEAR 2018?

The allowed dollar amount for 2018 for outpatient physical therapy and speech-language pathology combined is \$2,010. For occupational therapy alone, the cap also is \$2,010.

WHAT PART B OUTPATIENT THERAPY SETTINGS AND PROVIDERS ARE SUBJECT TO THE THERAPY CAP?

- Physical therapist private practices
- Offices of physicians and certain nonphysician practitioners
- Part B skilled nursing facilities
- Home health agencies (visits provided on an outpatient basis)
- Rehabilitation agencies (also known as outpatient rehabilitation facilities)
- Comprehensive outpatient rehabilitation facilities
- Critical access hospitals (CAHs)

WHAT IS THE TARGETED MEDICAL REVIEW THRESHOLD FOR 2018?

It is unclear whether there is a targeted medical review threshold in place at this time. We encourage providers to be aware that if claims are submitted over the \$3,700 threshold, a provider could be subject to targeted medical review. Note: The threshold amount is subject to change, pending congressional action.

DOES THE 2018 THERAPY CAP APPLY TO HOSPITAL OUTPATIENTS?

Although under the law hospital outpatient departments (HOPDs) are not subject to the hard cap as of January 1, there is a high likelihood that when Congress enacts the therapy cap permanent fix legislation, the exceptions process will be retroactive to January 1 and will be

applied for all claims filed on or after January 1. We recommend that HOPDs include the KX modifier on claims above \$2,010 in anticipation of a potential retroactive fix.

WHICH FACILITIES ARE CONSIDERED HOPDs OR “OFF CAMPUS” HOSPITAL OUTPATIENT SITES?

Whether an offsite facility or outpatient site is considered part of the HOPD depends on the relationship between the 2 providers. Hospital-based facilities that provide therapy must meet Medicare’s provider-based requirements to be exempt from the therapy cap. To qualify as provider-based, an entity, among other things, must be within a specific proximity to the hospital whose Medicare provider number it uses, must comply with the state’s health care facility licensure laws, must be included in the accreditation of the provider from which it is based, and must be operated under common ownership and control with their main provider. To view the full list of requirements for determination of provider-based status, see 42 CFR 413.65.

DOES THE THERAPY CAP APPLY TO OBSERVATION-STATUS PATIENTS IN HOSPITAL OUTPATIENT DEPARTMENTS?

Therapy services furnished to patients on observation status are billed as outpatient therapy services under Medicare Part B. Although under the law HOPDs are not subject to the cap, there is a high likelihood that when Congress enacts the therapy cap permanent fix legislation, the exceptions process will be retroactive to January 1 and will be applied for all claims filed on or after January 1. We recommend that HOPDs include the KX modifier on claims for all hospital outpatients, including observation-status patients, above \$2,010 in anticipation of a potential retroactive fix.

DOES THE THERAPY CAP APPLY TO CAHs?

Yes. Before October 1, 2012, the therapy cap applied to all outpatient therapy services except those furnished by outpatient hospitals and CAHs. Beginning January 1, 2014, the outpatient therapy caps, and related provisions, were applied to therapy services furnished by a CAH.

WHEN ARE THERAPISTS REQUIRED TO ISSUE THE MANDATORY ADVANCE BENEFICIARY NOTICE (ABN) FOR THERAPY SERVICES?

CMS has issued guidance stating that providers can continue to use the KX modifier when delivering therapy services over the cap that are medically necessary. Providing the patient with an ABN transfers liability and charge to the beneficiary. Therapists are required to issue

the ABN to traditional fee-for-service Medicare beneficiaries before providing therapy that is not medically reasonable and necessary, either under or over the cap.

HOW DO I DETERMINE THE AMOUNT OF DOLLARS ACCRUED TOWARD THE CAP?

After the patient pays his or her yearly deductible for Medicare Part B (\$183 for 2018), Medicare pays its share (80%) and the patient pays his or her share (20%) of the cost for therapy services. Medicare will pay its share for therapy services until the total amount paid by the patient and Medicare reaches the cap limit. Amounts paid by the patient include costs such as the deductible and coinsurance. All providers and contractors may access the accrued amount of therapy services from the ELGA screen inquiries (now Medicare Health Insurance Portability and Accountability Act Eligibility Transaction System, or HETS) in the common working file (CWF). Suppliers who do not have access to these inquiries may call the contractor to obtain the amount accrued.

