DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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MLN Matters® Number: MM8036 Revised

Related Change Request (CR) #: CR 8036

Related CR Release Date: September 25, 2012

Effective Date: October 1, 2012

Related CR Transmittal #: R1124OTN

Implementation Date: October 1, 2012

Manual Medical Review of Therapy Services

Note: This article was revised on September 28, 2012, to reflect the revised CR8036 issued on September 25. In the article, the CR release date, transmittal number, and the Web address for accessing the CR were revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for occupational therapists, speech language therapists, physical therapists, physicians, other practitioners, in certain provider settings submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, and A/B Medicare Administrative Contractors (MACs)) for therapy services to Medicare beneficiaries.

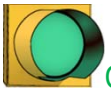
Provider Action Needed

STOP – Impact to You

All requests for therapy services above $3,700 provided by speech language therapists, physical therapists, occupational therapists, and physicians must be approved in advance. This includes services in these settings: Part B Skilled Nursing Facilities (SNFs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), rehabilitation agencies (Outpatient Rehabilitation Facilities (ORFs), private practices, home health agencies (TOB 34X), and hospital outpatient departments.

CAUTION – What You Need to Know

You must send a request for approval to the MAC or legacy contractor, i.e., FI, RHHI, or carrier, in advance of providing service. There are no automatic exceptions. Your MAC or legacy contractor will provide a fax number and mailing address where requests for pre-claim review can be submitted.



GO – What You Need to Do

Please read the Background and the Additional Information sections for details. Make sure that your billing staffs are aware of these changes.

Background

The Balanced Budget Act of 1997 enacted financial limitations on outpatient physical therapy, occupational therapy, and speech-language pathology services in all settings except outpatient hospital. Exceptions to the limits were enacted by the Deficit Reduction Act, and have been extended by legislation several times.

Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) extended the therapy caps exceptions process through December 31, 2012, and made several changes affecting the processing of claims for therapy services. Suppliers and providers will continue to use the KX modifier to request an exception to the therapy cap on claims that are over the 2012 cap amounts -- $1,880 for occupational therapy services and $1,880 for the combined services for physical therapy and speech-language pathology. Use of the KX modifier indicates that the services are reasonable and necessary and that there is documentation of medical necessity in the patient's medical record.

MCTRJCA also established a requirement for manual medical review of claims over $3,700.
In mid-September 2012, CMS will mail a letter to beneficiaries who have received therapy services in Calendar Year (CY) 2012 over $1,700. The CMS letter will inform them of the $1,880 therapy cap, the exceptions process and that, if services over the cap do not qualify for the exception as medically necessary, that they will be responsible for the charges.

Request for Approval and Review Process

You must send a request for approval to the MAC or legacy contractor in advance of providing service. The MAC or legacy contractor will provide a mailing address and may provide a fax number where requests for pre-claim review can be submitted. Pre-claim reviews will not be reviewed any sooner than 15 days before the start of each Phase for providers within that phase.

The request must contain the following information:

- Beneficiary Last Name;
- Beneficiary First Name;
- Beneficiary Middle Initial;
- Beneficiary Medicare Claim Number (HICN);
- Beneficiary Date of Birth;
- Beneficiary Address and Telephone Number;
- Name of Provider Certifying Plan of Care;
- Address of Provider Certifying Plan of Care;
- Telephone and Fax Number of Provider Certifying Plan of Care;
- Provider Number (National Provider Identifier (NPI)) of Physician/NPP Certifying Plan of Care;
- Name of Performing Provider;
- Address of Performing Provider;
- Performing Provider Number (NPI);
- Telephone and Fax Number of Performing Provider;
- Number of treatment days requested;
- Expected date range of services; and
- Date of Submission.

A cover/transmittal sheet containing the following information and documentation must be sent:

- Cover sheet;
- Justification;
- Evaluation or reevaluation(s) for Plan(s) of Care;
- Certification(s) of the plan(s) of care, where available;
- Objectives and measurable goals and any other documentation requirements of the Local Coverage Determinations (LCDs);
- Progress reports;
- Treatment notes;
- Any orders, if applicable, for the additional therapy services; and
- Any additional information requested by the Medicare contractor.

