

## New Congressional Legislation

### Finally Eliminates the Medicare Therapy Cap

by Tina Ortolan, MJ, M.Ed., CCC-SLP (Author's bio follows main text)

*For the past 20 years, there has been a cap in place to limit the amount of therapy that Medicare beneficiaries can receive. This cap has had a harmful effect, in many cases, preventing patients from receiving the amount of therapy that would help them return to a fully functional life after a devastating illness or injury. After many years of work by Medicare advocacy groups and professional organizations, Congress is finally about to act on legislation that would permanently eliminate the Medicare therapy cap.*

#### I. INTRODUCTION

Over 700,000 Americans suffer a stroke each year, and if they are Medicare beneficiaries who want to utilize outpatient therapy services, they will face the harsh reality that these services will not be covered when the Medicare therapy cap exception expires in December of this year.<sup>1</sup>

Therapy caps are annual reimbursement limitations under Medicare Part B for outpatient therapy services of physical therapy, occupational therapy, and speech therapy.<sup>2</sup> For 2017, the therapy cap amounts are \$1,980 for physical therapy and speech therapy combined and another \$1,980 for occupational therapy for a combined total of \$3,960.<sup>3</sup> Currently under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), there is an exception process in place that allows practitioners to request additional therapy services above the \$3,960 threshold provided that the practitioner attests that the services are “reasonable and necessary” and documentation of “medical necessity” is in the medical record.<sup>4</sup> After the documentation is submitted, a Medicare contractor, who is most often a nurse and not a therapist, makes the final determination if additional therapy is warranted.<sup>5</sup> This exception process is in place until

---

<sup>1</sup> *Post Stroke Rehabilitation*, National Institute of Health, 1 (September 2014), available at <http://www.stroke.nih.gov/materials/rehabilitation.htm>.

<sup>2</sup> *Therapy Services, Spotlight*, (16 December 2016) <https://www.cms.gov/Medicare/Billing/TherapyServices/>

<sup>3</sup> *Ibid.*

<sup>4</sup> *Ibid.*

<sup>5</sup> Ingrida Lulis, *Medicare Patients May Exceed Therapy Caps*, *The ASHA Leader*, Vol. 11, 1-21, 1 (March 2006).

December 31<sup>st</sup> of 2017 at which time, the hard therapy cap goes back into effect<sup>6</sup> which could cause more than one million Medicare beneficiaries to go without needed outpatient therapy services.<sup>7</sup> Therefore, when the Medicare therapy cap exception expires in December of 2017, the therapy cap should be permanently eliminated as it restricts access to needed therapy services for Medicare beneficiaries and could potentially create more long-term cost to Medicare due to lack of needed treatment for acute and chronic conditions.

The purpose of this paper is to educate the reader on the current status of reimbursement of outpatient therapy services and the impending changes that could further limit beneficiaries' access to needed services. In part II of this paper, the history of the therapy services will be discussed detailing the past legislative and legal actions that have impacted therapy delivery to Medicare beneficiaries dating back to 1972. Current legislation introduced in February of 2017 will also be discussed which highlights why this is such a relevant topic in light of the approaching implementation of the therapy cap at the end of this year. Part III will delineate why the Medicare therapy caps must be eliminated. This argument will examine the striking down of the Medicare improvement standard<sup>8</sup>, prove the cap is ineffective due to fraud occurrence with caps in place, and present clinical evidence of the need for prolonged therapy services in acute and chronic conditions. In part IV, the rationale for establishing the therapy caps and keeping them in place will be explored including fraud, waste, and abuse involving therapy services and the ever important need to control Medicare spending as more baby boomers reach Medicare age every year. Finally, alternative payment models will be examined in part V that could replace the therapy caps while still being fiscally responsible and delivering needed services to Medicare beneficiaries.

## II. History of Therapy Services

In 1972, Public Law 92-03, "The Social Security Amendments" expanded therapy coverage to services provided by physical therapists working as independent practitioners to allow for greater access for beneficiaries who were not able to travel to a hospital outpatient facility.<sup>9</sup> Shortly after this expansion of services, Congress enacted a payment limit to control the cost of therapy.<sup>10</sup> Congress first signaled its concern over therapy costs when it then limited payment for physical therapy provided by an independent practitioner to \$100 in a calendar year as stated in the Social Security Amendments of 1979.<sup>11</sup> This amount was increased to \$500 with the passage of the Medicare and Medicaid Amendments of 1980.<sup>12</sup> The Omnibus Budget Reconciliation Act passed in 1989 again increased the limit of outpatient physical therapy

---

<sup>6</sup> Ibid.

<sup>7</sup> APTA, AOTA, and ASHA Agree: Medicare SGR Bill Leaves Beneficiary Access Issue Behind, American Physical Therapy Association, 1 (3/24/15).

<sup>8</sup> The Medicare improvement standard was criteria used to deny claims for therapy based on lack of improvement.

<sup>9</sup> *History of Medicare Therapy Caps*, (01/19/2016) <http://www.apta.org/FederalIssues/TherapyCap/History/>.

<sup>10</sup> Rene R. Savarise, *The Continuing Saga of Medicare Therapy Caps*, Medical News, (January 28, 2013).

<sup>11</sup> *History of Medicare Therapy Caps*, (01/19/2016) <http://www.apta.org/FederalIssues/TherapyCap/History/>.

<sup>12</sup> Ibid.

provided by independent practitioners outside of a hospital setting to \$750.<sup>13</sup> And once more to \$950 through the Omnibus Budget Reconciliation Act of 1993.<sup>14</sup>

One year later, in 1994, Section 143 of the Social Security Amendments of 1994 mandated that the Department of Health and Human Services conduct a study to determine the need to continue the \$950 cap under Medicare signaling increased attention to this area by legislatures.<sup>15</sup> Three years later, significant legislation affecting outpatient therapy services was passed with the Balanced Budget Act of 1997 which greatly expanded the scope of the therapy cap to include not just outpatient physical therapy provided in independent practitioners' offices, but to outpatient therapy services provided in skilled nursing facilities (Part B), physician's offices, and home health agencies (Part B).<sup>16</sup> The allowed expenditure was increased to \$1,500 in a calendar year.<sup>17</sup> The rule stated that "once a beneficiary reaches the \$1,500 therapy caps, the beneficiary is financially responsible for any additional therapy services furnished during the calendar year."<sup>18</sup> The therapy cap went into effect on January 1, 1999.<sup>19</sup>

On November 19<sup>th</sup> of that year, a two year moratorium on the therapy cap was granted through Congress passing the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 signed by President Clinton on November 29<sup>th</sup>.<sup>20</sup> The moratorium was extended through 2002, when President Clinton signed the Medicare, Medicaid, and SCHIP Benefit Improvement and Protection Act of 2000 in December of 2000.<sup>21</sup>

In late 2001 and early 2002, legislation was introduced in the Senate and House titled "Medicare Access to Rehabilitation Services Act" which would repeal the Medicare therapy cap, but Congress adjourned in November of that year without passing any Medicare reform legislation.<sup>22</sup> In February of 2003, the Consolidated Appropriations Resolution was passed by Congress and signed into law by President George W. Bush, which provided a 1.6% increase in payments under the Medicare physician fee schedule, but did not block or repeal the Medicare therapy cap.<sup>23</sup>

In June of 2003, in response to President Bush's failure to block or repeal the therapy cap, the Medicare Rights Center, American Parkinson Disease Association, and Easter Seals filed a lawsuit against Tommy Thompson, secretary of the U.S. Department of Health and

---

<sup>13</sup> Omnibus Budget Reconciliation Act of 1989, H.R. 3299 § 6133 (1989).

<sup>14</sup> Omnibus Budget Reconciliation Act of 1993, H.R. 2264 § 13555 (1993).

<sup>15</sup> Social Security Act Amendments of 1994, H.R. 5252 § 143 (1994).

<sup>16</sup> *History of Medicare Therapy Caps*, (01/19/2016) <http://www.apta.org/FederalIssues/TherapyCap/History/>.

<sup>17</sup> *Ibid*.

<sup>18</sup> Carolyn C. Zollar, *Highlights of Issues Regarding Outpatient Rehabilitation Services*, 12 *Health Lawyer* 1, 10-11 (1999).

<sup>19</sup> Cherilyn G. Murer, J.D., *Out to Lunch on the \$1500 Cap*, 1 (2003), available at <https://www.ncbi.nlm.nih.gov/pubmed/12741252>.

<sup>20</sup> *History of Medicare Therapy Caps*, (01/19/2016) <http://www.apta.org/FederalIssues/TherapyCap/History/>.

<sup>21</sup> *Ibid*.

<sup>22</sup> S.1394-Medicare Access to Rehabilitation Services Act, available at <https://www.congress.gov/bill/107th-congress/senate-bill/1394>

<sup>23</sup> [CONFERENCE REPORT ON H.J. RES. 2, CONSOLIDATED APPROPRIATIONS RESOLUTION, 2003, 149 Cong Rec H 707](#), 789 (2003).

