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Eli's Rehab Report

Outpatient Outlook: Grab Some Last-Minute Insight On Therapy Cap Changes

Providers play dodge ball with snafus in CMS' NPI assignments.

Scrambling to prepare for CMS' new take on therapy caps? You're not alone. Starting Oct. 1, the Centers for Medicare & Medicaid Services begin phasing in outpatient rehab providers to manual medical review. After a patient reaches $3,700 of therapy dollar reimbursement for occupational therapy, or speech and physical therapy combined, the therapy provider must apply to CMS for advanced approval of further claims.

Snag: All the fuss may be for naught when Jan. 1 rolls around. Congress needs to act by the end of the year to keep therapy cap exceptions in place, as well as the new manual medical process.

That means, "we may be implementing a complex process for two months, then it may go away. That is a little disconcerting," comments **Meryl Freeman, MS, PT,** manager of outpatient rehabilitation for **Rex Healthcare** in Raleigh, NC.

Hospital providers, especially, are under pressure to ramp up, having never been subject to therapy caps before. "For us, accurately tracking the cap, getting the KX modifiers on the claims in a timely manner, and making sure our documentation supports the exceptions/appending the KX modifier are all concerns," Freeman shares. "Our billing, HIM and therapy departments are meeting to finalize a process next week."

"We are working very closely with our coding and patient financial services department, preparing educational information for our patients and our therapists," says **Nicole Scheiman, OTR/L, MHS, CEES, CKTP, CLT-LANA, CSST,** director of rehabilitative and wellness services at **Florida Hospital DeLand Sports Medicine and Rehabilitation**. "It is critical we all understand the process and are on the same page."

Tight spot: Some outpatient hospital departments see a high volume of Medicare patients, adding to the challenge. "We are trying to find ways to meet the requirements that won't tax our therapists, front office staff, and billing department," Freeman says.

Manual medical review throws an additional curve ball. "This may typically hit our multi-disciplinary patients, medically complicated patients, or lymphedema patients who may need longer term care," Freeman adds.

Beware NPI Confusion

CMS used national provider identifier (NPI) numbers to assign rehab providers phase-in dates to manual medical review (either Oct. 1, Nov. 1, or Dec. 1).

Major glitch: Some providers received more than one phase-in date notification from CMS. The problem stemmed from individual therapists having their own NPI numbers yet working for and reassigning to a group that has a separate NPI number, explains **Donna Senft, JD, PT,** healthcare attorney with **Ober/Kaler** in Baltimore.

"We posted a question to CMS, about this," Senft continues. "They said to use the NPI number on the claim form used to bill for services. Since there are multiple NPI numbers on the claim form, we asked them to clarify if they were referring to the NPI number that goes on the 1500 form in Box 33A,or the treating therapist NPI number that goes with Box 24J.'" At press time, CMS confirmed that it is the NPI in Box 33A.

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CMS recently sent letters to Medicare beneficiaries to inform them if they were reaching the $3,700 limit.

These letters have tended "to elicit fear," Scheiman reports. That said, "It is very important to educate patients and therapists that the cap doesn't mean therapy [automatically] stops." You want to explain that if additional care is medically necessary, the rehab provider must take further steps to approve continued therapy.

In the past, the Notice of Exclusion of Medicare Benefits (NEMB) form was considered most appropriate to inform patients that services above therapy caps were statutorily non-covered (if there were no exceptions). But for manual medical review cases, CMS and several professional rehab associations suggest using the Advance Beneficiary Notice of Non-coverage (ABN) form.

"The reason for suggesting the ABN may be because the services may still be covered; there simply is no required exclusion of coverage for services beyond the $3,700 limit," Senft explains.

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