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M E M O R A N D U M

TO: RHCF and Community Services Members

FROM: Patrick Cucinelli, Senior Director of Public Policy Solutions

DATE: February 29, 2012

SUBJECT: **Therapy Caps Exceptions Process**

ROUTE TO: Administrator, CFO, Billing

ABSTRACT: Follow up information on therapy caps exceptions process for 2012.

Introduction

As discussed in LeadingAge NY Doc. ID # n00005392, Congress passed the *Middle Class Tax Relief and Job Creation Act of 2012* on February 17th , which contains several provisions critical to LeadingAge NY members, including:

- A further extension of the "doc fix" which prevents a 27.4 percent decreases in Medicare Part B rates for all providers; and
- An extension of the therapy caps exceptions process through the end of this year; and

President Obama signed the legislation into law on February 22, 2012.

Part B Rates

As noted, the new law extends the current zero percent payment update through December 31, 2012 for physician and ancillary Part B services. Members are reminded that LeadingAge has updated the Part B Calculation Tool© to reflect these latest adjustments. This tool automatically calculates your facility's Medicare reimbursement for CY 2012 rates, effective January 1, 2012.

Additional Details on Therapy Caps Exceptions Process

The therapy caps were implemented to limit Medicare Part B payment for therapy services. For 2012, the limit for incurred expenses for these services was set at $1,880 for physical therapy and speech language pathology services combined, and a separate cap of $1,880 for occupational therapy services. However, the spending caps are temporarily expanded (through December 31, 2012) to include spending for therapy services provided in hospital outpatient departments as noted below.

Because therapy caps are determined for a beneficiary on a calendar year basis (January 1 through December 31), all beneficiaries began a new cap for outpatient therapy services received on January 1, 2012. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used. We are currently seeking additional clarification on some of the changes being implemented with this latest renewal of the therapy caps exceptions process.

These changes include:

- Applying the Therapy Caps to hospital outpatient settings. The new law expands the cap to therapy services furnished in a hospital outpatient department (OPD). This was done to prevent a shift in the site of service to higher cost settings once a patient hits their financial limit. More information about the changes affecting hospital OPDs will become available in the future.

- A mandate that Medicare perform manual medical review of therapy services furnished beginning on October 1, 2012, if outpatient therapy service to a beneficiary has reached the dollar aggregate threshold amount of $3,700, including therapy services furnished in hospital outpatient department, for a year.

- Requires that all claims for therapy services furnished on or after October 1, 2012, include the National Provider Identifier of the physician who reviews the therapy plan.

- Providers of outpatient therapy services, including SNFs, are required to continue to submit the KX modifier on their therapy claims, when an exception to the cap is requested for medically necessary services furnished through December 31, 2012.

Additional information about the exception process for therapy services may be found in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 5, Section 10.3.

As noted, we anticipate that CMS will be issuing additional guidance on these changes shortly.

Please contact me with any questions at pcucinelli@leadingageny.org or call 518-867-8827.