◆ ***Assemble a team to work on appeals.*** Stick with your story, and make the narrative easy to understand and consistent, which is cost effective.

◆ ***Use one physician for all medical-necessity RAC appeals.*** This shouldn't necessarily be the treating physician because too many cooks could spoil the broth. "Train one physician to get used to testimony [before the administrative law judge (ALJ)] and to say the right things," Glaser says. "When these things go wrong in a hearing, it's often the physician wandering off in a direction you didn't expect."

◆ ***"Base your story on manual language,"*** Ilten says. "Make it your outline for appeal letters and testimony at the ALJ level. It is easy to get mired in the details about different manual sections and CMS review policies and condition code 44, so bring back the focus on who makes the decisions — physicians."

Contact Taylor at Michael.taylor@marsauditor.com, Pollack at evan.pollack@marsauditor.com, Miani at mark.miani@marsauditor.com, Glaser at dglaser@fredlaw.com and Ilten at kilten@fredlaw.com. View the new Medicare fee-for-service improper payment report at www. cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/CERT-Reports-Items/MedicareFFS2011CERTReport.html. ✧

CMS Sets Dates for Therapy Medical Reviews by NPIs in New Database

Hospitals and other outpatient therapy providers are now able to determine when they will face manual medical review for Medicare claims that exceed the $3,700 per-beneficiary threshold. CMS has posted a giant list of national provider identifier (NPI) numbers that correspond to the start dates — either Oct. 1 or Nov. 1 — for manual medical review of speech, physical and occupational therapy above the cap. Outpatient therapy providers who aren't mentioned in the database will presumably face manual medical review on Dec. 1, but CMS will confirm this in letters it sends to providers that describe the three phases of the heightened oversight.

Effective Oct. 1, Medicare's per-beneficiary cap on outpatient rehab applies to hospital outpatient departments in addition to nonhospital settings. Medicare Part B limits the amount it will pay per beneficiary for outpatient speech, physical and occupational therapy. There's a $1,880 cap for physical and speech therapy combined and a separate $1,880 cap for occupational therapy. To exceed it, providers attach the KX modifier, which will facilitate payment with automated review. Then there's a $3,700 threshold for physical and speech therapy combined and a $3,700 threshold for occupational therapy, and exceeding them requires jumping through the new hoop of manual medical review. However, in August CMS unveiled a preapproval process for exceeding the $3,700 threshold. When they anticipate their patients will need more physical, speech or occupational therapy than Medicare covers, hospitals and other outpatient rehab providers may ask Medicare administrative contractors (MACs) for the green light at least 10 days before providing the services *(RMC 8/13/12, p. 1)*. Both the extension of the therapy cap to hospital outpatient providers and manual medical review were required by the 2012 Middle Class Tax Relief and Job Creation Act *(RMC 2/27/12, p. 1)*.

Look for Instructions on MAC Websites

"Now hospitals can begin planning for when they will go under the manual medical review process," Nancy Beckley, president of Nancy Beckley & Associates in Wisconsin, said at a recent RACMonitor.com webinar. Hospitals with an October start date "need to scramble," she said. "They have four weeks to start planning for patients whose anticipated number of therapy visits will cause the patient to go over $1,880." She encourages hospitals to start looking at their rehab outpatients now. If they are approaching the $3,700 threshold, hospitals should start preparing to request preapproval to exceed it through the new manual medical review process, Beckley said. But hospitals should revisit the documentation first to ensure it supports the medical necessity for continuing therapy. When requesting preapproval, hospitals probably will have to send the MAC the plan of care, valid physician order and documentation showing skilled care is necessary. MACs are expected to post pre-approval requirements on their websites by Sept. 1, Beckley said. Even though the cap takes effect for hospitals on Oct. 1, the counting toward it is retroactive to Jan. 1, 2012.

