Bipartisan Budget Act of 2018 repeals therapy caps: What does it mean for hospital outpatient therapy departments?

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Do you have a hospital outpatient therapy clinic? And do you think the provider-based rules do not apply to that clinic?

Prior to January 1, 2018, CMS did not make provider-based status determinations for facilities furnishing only physical, occupational and speech therapy services to ambulatory patients while the Medicare "therapy caps" and the related exceptions process were in place.

"Therapy caps" date back to the Balanced Budget Act of 1997, which limited (or "capped") the amount of annual per-patient therapy expenditures under Medicare Part B. However, Congress created an exceptions process in 2006, allowing payment for therapy services to exceed the cap based on medical necessity. This exceptions process was most recently extended by The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) through December 31, 2017, when MACRA expired. The expiration of MACRA meant that Medicare beneficiaries became financially liable for 100 percent of the expenses they incurred for therapy services in non-hospital settings that exceeded the cap. That is, until February 9, 2018, when the Bipartisan Budget Act (BBA) of 2018 permanently repealed the therapy caps retroactive to January 1, 2018.

What does the BBA repeal of the therapy caps mean for hospital outpatient therapy departments? Now that the therapy caps have been permanently repealed, CMS is making provider-based status determinations for hospital outpatient therapy locations. Hospitals with outpatient therapy departments should take steps to ensure that their hospital outpatient therapy departments meet all applicable provider-based requirements in the regulation to continue billing the therapy services as outpatient hospital services. Hospitals also may now seek confirmation from CMS that their hospital outpatient therapy departments meet all of the

provider-based requirements by submitting a voluntary attestation to CMS.

In addition, hospitals should be aware that although the BBA repealed the therapy caps, it retained the former cap amount as a threshold above which claims must include the "KX" modifier to indicate that the services are medically necessary as justified by appropriate documentation in the medical record. As a result, hospitals must still bill outpatient therapy claims using the modifier "KX" for claims above the current $2,010 annual threshold. The BBA also provides for targeted medical reviews of therapy claims that exceed a medical review threshold of $3,000 annually.

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