To: All AHCA/NCAL Member Constituencies  
From: Dan Ciolek, AHCA Associate Vice President, Therapy Advocacy  
Re: Impact of the Congressional delay on Medicare extenders including Part B therapy caps starting on January 1, 2018

Congress has adjourned for 2017 and did not enact legislation to address what is often referred to as Medicare “extender payment policies.” These policies expire on December 31 and include the Part B therapy cap exception process. This means that effective January 1, 2018, SNFs will operate under prior therapy caps without any exceptions based on patient need. It is highly likely that Congress will fix this issue when they return in January and our hope is that they will fix it by the time they must address the current Continuing Resolution that expires on January 19.

Congress will likely address therapy caps in one of two ways: a permanent repeal or a one or more year extension of the current exceptions process. Currently, there is a bipartisan and bicameral agreement on a policy to permanently repeal the Medicare outpatient therapy caps that is broadly supported by therapists, providers, and consumers that is awaiting a legislative vehicle to become enacted. However, if they are not able to get final agreement on a permanent therapy cap repeal, there is an overwhelming probability they will enact a one or more year extension of the current exceptions process, as they have done several times previously.

While there will be some uncertainty for a few weeks, we feel confident that Congress will act to address this issue. We have made the Centers of Medicare and Medicaid Services (CMS) aware of coverage and billing questions related to this issue and have requested they provide appropriate and timely billing guidance. Additionally, we will continue actively working on this issue with Members of Congress over the next several weeks.

This situation has happened before, and likely will result in minimal to no disruption in operations, care delivery, and payment if Congress acts quickly. Since the cap dollars don't start counting until January 1, and in most cases, it takes a beneficiary several weeks of therapy before they surpass the 15 or more treatment sessions required to surpass the caps, it is highly unlikely that SNFs would see many beneficiaries that would be impacted. In addition, for those few that may be impacted, Congress has historically applied the policy retroactively permitting CMS to pay facilities for the therapy provided over the cap threshold. It's not uncharted territory.

AHCA/NCAL is providing the following in a frequently asked questions (FAQ) format, based on currently available knowledge. You may wish to specifically share questions 1-4 with your billers and therapy clinicians. We have also reached out to CMS for updated guidance, as its Therapy Services webpage does not currently address 2018 therapy cap coverage policy.

Q1: What happens January 1, 2018 regarding Part B therapy services if Congress doesn’t act?  
A1: Beginning January 1, 2018, there will be a hard cap on the annual amount of allowed charges for Medicare Part B physical therapy and speech-language pathology services (PT/SLP) combined of $2,010, and a separate limit of $2,010 for occupational therapy (OT) services.

- See this MLN Matters Article for more information on the 2018 therapy cap amounts.
- Services furnished to a beneficiary in 2017, even if under the same episode of care would not apply to the 2018 caps. The cap dollar counts start on January 1, 2018.
- For each cap threshold, all services furnished in 2018, regardless of the number of episodes of care would apply to the same cap threshold. For example, if a beneficiary used up $500 of PT services during the first week of January, then stopped. Then started PT services during the third week of January for a completely different condition, the PT/SLP cap dollar count for the second PT episode would start at $500 and not $0.

Q2: Can therapy services continue to be furnished to beneficiaries above the $2,010 PT/SLP or
$2,010 OT cap thresholds in 2018?
A2: Yes. At this point, it appears that the beneficiary would be responsible for payment of the services above the therapy cap thresholds if the provider furnishes the appropriate beneficiary notification (see Q3 below). It is possible that Congress could enact legislation in 2018 that would be retroactive to January 1, at which time CMS and AHCA would provide further guidance as to how it may be appropriate to instead bill Medicare for services furnished above the threshold retroactively.

- Each cap is treated separately, and a separate notification would be needed for each cap. For example, a beneficiary could surpass the PT/SLP cap and would no longer be covered under Medicare Part B, and once receiving notification, would pay privately or through other secondary insurance. In the meantime, the beneficiary could still be covered by Medicare for OT services if the OT cap threshold has not been reached, but would need separate notification if they later surpassed the OT cap threshold.

Q3: How do SNFs notify beneficiaries/responsible parties that the beneficiary has reached either or both PT/SLP or OT $2,010 caps, and before the enactment of cap relief legislation in 2018?
A3: According to the most recent relevant CMS ABN FAQ regarding this subject:

- Section 603 (c) of the ATRA amended §1833(g)(5) of the Social Security Act (the Act) to provide limitation of liability (LOL) protections (See §1879 of the Act) to beneficiaries receiving outpatient therapy services on or after January 1, 2013, when services are denied and the services provided are in excess of therapy cap amounts and don't qualify for a therapy cap exception. Now, the provider/supplier must issue a valid, mandatory ABN to the beneficiary before providing services above the cap when the therapy coverage exceptions process isn't applicable. The ABN informs the beneficiary why Medicare may not or won't pay for a specific item or service and allows the beneficiary to choose whether or not to get the item or service and accept financial responsibility. ABN issuance allows the provider to charge the beneficiary if Medicare doesn't pay. If the ABN isn't issued when it is required and Medicare doesn't pay the claim, the provider/supplier will be liable for the charges.

However, this CMS guidance is somewhat dated, and the examples provided only describe scenarios where there is an exceptions process in place, and not the current situation where legislation permitting exceptions is essentially "pending."

- AHCA believes that, since the exceptions provisions technically expires at the end of 2017, unless there is Congressional action, a mandatory ABN would be necessary at the $2,010 threshold because the cap has been met and the services above that amount would not be eligible for an exceptions process.
- AHCA has requested guidance from CMS, to which they have indicated they are following the legislative activity and will update guidance as needed if Congress does not act before January 1, 2018.

Q4: Do SNFs need to do any special claim coding if therapy services are furnished on or above the $2,010 therapy cap thresholds on or after January 1, 2018, and before the enactment of cap relief legislation in 2018?
A4: It is unclear, and we have asked CMS to provide guidance. However, under the existing exceptions process, therapy providers that attest the services furnished above the cap threshold are medically necessary must use the -KX modifier to the Medicare Part B services codes being billed as described in the CMS ABN FAQ. However, since SNFs typically submit Medicare claims monthly, which would likely mean that January 2018 claims would be submitted during February 2018, AHCA suggests that SNFs continue the current process of preparing to append the -KX modifier to medically necessary services furnished above the $2,010 cap threshold for January 2018 claims. We anticipate that prior to the end of January, CMS and AHCA will be able to provide further guidance depending on the results of any Congressional action.
Q5: Is there anything SNF providers can do to encourage Congress to enact legislation to assure that beneficiary access to necessary SNF Medicare Part B therapy is maintained and not restricted by the therapy cap benefit limits in 2018 and beyond?

A5: AHCA/NCAL encourages members to educate their members of Congress about the problems therapy caps create on beneficiary access and care delivery, particularly for residents with multiple chronic conditions and mobility deficits in the SNF and AL environments. Once the language of the final policy and the way it will be paid for is put forth by Congress, we will notify you about any specific advocacy activities we recommend.

For questions related to the status of Medicare Part B Therapy Caps and 2018 payment and billing policy, please contact Dan Ciolek, AHCA Associate Vice President, Therapy Advocacy.

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