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## **2003 Medicare Therapy Cap Implementation**

### **Questions and Answers**

Effective September 1, 2003, the Centers for Medicare and Medicaid Services (CMS) will begin implementing financial limitations on outpatient rehabilitation therapy services provided to Medicare beneficiaries. The following questions and answers were developed based on CMS program memoranda to assist speech language-pathologists in assuring compliance with this requirement. We refer to the financial limitation as the therapy cap throughout the questions and answers. If you have any questions regarding the implementation of the Medicare therapy caps, contact Ingrida Lusic, ASHA's Director of Health Care Regulatory Advocacy, at 800-498-2071, ext. 4482 or via e-mail at [ilusic@asha.org](mailto:ilusic@asha.org), or Mark Kander, ASHA's Director of Health Care Regulatory Analysis, at [mkander@asha.org](mailto:mkander@asha.org) or at 800-498-2071, ext. 4139

#### **When does the therapy cap go into effect?**

The Medicare cap on therapy services will go into effect September 1, 2003. For this year only, the cap will be implemented prospectively from September 1 – December 31, 2003. In other words, all services provided up to August 31 are not covered under the 2003 cap. If not delayed or repealed for 2004, the cap would be implemented, starting January 1 – December 31, 2004.

#### **What is the financial limitation on speech language pathology services?**

The Centers for Medicare and Medicaid Services (CMS) continues to combine speech-language pathology services with physical therapy services for the purpose of the rehabilitation caps. Therefore, for 2003, there is an overall \$1590 limit for combined physical therapy and speech-language pathology services.

#### **Does this mean that the beneficiary will receive \$1590 of Medicare reimbursable services?**

No. The \$1590 limit is based on incurred expenses, which are defined as the Medicare Physician Fee Schedule, and includes the applicable deductible of \$100 and the 20 percent coinsurance. For example, if the deductible for the year has been met and services are received, and they total \$1590 (the limit of the allowed amount), Medicare pays 80 percent of the allowed amount (\$1272) and the beneficiary pays \$318 in coinsurance.

#### **Does the therapy cap apply to all Medicare services?**

No, the cap applies only to Medicare outpatient speech-language pathology, occupational therapy and physical therapy services (Part B). Rehabilitation services under Part A (inpatient prospective payment, PPS in skilled nursing facilities, acute hospitals, and most home health) are not subject to the cap.

**What happens if my patient exceeds the cap and still requires care?**

Hospital outpatient departments are excluded from the cap and beneficiaries may continue to receive outpatient rehabilitation services through these facilities.

**Is this a per provider cap?**

No, the limitation is per Medicare beneficiary. This cap is a yearly cap on total expenses, regardless of the number of episodes of care.

**How will the Medicare contractors track this information?**

The Common Working File (CWF) will track the financial limitation based on the presence of therapy modifiers. This information is expected to be available electronically to the providers as of October 2003.

**What are the therapy modifiers?**

All providers of therapy services will be required to use specific modifiers in submitting claims to the contractors.

GN – Services provided under an outpatient speech-language pathology plan of care

GO – Services delivered under an outpatient OT plan of care

GP – Services delivered under the outpatient PT plan of care

On the UB-92 and CMS 1500, the modifier should be placed next to the procedure code in the appropriate column. Failure to utilize a modifier will result in the return of an unprocessed claim.

**How will beneficiaries be notified that they have exceeded the cap?**

Medicare contractors will use existing Medicare Summary Notice (MSN) messages to alert beneficiaries of the amount they have used toward the cap. The MSN is a statement that is sent by Medicare designed to alert beneficiaries of claims that have been processed on their behalf. It is not a bill for services. The statement contains information about the submitted charges, the amount that Medicare paid, and the amount the beneficiary is responsible to pay.

**How does the cap affect Skilled Nursing Facility Residents?**

SNF residents will be the most adversely affected beneficiary population. Due to CMS' interpretation of the SNF prospective payment and therapy cap requirements, SNF residents will not be able to receive therapy services provided by outpatient hospitals once the cap has been exceeded.

For SNF residents in a covered Part A stay, rehabilitation services are included within the Part A per diem payment that the SNF receives under PPS. For SNF residents who have exhausted their Part A benefits, consolidated billing requires all outpatient rehabilitation services be billed to Part B by the SNF. Once a resident has reached the financial limitation and remains in the SNF, no further payment will be made to the SNF or any other entity.

**What providers are affected by the therapy caps?**

The caps apply to outpatient speech-language pathology, physical therapy and occupational therapy services billed by speech-language pathologists, physical therapists, occupational therapists, physicians, nurse practitioners, clinical nurse specialists, and physician assistants.

### **What settings are affected by the caps ?**

Settings affected by the caps consist of all settings paid under the Medicare Physician Fee Schedule except the outpatient hospital setting. These include:

- Comprehensive outpatient rehabilitation facilities;
- Rehabilitation agencies, (e.g., outpatient rehabilitation facilities, outpatient physical therapy providers);
- Part B services in skilled nursing facilities (see discussion on SNF coverage);
- Home health agencies providing therapies to patients whom are not homebound;
- Physician offices;
- Non-physician practitioner offices; and
- Physical and occupational therapists in private practice.

