Codify
BY AAPC

Eli's Rehab Report

Therapy Caps: Jump on the Advanced Approval Bus if You're Pushing $3,700

Get advanced approval, or wait up to 60 days to get high-dollar claims reviewed.

CMS has finally revealed details about the manual medical review process for therapy dollar amounts exceeding $3,700. Last February, the Middle Class Tax Relief and Job Creation Act of 2012 (H.R. 3630) saved the therapy cap exceptions process by a hair -- but not without a catch. Effective Oct. 1, 2012, after a patient hits $3,700 in exceptions, further therapy payments will be subject to manual medical review.

Don't miss: H.R. 3630 also deemed outpatient hospital rehab under this new therapy cap system. Critical access hospitals are not, however, included.

Prepare for a Time-Crunch

Experts predict a massive scramble as rehab providers and their Medicare administrative contractors have about a month to get up to speed before everything goes live Oct. 1.

How it works: The first level to therapy cap exceptions stays the same. When you hit the $1,880 therapy cap, bill with the KX modifier -- as long as you're under $3,700 for OT or for PT/SLP combined. If you hit or exceed $3,700 in your claims, your reimbursement will stop, and CMS will request medical records for a prepayment review -- which could take up to 60 days.

Better option: CMS has offered providers to get advanced approval for payments above $3,700, which allows patients to receive up to 20 more days of therapy -- and this approval will take only 10 business days. But you have to apply before your claims hit $3,700. You can submit a request for advanced authorization up to 15 days before manual medical review takes effect. So if you know you're going to reach $3,700, get the ball rolling sooner than later.

"AOTA is advising outpatient therapy providers to use voluntary Advance Beneficiary Notices (ABNs) and to request pre-approval in a timely manner so that medically necessary therapy need not be halted," says **Jennifer Hitchon** regulatory counsel for the American Occupational Therapy Association.

Important: Advance approval doesn't guarantee reimbursement. Your MAC can still retroactively review and deny your claims based on the usual rules in the Medicare Benefits Policy Manual.

Just understanding the process is the first challenge, says **Gayle Lee,** senior director of health finance and quality for the American Physical Therapy Association."There's not much time for therapists to come up to speed, so we're concerned from an educational standpoint."

Key: "The other big piece is whether the MACs will be ready and whether they will have a good process in place, especially at the local level," Lee adds.

Cross Your Fingers for Phase 3 -- Especially Hospitals

CMS opted for a 3-part phase-in system to keep MACs from being overloaded with the new manual medical review process. MACs must notify you by Sept. 1 of your assigned phase. Providers in phase 1 will be subject for manual medical review Oct.1, those in Phase 2 will be subject Nov. 1, and providers in Phase 3 will be subject Dec. 1.

Remember: If, after Oct. 1, you are above $3,700 and have not phased in yet, submit your claims as usual with the KX

modifier until your specific phase-in date takes effect, CMS advised in a Special Open Door Forum.

"Barring additional Congressional action, some outpatient therapy providers will only be subject to review for one month," Hitchon points out.

Deciding method: CMS will not put rehab providers into the phases arbitrarily. "CMS has not made clear what algorithm they will use to determine providers' phase-in dates, but the factors under consideration include geographic area, beneficiary volume, billing practices, MAC workload," Hitchon says.

One fact we do know is, "anyone that recently came into the Medicare system -- within the last three to four months -- will automatically be put into Phase 3," notes **Mark Kander,** director of health care regulatory analysis for the American Speech-Language Hearing Association.

Unfortunately, hospitals are going to be in a tough spot, regardless. MACs will not have the data files listing this year's reimbursed therapy dollar amounts available to you until Oct. 1. -- the day this all goes into place, Kander points out.

"This means hospitals won't even know if they should be applying for advance approval -- and we're most concerned about the group that [phases in]on Oct. 1," Kander says. And those in Phase 1 also won't have a chance to submit an advanced approval request 15 days in advance.

Silver lining: If your MAC doesn't respond to your request for advanced approval within 10 days, your claims beyond $3,700 are automatically approved. "We were really happy to see this," Kander says.

Resource: For more information, view CMS' transcript of the special open door forum on manual medical review here: www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/080712TherapyClaimsSODFAnnouncementTranscriptAudio.pdf.