

Eli's Rehab Report

Outpatient Outlook: Therapy Cap Exceptions Lose Prior Approval Process Under New Interim Guidance

Hold tight: CMS promises a more permanent solution soon.

In late February, the **Centers for Medicare & Medicaid Services** (CMS) released interim guidance for patients hitting the \$3,700 therapy cap threshold. The agency said it will not offer advanced approval of extra therapy visits like it did in 2012. Instead, additional claims will fall under prepayment review (manual medical review).

Before: From October through December of 2012, CMS allowed therapists to apply with their MACs for advanced approval of up to 20 additional therapy visits if claims hit the \$3,700 threshold for occupational therapy or speech/physical therapy combined. Therapists who missed the opportunity for advanced approval had to wait on prepayment review, which could take up to 60 days.

CMS Pushes for Shorter Wait

Now, when your patient reaches \$3,700 in outpatient therapy services, your MAC will send you an additional development request (ADR); then, you'll submit documentation supporting the need for additional therapy. Once the MAC receives your paperwork, it will conduct the prepayment review.

Many therapy providers are concerned about the lapses in rehab care while waiting for the MAC's decision. And providers that bill on 30-day cycles could be hit the worst.

Example: A patient receiving therapy at a hospital hits \$3,700 at the beginning of March, but the hospital doesn't submit its bills for payment until March 31. "The prepayment review wouldn't be triggered until March 31," explains **Gayle Lee, JD**, senior director of health finance and quality for the **American Physical Therapy Association**. "And the 60 day wait doesn't start until the contractor receives the documentation."

Saving grace: You might not have to wait the full 60 days for the MAC to give you the go-ahead for additional therapy. "In the interim guidance, CMS encouraged that the MACs turn a decision around in 10 days."

Because CMS used the term "encouraged," some of the contractors, however, are arguing that the language doesn't specifically say "mandatory" for the 10-day turnaround, Lee says. So don't be surprised if your decision comes late.

Hold Out for a Better Overall Solution

If it softens the blow of losing advanced approval, it was a less-than-perfect system.

"While in theory the 20-visit advanced approval would reduce waiting times and interruptions to care, in practice we found that care was disrupted, or patients or providers were burdened with the unexpected financial liability," points out **Lisa Satterfield**, director of health care regulatory advocacy for the **American Speech-Language Hearing Association**.

For instance, "the MACs did not have the ability to accept reviews electronically," Satterfield notes. Providers had to mail

or fax all their documents without confirmation that they were received. In addition, the 10-day turnaround didn't always happen because determinations were sent via mail or sent to the patient or primary care physician instead of the therapy provider, Satterfield adds.

Watch for: "CMS told us that they are going to issue a more permanent manual medical review policy soon," Lee says.

For now, keep your documentation as solid as ever to ensure smooth prepayment reviews. "Make sure all of the pertinent information is included," Satterfield says. That means assessment of improvement and goals, plans for continued treatment, functional outcome reporting, etc., to justify the necessity of your continued skilled services.