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MDS Alert

Medicare Reimbursement: Ready or Not -- Here Comes the Manual Medical Review of Medicare Outpatient Therapy Claims

Providers dodge snafus with CMS' NPI assignments.

Scrambling to prepare for CMS' new take on therapy caps? You're not alone. Starting Oct. 1, the **Centers for Medicare & Medicaid Services** begin phasing in outpatient rehab providers to manual medical review. After a patient reaches $3,700 of therapy dollar reimbursement for occupational therapy, or speech and physical therapy combined, the therapy provider must apply to CMS for advanced approval of further claims.

Snag: All the fuss may be for naught when Jan. 1 rolls around. Congress needs to act by the end of the year to keep therapy cap exceptions in place, as well as the new manual medical process.

That means, "we may be implementing a complex process for two months, then it may go away. That is a little disconcerting," comments **Meryl Freeman, MS, PT**, manager of outpatient rehabilitation for **Rex Healthcare** in Raleigh, North Carolina.

Beware NPI confusion

CMS used national provider identifier (NPI) numbers to assign rehab providers phase-in dates to manual medical review (either Oct. 1, Nov. 1, or Dec. 1).

Major glitch: Some providers received more than one phase-in date notification from CMS. The problem stemmed from individual therapists having their own NPI numbers yet working for and reassigning to a group that has a separate NPI number, explains **Donna Senft, JD, PT**, healthcare attorney with **Ober/Kaler** in Baltimore, Maryland.

"We posted a question to CMS about this," Senft continues. "They said to use the NPI number on the claim form used to bill for services. Since there are multiple NPS numbers on the claim form, we asked them to clarify if they were referring to the NPI number that goes on the 1500 form in Box 33A, or the treating therapist NPI number that goes with Box 24J." At press time, CMS confirmed that it is the NPI in Box 33A.

Get savvy with your patient education

CMS recently sent letters to Medicare beneficiaries to inform them if they were reaching the $3,700 limit. These letters have tended "to elicit fear," N**icole** S**cheiman,** OT**R/L, MH**S**, C**EES**, CK**T**P, CL**T**-L**ANA**, C**SST, director of rehabilitative and wellness services at **Florida Hospital DeLand** S**ports Medicine and Rehabilitation,** reports.

That said, "It is very important to educate patients and therapists that the cap doesn't mean therapy [automatically] stops," Scheiman emphasizes. You want to explain that if additional care is medically necessary, the rehab provider must take further steps to approve continued therapy.

In the past, the Notice of Exclusion of Medicare Benefits (NEMB) form was considered most appropriate to inform patients that services above therapy caps were statutorily non-covered (if there were no exceptions). But for manual medical review cases, CMS and several professional rehab associations suggest using the Advance Beneficiary Notice of Non-coverage (ABN) form.

"The reason for suggesting the ABN may be because the services may still be covered; there simply is no required exclusion of coverage for services beyond the $3,700 limit," Senft explains.

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