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MedPAC Eyes Proposing Lower Therapy Caps, More Manual Medical Reviews

The Medicare Payment Advisory Commission is considering draft recommendations to lower the cap on therapy services, increasing the share of services that would require a manual medical review, as part of an effort to curb increased spending on therapy without impeding access to care. But therapy providers says the draft recommendations, discussed by MedPAC on Friday (Oct. 5), would expand manual reviews prematurely, as the manual medical reviews have only been in place for a week and, according to one provider, are already causing chaos within the therapy provider community.

MedPAC Chairman Glenn Hackbarth said returning to a system of caps on therapy services without any exceptions process would impede access to care for beneficiaries, but he added: "Having said that, it is still incumbent on us to find ways to help Congress keep that expenditure low and targeted to those in need of the services." Hackbarth said the draft recommendations would simply increase the share of beneficiaries who need to be reviewed prior to receiving therapy.

One set of draft recommendations the commissioners discussed included reducing therapy caps for physical therapy and speech-language pathology services combined, and for occupational therapy, and to implement a manual review process for therapy exceeding that amount. The draft also specifies that Congress should "provide the resources to CMS for this purpose." Services delivered in hospital outpatient departments would also be included under the cap.

The draft recommendation does not specify where Congress should place the caps and when the manual reviews would kick in.

The commission will vote on the recommendations in November, sending them to Congress before many of the therapy provisions — including the manual medical reviews that went into effect Oct. 1 and the inclusion of hospital outpatient departments under the caps — expire in December.

Commissioner Herb Kuhn questioned what "army of contractors" would need to be hired to increase the amount of manual medical reviews. Mark Miller, MedPAC's deputy director, said that most likely there is a point where the administrative capacity to conduct these manual medical reviews stops. That line, he said, may be the place to institute caps.

Although provider groups at the meeting were supportive of MedPAC's decision not to consider hard caps in the draft recommendations, Jennifer Hitchon at the American Occupation Therapy Association told the commissioners that Congress set the level of the manual medical reviews at current levels, when a beneficiary reaches $3,700, because that was the level they thought was necessary and the level where they could be successfully carried out.

The program MedPAC wishes to expand is only five days old, Morton pointed out, adding that implementation of the manual medical reviews is a "chaotic mess," with providers spending hours attempting to get paperwork to the Medicare Administrative Contractors and contractors not yet able to track how much therapy a patient has had.

The package of draft recommendations the commission considered on Friday also included deeper multiple procedure payment reductions when a beneficiary has more than one therapy session in a day, increasing the cuts to 50 percent. The move surprised providers, according to Cynthia Morton at the National Association for the Support of Long Term Care, as commissioners had not discussed such an option at the September meeting. Hitchon disagreed with the MPPR because she said redundancies in payment for practice expenses for a second or third therapy session have already been reduced by the Relative Value Update Committee (RUC).

Providers were in favor of the recommendation to collect functional status information on therapy claims and using this information to measure a patient's improvement. This payment, the draft recommendation says, could provide the basis for global payment approaches.

Other draft recommendations include reducing the certification period for outpatient therapy plans of care from 90 days down to 45. The commissioners also suggested Congress use anti-fraud authority to target high-use geographic areas and providers with unusual billing patterns, and implement payment edits to target "implausible amounts of therapy."

The commissioners also discussed prohibiting the use of v-codes, which often are vague and do not describe why a beneficiary needs therapy services. — *Michelle M. Stein*