

## MDS Alert

### Medicare Part B: Therapy Caps Exceptions Get Legislative Boost

#### Hospitals to play a key part starting in October.

Therapy cap exceptions, as well as the 2011 Medicare Physician Fee Schedule conversion factor now apply through Dec. 31, 2012. And it's all thanks to last-minute congressional action, via the Middle Class Tax Relief and Job Creation Act of 2011 (HR 3630).

But stay on your toes -- this legislation presents a few new twists:

1. Manual medical review. Therapy caps kick in at \$1,880, but effective Oct. 1, 2012, any therapy claims above \$3,700 will be subject to a manual medical review process. The American Occupational Therapy Association, American Physical Therapy Association, and American Speech-Language Hearing Association are currently arranging meetings with CMS to discuss what the review process will entail.

"One of the reasons why \$3,700 was picked is because 95 percent of claims never reached that level," explains **Tim Nanof**, director of federal affairs for AOTA.

Remember: "All therapy claims are still subject to medical review," Nanof tells **Eli**. "Standards for coverage or medical necessity do not change at \$3,700."

"We are also requesting, along with APTA and AOTA, that the manual medical review be performed by like professionals; for example, reviews for speech pathology services should be performed by an SLP," reports **Lisa Satterfield, MS, CCC/A**, director of health care regulatory advocacy for ASHA.

2. Hospital participation. For the first time in therapy cap history hospital outpatient department settings will have to participate "but not until this October through December of 2012.

"Initially there was some discussion about permanently applying the therapy cap to the hospital outpatient setting as a way to pay for a longer extension of the exceptions process," Nanof says. "We opposed that because the hospital outpatient setting has been a safety net for beneficiaries."

"People in critical access hospitals have expressed some concerns to us because they tend to have very high-cost patients," reports **Gayle Lee**, director of federal payment and regulatory affairs for the APTA. "So we're also seeking clarification from CMS on their participation."

3. Cracking down on details. The new law mandates that the KX modifier is a must. "Previously, when a therapist or an agency would forget a KX modifier, they were still getting paid," Nanof says. "We're expecting that CMS will have some sort of automatic edits to deny those claims, so it's very important that therapists use the KX modifier on all claims over \$1,880."

In addition, starting Oct. 1, 2012, all therapy claims -- regardless of whether they are above or below the caps -- must include the referring physician's National Provider Identifier.

4. Premonitions of payment reform. The new legislation requires CMS to begin collecting data from therapy claims, starting Jan. 1, 2013. MedPAC has already been looking closely at rehab, according to Lee, and, in fact, had a meeting on March 9, to discuss its current findings and upcoming tasks required in the legislation.

In that meeting, MedPAC went public with some stats that scrutinize growing therapy usage under the caps, according to Satterfield, the first being that physical therapy covers 73 percent of the spending under therapy caps. Secondly,

MedPAC revealed an eightfold increase in speech claims by between 2009 and 2010. "In 2010, SLPs were able to bill independently for the first time, so we take that into consideration, but we did not expect an 8x increase, and we're investigating that," Satterfield says.

"We'll continue to push to get rid of the cap and replace it with an alternative payment methodology," Lee assures. "We've also been working on our own approach that involves developing per session codes that correct for procedure codes."