Human Services (HHS), for failing to give proper notice to Medicare beneficiaries regarding the therapy cap and asked for a restraining order preventing implementation of the cap.<sup>24</sup> HHS settled with the plaintiffs and enforcement of the cap was delayed for 60 days with the cap eventually going back into effect on September 1, 2003.<sup>25</sup>

Later that year in December of 2003, the signing of the Medicare Prescription Drug Improvement and Modernization Act placed a two year moratorium on the implementation of the therapy cap.<sup>26</sup> With the moratorium nearing expiration in December of 2005, proposed legislation was introduced with bipartisan support with provisions to repeal the therapy cap.<sup>27</sup> In spite of bipartisan support, the bills did not pass and the Medicare therapy caps went back into effect on January 1, 2006.<sup>28</sup> One month later, Congress passed the Deficit Reduction Act of 2006 which allowed CMS to create an exception process to the therapy cap for beneficiaries needing coverage above the fixed dollar amount.<sup>29</sup>

Over the next four years, multiple pieces of legislation were passed, each extending the exception process by one to two years until January of 2010 when lack of Congressional action allowed the exception process to expire with a \$1,860 cap on therapy services in place.<sup>30</sup> With the landmark passage of the Patient Protection and Affordable Care Act, the therapy cap exception process was once again implemented through the end of 2010 and then through the end of 2011 when President Obama signed the Medicare and Medicaid Extenders Act of 2010.<sup>31</sup>

From the years 2011 until 2015, President Obama signed legislation each year for the continuation of the therapy cap exception process to allow beneficiaries to go beyond the therapy cap dollar amount in place.<sup>32 33 34 35</sup> In April of 2015, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law, extending the therapy cap exceptions process and modifying the manual medical review process for therapy services through December 31, 2017.<sup>36</sup> Prior to the signing of MACRA, all claims exceeding the cap

---

<sup>24</sup> *History of Medicare Therapy Caps*, (01/19/2016) <http://www.apta.org/FederalIssues/TherapyCap/History/>.

<sup>25</sup> *Ibid*.

<sup>26</sup> Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173 § 624 (2003).

<sup>27</sup> Sheila K. Nicholson, Esq., *Medicare Part B's \$1740 Therapy Cap and New Exception Process*, (February 23, 2017), available at <http://www.qpwblaw.com/medicare-part-bs-1740-therapy-cap-new-exception-process/>.

<sup>28</sup> *History of Medicare Therapy Caps*, (01/19/2016) <http://www.apta.org/FederalIssues/TherapyCap/History/>.

<sup>29</sup> Therapy Caps Exception Process, Provider Inquiry Assistance, (February 2006), available at <https://www.cms.gov/Medicare/Medicare-Contracting/ContractorLearningResources/downloads/ja4364.pdf>.

<sup>30</sup> *History of Medicare Therapy Caps*, (01/19/2016) <http://www.apta.org/FederalIssues/TherapyCap/History/>.

<sup>31</sup> Therapy Cap Values for Calendar Year (CY) 2012, Department of Health and Human Services, Centers for Medicare and Medicaid Services, 1 (November 18, 2011), available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7529.pdf>.

<sup>32</sup> Temporary Payroll Tax Cut Continuation Act of 2011, Public Law 112-78 § 304 (December 23, 2011), available at <https://www.congress.gov/112/plaws/publ78/PLAW-112publ78.pdf>.

<sup>33</sup> Middle Class Tax Relief Act of 2012, Public Law 112-96 § 3005 (February 22, 2012), available at <https://www.gpo.gov/fdsys/pkg/PLAW-112publ96/pdf/PLAW-112publ96.pdf>.

<sup>34</sup> American Taxpayer Relief Act of 2012, H.R. 8 § 603 (January 2, 2013), available at <https://www.congress.gov/bill/112th-congress/house-bill/8/text>.

<sup>35</sup> Bipartisan Budget Act of 2013/Pathway for SGR Reform Act of 2013, Section 1103 (December 16, 2013), Republican + Policy, available at [https://www.rpc.senate.gov/imo/media/doc/RPC%20Legislative%20Notice\\_HJRes59\\_BBAandSGR.pdf](https://www.rpc.senate.gov/imo/media/doc/RPC%20Legislative%20Notice_HJRes59_BBAandSGR.pdf).

<sup>36</sup> *Manual Medical Review Process for Therapy Claims*, American Speech-Language Hearing Association, available at <https://www.asha.org/Practice/reimbursement/medicare/Manual-Medical-Review-Process-for-Therapy-Claims/>.

were reviewed by Medicare contractors, whereas the modification allowed for a more targeted approach with reviews only for providers with a high percentage of claims beyond the therapy cap threshold as compared to their peers.<sup>37</sup> At that time, there was a vote to amend the bill to include a full repeal of the therapy caps which failed by only two votes, the most significant attempt to repeal the caps in its 18 year history.<sup>38</sup> As of this writing, the therapy cap amount is \$1,980 for physical therapy and speech therapy combined and an additional \$1,980 for occupational therapy.<sup>39</sup>

In February of 2017, H.R. 807 and S. 253 titled Medicare Access to Rehabilitation Services Act of 2017 was introduced to both houses of Congress with provisions to repeal the Medicare therapy cap.<sup>40 41</sup> This bill has bipartisan support and could end the ongoing battle that threatens to limit the amount of therapy that a Medicare beneficiary can receive.<sup>42</sup> The American Physical Therapy Association, American Occupational Therapy Association, and American Speech-Language Hearing Association (the “TriAlliance”) have collectively endorsed this legislation and asked their thousands of members to ask their Representatives to support the bill.<sup>43 44 45</sup> Since Congress first expanded Medicare outpatient physical therapy coverage in 1972 until now, Congress has adjusted and implemented limitations on therapy coverage many times to balance medically necessary therapy services with growing costs.<sup>46</sup> With the December 31<sup>st</sup> deadline quickly approaching, this is an urgent issue that needs attention so that Medicare beneficiaries can receive the proper amount of therapy to maximize their functional potential.<sup>47</sup>

### III. Rationale for Permanently Eliminating Therapy Cap

The Medicare therapy cap was originally implemented to help control the rising cost of outpatient therapy services.<sup>48</sup> The *improvement standard* has been another cost controlling

---

<sup>37</sup> *Therapy Cap, Manual Medical Review of Therapy Claims Above the \$3700 Threshold*, CMS.gov (February 9, 2016) <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/TherapyCap.html>.

<sup>38</sup> *History of Medicare Therapy Caps*, (01/19/2016) <http://www.apta.org/FederalIssues/TherapyCap/History/>.

<sup>39</sup> *Physical therapy/occupational therapy/speech-language pathology services*, Medicare.gov, available at <https://www.medicare.gov/coverage/pt-and-ot-and-speech-language-pathology.html>.

<sup>40</sup> Medicare Access to Rehabilitation Services Act of 2017, H.R. 807 § 2 (February 1, 2017), available at <https://www.govtrack.us/congress/bills/115/hr807>.

<sup>41</sup> Medicare Access to Rehabilitation Services Act of 2017, S. 253 § 2 (February 1, 2017), available at <https://www.govtrack.us/congress/bills/115/s253>.

<sup>42</sup> *Welcome Back: Therapy Cap Repeal is Reintroduced in Congress*, (February 2, 2017), available at <http://www.apta.org/PTinMotion/News/2017/2/2/TherapyCapRepealReintroduced/>.

<sup>43 44</sup> *End the Therapy Cap*, Issues and Legislations, American Occupational Therapy Association, (2/2017) available at <http://capwiz.com/aota/issues/alert/?alertid=74944626>.

<sup>44</sup> D’Jaris Coles-White, et al., *Blueprint for Action, 2017 Public Policy Agenda*, American Speech-Language Hearing Association, 8 (2017) available at <http://www.asha.org/Advocacy/2017-ASHA-Public-Policy-Agenda/>.

<sup>45</sup> *Welcome Back: Therapy Cap Repeal is Reintroduced in Congress*, (February 2, 2017), available at <http://www.apta.org/PTinMotion/News/2017/2/2/TherapyCapRepealReintroduced/>.

<sup>46</sup> Rene R. Savarise, Esq., *The continuing saga of Medicare therapy caps*, Medical News (January 28, 2013), available at <http://www.medicalnews.md/the-continuing-saga-of-medicare-therapy-caps/>.

<sup>47</sup> *End the Therapy Cap*, Issues and Legislations, American Occupational Therapy Association, available at <http://capwiz.com/aota/issues/alert/?alertid=74944626>.

<sup>48</sup> Jennifer E. Gladieux, Michael Basile, [Jimmo and the Improvement Standard: Implementing Medicare Coverage Through Regulations, Policy Manuals and Other Guidance](#), 40 *Am. J. L. and Med.* 7, 22 (2014).

policy that CMS promoted for years through its Medicare Administrative Contractors' (MACs) local coverage decisions (LCDs).<sup>49 50</sup> The term *improvement standard*, first used by consumer advocates, describes how CMS has allowed Medicare therapy claims to be denied based on lack of improvement in the patient's condition.<sup>51</sup> Although the regulations related to criteria for skilled therapy services clearly state that "restoration potential of a patient is not the deciding factor in determining whether skilled therapy services are needed," the Center for Medicare Advocacy has noted that the improvement standard has been inappropriately applied for the last 30 years.<sup>52</sup> The improvement standard, as it related to Medicare therapy coverage, was applied to Part B therapy services in the outpatient setting, home health, and skilled nursing facilities.<sup>53</sup> CMS has separate Policy Manuals and regulations for each setting for the purpose of aiding the MACs in making coverage determinations in each area.<sup>54</sup> Across all settings, the Policy Manual and regulations consistently state that an individualized approach to coverage must be made, yet there is also language that states that Medicare will not cover therapy if there is little chance for improvement.<sup>55</sup> The ambiguous language related to the improvement standard was the precipitating factor for the filing of *Jimmo v. Sebelius*.<sup>56</sup>

In *Jimmo v. Sebelius*, six individuals and seven organizations filed a class action lawsuit in January of 2011, to challenge the improvement standard after these individuals' Medicare therapy claims were denied because the care would only "maintain" and not "improve" their conditions.<sup>57</sup> The plaintiffs argued that the improvement standard was more restrictive than what was allowed under existing federal Medicare laws and regulations and that federal regulations do not refer to an improvement standard.<sup>58</sup> The United States District Court for the District of Vermont found that in CMS applying the improvement standard, it may have violated the rulemaking provisions of the Administrative Procedure Act (APA) and subsequently denied CMS' motion for summary judgement; the parties settled out of court.<sup>59</sup>

---

<sup>49</sup> Jennifer E. Gladieux, Michael Basile, [\*Jimmo and the Improvement Standard: Implementing Medicare Coverage Through Regulations, Policy Manuals and Other Guidance\*](#), 40 *Am. J. L. and Med.* 7, 8 (2014).

