History of the Medicare Therapy Cap

1972 — The 1972 Social Security Amendments (Public Law 92-03) expands the scope of existing Medicare coverage of outpatient physical therapy to include the services of a qualified physical therapist in independent practice when furnished in the therapist's office or the patient's home. The primary purpose of this amendment was to make physical therapy more readily available to the beneficiary in cases where the therapist's office might be more accessible than a provider facility to which the beneficiary must travel.

1979 — Section 279(b) of the Social Security Amendments of 1979 limits the payment for the services furnished by a physical therapist in independent practice to no more than $100 of the incurred expenses in a calendar year. This limitation reflected Congress' concern that the expansion in coverage would result in increasing the overall cost of physical therapy.

1994 — Section 143 of the "Social Security Amendments of 1994" requires the Secretary of Health and Human Services to conduct a study of the appropriateness of continuing the $900 cap under the Medicare program.

1997 — The "Balanced Budget Act of 1997" imposes $1,500 cap on outpatient therapy services. Section 4541 (c) and (d) of the act increased the financial limitation to no more than $1500 of the incurred expenses in a calendar year, and applied it to outpatient therapy services furnished in skilled nursing facilities, physician's offices, home health agencies (Part B), skilled nursing facilities (Part B), in addition to physical therapist private practice offices. The effective date of this $1,500 cap was January 1, 1999.

November 2, 1998 — HCFA publishes a final rule implementing the $1,500 cap, effective January 1, 1999.


December 21, 2000 — President Clinton signs "Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000", extending the moratorium of the $1,500 cap for an additional year, through 2002.

June 28, 2002 — The House passes a two-year extension of the cap moratorium as part of a comprehensive Medicare bill (H.R. 4954).

January 17, 2003 — A major study of Medicare claims from 1998 to 2000 confirms that the fee schedule for outpatient therapy services is responsible for controlling the growth in payments, not the $1,500 cap on those services. The long-awaited DynCorp report bolsters arguments that the therapy cap should be repealed. DynCorp analyzed claims data from more than 15 million outpatient therapy claims per calendar year, examining utilization based on beneficiary demographic characteristics, the setting in which services were furnished, and the patient’s primary claim diagnosis.
February 7, 2003 — The Centers for Medicare and Medicaid Services (CMS) issued a program memorandum officially delaying implementation of the therapy cap until July 1, 2003.

May 2, 2003 — The Centers for Medicare and Medicaid Services (CMS) issued a program memorandum which supplements PM AB-03-018, dated February 7, 2003. The PM adds a new MSN message, which would be effective October 2003, to inform patients about the cap. It also clarifies that due to consolidated billing SNF residents in the Medicare certified section of the facility would not be able to receive rehabilitation services from an outpatient hospital after the cap is exceeded. However, SNF residents who are in a non-Medicare certified section of the facility may be covered at the outpatient hospital facility. Beginning October, 2003, providers may access the accrued amount of therapy services from the ELGA and ELGB screens.

May 23, 2003 — CMS issued program memorandum AB-03-073, which includes an article for intermediaries and carriers to use to inform providers about implementation of the caps. It clearly identifies the settings and the services subject to the cap. It also explains that a beneficiary, physician, therapist, or supplier who accepts assignment may appeal a claim denied due to exceeding the cap. Physicians, therapists, and other suppliers who do not accept assignment and institutional providers do not have the right to appeal.

June 25, 2003 — The Medicare Rights Center, American Parkinson Disease Association, and Easter Seals brought a lawsuit against Tommy Thompson, secretary of the U.S. Department of Health and Human Services, and other government officials in U.S. District Court in Washington. The groups argued that CMS hadn't given its Medicare beneficiaries proper notice of the new caps, and sought a temporary restraining order preventing enforcement of the cap.

June 30, 2003 — The agency entered into a settlement agreement with the plaintiffs that enforcement of the cap would be delayed for 60 days. CMS would be committed to notify Medicare beneficiaries through Medicare Summary Notices and the CMS Web site that the caps will be enforced beginning September 1, 2003.

July 3, 2003 — In a program memorandum (AB-03-097), CMS announces the delay in implementation of the Part B therapy caps from July 1, 2003, to September 1, 2003.

September 1, 2003 — The $1590 cap went into effect.

September 4, 2003 — The plaintiffs in the lawsuit filed a motion to enforce the partial settlement agreement, or, in the alternative, to extend the moratorium on the cap to conform to representations made in the partial settlement agreement. They claimed that CMS stated that they would inform 90% of the Medicare beneficiaries about the cap, and that this goal was not achieved.

September 22, 2003 — Federal District Court Judge Emmet G. Sullivan ruled that CMS could enforce the caps.

October 8, 2003 — A hearing was scheduled regarding the policy that Medicare beneficiaries in SNFs cannot go to an outpatient hospital department after exceeding the cap due to consolidated billing.

December 8, 2003 — The President signed into law the Medicare Prescription Drug Improvement and Modernization Act (DIMA). The law placed a moratorium on the implementation of the cap beginning December 8, 2003, through December 31, 2005. The act requires the Secretary of HHS to submit reports required by the BBA of 1997 and BIPA on outpatient therapy utilization and alternatives to the cap.
These reports must be submitted by March 31, 2004. The act also requires the GAO to study and report to Congress no later than October 1, 2004, on diagnoses that are likely to exceed the cap.

**January 1, 2006** — Therapy caps go into effect.

**February 1, 2006** — Congress passes the Deficit Reduction Act including a provision to allow CMS to develop an exceptions process for beneficiaries needing coverage above the therapy caps - but only through December 31, 2006.

**March 13, 2006** — CMS implements the therapy cap exceptions process allowing for either automatic or manual exceptions to the therapy cap.

**December 7, 2006** — Congress passes the Tax Relief and Health Care Act of 2006 including a provision to extend the therapy cap exceptions process through December 31, 2007.

**July 12, 2007** — The Centers for Medicare and Medicaid Services (CMS) releases "Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008 and Other Part B Payment Policies," also known as the Medicare physician fee schedule proposed rule. CMS states that in accordance with the statute, it will continue to implement the therapy caps, but the therapy cap exceptions process will no longer be applicable beginning January 1, 2008. Congressional action is necessary to repeal the therapy cap, place a moratorium on its implementation, or extend the exceptions process in 2008.

**December 29, 2007** — President Bush signs the "SCHIP, Medicare, and Medicaid Extension Act" (PL 110-173) into law providing a six month extension of the exceptions process to July of 2008.

**July 15, 2008** — President Bush signs the "Medicare Improvement for Patients and Providers Act" (MIPPA) (PL 110-275) which provides for an 18 month extension of the exceptions process through the end of 2009.

**January 1, 2010** — Due to a lack of Congressional action, the therapy cap exceptions process expires with a $1,860 cap on Physical Therapy and Speech Language Pathology services.

**March 3, 2010** — President Obama signs HR 4691, the "Temporary Extension Act of 2010" reinstating the therapy cap exceptions process until March 31, 2010.

**March 23, 2010** — President Obama signs HR 3590, the "Patient Protection and Affordable Care Act" which extended the therapy cap exceptions process until December 31, 2010.

**December 15, 2010** - President Obama signs Senate Amendment to HR 4994, the "Medicare and Medicaid Extenders Act of 2010" which includes an extension to the Medicare therapy cap exceptions process until December 31, 2011.


**February 22, 2012** - President Obama signs H.R. 3630, the “Middle Class Tax Relief and Job Creation Act of 2012” which includes a 10 month extension of the Medicare therapy cap exceptions process until December 31, 2012.