Long-Term Care Survey Alert

What Do You Think?: Follow This Expert's Advice on SNF Part B Therapy Billing

The following Q&As were provided courtesy of **Rick Gawenda, PT**, principal of **Gawenda Consulting and Education** (www.gawendaseminars.com).

Question: Where do I find information about the amount of dollars that my patient has accrued toward the therapy cap?

Answer: All providers and contractors may access the accrued amount of therapy services from the ELGA screen inquiries into CWF. Providers/suppliers may access the remaining therapy services limitation dollar amount through the 270/271 eligibility inquiry and response transaction. Providers who bill to Medicare Part A contractors or fiscal intermediaries will find the amount a beneficiary has accrued toward the financial limitations on the HIQA.

Private practices billing to Medicare Part B contractors or carriers may, in addition, have access to the accrued amount of therapy services from the ELGB screen inquiries into CWF. Suppliers and providers who do not have access to these inquiries may call the contractor to obtain the amount accrued.

Question: What is the current status on the therapy cap and the therapy cap exception process for 2012?

Answer: As of Jan. 1, 2012, the therapy cap is in place for all settings except for outpatient hospital therapy departments. The therapy cap dollar amount in 2012 is $1,880 for PT and SLP combined and a separate $1,880 for OT. This dollar amount is based on the Medicare allowed amount, not what you bill or get reimbursed by the Medicare program. The dollar amount is calendar year, Jan. 1-Dec. 31, 2012, and not per episode of care.

No later than Oct. 1, 2012, the Centers for Medicare & Medicaid Services (CMS) must implement the therapy cap to outpatient hospital therapy departments who are reimbursed under the Medicare Physician Fee Schedule. The therapy cap applied to outpatient hospital therapy departments will expire at the end of 2012 unless Congress passes additional legislation to continue the therapy cap into 2012 and beyond.

Starting Oct. 1, claims for patients who meet or exceed $3,700 in therapy expenditures in a calendar year will be subject to a manual medical review. The legislation designates that this medical review will be similar to the process used following implementation of the Deficit Reduction Act in 2006. The $3,700 threshold will be applied to a combined physical therapy and speech language pathology cap. A separate $3,700 threshold will be applied to the occupational therapy cap.

Rehab professionals are awaiting a transmittal release from CMS on how they will implement the therapy cap to outpatient hospital therapy departments as well as how the manual medical review process will work. Stay tuned for further updates.