WASHINGTON STRATEGIC CONSULTING

WSC POLICY BRIEF

MEDICAL THERAPY CAPS: BACKGROUND, CARDIAC REHABILITATION EXEMPTION, AND IMPLICATIONS FOR STROKE PROGRAMS

1. INTRODUCTION

Established by the Balanced Budget Act of 1997 (Public Law 105-33), the Medicare therapy cap is a statutory restriction on the *dollar amount* of rehabilitation therapy services a patient can receive under Medicare Part B in a calendar year. Rehabilitation therapists provide physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services to patients in nursing facilities and other settings through the Medicare Part B outpatient therapy benefit.

Federal law provides for coverage of therapy services furnished under cardiac rehabilitation (CR) and intensive cardiac rehabilitation (ICR) programs. These services are subject to a limit on the *number of sessions* over a specified period of time and are not subject to the monetary caps applied to non-CR or ICR rehabilitation programs.

Unlike therapy services for cardiac rehabilitation, stroke-related rehabilitation therapy is subject to the Medicare therapy caps. This may be problematic for providers and stroke patients, as the statute counts the total expenditures for PT and SLP under a single combined cap. Because the therapy caps are established by law, any change to the policy would require congressional action.

2. MEDICARE THERAPY CAP

Overview

Medicare covers three types of outpatient (Part B) rehabilitation therapy: physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP). These services are primarily furnished by qualified therapists and therapist assistants under the supervision of qualified therapists. Therapist services are provided in multiple settings, including private practices, nursing facilities, hospital outpatient departments (HOPDs), and outpatient rehabilitation facilities (ORFs).

The Balanced Budget Act of 1997 (P.L. 105-33), Section 4541(c) [42 USC Sec. 1395l(g)(1)], applies annual, per-beneficiary financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B, commonly referred to as "therapy caps."
The limits are based on incurred expenses and included applicable deductibles and coinsurance.

The therapy cap amounts are determined on a calendar year (CY) basis using the Medicare Economic Index, and all beneficiaries begin a new cap each year. For CY 2018, the limit on incurred expenses is $2,010 for physical therapy and speech-language pathology services *combined*. There is another limit of $2,010 for occupational therapy services.

Exceptions

Since the creation of therapy caps, Congress has enacted several moratoria. Section 5107 of the Deficit Reduction Act of 2005 [42 USC Sec. 1395l(g)((5)(A)] required an exceptions process to the therapy caps for reasonable and medically necessary services. The exceptions process for the therapy caps has been continuously extended several times through subsequent legislation.

If a patient qualifies for an exception, Medicare will continue to pay its share for therapy services after the patient reaches the therapy cap limits. The therapist or therapy provider must:

- Establish the need for medically reasonable and necessary services and document this in the patient's medical record; and
- Indicate on the Medicare claim for services above the therapy cap that the outpatient therapy services are medically reasonable and necessary.

As part of the exceptions process, there are additional limits (called "thresholds"). If the patient receives outpatient therapy services higher than the threshold amounts, a Medicare contractor may review the medical records to check for medical necessity. The threshold amounts for 2018 are:

- $3,700 for PT and SLP combined; and
- $3,700 for OT.

Federal law requires CMS to utilize a *targeted medical review* of therapy services instead of reviewing all therapy claims for beneficiaries whose annual therapy spend exceeds the threshold. CMS' criteria for targeted medical review focuses on services furnished by providers with high claims denial rates, patterns of billing that are aberrant compared with peers or other factors. No special documentation is submitted to the contractor for exceptions, but documents may be requested as part of an Additional Documentation Request (ADR) for claims that are selected for medical review.

2018 Hard Caps/Outpatient Hospital Exclusion

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 extended the Medicare therapy cap exceptions process through December 31, 2017. The therapy caps, and related provisions, were first applied to outpatient hospitals on October 1, 2012, and this application was extended through MACRA until January 1, 2018.

Congress recessed for 2017 ***without addressing the Medicare therapy cap***. This means that beginning January 1, 2018, a $2,010 hard cap on rehabilitation services will be applied, with no exceptions process. It also means that **hospital outpatient departments are not currently subject to the therapy cap**. Note, however, that this is likely to change if Congress reinstates the exceptions process, so it would not be prudent at this point for HOPDs to factor this exemption into their long-term strategies.

Repeal Efforts

In October 2017, bipartisan leaders of the Ways and Means Committee and the Energy and Commerce Committee had reached an agreement on a permanent repeal of the Medicare therapy caps. The policy would repeal the therapy caps, continue to require that an appropriate modifier is included on claims submitted over the new threshold, and continue targeted medical review of claims established by MACRA.