WILL SECONDARY INSURANCE PAY FOR THERAPY SERVICES WHEN MEDICARE ISSUES A DENIAL?

You may bill the secondary insurance when Medicare denies services. However, the secondary insurance may require a denial from the Medicare program before it will cover services. Please verify with the Medicare beneficiary that he or she has completed the secondary insurer's coordination of benefits form.

DOES THE THERAPY CAP APPLY TO PATIENTS SEEN DURING A HOME HEALTH EPISODE?

Therapy visits furnished during a Part A home health episode do not count toward the therapy cap. The therapy cap applies to Medicare home health therapy visits provided on an outpatient basis (type of bill 34X). <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/TherapyCap.html>.

HOW DOES JIMMO V SEBELIUS AFFECT THE THERAPY CAP POLICY?

Jimmo v Sebelius has no influence on the expiration of the therapy cap exceptions process.

WHY DOES THE MEDICARE WEBSITE STATE THAT MEDICARE PATIENTS MAY QUALIFY FOR THE EXCEPTION TO THE THERAPY CAP?

CMS recently issued guidance regarding the therapy cap and the exceptions process. CMS states that it "is taking steps to limit the impact on Medicare beneficiaries by holding claims affected by the therapy caps exceptions process expiration for a short period of time beginning on January 1, 2018. Only therapy claims containing the KX modifier are being held; claims submitted with the KX modifier indicate that the cap has been met but the service meets the exception criteria for payment consideration. Currently if claims are submitted without the KX modifier and the beneficiary has exceeded the cap the claim will be denied.

CMS is not holding any other claims except those affected by the therapy caps. If legislation regarding the therapy caps is not enacted in this short period of time, then CMS will release and process the therapy claims accordingly. Under current law, CMS may not pay electronic claims sooner than 14 calendar days (29 days for paper claims) after the date of receipt but generally pays clean claims within 30 days of receipt." For more information, see: <https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html>.

HOW CAN THE THERAPY CAP NOT APPLY TO HOSPITALS AND ONLY TO PRIVATE PRACTICES?

The Balanced Budget Act of 1997 imposed the initial cap on outpatient therapy services. Until October 1, 2012, therapy services furnished by a hospital to an outpatient, or by another entity under an arrangement with a hospital, did not count toward the therapy cap. However, effective October 1, 2012, through December 31, 2017, outpatient therapy services furnished by a hospital were subject to the therapy cap.

WHY ARE G CODES REQUIRED FOR BILLING IF OUTPATIENT HOSPITAL DEPARTMENTS ARE NOT SUBJECT TO THE CAP?

Beginning January 1, 2013, CMS implemented a claims-based data-collection strategy as part of efforts to help reform the Medicare payment system for outpatient therapy. The system is designed to provide for the collection of data on patient function during the course of therapy services. All practice settings that provide outpatient therapy services under Medicare Part B must include functional limitation data on the claim form. Specifically, the policy applies to physical therapy, occupational therapy, and speech-language pathology services furnished in hospitals, CAHs, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, rehabilitation agencies, home health agencies (when the beneficiary is not under a home health plan of care), and in private offices of therapists, physicians, and nonphysician practitioners. More information is available about functional reporting on APTA's website at: <http://www.apta.org/Payment/Medicare/CodingBilling/FunctionalLimitation/>.

WHERE CAN WE VERIFY THAT HOSPITAL OUTPATIENT DEPARTMENTS ARE NOW EXCLUDED FROM THE CAP, AGAIN, WITH THE 2018 CHANGES?

Under Social Security Act Section 1833(g)(1) [therapy caps for PT and SLP services], services furnished in hospital outpatient departments are generally not subject to the cap. That exclusion was changed temporarily for the period beginning October 1, 2012, and subsequently extended via the American Taxpayer Relief Act, Protecting Access to Medicare Act of 2014, and finally the Medicare Access and CHIP Reauthorization Act, through December 31, 2017. Thus the cap did apply to those services in HOPDs during that time period.