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MDS Alert

Practice Pointers: Nail Down Therapy Cap Details With This Q&A

Resolve your queries about therapy evals, appeals and more.

More information leads to more questions -- which has certainly been the case since CMS released transmittals on the therapy cap manual medical review process starting Oct. 1. To help, we've gathered your most gnawing questions below and found the answers.

1. **Q:** Suppose I have a patient who reaches the $3,700 threshold, and I need to perform a therapy evaluation to determine if she needs additional services. Will I lose money on that evaluation if CMS decides not to approve my request for additional therapy?

A: According to Transmittal 2537, "once the $3,700 threshold amount is met, therapists may still perform evaluations and be reimbursed for them (using the appropriate KX modifier)," says **Jennifer Hitchon**, regulatory counsel for the **American Occupational Therapy Association**. See the transmittal for a list of evaluation CPT codes exempt from the caps.

Important: If you determine from the eval that therapy treatment is medically necessary and have a physician sign the plan of care, you "must then request prior authorization before providing services and billing for them," Hitchon explains.

2. **Q:** CMS says I may request pre-approval of up to 20 treatment days. What happens after the 20 days are used up?

A: "After a patient has used the pre-approved 20 treatment days over the $3,700 amount, a therapist must seek prior authorization for a second set of 20 treatment days," Hitchon says.

3. **Q:** Am I in the clear for reimbursement once CMS pre-approves additional therapy?

A: Not necessarily. According to Transmittal 1117, "Pre-authorization itself is not a guarantee of payment. Retrospective reviews of claims receiving pre-approval may still be performed." The transmittal, however, notes that contractors should not routinely subject claims with prior approval to prepayment medical review unless fraud or abuse is suspected.

4. **Q:** CMS says it requires a cover sheet with a "justification" when I request pre-approval. What should this entail?

A: "CMS contractors are in the process of releasing guidance as to what information must be supplied for prior authorization over $3,700," Hitchon confirms. "My expectation would be that the justification must be linked to the initial medical necessity of the therapy," says **Donna Thiel, JD**, partner with **King & Spaulding** in Washington, DC. "That is, the special circumstances that justify extended therapy are often the same factors that lead the patients to need therapy in the first instance, including the patients' medical condition and rehabilitative potential."

Be sure your justification documents "specific medical information on each patient, including objective measurements of improvement," Thiel stresses. "Success in prior therapy approval is most helpful in justifying continuing need. CMS manuals support that notion."

Key: Transmittal 1117 states, "The contractors shall use the coverage and payment policy requirements contained within Publ. 100-02. Medicare Benefit Policy Manual, section 220 and any applicable local coverage decision policies when making decisions as to whether a service shall be preapproved."

5. **Q:** Transmittal 117 mentions the option of appealing my Medicare contractor's decision, yet it also mentions the option of sending additional requests for approval with more information. What is the difference? Which option should I choose?

A: "A decision not to approve an extension would not result in an appeal but a reapplication," Thiel says. "An appeal would follow a denial of a claim submitted for payment."

Edior's Note: To view the CMS transmittals, visit www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R11170TN.pdf and www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2537CP.pdf.