CMS phased in the manual medical review start dates to ease the burden on MACs. But it may not be as straightforward as it sounds. For example, one facility has expressed anxiety about various start dates for its four outpatient therapy clinics because they have separate NPIs, Beckley says. The reason is that CMS is assigning start dates based on a combination of factors, including claims volume and the provider's historical volume of claims over the cap, adjusted for the MAC's workload, George Mills, director of the CMS Provider Compliance Group, said at a CMS open-door forum. About 47,000 NPI numbers are on the CMS website now for the first two phases. "It's a tool for providers to search for their NPIs" and find out when manual medical review applies to them, Beckley said. Judging by the volume of the first two phases, she figures another 20,000 to 25,000 will be in the third phase.

continued

Beckley says that payments from "always therapy" codes are subject to the cap, but hospitals should be aware of the occasional exception. "Always therapy" codes refer to codes that are always for therapy services no matter who performs them. For example, wound care is performed variously by physicians, nurses and physical therapists, but wound care codes are not always therapy codes. If a physical therapist does wound care pursuant to the therapy plan of care, it falls under the therapy cap, she says. But if a nurse provides wound care that isn't under a therapy plan of care, it's not subject to the cap. "Hospitals have not been subject to the cap before so they wouldn't know, but wound care is a perfect example" of how mistakes can be made with cap compliance, Beckley said.

Mistakes are more perilous for hospitals with the implementation of manual medical review.

Also, by Sept. 1, CMS will send letters to beneficiaries who have received at least $1,700 worth of therapy under each cap and explain the new manual medical review requirement. Beneficiaries may be confused by the implications and ask hospitals for an explanation, Beckley said. "They can continue to get therapy if they need it, but the therapist must comply with benefit rules and medical necessity and documentation rules," she said.

CMS Transmittals and *Federal Register* Regulations
Aug. 24 — Aug. 30

Transmittals

Link to transmittals at www.cms.gov/Transmittals/2012Trans/list.asp.
((R) indicates a replacement transmittal.)

Pub. 100-04, Medicare Claims Processing Manual

- October 2012 Update of the Hospital Outpatient Prospective Payment System, Trans. 2531, CR 8031 (Aug. 24; eff./impl. Oct. 1, 2012)
- October Update to the CY 2012 Medicare Physician Fee Schedule Database, Trans. 2530, CR 8017 (Aug. 24; eff./impl. Oct. 1, 2012)
- 2013 Healthcare Common Procedure Coding System Annual Update Reminder, Trans. 2529, CR 7909 (Aug. 24, 2012; eff. Jan. 1; impl. Jan. 7, 2013)
- Revised Medicare Summary Notice Message Regarding Outpatient Therapy Caps, Trans. 2523, CR 7891 (Aug. 24; eff./impl. Oct. 1, 2012)

Federal Register Regulations

None issued during time period.

Editor's Note: The final FY 2013 rule for the Hospital Inpatient Prospective Payment Systems, Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers was published on Fri., Aug. 31, 2012

Another challenge for hospitals is that the cap attaches to beneficiaries, which means it doesn't matter where they receive rehab. As a result, hospitals may find themselves applying for preapproval to exceed the cap on behalf of a beneficiary who until that point received therapy elsewhere. There are concerns that rehab providers won't know when a beneficiary is approaching the cap. Without that information, rehab providers could end up serving patients for free. Mills said a forthcoming Medicare transmittal will explain how Medicare will give hospitals access to therapy counting toward the cap so they know when to ask for approval to exceed the cap.

Hospitals are still are in a bind, Beckley tells *RMC*. They can't query previous cap data until Oct. 1. "If I am an outpatient practice or a comprehensive outpatient rehab facility, for example, I can query the common working file, C-SNAP or IVR to see how much of the cap was used. But hospitals have been exempt from the cap, so CMS won't have their systems collated until the drop-dead date," she says. Fortunately, "CMS has stressed flexibility."

If the MAC does not approve the exception to the therapy cap, it will explain why. "We want to give people details so it's a feedback mechanism, and we don't have the same problems over and over," Mills said. For example, if the physician order was stamped rather than signed, the MAC will deny the request.

All the manual medical review business expires Jan. 1. But Beckley suspects that Congress will extend the cap and manual medical review. Otherwise, she says she doubts CMS would have directed MACs to build the preapproval system. CMS tells *RMC* it has no comment on what Congress may or may not do.

CMS's letters about the phases of manual medical review will be sent to all outpatient rehab providers who billed therapy and are in Medicare's Provider Enrollment, Chain and Ownership System (PECOS).

Contact Beckley at nancy@nancybeckley.com. View the database at http://tinyurl.com/8gbwt3m. ✧

Hospital Settles Stark Case

continued from p. 1

In 2008, Reinberg says, Memorial began an internal compliance review of its leases with physicians as a routine compliance-program function. It found potential problems in deals with physicians who leased space and services next to the two hospitals' sleep centers. There was also a hospital storage closet that a physician used for free for about 20 years.

According to the settlement, Memorial had leases with nine physicians and/or medical groups. The