<sup>50</sup> Local Coverage Determinations (LCDs) are determinations by a fiscal intermediary as to whether or not a particular item or service is covered by Medicare. Medicare Administrative Contractors (MACs) will not approve the claim if the coverage criteria established in the LCD has not been met.

<sup>51</sup> Susan A. Edwards, Mary D. Van de Kamp, *Note and Comments: The Jimmo Settlement: Is It a Milestone Moment for Medicare Coverage?*, *Vol. 7, No. 3, J. Health & Life Sci. L. Pg. 1*, 1 (2014).

<sup>52</sup> *Ibid.*

<sup>53</sup> Jennifer E. Gladieux, Michael Basile, [\*Jimmo and the Improvement Standard: Implementing Medicare Coverage Through Regulations, Policy Manuals and Other Guidance\*](#), 40 *Am. J. L. and Med.* 7, 9 (2014).

<sup>54</sup> Jennifer E. Gladieux, Michael Basile, [\*Jimmo and the Improvement Standard: Implementing Medicare Coverage Through Regulations, Policy Manuals and Other Guidance\*](#), 40 *Am. J. L. and Med.* 7, 10 (2014).

<sup>55</sup> *Ibid.*

<sup>56</sup> *Ibid.*

<sup>57</sup> Morris Klein, *2013 Emerging Issues 7131, Landmark Settlement Helps Medicare Patients Receive Skilled Care*, 1 (December 23, 2013) available at <http://advance.lexis.com/search/?pdmfid=1000516&crd=e9818013-9a2f-4edc-8f0e-0ec970b3b649&pactivityid=670f2780-a675-4d98-9739-8720779e90f2&pdtargetclientid=-None-&comp=24ttk&prid=547c3771-438e-490f-8e20-2410548965f5>.

<sup>58</sup> *Ibid.*

<sup>59</sup> Jennifer E. Gladieux, Michael Basile, [\*Jimmo and the Improvement Standard: Implementing Medicare Coverage Through Regulations, Policy Manuals and Other Guidance\*](#), 40 *Am. J. L. and Med.* 7, 7 (2014).

The Settlement Agreement was issued on January 24, 2013, and mandated a number of requirements including revising Policy Manuals, producing an educational campaign, and enacting accountability measures.<sup>60</sup> Most relevant to this argument is the imposition that CMS must revise the *Medicare Benefit Policy Manual* to state that outpatient therapy services coverage is not reliant on the presence or absence of an individual's potential for improvement from therapy, "but rather on the beneficiary's need for skilled care."<sup>61</sup> With Medicare's regulations requiring an individualized approach to care, the very existence of a "one size fits all" dollar amount therapy cap provides yet more ambiguity for beneficiaries attempting to get coverage for outpatient therapy services.<sup>62</sup>

The federal district court furthered its opinion that Medicare beneficiaries should receive therapy coverage decisions based on individualized assessments of their unique clinical conditions by granting in part a motion for resolution of noncompliance of the settlement agreement set forth in *Jimmo v. Sebelius*.<sup>63</sup> In *Jimmo v. Burwell*, filed and decided on August 17, 2016, the Plaintiffs cited noncompliance with the original settlement agreement by the Secretary of Health and Human Services including a refusal to revise the Medicare Policy Manual and a deficient educational campaign.<sup>64</sup> The court agreed, stating that the Secretary provided non-responsive and incorrect information to Medicare contractors during training sessions which caused increased confusion regarding the newly established maintenance coverage standard.<sup>65</sup> The court also agreed with the Plaintiffs that the educational campaign, mandated by the settlement agreement, contained inaccurate information and did not explain the maintenance coverage standard.<sup>66</sup>

On February 1, 2017, the United States District Court of Vermont decided on a corrective action plan that the Secretary and CMS must follow to remedy their noncompliance with the original settlement agreement.<sup>67</sup> The corrective action plan includes numerous requirements including a disavowal of the application of the improvement standard as improper Medicare Policy.<sup>68</sup> Other requirements include a webpage dedicated to the *Jimmo* settlement with a Frequently Asked Questions (FAQs) section and a clarified summary provided to contractors and adjudicators regarding the new maintenance coverage standard to supersede misinformation previously provided by the Secretary.<sup>69</sup> To clarify any remaining confusion over the striking down of the improvement standard, the court ordered the disavowal to be specifically stated in the following terms, in part:

---

<sup>60</sup> Susan A. Edwards, Mary D. Van de Kamp, *Note and Comments: The Jimmo Settlement: Is It a Milestone Moment for Medicare Coverage?*, *Vol. 7, No. 3, J. Health & Life Sci. L. Pg. 1*, 1 (2014).

<sup>61</sup> *Ibid.*

<sup>62</sup> Jennifer E. Gladieux, Michael Basile, *Jimmo and the Improvement Standard: Implementing Medicare Coverage Through Regulations, Policy Manuals and Other Guidance*, 40 *Am. J. L. and Med.* 7, 22 (2014).

<sup>63</sup> *Jimmo v. Burwell*, 2016 U.S. Dist. LEXIS 109666, 1, 3 (D. Vt. Aug. 17, 2016).

<sup>64</sup> *Ibid.*

<sup>65</sup> *Jimmo v. Burwell*, 2016 U.S. Dist. LEXIS 109666, 1, 37-38 (D. Vt. Aug. 17, 2016).

<sup>66</sup> *Jimmo v. Burwell*, 2016 U.S. Dist. LEXIS 109666, 1, 42 (D. Vt. Aug. 17, 2016).

<sup>67</sup> *Jimmo v. Burwell*, 2017 U.S. Dist. LEXIS 14375, 1, 8-9 (D. Vt. Feb. 1, 2017).

<sup>68</sup> *Jimmo v. Burwell*, 2017 U.S. Dist. LEXIS 14375, 15 (D. Vt. Feb. 1, 2017).

<sup>69</sup> *Jimmo v. Burwell*, 2017 U.S. Dist. LEXIS 14375, 15-17 (D. Vt. Feb. 1, 2017).

*“The Centers for Medicare and Medicaid Services reminds the Medicare community of the Jimmo Settlement Agreement (January 2014), which clarified that the Medicare program will pay for skilled nursing and skilled rehabilitation services when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met). Specifically, the Jimmo Settlement adopted a ‘maintenance coverage standard’ for both skilled nursing and therapy services.”*<sup>70</sup>

The court ordered compliance with this Order by September 4, 2017.<sup>71</sup>

In addition to the elimination of the improvement standard, another argument for change to the current therapy cap billing process has been made by the Department of Health and Human Services with agreement from CMS in regards to questionable billing practices for Medicare outpatient therapy services.<sup>72</sup> In a report published by the Department of Health and Human Services in 2010, it was stated that Medicare expenditures for outpatient therapy services increased by 133 percent from 2000 to 2009 while the number of Medicare beneficiaries receiving therapy services only increased by 26 percent.<sup>73</sup> The report identified 20 counties in the United States with 1) the highest average payment per beneficiary and 2) more than \$1 million dollars for Medicare payments for outpatient therapy.<sup>74</sup> By studying the claims from these 20 high utilization counties, six questionable Medicare outpatient billing therapy practices came to light indicating possible fraud including: 1) exceeding the therapy cap for the same service consistently, 2) providers indicating that the therapy cap would be exceeded on the first day of the beneficiary’s service, 3) beneficiaries receiving outpatient therapy from multiple providers<sup>75</sup>, 4) payments for therapy services throughout the year<sup>76</sup>, 5) payments for therapy services exceeding the cap, and 6) providers receiving payments for more than 8 hours of outpatient therapy services in a single day.<sup>77</sup>

Based on these six questionable billing practices for outpatient therapy services, the Office of the Inspector General made four recommendations to CMS regarding outpatient therapy services including revising the current therapy cap exception process.<sup>78</sup> In his report, Inspector General Levinson stated: “The current therapy cap exception process does not ensure appropriate utilization of Medicare outpatient therapy services.”<sup>79</sup> The report went on to recommend that CMS revise the current therapy cap exception process to include per beneficiary

---

<sup>70</sup> [Jimmo v. Burwell, 2017 U.S. Dist. LEXIS 14375, 22-23 \(D. Vt. Feb. 1, 2017\).](#)

<sup>71</sup> [Jimmo v. Burwell, 2017 U.S. Dist. LEXIS 14375, 26 \(D. Vt. Feb. 1, 2017\).](#)

<sup>72</sup> Daniel R. Levinson, Inspector General, *Questionable Billing for Medicare Outpatient Therapy Services*, iii-iv (December 2010) available at <https://oig.hhs.gov/oei/reports/oei-04-09-00540.pdf>.

<sup>73</sup> Daniel R. Levinson, Inspector General, *Questionable Billing for Medicare Outpatient Therapy Services*, i (December 2010) available at <https://oig.hhs.gov/oei/reports/oei-04-09-00540.pdf>.

<sup>74</sup> *Ibid.*

<sup>75</sup> Indicating possible fraud on behalf of the beneficiary for over-utilization of therapy services.

<sup>76</sup> Receiving therapy services throughout the year can raise a red flag for lack of medical necessity if there is not documentation of onset of a new condition or need for therapy to prevent decline in functional status.

