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Outpatient Facility Coding Alert

Reimbursement: Keep a Check on Therapy Caps, or Risk Repeated Reviews

Get advanced approval if patient nears $3,700, or wait up to 60 days for CMS payment.

If your ASC provides therapy services, get ready for closer scrutiny. All therapy payments are subject to CMS manual medical review after the patient reaches $3,700 in exceptions, effective Oct. 1, 2012.

Know When KX Still Applies -- and When It Doesn't

The first level to therapy cap exceptions remains the same, even after Oct. 1. When the patient reaches the $1,880 therapy cap, bill your services with modifier KX (Requirements specified in the medical policy have been met). Verify, however, that the cumulative bill is still under $3,700 for OT or for PT/SLP combined. If your claims for the patient reach or exceed $3,700, your reimbursement will stop and CMS will request medical records for a prepayment review. The review process could take up to 60 days.

Plan ahead: If you think the patient's therapy will surpass $3,700, CMS offers a loophole of sorts to keep your payments coming. You can apply for advance approval of payments above $3,700. Approval only takes 10 business days, and allows patients to receive up to 20 more days of therapy. You must request advance authorization before reaching the $3,700 mark, however -- up to 15 days before the manual medical review goes into effect.

If your MAC doesn't respond to your request for advanced approval within 10 days, your claims beyond $3,700 are automatically approved.

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

Caution: Advance approval of the patient's therapy 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.

The biggest challenge for many facilities lies in understanding the process, according to **Gayle Lee,** senior director of health finance and quality for the American Physical Therapy Association (APTA).

Learn When the New System Applies to Your ASC

CMS is implementing the system over a three-month period to keep MACs from being overwhelmed with the new manual medical review process. 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.

"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, and MAC workload," Hitchon says.

Remember: If, after Oct. 1, you are above $3,700 and have not been 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.

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.

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