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CLIENT ADVISORY

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Recovery Auditors Begin Medical Record Reviews of Therapy Services Exceeding the Therapy Threshold – Prepayment Reviews Mandatory in Some States

The American Taxpayer Relief Act (effective January 2, 2013) extended the Medicare Part B outpatient therapy cap exceptions process through December 31, 2013 and added outpatient therapy services provided in hospital outpatient departments to the list of services that count toward the therapy cap and threshold. For calendar year 2013, the Medicare Part B outpatient therapy cap for occupational therapy (OT) is $1900 and the combined therapy cap for physical therapy (PT) and speech-language pathology services (SLP) is also $1,900. This is an annual per beneficiary therapy cap amount applied per calendar year. Medically necessary outpatient therapy services provided beyond the cap, must be billed using the "KX" modifier. Once outpatient therapy services reach $3,700 for OT or PT/SLP combined – the new statutory therapy threshold – Medicare Administrative Contractors (MACs) are instructed to suspend payment until the claim passes through a manual medical record review process to ensure the services are needed. The therapy cap applies to all Part B outpatient therapy settings and providers including:

- Private therapy practices and physician offices;
- Part B skilled nursing facilities;
- Home health agencies;
- Rehabilitation agencies;
- Comprehensive Outpatient Rehabilitation Facilities (CORFs); and
- Hospital outpatient departments (excluding Critical Access Hospital (CAHs)).

As of April 1, 2013, Recovery Auditors were instructed to review all therapy claims that exceed the outpatient therapy threshold. Connolly Consulting Associates, the Region C Recovery Auditor was the first of the Recovery Auditors to post review of the outpatient therapy cap as an approved issue. Recovery Auditors will complete two types of medical record reviews as outlined below:

Prepayment Review:

- Prepayment reviews will take place in the states that are currently involved in the RAC Prepayment Demonstration program that began September 2012: Florida, California, Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina and Missouri.
- In these states, the MAC will send an Additional Documentation Request (ADR) to the provider requesting the additional documentation be sent to the Recovery Auditor (unless another process is used by the MAC and the Recovery Auditor).
- The Recovery Auditor will conduct prepayment review within 10 business days of receiving the additional documentation and will notify the MAC of the payment decision.

Post-payment Review:

- In the remaining states, the Recovery Auditors will conduct immediate post-payment review.
- In these states, the MAC will flag the claims that meet the criteria and pay the claim. The MAC will then send an ADR to the provider requesting that the additional documentation be sent to the Recovery Auditor. The Recovery Auditor will conduct post-payment review and will notify the MAC of the payment decision. Recovery Auditor decisions to recoup payments will be followed by a demand letter from the MAC.

For hospitals that have grown accustomed to receiving routine RAC requests, you can add this to your growing list of Recovery Auditor approved issues; but for outpatient therapy providers who have never seen a Recovery Auditor request, this is a new ball game and you need to be

prepared because you are likely to get audited in the near future. All outpatient therapy providers are urged to review medical records for PT, OT and SLP services that will or are expected to exceed the therapy threshold to ensure compliance with all Medicare documentation requirements and local coverage determinations. Reviews should focus on ensuring that documentation contained in the medical record clearly demonstrates the medical necessity for the continued outpatient therapy services. In either a prepayment or a post-payment review, providers are reminded that, although it is a safe practice, issuing an Advanced Beneficiary Notice is not required to bill beneficiaries for denied services that exceed the statutory outpatient therapy cap.

If you have any questions or need assistance with Medicare reimbursement or appeals issues related to rehabilitation therapy services, please contact Mary Malone (mmalone@hdjn.com), Emily Towey (etowey@hdjn.com), Michelle Calloway (mcalloway@hdjn.com), Colin McCarthy (cmccarthy@hdjn.com) or Thomas Miller (tmiller@hdjn.com). In addition to email, they can be reached by phone at (866) 967-9604. Further information about Hancock, Daniel, Johnson & Nagle, P.C., is available on the firm's website at www.hdjn.com.