Therapy Cap Fact Sheet

Medicare Part B Outpatient Therapy Cap and Exceptions Process

The American Taxpayer Relief Act of 2012 was passed by Congress on January 1, 2013 and signed into law by President Obama on January 2, 2013. This legislation extends the Medicare Part B Outpatient Therapy Cap Exceptions Process through December 31, 2013. Section 603 of this Act contains a number of Medicare provisions affecting the outpatient therapy caps and manual medical review (MR) threshold.

Background

The statutory Medicare Part B outpatient therapy cap for Occupational Therapy (OT) is $1,900 for 2013, and the combined cap for Physical Therapy (PT) and Speech-Language Pathology Services (SLP) is also $1,900 for 2013. This is an annual per beneficiary therapy cap amount determined for each calendar year. Medicare allowable charges,which includes both Medicare payments to providers and beneficiary coinsurance, are counted toward the therapy cap. In outpatient settings, Medicare will pay for 80 percent of allowable charges and the beneficiary is responsible for the remaining 20 percent of the amount.

The therapy cap applies to all Part B outpatient therapy settings and providers including:

- private practices,
- skilled nursing facilities,
- home health agencies,
- outpatient rehabilitation facilities,
- comprehensive outpatient rehabilitation facilities
- hospital outpatient departments (HOPD)

The law requires an exceptions process to the therapy cap that allows providers to receive payment from Medicare for services above the therapy cap amount. Therapy furnished by providers must always be reasonable and medically necessary, require the specialized skills of medical professional, and be justified by supporting documentation in the patient's medical record. When these conditions are met for care exceeding the therapy cap in a calendar year, which is $1,900 for 2013, a provider may submit claims for a beneficiary with a KX modifier included on the claim form. The KX modifier on the claim indicates that the requirements for an exception to the therapy cap have been met. Claims that exceed the cap and do not include the KX modifier will be denied.

Manual Medical Review Process

CMS is in the process of determining how the manual medical review process for annual per beneficiary services over $3700 will be conducted in 2013. CMS will post further details regarding this process as soon as possible.

Further questions?

You can contact CMS with questions about the therapy cap and new threshold via a designated email box, at therapycapreview@cms.hhs.gov.

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