<sup>77</sup> Daniel R. Levinson, Inspector General, *Questionable Billing for Medicare Outpatient Therapy Services*, i (December 2010) available at <https://oig.hhs.gov/oei/reports/oei-04-09-00540.pdf>.

<sup>78</sup> Daniel R. Levinson, Inspector General, *Questionable Billing for Medicare Outpatient Therapy Services*, iii (December 2010) available at <https://oig.hhs.gov/oei/reports/oei-04-09-00540.pdf>.

<sup>79</sup> *Ibid.*



edits and a maximum payment amount; CMS concurred with this recommendation.<sup>80</sup> Though the report did not state that the caps should be eliminated, it clearly stated that the current billing process for Medicare outpatient therapy allows for possible fraudulent claims and does not provide any safeguards for proper utilization of therapy services.<sup>81</sup>

A third important consideration for eliminating the Medicare therapy cap is the need for extensive rehabilitative services for both acute conditions such as stroke and brain injury as well as chronic conditions such as Parkinson's disease and Multiple Sclerosis.<sup>82 83 84 85</sup> The goal of rehabilitation for acute diagnoses such as stroke and brain injury is to reduce impairment and increase independence.<sup>86</sup> With only 10% of stroke survivors having a complete recovery, most of the estimated 700,000 Americans that have a stroke every year are left with residual impairments and the need for rehabilitation.<sup>87</sup> Studies have shown that intensive rehabilitation after an acute stroke can significantly improve a patient's functional ability in their activities of daily living which improves the quality of their life.<sup>88</sup> Clinical practice guidelines recommend outpatient rehabilitation for stroke survivors recently discharged from an inpatient rehabilitation setting as well as less impaired stroke survivors discharged from the acute hospital setting, which means that >50% of stroke survivors should be going to outpatient therapy following a stroke.<sup>89</sup> Even years after a stroke, rehabilitation studies have documented improvement in chronic conditions secondary to stroke with continued outpatient therapy.<sup>90 91</sup>

When the Medicare therapy caps were put into place, physical therapy and speech therapy shared an allowed amount of funds while occupational therapy was assigned a separate allotment of funds, which is still the case today.<sup>92</sup> This situation creates a significant hardship on

---

<sup>80</sup> Daniel R. Levinson, Inspector General, *Questionable Billing for Medicare Outpatient Therapy Services*, iii-iv (December 2010) available at <https://oig.hhs.gov/oei/reports/oei-04-09-00540.pdf>.

<sup>81</sup> Ibid.

<sup>82</sup> J. Xie, et al., *Outpatient Rehabilitation Among Stroke Survivors-21 States and the District of Columbia, 2005*, MMWR Weekly, CDC, May 25, 2007, 56 (20);504-507, 504, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5620a4.htm>.

<sup>83</sup> YouRong Sophie Su, et al., *Translational Research in Traumatic Brain Injury*, Chapter 8 (2016).

<sup>84</sup> G. Kwakkel, *Impact of physical therapy for Parkinson's disease: A critical review of the literature*, Parkinsonism and Related Disorders, Vol. 13, Supplement 3, 478-487, 478 (2007).

<sup>85</sup> U. Daglas, et al., *Multiple sclerosis and physical exercise: recommendations for the application of resistance-, endurance-, and combined training*, Multiple Sclerosis 14, 35-53, 35 (2008).

<sup>86</sup> Bruce H. Dobkin, et al., *New Evidence for Therapies in Stroke Rehabilitation*, Current Atherosclerosis Reports, Vol.15, No. 6, 331, 331 (June 2013).

<sup>87</sup> J. Xie, et al., *Outpatient Rehabilitation Among Stroke Survivors-21 States and the District of Columbia, 2005*, MMWR Weekly, CDC, May 25, 2007, 56 (20);504-507, 504, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5620a4.htm>.

<sup>88</sup> Ibid.

<sup>89</sup> J. Xie, et al., *Outpatient Rehabilitation Among Stroke Survivors-21 States and the District of Columbia, 2005*, MMWR Weekly, CDC, May 25, 2007, 56 (20);504-507, 505, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5620a4.htm>.

<sup>90</sup> Jerzy P. Szaflarski, et al., *Constraint-induced aphasia therapy stimulates language recovery in patients with chronic aphasia after ischemic stroke*, Med Sci Monit, Vol. 14(5) 243, 243 (May 2008).

<sup>91</sup> J.G. Broeks, et al., *The long-term outcome of arm function after stroke: results of a follow-up study*, Disability and Rehabilitation, Vol. 21, Issue 8, 357, 357 (July 7, 2009).

<sup>92</sup> *Therapy Services, Spotlight*, (16 December 2016) <https://www.cms.gov/Medicare/Billing/TherapyServices/>.

beneficiaries requiring speech therapy due to the fact that aphasia is associated with increased mortality and overall higher utilization of healthcare resources.<sup>93</sup> With \$1,980 of funds split between physical therapy and speech therapy, beneficiaries have to decide whether they want to talk or walk again.<sup>94</sup> With the average yearly rehabilitation cost after a stroke being \$11,689, the combined yearly therapy cap for physical therapy, speech therapy, and occupational therapy of \$3,960 seems woefully inadequate.<sup>95</sup>

In the case of progressive and chronic diseases such as Parkinson's disease and Multiple Sclerosis, research shows that permanent treatment in the form of therapy is needed due to a decline in functional ability once therapy intervention has ended.<sup>96</sup> It is these beneficiaries who are the most negatively impacted when their therapy ends.<sup>97</sup> Ongoing physical therapy, occupational therapy, and speech therapy is needed for patients with these diseases to merely slow the deterioration of their functional abilities and, in the best circumstances, maintain what they are able to do day to day.<sup>98</sup> Whether a person has an acute condition or a chronic, debilitating one, early discharge from therapy due to meeting a therapy cap is inappropriate, can negatively impact a patient's long term health and decrease their overall independence.<sup>99</sup>

#### IV. Justifications Used for Keeping Therapy Caps in Place

As early as 1979, Congress showed its concern over rising therapy costs by passing legislation to cap the dollar amount a beneficiary could spend on rehabilitation services in a given year.<sup>100</sup> With Medicare spending accounting for 20% of the National Health Expenditure, an argument can easily be made for the need for cost controlling measures.<sup>101</sup> Two factors make this argument more relevant than ever: 1)The rising number of baby boomers reaching Medicare age, and 2)The striking down of the Medicare improvement standard discussed earlier in this paper.<sup>102 103</sup>

With 75 million Americans making up the baby boomer generation, approximately 3 million baby boomers will reach retirement age and potentially become Medicare eligible each

---

<sup>93</sup> Charles Ellis, PhD et al., *The One-Year Attributable Cost of Poststroke Aphasia*, *Stroke*, Vol. 43, 1429, 1429 (2012).

<sup>94</sup> Jennifer E. Gladieux, Michael Basile, *Jimmo and the Improvement Standard: Implementing Medicare Coverage Through Regulations, Policy Manuals and Other Guidance*, 40 *Am. J. L. and Med.* 7, 22 (2014).

<sup>95</sup> Kyler M. Godwin, et al., *Cost Associated with Stroke: Outpatient Rehabilitation Services and Medication*, *Topics in Stroke Rehabilitation*, Vol. 18, 676, 676 (2011).

<sup>96</sup> G. Kwakkel, et al., *Impact of physical therapy for Parkinson's disease: A critical review of literature*, *Parkinsonism & Related Disorders*, Vol. 13, Supplement 3, 478, 478, (2007).

<sup>97</sup> Susan A. Edwards, Mary D. Van de Kamp, *Note and Comments: The Jimmo Settlement: Is It a Milestone Moment for Medicare Coverage?*, Vol. 7, No. 3, *J. Health & Life Sci. L.* Pg. 1, 7 (2014).

<sup>98</sup> *Ibid.*

<sup>99</sup> *Self Help Packet for Outpatient Therapy Denials Including "Improvement Standard" Denials*, available at <http://www.medicareadvocacy.org/self-help-packet-for-outpatient-therapy-denials/>.

<sup>100</sup> *History of Medicare Therapy Caps*, (01/19/2016) <http://www.apta.org/FederalIssues/TherapyCap/History/>.

<sup>101</sup> *NHE Fact Sheet*, (June 2017), <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>.

<sup>102</sup> James R. Knickman and Emily K. Snell, *The 2030 Problem: Caring for Aging Baby Boomers*, *Health Services Research*, 37 (4), 849, 849 (August 2002).

