Part B Insider (Multispecialty) Coding Alert

Follow These 7 Steps to Secure Your Outpatient Therapy Payments

Hint: Once you're past the cap amount, ABNs are strongly recommended (although not required).

As most Part B practices are aware, therapy cap exceptions now apply through Dec. 31, thanks to the Middle Class Tax Relief and Job Creation Act of 2011 (H.R. 3630) signed into law in February. But there's more to the story--and Part B therapy providers should stay on their toes, because the law presents a few new twists.

Check out these seven simple steps to ensure you don't come up short when trying to collect for your therapy services.

1) Know the cap levels. "For 2012, the therapy caps are $1,880 for occupational therapy (OT) services and $1,880 for combined physical therapy (PT) and speech language pathology (SLP)," said CMS's **Stewart Streimer** during an April 17 Open Door Forum.

2) Manual medical review will take place for high-dollar claims. Therapy caps kick in at $1,880, but effective Oct. 1, 2012, any therapy services that exceed a $3,700 threshold per category (e.g., $3,700 for OT and $3,700 for PT and SLP) will be subject to a manual medical review process, Streimer added.

"If a claim exceeds that, if it's got the KX modifier on it, it will be required to have manual medical review," Streimer said. "If it doesn't have the KX modifier, like any other claim that exceeds the therapy cap, it will be denied."

The American Occupational Therapy Association, American Physical Therapy Association, and American Speech-Language Hearing Association are arranging meetings with CMS to discuss what the review process will entail.

"One of the reasons why $3,700 was picked is because 95 percent of claims never reached that level," explains AOTA's **Tim Nanof**. Remember: "All therapy claims are still subject to medical review," Nanof says. "Standards for coverage or medical necessity do not change at $3,700."

"We are also requesting, along with APTA and AOTA, that the manual medical review be performed by like professionals; for example, reviews for speech pathology services should be performed by an SLP," reports ASHA's **Lisa Satterfield**.

3) Payers are cracking down on details. The new law mandates that the KX modifier is a must. "Previously, when a therapist or an agency would forget a KX modifier, they were still getting paid," Nanof says. "We're expecting that CMS will have some sort of automatic edits to deny those claims, so it's very important that therapists use the KX modifier on all claims over $1,880."

In addition, starting Oct. 1, 2012, all therapy claims -- regardless of whether they are above or below the caps -- must include the referring physician's National Provider Identifier (NPI).

4) Premonitions of payment reform. The new legislation requires CMS to begin collecting data from therapy claims, starting Jan. 1, 2013. The **Medicare Payment Advisory Commission** has already been looking closely at rehab, according to APTA's **Gayle Lee**.

In a March 9 meeting, MedPAC went public with some stats that scrutinize growing therapy usage under the caps, according to Satterfield, the first being that physical therapy covers 73 percent of the spending under therapy caps. Secondly, Med-PAC revealed an eightfold increase in speech claims between 2009 and 2010. "In 2010, SLPs were able to bill independently for the first time, so we take that into consideration, but we did not expect an 8x increase, and we're investigating that," Satterfield says.

"We'll continue to push to get rid of the cap and replace it with an alternative payment methodology," Lee assures.

"We've also been working on our own approach that involves developing per session codes that correct for procedure codes."

5) Hospital participation will be mandatory. For the first time in therapy cap history, hospital outpatient department settings will have to participate -- but not until October through December of 2012.

"Beginning October 1, hospital outpatient department therapy services will be looked at against the therapy cap," Streimer said on the April 17 call. "In addition, outpatient hospitals may begin using the KX modifier for exceptions for those therapy services which exceed the cap," he added.

"Initially there was some discussion about permanently applying the therapy cap to the hospital outpatient setting as a way to pay for a longer extension of the exceptions process," Nanof says. "We opposed that because the hospital outpatient setting has been a safety net for beneficiaries."

Critical access hospitals tend to have very high-cost patients, Lee reports. "So we're also seeking clarification from CMS on their participation."

6) When patients exceed cap, ABN is encouraged. If you know a patient has exceeded the therapy cap and the patient still wants you to provide a therapy service, your best bet is to have the patient sign an advance beneficiary notice (ABN) to confirm that he knows he will have financial responsibility for the service.

"We are encouraging providers to supply the voluntary ABN to their patients," a CMS rep added during the April 17 call.

7) It's up to you to explain cap to patients. When a caller to the April 17 forum asked whether CMS would be educating Medicare beneficiaries about changes to the therapy cap, Streimer said no, noting that medical practices will have to let patients know the details of the cap.

"It will be up to the therapist to basically work with the beneficiary and advise them of their rights and what the potential is in terms of having their services paid for," Streimer said. He did add, however, that he plans to discuss the issue with CMS's beneficiary relations department regarding whether patients should be apprised of the changes.