The deal was part of a larger piece of legislation that included other changes to Medicare, such as payments for ground ambulances and reauthorization of special needs plans. The package of "Medicare extenders" was supposed to be adopted in early December, but debate over tax reform in the final weeks of the year pushed nearly all other issues to 2018.

3. CARDIAC REHABILITATION

Overview

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 [42 USC Sec. 1395x(eee)(1) and 1395x(eee)(4)(A)] provided for coverage of items and services furnished under cardiac rehabilitation (CR) and intensive cardiac rehabilitation (ICR) programs. Notably, the provisions of the Act enacted *session limits* and exempted those sessions from the existing monetary caps on physical therapy, speech-language pathology services, and occupational therapy.

Medicare Part B pays for CR/ICR programs and related items/services if specific criteria are met by the Medicare beneficiary, the CR/ICR program itself, the setting in which it is administered,

and the physician administering the program.

Medicare regulations at 42 CFR 410.49 define key terms, address the components of a CR program, establish the standards for physician supervision, and limit the maximum number of program sessions that may be furnished. The regulations also describe the cardiac conditions that would enable a beneficiary to obtain CR services.

Covered Beneficiary Rehabilitation Services

Effective for dates of service on and after January 1, 2010, coverage is permitted for beneficiaries who have experienced one or more of the following:

- An acute myocardial infarction within the preceding 12 months;
- A coronary artery bypass surgery;
- Current stable angina pectoris;
- Heart valve repair or replacement;
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; and
- A heart or heart-lung transplant.

Cardiac rehabilitation programs and intensive cardiac rehabilitation programs must include all of the following:

- Physician prescribed exercise;
- Cardiac risk factor modification, including education, counseling, and behavioral intervention;
- Psychosocial assessment;
- Outcomes assessment; and
- An individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed off by a physician every 30 days.

Because the codes for cardiac rehabilitation are comprehensive and cover all components of a cardiac rehabilitation program, the exercise services are not separately reportable when provided by a therapist – and therefore are not subject to the therapy caps discussed in Section 1 of this report.

Frequency Limitations

Under 42 CFR 410.49, cardiac rehabilitation sessions are limited to a maximum of 2 one-hour sessions per day (up to 36 sessions, over a period of up to 36 weeks), with the option for an

additional 36 sessions over an extended period of time if approved by the Medicare contractor under Section 1862(a)(1)(A) of the Social Security Act.

Intensive cardiac rehabilitation sessions are limited to 72 one-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks.

4. STROKE REHABILITATION

Overview

Most survivors of a stroke are left with chronic disability. Medicare requires that patients can tolerate at least three hours of therapist-directed treatment a day, usually begun within 5–10 days after onset of stroke. Rehabilitation efforts during the initial three to six months after stroke aim to maximize patients' physical, communicative, and cognitive functioning. In the outpatient setting, patients work with physical, occupational, and speech therapists to refine and build upon these skills to increase their functional independence in the home and community.

Unlike therapy services for cardiac rehabilitation, stroke-related rehabilitation therapy is subject to the Medicare therapy caps discussed in Section 2. The current Medicare therapy cap of $2,010 is a combined amount for both physical and speech therapy services. People with complex conditions (e.g., those who suffer from a stroke) requiring multiple therapy disciplines may end up reaching the therapy cap amount much more quickly than those without complex conditions.

Legislative Remedy

Because the therapy cap, exceptions process, and cardiac rehabilitation exemption are established by federal statute, at this time there is not an administrative remedy for the therapy cap on stroke rehabilitation services. Any changes to the monetary cap on these services would therefore require congressional action (or, in certain instances, inaction).

There are four potential legislative actions that could impact the therapy caps on stroke rehabilitation. They are listed here, in order of most to least likely:

1. Congress could take no action on therapy caps. This would leave in place the "hard cap" for therapy services, but would also exempt hospital outpatient departments from the therapy cap indefinitely.

2. The therapy cap exception process could be reinstated as part of a larger government funding bill. This would once again allow providers to go over the therapy cap for reasonable and medically necessary services, but would also subject hospital outpatient departments to the cap.

3. The therapy caps could be repealed altogether in line with the bipartisan framework established last year by the House Ways and Means and Energy and Commerce Committees. A repeal of the caps would apply to therapy services provided in all settings, but a reporting and review structure would likely remain in place.

4. A separate piece of legislation creating a payment system and session limits for stroke rehabilitation programs could be included in a larger package. This outcome would result in a similar "carve-out" for stroke-related therapy services similar to the one adopted by Congress for cardiac rehabilitation in 2008.

Although the third option (repealing the therapy cap) would be most advantageous for stroke rehabilitation programs, it is actually *more likely* to occur than the more complicated process of establishing a separate fee structure and cap exemption similar to the system adopted for CR and ICR programs.

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