<sup>103</sup> Susan A. Edwards, Mary D. Van de Kamp, *Note and Comments: The Jimmo Settlement: Is It a Milestone Moment for Medicare Coverage?*, *Vol. 7, No. 3, J. Health & Life Sci. L.* Pg. 1, 1 (2014).

year for the next 20 years.<sup>104</sup> As the baby boomers age, their health care costs will increase with Medicare costs projected to increase six fold by the year 2040, for those aged 85 and above.<sup>105</sup> Federal spending for Medicare, as a percentage of the Gross Domestic Product (GDP), is expected to increase by 73% between 2010 and 2030.<sup>106</sup> In 1998, President Clinton characterized health care costs of the elderly in the twenty-first century as one of several factors that “threaten the financial future of our nation.”<sup>107</sup> Biomedical ethicist Daniel Callahan used even more controversial language calling the elderly population “a new social threat” and proposed withholding lifesaving treatments for those over the age of eighty.<sup>108</sup> Changing public and political attitudes have emerged and containing Medicare costs now dominates the healthcare discourse and the energies of elected officials.<sup>109</sup> With Medicare eventually expected to become financially insolvent, the Bipartisan Commission to Reform Medicare is considering revenue generating proposals to Medicare such as raising the eligibility age, imposing means-testing, increasing premiums, and moving beneficiaries into managed care.<sup>110</sup> One reason that it is difficult to control Medicare costs is due to the fact that the current Medicare spending structure is mostly dependent on the amount and type of healthcare that a beneficiary needs and the expense in providing it.<sup>111</sup> For this reason, one can argue for the need for Medicare therapy caps to operate within a fixed budget that a “capped” program offers.<sup>112</sup>

A second argument to be made for keeping therapy caps in place to control Medicare spending has to do with the recent striking down of the improvement standard.<sup>113</sup> After 30 years of allowing the MACs to deny therapy claims based on lack of progress, CMS is now faced with paying for therapy services provided to thousands of beneficiaries annually who were previously denied services solely based on lack of progress in therapy.<sup>114</sup> When the therapy caps were first put in place, the Congressional Budget Office (CBO) estimated that it would save Medicare Part B \$5.2 billion over ten years.<sup>115</sup> However, the caps placed an excessive burden on beneficiaries who did not receive customized care decisions and on providers who had to calculate the caps.<sup>116</sup>

---

<sup>104</sup> Paul Barr, *Baby Boomers Will Transform Health Care as They Age*, Hospitals and Health Networks (January 14, 2014) <http://www.hhnmag.com/articles/5298-Boomers-Will-Transform-Health-Care-as-They-Age>.

<sup>105</sup> Edward L. Schneider, MD and Jack M. Guralnik, MD, PhD, *The Aging of America, Impact on Health Care Costs*, JAMA 263 (17), 2335, 2335 (1990).

<sup>106</sup> Robert H. Binstock, *Public Policies on Aging in the Twenty-First Century*, 9 Stan. L. & Policy Rev 311, 316 (Spring, 1998).

<sup>107</sup> Robert H. Binstock, *Public Policies on Aging in the Twenty-First Century*, 9 Stan. L. & Policy Rev 311, 317 (Spring, 1998).

<sup>108</sup> *Ibid.*

<sup>109</sup> Fernando M. Torres-Gil, *The New Aging: Individual and Societal Responses*, 10 Elder L.J. 91, 105 (2002).

<sup>110</sup> Fernando M. Torres-Gil, *The New Aging: Individual and Societal Responses*, 10 Elder L.J. 91, 106 (2002).\*

<sup>111</sup> Robert H. Binstock, *Public Policies on Aging in the Twenty-First Century*, 9 Stan. L. & Policy Rev 311, 316 (Spring, 1998).

<sup>112</sup> Robert H. Binstock, *Public Policies on Aging in the Twenty-First Century*, 9 Stan. L. & Policy Rev 311, 316 (Spring, 1998).

<sup>113</sup> Susan A. Edwards, Mary D. Van de Kamp, *Note and Comments: The Jimmo Settlement: Is It a Milestone Moment for Medicare Coverage?*, [Vol. 7, No. 3, J. Health & Life Sci. L. Pg. 1, 1 \(2014\)](#).

<sup>114</sup> *Ibid.*, p. 7.

<sup>115</sup> Jennifer E. Gladieux, Michael Basile, [Jimmo and the Improvement Standard: Implementing Medicare Coverage Through Regulations, Policy Manuals and Other Guidance](#), 40 Am. J. L. and Med. 7, 23 (2014).

<sup>116</sup> *Ibid.*

The exception process allowed for additional therapy services which cost Medicare about \$1 billion a year.<sup>117</sup> With the MACs implementing the improvement standard, many providers did not seek additional therapy services through the exception process out of fear of denials, which limited outpatient therapy costs.<sup>118</sup> CMS allowed the MACs to make the unpopular coverage determinations while recouping some of the money that the exception process cost.<sup>119</sup> The revision of this Medicare skilled care standard has increased program costs, though the final impact is still unclear.<sup>120</sup> Estimates put the cost of the increased utilization of therapy services at millions, and possibly billions of dollars.<sup>121</sup>

Other than controlling Medicare spending, another very important factor should be discussed in defense of keeping the therapy caps in place: Fraud, waste, and abuse.<sup>122</sup> In recent years, Office of Inspector General (OIG) reviews have identified outpatient physical therapy services as an area vulnerable to fraud, waste, and abuse.<sup>123</sup> In order for Medicare Part B to cover outpatient therapy services, very specific criteria must be met which is stated in CMS's *Medicare Benefits Policy Manual* and *Medicare Claims Processing Manual*.<sup>124</sup> These criteria state that services must be 1) medically reasonable and necessary, 2) be provided as set forth in a prescribed plan of care established by a qualified therapist, 3) be periodically reviewed by a physician, 4) have a physician's certification of need for such services, 5) be billed using standardized billing codes, and 6) that the services be provided by, or under the direct supervision of, a qualified therapist.<sup>125</sup> Unfortunately, many therapists do not comply with these criteria as one can deduce by reading the Department of Justice website press releases.<sup>126</sup> From January 2009 to June of 2016, \$18.3 billion dollars were recovered in False Claims Act cases involving health care programs.<sup>127</sup> In these cases, defendants allegedly submitted claims to Medicare that were incorrectly coded for a higher levels of reimbursement, provided treatments

---

<sup>117</sup> Ibid.

<sup>118</sup> Jennifer E. Gladieux, Michael Basile, *Jimmo and the Improvement Standard: Implementing Medicare Coverage Through Regulations, Policy Manuals and Other Guidance*, 40 *Am. J. L. and Med.* 7, 25 (2014).

<sup>119</sup> Ibid.

<sup>120</sup> Morris Klein, *2013 Emerging Issues 7131, Landmark Settlement Helps Medicare Patients Receive Skilled Care*, (December 23, 2013) available at <http://advance.lexis.com/search/?pdmfid=1000516&crd=e9818013-9a2f-4edc-8f0e-0ec970b3b649&pactivityid=670f2780-a675-4d98-9739-8720779e90f2&pdtargetclientid=-None-&comp=24ttk&prid=547c3771-438e-490f-8e20-2410548965f5>.

<sup>121</sup> Jennifer E. Gladieux, Michael Basile, *Jimmo and the Improvement Standard: Implementing Medicare Coverage Through Regulations, Policy Manuals and Other Guidance*, 40 *Am. J. L. and Med.* 7, 25 (2014).

<sup>122</sup> Ibid, p. 24.

<sup>123</sup> Brian P. Ritchie, Assistant Inspector General, *A Kansas Physical Therapy Practice's Outpatient Physical Therapy Services*, Department of HHS, Office of Inspector General, i (August 2016), <https://oig.hhs.gov/oas/reports/region7/71401146.pdf>.

<sup>124</sup> Ibid, p. 2.

<sup>125</sup> Sections 1862(a)(1)(A), 1861(p), and 1835(a)(2)(C) of the Act; 42 CFR §§ 410.60 and 410.61.

<sup>126</sup> *National Health Care Fraud Takedown Results in Charges against 201 individuals for Approximately \$900 Million in False Billing*, Department of Justice, Office of Public Affairs, (June 2016), <https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-charges-against-301-individuals-approximately-900>.

<sup>127</sup> *National Health Care Fraud Takedown Results in Charges against 201 individuals for Approximately \$900 Million in False Billing*, Department of Justice, Office of Public Affairs, (June 2016), <https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-charges-against-301-individuals-approximately-900>.

that were medically unnecessary, and/or billed for services that were never provided.<sup>128</sup> These three areas of fraud, waste, and abuse will be discussed in the next section of the paper as well as how keeping the therapy caps in place could help reduce fraudulent activity associated with Medicare billing for outpatient therapy services.<sup>129</sup>

The first area of fraud to be discussed is in regards to coding.<sup>130</sup> Upcoding occurs when a provider submits a claim to Medicare for a billing code that will generate a higher level of reimbursement than the actual service, procedure, or good that was provided.<sup>131</sup> When a therapist submits a claim to Medicare, there must be proper documentation in place to support the service that was provided so that Medicare can reimburse at the appropriate rate.<sup>132</sup> Failure to provide the appropriate code and accompanying documentation can have severe financial, and possibly criminal, consequences.<sup>133</sup> A chain of physical therapy clinics in 15 states settled a False Claim Act case for \$7 million when a whistleblower alleged that the clinics were upcoding group therapy charges to individual therapy charges, which would generate a significantly higher reimbursement rate.<sup>134</sup> Though the therapy caps do not prevent the practice of upcoding, the caps do help limit the overall charges submitted per patient.<sup>135</sup>

Another pervasive area of Medicare fraud involving therapy services is the practice of providing therapy to patients that is medically unnecessary.<sup>136</sup> The first criteria that must be met in order for Medicare to cover outpatient therapy services is that the services must be *reasonable and necessary*.<sup>137</sup> Medicare lists specific conditions that must be present in order for the service to be considered reasonable and necessary.<sup>138</sup> First, the therapy provided must be consistent with accepted standards of practice specific to the patient's condition.<sup>139</sup> Second, the patient's condition should warrant services that are of such a complex and sophisticated nature, that they can only be performed by a skilled, qualified therapist.<sup>140</sup> Third, the amount, frequency, and duration of services must be appropriate under accepted standards of practice.<sup>141</sup> Though the OIG has recommended that the therapy cap system be revised as it does not ensure proper

---

<sup>128</sup> Federal False Claims act and Qui Tam Litigation § 5.02.

<sup>129</sup> Daniel R. Levinson, Inspector General, *Questionable Billing for Medicare Outpatient Therapy Services*, iii, (December 2010) available at <https://oig.hhs.gov/oei/reports/oei-04-09-00540.pdf>.

<sup>130</sup> Federal False Claims act and Qui Tam Litigation § 5.02.

