Issue Brief

Ensuring Access to Medicare Part B Outpatient Therapy Services: Improving the Manual Medical Review Process

Medicare Part B outpatient physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services enable beneficiaries to restore or maintain their highest level of functional independence following an illness or injury, or recent decline resulting from a degenerative condition. These cost-effective rehabilitative therapies help prevent hospital admissions, institutionalization, and facilitates an individual's return to community living following an inpatient stay.

Current law limits the annual Part B outpatient therapy benefit to a fixed dollar amount (therapy caps), however, since 2006, Congress has continually enacted an *exceptions process* to ensure that beneficiaries receive medically necessary therapy services beyond the caps. Nearly one million beneficiaries per year in nursing facilities benefit from the exceptions process.

As part of the 2012 *American Taxpayer Relief Act* provisions to extend the Part B outpatient therapy cap exceptions process, Congress required the Centers for Medicare and Medicaid Services (CMS) to conduct Manual Medical Review (MMR) when a beneficiary's annual Part B outpatient therapy expenditures reached $3,700 for OT services, or PT and SLP services combined. There is no differentiation for patient condition or need. When the cost of a beneficiary's therapy services reaches this arbitrary threshold, Medicare contractors are required to manually review each claim. The therapy caps exceptions process and the related MMR process are currently set to expire December 31, 2013.

While Congress intended for the MMR process to be completed within a brief ten day window to avoid disruption of care, the process implemented by CMS and its contractors has been an administrative nightmare, as reflected in recent Medicare Payment Commission (MedPAC) report and the Government Accountability Office (GAO) study. It has been over a year since the MMR process was implemented in October 2012, yet to this day, providers receive inconsistent and inefficient instructions, often wait weeks to months beyond the required ten day review window to receive a payment decision, and often wait even longer to receive payments for services provided.

NASL Asks Congress

Until an appropriate patient-centered alternative payment model for Part B outpatient therapy services is implemented, support a Congressional extension of the current Part B therapy cap exceptions process, along with necessary safeguards to prevent against inappropriate therapy utilization. NASL has worked with others in the therapy sector and supports recommendations that would improve the MMR process:

- Protect beneficiary access from care disruptions by strengthening the ten day MMR requirement.
- Improve the MMR process by simplification, standardization, and automation of contractor and provider communications.
- Requiring a GAO analysis to identify opportunities to better design and tailor the Part B outpatient therapy benefit, and to improve the MMR process to better target medical review of outliers.

Ask Congress

To extend the therapy cap exceptions process and make improvements to the Manual Medical Review process.

Key Facts

Arbitrary, annual caps on therapy services discriminate against the oldest, sickest Medicare patients, who require the most therapy for their care.

About 16% of nursing facility patients received Part B outpatient therapy–31% of those patients exceeded the PT/SLP cap & 71% exceeded the OT cap. Even greater percentages of patients must have their therapy claims reviewed under Manual Medical Review.

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