You may request preapproval of up to 20 treatment days of services.

The contractor will make a decision and inform (by telephone, fax, or letter (if by letter, the letter must be postmarked by the 10th day)) the provider and beneficiary within 10 business days of receipt of all requested documentation. If the contractor cannot make a decision with 10 days, the therapy will be considered approved. The letter will indicate that the approval was made because of time constraints and not on the information provided to the contractor.

The contractors will use the coverage and payment policy requirements contained in the "Medicare Benefit Policy Manual," Chapter 15, Section 220 (available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf) and any applicable local coverage decision policies when making decisions as to whether a service will be preapproved.

If the decision is non-affirmative, the letter communicating the decision will be detailed. If the request was non-approved, you may submit additional requests and provide additional information for consideration.

Contractors shall develop a methodology to identify preapproval requests that have been submitted for pre-approval and match them to submitted claims for specific periods of time. Contractor shall inform the provider of the tracking mechanism being used for preapproval requests (either approved or denied) and instructions on how to submit the claim. Contractors shall use the tracking mechanism to identify that the claims were preapproved or non-approved.

Pre-authorization itself is not a guarantee of payment. Retrospective reviews of claims receiving pre-approval may still be performed. Any claims submitted without the pre-approval notice from providers in the respective Phase will be subject to pre-payment review. If you or the beneficiary wishes to appeal a decision, you may provide the service.The MAC or legacy contractor will, upon receipt of the claim, deny the claim. Then you or the beneficiary may file an appeal.

CMS will notify beneficiaries when they reach the $1,700 level by September 1, 2012 by letter.

Phased Implementation

Implementation will occur in three phases. The requirement for pre-approval of all therapy services shall apply to specifically identified providers on the effective date determined by CMS for the phase. CMS will publish the list of providers (by NPI number only) and the Phase to which they are assigned. If CMS publishes a list and a provider is not on the list, then that provider shall be deemed to be in Phase III. Contractors will post the list of NPI numbers CMS provides on their websites.

CMS will publish a list of providers and the respective phases in which they are placed. In addition, CMS shall send a mailing to every provider subject to the therapy manual medical review threshold notifying them of the respective phase they have been placed into. CMS is implementing this process in phases in order to ensure a smooth transition to the new process. Effective dates for the phases are:

- Phase I: October 1, 2012 – December 31, 2012
- Phase II: November 1, 2012 – December 31, 2012
- Phase III: December 1, 2012 – December 31, 2012

Claims suspended because of the cap will be automatically approved unless the provider is being reviewed in Phase I, Phase II, or Phase III.

Contractors will notify providers by posting on their website when they have stopped doing the reviews.

Out of Sequence Claims – Post Pay Review Not Required

Medicare has a 12 months claims filing limitation. Therefore, claims may be received and processed in a sequence different than that of the services provided. When this occurs, a contractor is not required to conduct post payment review on claims that would have been subjected to the $3,700 manual medical review threshold had the claims been received and processed in the order provided.

For example, a beneficiary was in a SNF and exhausted their SNF benefit days under Part A. The beneficiary continued to receive therapy services under Part B totaling $3,600 (all dates of service before 10/1/2012). The beneficiary was then discharged from the SNF and received therapy services from an independently practicing PT totaling $1,800. The independent PT billed in November 2012 for services provided after 10/1/2012. The MAC received the claims and processed them. After these claims were processed the MAC received the SNF Part B claims totaling $3,600 and processed them. Had these claims been received in advance of the independent PT services, the independent PT would have been required to have the services approved in advance. In circumstances such as this example, the contractor is not required to perform post payment review on the $1,800 provided by the independent therapist.

Additional Information

The official instruction, CR8036, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1124OTN.pdf on the CMS website.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.