<sup>131</sup> *Ibid.*

<sup>132</sup> *Ibid.*

<sup>133</sup> *Ibid.*

<sup>134</sup> *Drayer Physical Therapy Institute, LLC Settle False Claims Act Case for \$7,000,000*, Department of Justice, U.S. Attorney's Office, District of South Carolina, (July 5, 2016)

<https://www.justice.gov/usao-sc/pr/drayer-physical-therapy-institute-llc-settle-false-claims-act-case-7000000>

<sup>135</sup> *Therapy Services, Spotlight*, (16 December 2016) <https://www.cms.gov/Medicare/Billing/TherapyServices/>.

<sup>136</sup> *National Health Care Fraud Takedown Results in Charges against 201 individuals for Approximately \$900 Million in False Billing*, Department of Justice, Office of Public Affairs, (June 2016),

<https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-charges-against-301-individuals-approximately-900>.

<sup>137</sup> *Medicare Benefits Policy Manual*, chapter 15 § 1862(a)(1)(A), 171 (2017).

<sup>138</sup> *Ibid*, p. 171-172.

<sup>139</sup> *Ibid*, p. 171.

<sup>140</sup> *Ibid*, p. 172.

<sup>141</sup> *Ibid*.

utilization of therapy services, the caps do seem to have stymied overutilization of services, unlike what is occurring in the skilled nursing facility (SNF) setting.<sup>142</sup>

The SNF industry has been a major focus for the DOJ's False Claims Act enforcement efforts in recent years, no doubt due to the \$30 billion that Medicare pays to skilled nursing facilities each year to care for America's elderly and infirmed.<sup>143</sup> In a series of reports from the Department of Health and Human Services, serious problems have been identified in the SNF industry related to a pattern of providing unnecessary skilled therapy services in order to inflate Medicare reimbursement amounts.<sup>144</sup> Whereas a therapy cap and exception process is in place for payment of claims for outpatient therapy services, billing for therapy services in a SNF is based on a Resource Utilization Groups (RUG) level.<sup>145</sup> RUGs are a metric used by Medicare and Medicaid to determine levels of needed resources in long term care facilities and are based on data elements derived from the long term care Minimum Data Sets (MDS).<sup>146</sup> The highest RUG levels warrant increased intensity and duration of therapy services which yields the largest revenues for therapy providers.<sup>147</sup> In 2009, the OIG found that one-quarter of SNF claims billed were in error resulting in \$1.5 billion in inappropriate Medicare payments.<sup>148</sup> A percentage of this erroneous billing was due to increased billing for higher paying RUGs although patients' ages and diagnoses at admission remained largely unchanged from previous years.<sup>149</sup>

Last year, the DOJ intervened in qui tam lawsuits against the nation's largest therapy provider, RehabCare Group Inc, and another large nursing home chain, SavaSeniorCare LLC, for billing Medicare for unnecessary therapy services.<sup>150</sup> The government reached a \$125 million settlement with RehabCare Group Inc and denied Sava's request to dismiss the DOJ's FCA complaint against the provider.<sup>151</sup> In the case against Sava, the government alleges that the fraud occurred due to corporate executives pressuring staff at individual facilities to increase RUG levels for increased Medicare reimbursement amounts regardless of patient's needs.<sup>152</sup> In a 2015

---

<sup>142</sup> Daniel R. Levinson, Inspector General, *Questionable Billing for Medicare Outpatient Therapy Services*, iii (December 2010) available at <https://oig.hhs.gov/oei/reports/oei-04-09-00540.pdf>.

<sup>143</sup> Jeanne Markey and Raymond M. Sarola, *DOJ Approach to Skilled Nursing Facility Fraud Is Affirmed*, Law 360, 1 (October 5, 2016).

<sup>144</sup> Jeanne Markey and Raymond M. Sarola, *DOJ Approach to Skilled Nursing Facility Fraud Is Affirmed*, Law 360, 1 (October 5, 2016).

<sup>145</sup> Anthony M. Tucker, PhD, *Resource Utilization Groups (RUGs)*, The Hilltop Institute, 2 (September 2, 2009), available at <http://www.hilltopinstitute.org/publications/ResourceUtilizationGroups-RUGs-September2009.pdf>.

<sup>146</sup> *Ibid.*

<sup>147</sup> Daniel R. Levinson, Inspector General, *Questionable Billing By Skilled Nursing Facilities*, i (December 2010), available at <https://oig.hhs.gov/oei/reports/oei-02-09-00202.asp>.

<sup>148</sup> Daniel R. Levinson, Inspector General, *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than A Billion Dollars In 2009*, i (November 2012), available at <https://oig.hhs.gov/oei/reports/oei-02-09-00200.pdf>.

<sup>149</sup> Daniel R. Levinson, Inspector General, *Questionable Billing By Skilled Nursing Facilities*, ii (December 2010), available at <https://oig.hhs.gov/oei/reports/oei-02-09-00202.asp>.

<sup>150</sup> Jeanne Markey and Raymond M. Sarola, *DOJ Approach to Skilled Nursing Facility Fraud Is Affirmed*, Law 360, 1 (October 5, 2016).

<sup>151</sup> Jeanne Markey and Raymond M. Sarola, *DOJ Approach to Skilled Nursing Facility Fraud Is Affirmed*, Law 360, 1 (October 5, 2016).

<sup>152</sup> *Ibid.*

report, the Department of HHS recommended a revision of the SNF payment process due to the current system incentivizing billing for unnecessary therapy services.<sup>153</sup> CMS agreed with this recommendation.<sup>154</sup>

A third area of fraud related to therapy services that warrants keeping the Medicare therapy caps in place is the billing of therapy services that were never provided.<sup>155</sup> The most obvious liability for a FCA violation occurs when a provider bills for a service that was never rendered.<sup>156</sup> Billing a service that was never provided can be one of the easiest types of fraud to prove in cases where the service involves supplying a tangible item, leaves a physical manifestation, or is painful, intrusive, and/or time consuming.<sup>157</sup> However, for services such as outpatient therapy, a number of factors can make proving the fraud difficult, including the patient's age, illness, and passage of time since the alleged fraudulent billing.<sup>158</sup> Also, if a patient does receive some therapy sessions, the patient may simply be unable to recall the dates/times of the real sessions versus the billed sessions that were never rendered.<sup>159</sup> Often, this type of fraudulent activity related to therapy services is discovered through the OIG reviewing and comparing providers' billing practices to identify outliers.<sup>160</sup> In the 2010 report by the OIG entitled *Questionable Billing for Medicare Outpatient Therapy Services*, one of the questionable billing characteristics was providers who were paid for more than 8 hours of outpatient therapy provided in a single day.<sup>161</sup> The report goes on to explain that this practice could signal that services are being billed that may not have been provided due to the infeasibility of providing more than 8 hours of therapy to a single beneficiary in a single calendar day because of the characteristics of the Medicare population and the nature of the service provided.<sup>162</sup> In 2009, a Detroit area provider pled guilty to paying hundreds of Medicare beneficiaries for their Medicare identification numbers after which he used the numbers to bill Medicare for physical therapy and occupational therapy services that were never rendered.<sup>163</sup> In 2015, the DOJ reported the same practice in two separate schemes in Brooklyn, New York, involving a total of \$58 million dollars in fraudulently billed physical therapy and occupational therapy services.<sup>164</sup> Unfortunately, the

---

<sup>153</sup> Federal False Claims Act and Qui Tam Litigation § 5.02.

<sup>154</sup> Daniel R. Levinson, Inspector General, *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than A Billion Dollars In 2009*, i (November 2012), available at <https://oig.hhs.gov/oei/reports/oei-02-09-00200.pdf>.

<sup>155</sup> *National Health Care Fraud Takedown Results in Charges against 243 Individuals for Approximately \$712 Million in False Billing*, Department of Justice, Office of Public Affairs, (June 2015), available at <https://www.justice.gov/opa/pr/national-medicare-fraud-takedown-results-charges-against-243-individuals-approximately-712>.

<sup>156</sup> Federal False Claims Act and Qui Tam Litigation § 5.02.

<sup>157</sup> Health Care Fraud Enforcement and Compliance § 2.02.

<sup>158</sup> *Ibid.*

<sup>159</sup> *Ibid.*

<sup>160</sup> Daniel R. Levinson, Inspector General, *Questionable Billing for Medicare Outpatient Therapy Services*, i (December 2010) available at <https://oig.hhs.gov/oei/reports/oei-04-09-00540.pdf>.

<sup>161</sup> *Ibid.*

<sup>162</sup> Daniel R. Levinson, Inspector General, *Questionable Billing for Medicare Outpatient Therapy Services*, 10 (December 2010) available at <https://oig.hhs.gov/oei/reports/oei-04-09-00540.pdf>.

<sup>163</sup> *Ibid.*, p. 4.

<sup>164</sup> *National Health Care Fraud Takedown Results in Charges against 243 Individuals for Approximately \$712 Million in False Billing*, Department of Justice, Office of Public Affairs, (June 2015), available at

complexity of the Medicare system provides numerous ways for unethical providers to bill for services that were never provided.<sup>165</sup> At least with the Medicare therapy caps in place, increased scrutiny is placed on claims that go beyond the allowed financial limit which helps to deter potential fraud.<sup>166</sup>

## V. Alternative Payment Models That Could Replace the Therapy Cap

The Medicare therapy cap were never intended to be a permanent policy with the original policy stating that an alternative payment method would be needed to replace the cap.<sup>167</sup> The legislative history of allowing the cap to go into effect, passing legislation to provide exceptions to the cap, and writing new legislation each one to two years to extend the cap is a piecemeal system that must finally be replaced.<sup>168</sup> Both private and public payers are increasingly moving towards payment models that will improve care and slow spending.<sup>169</sup> These new payment models are more patient-centered which allows for more individualized care decisions.<sup>170</sup> Three such payment models will be discussed in this section of the paper: Bundled Payment Model, Pay for Performance Model, and Severity Intensity Model.<sup>171 172</sup>

In the traditional fee-for-service model of reimbursement, Medicare pays separate payments to providers for each individual service they provide for a single illness or course of treatment.<sup>173</sup> A bundled payment model pays one lump sum to all providers for all services during an “episode of care.”<sup>174</sup> CMS defines an “episode of care” as all needed services provided to treat a clinical condition or procedure.<sup>175</sup> Whereas the Medicare therapy cap is a fixed amount for the entire year, a beneficiary could have multiple episodes of care during a year

---

<https://www.justice.gov/opa/pr/national-medicare-fraud-takedown-results-charges-against-243-individuals-approximately-712>.