### **Who is financially responsible for therapy services received after the limits are exceeded?**

If the beneficiary chooses not to seek care at a hospital outpatient facility, beneficiaries are responsible for payment of all outpatient rehabilitation services that exceed the cap on an annual basis.

### **How should I as a provider notify the beneficiary of their financial obligations?**

CMS has advised providers to use a Notice of Exclusion from Medicare Benefits (NEMB) form to notify beneficiaries of the therapy financial limitations and that these limits are applied in all Part B settings except hospital outpatient departments. It can be found on the CMS Web site at <http://www.cms.hhs.gov/medlearn/refabn.asp>. The NEMB should be provided to beneficiaries on their first visit. As part of the NEMB, the provider should inform beneficiaries that they will be responsible for 100% of the cost of therapy services above each respective therapy cap, unless the outpatient care is furnished directly or under arrangement by a hospital. Providers are permitted to create their own form. To assist members, ASHA has developed an alternative form that can be found on the ASHA Web site at <http://www.asha.org/about/legislation-advocacy/federal/cap/>.

*It is the provider's responsibility to present each beneficiary with accurate information about the therapy limits, and that medically necessary care above the limit can be obtained at a hospital outpatient speech-language pathology department.*

### **Should I advise my patients on how much therapy they are eligible to receive under the cap?**

Yes. Speech-language pathologists should provide Medicare beneficiaries with estimated cost so that the patients can make an informed decision on the care they are receiving. Speech-language pathologists should also advise patients against rationing care, and make sure they understand that additional rehabilitation services are available through a hospital outpatient department once the therapy cap is reached. The patient should also be informed that another \$1590 of services will be available in 2004.

### **What do I do if I know the beneficiary is reaching the cap limit?**

In situations where a beneficiary is close to reaching the financial limitation and a particular claim might exceed the limit, the provider should advise the patient that the care might exceed the cap. If the patient makes the informed choice to receive the services at the facility, the

provider should bill the Medicare Fee Schedule amount for the service furnished even though such charge might exceed the limit.

### **How will CMS determine which claims to reimburse when the beneficiary is close to reaching the therapy cap?**

CMS will determine, based on date of services, which claims will and will not be paid.

### **Do I have to charge Medicare rates after the cap has been reached?**

No. If the beneficiary chooses not to obtain services through a hospital outpatient setting, the provider may, if they choose, bill at the rate determined by the provider. Services provided that exceed the cap are not considered to be Medicare benefits and therefore are not subject to Medicare policies.

### **Why does Medicare place caps on rehabilitation services?**

Financial limitations on outpatient physical therapy services provided in private practice began in 1972. The Balanced Budget Act of 1997 expanded the caps to include all PT, SLP and OT services in every outpatient setting except outpatient hospitals. The caps were effective in 1999, but were not fully implemented due to Y2K issues. The Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act of 2000 suspended the caps for the years 2000, 2001 and 2002. The moratorium expired on December 31, 2002. In response to legal challenges being developed by ASHA and other rehabilitation groups, CMS agreed to delay the implementation of the caps by 8 months to September 1, 2003.

### **Where can I get additional information on the therapy caps?**

CMS has issued five guidance documents to date on the caps that can be found at:

AB-03-097, *Delay in Implementation of Outpatient Therapy Caps to September 1, 2003*

(July 3, 2003): [http://cms.hhs.gov/manuals/pm\\_trans/AB03097.pdf](http://cms.hhs.gov/manuals/pm_trans/AB03097.pdf)

AB-03-018, *Implementation of the Financial Limitations for Outpatient Rehabilitation Services*

(February 7, 2003): [http://www.cms.hhs.gov/manuals/pm\\_trans/AB03018.pdf](http://www.cms.hhs.gov/manuals/pm_trans/AB03018.pdf)

AB-03-507, *Implementation of the Financial Limitations for Outpatient Rehabilitation Services*

(May 2, 2003): [http://www.cms.hhs.gov/manuals/pm\\_trans/AB03057.pdf](http://www.cms.hhs.gov/manuals/pm_trans/AB03057.pdf)

AB-03-073, *Provider Education Article: Financial Limitations of Claims for Outpatient Services*

(May 23, 2003): [http://www.cms.hhs.gov/manuals/pm\\_trans/AB03073.pdf](http://www.cms.hhs.gov/manuals/pm_trans/AB03073.pdf)

AB-03-085, *Beneficiary Notice of Implementation of Outpatient Therapy Service Limitations*

(June 10, 2003): [http://www.cms.hhs.gov/manuals/pm\\_trans/AB03085.pdf](http://www.cms.hhs.gov/manuals/pm_trans/AB03085.pdf)

### **What can I do to protest these caps?**

- 1) Make it a priority to call or write your member of Congress and ask them to support our repeal legislation (S. 569 and H.R. 1125) TODAY!
- 2) Write to your newspaper using the draft op-ed letter, which is available on ASHA's Therapy Caps Advocacy Center at <http://www.asha.org/about/legislation-advocacy/federal/cap/>.
- 3) Identify all \$1500 cap implementation issues and case stories on how you and your patients are being negatively impacted by the cap and send them to ASHA at [therapycap@asha.org](mailto:therapycap@asha.org), so that we can confront CMS and Congress with them.