<sup>165</sup> Health Care Fraud Enforcement and Compliance § 2.02.

<sup>166</sup> Jennifer E. Gladieux, Michael Basile, *Jimmo and the Improvement Standard: Implementing Medicare Coverage Through Regulations, Policy Manuals and Other Guidance*, 40 *Am. J. L. and Med.* 7, 24 (2014).

<sup>167</sup> Justin Moore, PT, DPT, *Expiring Medicare Provider Payment Policies*, United States House of Representatives Committee on Ways and Means, Subcommittee on Health, 4, (September 21, 2011).

<sup>168</sup> *Ibid.*

<sup>169</sup> Mary Laschober, et al., *Developing Alternative Payment Models: Key Considerations and Lessons Learned from Years of Collaboration with CMS*, Mathematica Policy Research, 1, (October 2015).

<sup>170</sup> Jennifer E. Gladieux, Michael Basile, *Jimmo and the Improvement Standard: Implementing Medicare Coverage Through Regulations, Policy Manuals and Other Guidance*, 40 *Am. J. L. and Med.* 7, 24 (2014).

<sup>171</sup> Mary Laschober, et al., *Developing Alternative Payment Models: Key Considerations and Lessons Learned from Years of Collaboration with CMS*, Mathematica Policy Research, 1, (October 2015).

<sup>172</sup> Andrew A. Guccione, et al., *Can “Severity-Intensity” Be the Conceptual Basis of an Alternative Payment Model for Therapy Services Provided Under Medicare?*, *Physical Therapy*, Vol. 91, Number 10, 1564, (October 2011).

<sup>173</sup> *Bundled Payments for Care Improvement (BPCI)* (14 July 2017)

<http://innovation.cms.gov/initiatives/bundled-payments/>.

<sup>174</sup> Mary Laschober, et al., *Developing Alternative Payment Models: Key Considerations and Lessons Learned from Years of Collaboration with CMS*, Mathematica Policy Research, 8, (October 2015).

<sup>175</sup> CMS announces additional participants in pilot project to improve care and reduce costs for Medicare (13 August 2015)

<http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-08-13.html>.



under the bundled payment model system.<sup>176</sup> In the CMS Bundled Payments for Care Improvement (BPCI) Initiative, there are four different models that are linked to inpatient hospital admission and vary by provider type and length of episode.<sup>177</sup> Models 2 and 3 would be most appropriate for reimbursement of outpatient therapy services after a hospital admission for such diagnoses as joint replacement, stroke, coronary artery bypass graft, etc.<sup>178</sup> In these models, Medicare would pay a fixed amount based on diagnoses related group (DRG) episodes to all providers who participated in the episode of care.<sup>179</sup> If a beneficiary had a knee replacement in January and an unrelated stroke in May, these would be considered two separate episodes of care reimbursed independently from each other.<sup>180</sup> The bundled payment model has several advantages over the outpatient therapy cap system currently in place: 1) a lump sum payment discourages unnecessary care, 2) there is no constraint on number of episodes that can be reimbursed, and 3) greater transparency of costs for patients and payers.<sup>181</sup> A possible disadvantage of applying this model to outpatient therapy reimbursement is that there is not always a distinct beginning and end of an episode of care for such chronic medical conditions such as Parkinson's disease and congestive heart failure.<sup>182</sup>

Another alternative payment model to replace the Medicare outpatient therapy cap is the pay for performance model which is based on the quality, not quantity of care.<sup>183</sup> In pay for performance models, quality and resource use measures determine reimbursement levels so that providers who work the most efficiently and can show the best outcomes are financially rewarded.<sup>184</sup> By linking provider performance to reimbursement, there is an incentive to lower costs and improve care delivery.<sup>185</sup> Pay for performance models can vary with a wide array of metrics used to determine reimbursement including: process metrics, outcome metrics, cost metrics, and/or patient satisfaction metrics.<sup>186</sup> To replace the Medicare outpatient therapy cap, a

---

<sup>176</sup> Terry Shih, MD, et al., *Will Bundled Payments Change Health Care? Examining the Evidence Thus Far in Cardiovascular Care*, *Circulation*, 131(24), 2151, 2152 (16 June 2015).

<sup>177</sup> CMS announces additional participants in pilot project to improve care and reduce costs for Medicare (13 August 2015)  
<http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-08-13.html>.

<sup>178</sup> *Bundled Payments for Care Improvement (BPCI)* (14 July 2017)  
<http://innovation.cms.gov/initiatives/bundled-payments/>.

<sup>179</sup> Ibid.

<sup>180</sup> Ibid.

<sup>181</sup> Terry Shih, MD, et al., *Will Bundled Payments Change Health Care? Examining the Evidence Thus Far in Cardiovascular Care*, *Circulation*, 131(24), 2151, 2152 (16 June 2015).

<sup>182</sup> Ibid.

<sup>183</sup> Mary Laschober, et al., *Developing Alternative Payment Models: Key Considerations and Lessons Learned from Years of Collaboration with CMS*, *Mathematica Policy Research*, 1, (October 2015).

<sup>184</sup> Mary Laschober, et al., *Developing Alternative Payment Models: Key Considerations and Lessons Learned from Years of Collaboration with CMS*, *Mathematica Policy Research*, 1, (October 2015).

<sup>185</sup> *Pay for Performance Model*, McKesson, available at: <http://www.mckesson.com/population-health-management/resources/pay-for-performance-model/>.

<sup>186</sup> Ibid.

pay for performance model utilizing outcome metrics would be most appropriate.<sup>187</sup> Under this proposed payment model, data would be gathered from patients who have received outpatient therapy services to develop a value-based purchasing payment algorithm (VPPA) based on measures of clinical improvement cross matched with number of treatment sessions.<sup>188</sup> The VPPA would then be used to determine future payments to outpatient therapy providers based on their clinical outcomes.<sup>189</sup> Providers would be paid a bonus for achieving predicted functional improvement in fewer than predicted sessions with providers receiving less reimbursement for less than predicted functional outcomes in more than the predicted number of sessions.<sup>190</sup> If this model is applied to the outpatient therapy setting, it could be an incentive for clinicians to use evidenced based, patient centered interventions to achieve the best outcomes in the shortest period of time.<sup>191</sup> Benefits of the pay for performance model include financial savings, increased provider engagement, and better patient care.<sup>192</sup>

The final alternative payment model to be considered is the severity intensity model that is based on a clinician's judgement of a patient's clinical severity and anticipated intensity of services needed to treat a patient's condition.<sup>193</sup> Currently, medical necessity for Medicare Part B therapy services is determined by information provided on the claims form which, except for the medical diagnosis, is not clinically related.<sup>194</sup> The one piece of information indicating the patient's clinical condition, the medical diagnosis, is often missing from claims forms or is unrelated to the therapy being provided, therefore, a poor predictor for therapy utilization.<sup>195</sup> In the severity intensity model of payment, medical necessity is based on the confluence of four factors: "the medical conditions of the patient, the physical impairments resulting from these conditions, the patient's ability to function, and an assessment of the specific sociocultural and environmental factors that enable the individual to participate in his or her various societal roles."<sup>196</sup> Considering these four factors together allows the clinician to use clinical judgement to determine the *severity* of the patient's condition and the *intensity* need for therapy.<sup>197</sup> These two pieces of information are then used to assign a per session code for payment of therapy services.<sup>198</sup> Specifically, during the therapy evaluation, patients are classified as either low clinical severity, moderate clinical severity, or high clinical severity.<sup>199</sup> The need for intensity of

---

<sup>187</sup> Dennis L. Hart, PhD, PT and Jerome B. Connolly, PT, CAE, *Pay for Performance for Physical Therapy and Occupational Therapy: Medicare Part B Services*, CMS, 3 (1 June 2006).

<sup>188</sup> *Ibid*, p. 7.

<sup>189</sup> *Ibid*.

<sup>190</sup> *Ibid*.

<sup>191</sup> *Ibid*, p. 9.

<sup>192</sup> *Pay for Performance Model*, McKesson, available at: <http://www.mckesson.com/population-health-management/resources/pay-for-performance-model/>.

<sup>193</sup> Andrew A. Guccione, et al., *Can "Severity-Intensity" Be the Conceptual Basis of an Alternative Payment Model for Therapy Services Provided Under Medicare?*, *Physical Therapy*, Vol. 91, Number 10, 1564, (October 2011).

<sup>194</sup> *Ibid*, p. 1566.

<sup>195</sup> Dennis L. Hart, PhD, PT and Jerome B. Connolly, PT, CAE, *Pay for Performance for Physical Therapy and Occupational Therapy: Medicare Part B Services*, CMS, 6 (1 June 2006).

<sup>196</sup> *Ibid*.

<sup>197</sup> *Ibid*.

<sup>198</sup> Justin Moore, PT, DPT, *Expiring Medicare Provider Payment Policies*, United States House of Representatives Committee on Ways and Means, Subcommittee on Health, 5 (September 21, 2011).

<sup>199</sup> *Ibid*.

therapy is also designated as low, moderate, or high based on a series of judgements made by the clinician such as how much of any specific procedure to deliver during a session, the administration parameters of a procedure, and the appropriate frequency of the procedure throughout the episode of care.<sup>200</sup> These per session costs would represent appropriate valuation of therapy services and reflect individual patient's conditions and complexity of services needed to treat those conditions.<sup>201</sup>

The benefits of this payment model include long-term cost savings through improved efficiency and accuracy in billing, more predictable therapy expenditures, and compliance with Medicare policy of providing medically necessary care that is driven by a functional goal based plan of care.<sup>202</sup> Additionally, patients could be compared by classification for outcome data and outliers could be easily identified for the purposes of fraud detection.<sup>203</sup>

#### IV. Conclusion

When the Balanced Budget Act of 1997 was enacted, the Medicare therapy cap went into effect.<sup>204</sup> This payment model, intended to be temporary, has now been a part of the Medicare reimbursement process for outpatient therapy services for twenty years, while providers and beneficiaries wait on Congress to agree on a more suitable payment methodology.<sup>205</sup> The time has now come for this change to finally be made. When federal courts struck down the *improvement standard* in *Jimmo v. Sebelius* and the approved Settlement Agreement was issued in 2013, CMS was mandated to approve therapy based on individualized care and medically necessity, not improvement.<sup>206</sup> *Jimmo v. Burwell* reinforced this ideology by ordering the Secretary of HHS to put a corrective action plan in place to remedy noncompliance with the approved Settlement Agreement.<sup>207</sup> These federal cases ended 30 years of illegally denying Medicare beneficiaries their right to medical treatment and require CMS to follow their own regulations of providing individualized coverage determination.<sup>208</sup> Following the same ideology, the one size fits all Medicare therapy cap should also be struck down.

---

<sup>200</sup> Andrew A. Guccione, et al., *Can "Severity-Intensity" Be the Conceptual Basis of an Alternative Payment Model for Therapy Services Provided Under Medicare?*, *Physical Therapy*, Vol. 91, Number 10, 1566 (October 2011).

<sup>201</sup> Justin Moore, PT, DPT, *Expiring Medicare Provider Payment Policies*, United States House of Representatives Committee on Ways and Means, Subcommittee on Health, 5 (September 21, 2011).

<sup>202</sup> *Ibid.*

<sup>203</sup> Andrew A. Guccione, et al., *Can "Severity-Intensity" Be the Conceptual Basis of an Alternative Payment Model for Therapy Services Provided Under Medicare?*, *Physical Therapy*, Vol. 91, Number 10, 1568 (October 2011).

<sup>204</sup> Justin Moore, PT, DPT, *Expiring Medicare Provider Payment Policies*, United States House of Representatives Committee on Ways and Means, Subcommittee on Health, 2 (September 21, 2011).

<sup>205</sup> *Ibid.*

<sup>206</sup> Jennifer E. Gladieux, Michael Basile, [\*Jimmo and the Improvement Standard: Implementing Medicare Coverage Through Regulations, Policy Manuals and Other Guidance\*](#), 40 *Am. J. L. and Med.* 7, 25 (2014).

<sup>207</sup> *Court Orders Corrective Action Plan for Government's Noncompliance with Settlement in Jimmo v. Burwell*, Center for Medicare Advocacy (February 2, 2017) <http://www.medicareadvocacy.org/court-orders-corrective-action-plan-for-governments-noncompliance-with-settlement-in-jimmo-v-burwell/>.

<sup>208</sup> Jennifer E. Gladieux, Michael Basile, [\*Jimmo and the Improvement Standard: Implementing Medicare Coverage Through Regulations, Policy Manuals and Other Guidance\*](#), 40 *Am. J. L. and Med.* 7, 25 (2014).

Though the cap was originally put in place as a savings measure to counter rising costs of outpatient therapy, excessive billing continues to occur in spite of the cap.<sup>209</sup> The OIG and Senate Finance Committee both recommended replacing the therapy cap with a medical review program that utilizes reviewing medical documentation for individual patient's cases.<sup>210</sup> The OIG stated in its 2010 report *Questionable Billing For Medicare Outpatient Therapy Services* that the therapy cap and exception process "does not ensure appropriate utilization of Medicare outpatient therapy services."<sup>211</sup> Though CMS agreed with the OIG's recommendations, the therapy cap payment system is still in place.

In this writer's opinion, the most essential reason for eliminating the therapy cap is because it limits access to needed therapy services that beneficiaries are not only entitled to, but require for regaining functional abilities so that they may live their lives as independently as possible. When clinical research shows that therapy can continue to be beneficial years after an acute episode such as stroke, a yearly cap is not consistent with best practice and can put a beneficiary in a situation where they must garner their resources, choosing between physical therapy and speech therapy when both may be needed.<sup>212</sup> The populations most affected by the therapy cap are those with chronic, progressive neurological diseases where ongoing therapy is needed to prevent deterioration of function.<sup>213</sup> Although the exception process is in place to allow providers to request additional therapy when a patient exceeds the cap, the MACs may still decide that the therapy is not medically necessary and deny the claim.<sup>214</sup>

With rising Medicare costs and a system fraught with fraud, waste, and abuse, an unchecked payment system for outpatient therapy is unrealistic.<sup>215</sup> However, instead of the fixed dollar amount cap, an alternative payment model should be put in place that takes into account a patient's diagnosis, level of severity, individual need for therapy, and/or provider's outcomes.

With the introduction of the Medicare Access to Rehabilitation Services Act of 2017 into the Senate (S.253) and House of Representatives (H.R.807) in February of this year, proponents for a reformed payment system for therapy are optimistic that there may finally be a change.<sup>216</sup>

---

<sup>209</sup> Daniel R. Levinson, Inspector General, *Questionable Billing for Medicare Outpatient Therapy Services*, i (December 2010) available at <https://oig.hhs.gov/oei/reports/oei-04-09-00540.pdf>.

<sup>210</sup> Jennifer E. Gladieux, Michael Basile, *Jimmo and the Improvement Standard: Implementing Medicare Coverage Through Regulations, Policy Manuals and Other Guidance*, 40 *Am. J. L. and Med.* 7, 24 (2014).

<sup>211</sup> Daniel R. Levinson, Inspector General, *Questionable Billing for Medicare Outpatient Therapy Services*, iii (December 2010) available at <https://oig.hhs.gov/oei/reports/oei-04-09-00540.pdf>.

<sup>212</sup> J.G. Broeks, et al., *The long-term outcome of arm function after stroke: results of a follow-up study*, *Disability and Rehabilitation*, Vol. 21, Issue 8, 357, 357 (July 7, 2009).

<sup>213</sup> Susan A. Edwards, Mary D. Van de Kamp, *Note and Comments: The Jimmo Settlement: Is It a Milestone Moment for Medicare Coverage?*, *Vol. 7, No. 3, J. Health & Life Sci. L. Pg. 1*, 6 (2014).

<sup>214</sup> *Manual Medical Review Process for Therapy Claims*, American Speech-Language Hearing Association, available at <https://www.asha.org/Practice/reimbursement/medicare/Manual-Medical-Review-Process-for-Therapy-Claims/>.

<sup>215</sup> Jennifer E. Gladieux, Michael Basile, *Jimmo and the Improvement Standard: Implementing Medicare Coverage Through Regulations, Policy Manuals and Other Guidance*, 40 *Am. J. L. and Med.* 7, 23 (2014).

<sup>216</sup> Available at: <https://www.congress.gov/bill/115th-congress/senate-bill/253/all-info>.

<sup>217</sup> The Senate bill has been read twice and referred to the Committee on Finance.<sup>218</sup> The House bill was read and referred to the Committee on Ways and Means as well as to the Committee on Energy and Commerce.<sup>219</sup> On February 10, 2017, the House bill was referred to the Subcommittee on Health.<sup>220</sup> The Tri-Alliance was invited to give testimony to this subcommittee on the need to repeal the therapy cap. On July 20, 2017, a joint statement was delivered by the American Physical Therapy Association CEO Dr. Justin Moore that stated that the therapy community was ready to work with legislators to finally end the burdensome cap and put a permanent payment model in place.<sup>221</sup>

Therapists provide an essential service that changes and saves lives. Therapy should be treated as an art of medicine and not just another line on a budget. Congress should eliminate the Medicare therapy cap at the end of this year. It is time to remove overly burdensome regulations that restrict access to care and put a viable system in place that recognizes that each patient is unique and has unique needs.

## **About the Author**

*Tina Ortolan holds a Bachelor of Science and a Master of Education in Speech Language Pathology with a Certificate of Clinical Competence from the American Speech-Language-Hearing Association. Tina has also earned a Master of Jurisprudence in Health Law from Loyola University Chicago. Tina has provided speech therapy services to adults for the past 22 years in the hospital setting, skilled nursing facilities, outpatient clinics, and in home health. In the past, Tina was a clinical faculty member in the Communication Disorders Department graduate program at the University of Houston. Currently, Tina is a Senior Speech Language Pathologist for Trinity Health in Michigan.*

---

<sup>217</sup> Available at: <https://www.congress.gov/bill/115th-congress/house-bill/807/all-info>.

<sup>218</sup> Available at: <https://www.congress.gov/bill/115th-congress/senate-bill/253/all-info>.

<sup>219</sup> Available at: <https://www.congress.gov/bill/115th-congress/house-bill/807/all-info>.

<sup>220</sup> Ibid.

<sup>221</sup> Available at: <https://www.aota.org/Advocacy-Policy/Congressional-Affairs/Legislative-Issues-Update/2017/Exciting-News-Therapy-Cap.aspx>.