PUBLICATION

Outpatient Therapy: Caps for Hospitals, Mandated Medical Review and Proposed Functional Limitation Reporting [Ober|Kaler]

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Hospitals will become subject to the outpatient therapy cap beginning October 1, 2012. Although Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) extended the outpatient therapy cap exceptions process through 2012, two key changes to the 2012 process were required as a result of this legislation. One of those changes requires, for the first time, that the therapy cap be applied to outpatient *hospital services*. Additionally, the MCTRJCA imposed certain required data collection scheduled to begin in 2013.

Changes Effective October 1, 2012

CMS recently published a Therapy Cap Fact Sheet [PDF] to provide information regarding the manual medical review process noted below and plans to issue a transmittal to include the new procedures in the applicable CMS manual. Following passage of the law, CMS released Transmittal 2457 [PDF] on April 27, 2012, with an effective date of October 1, 2012, to revise the CMS manual guidance to implement the other statutory requirements noted below. As a result of the MCTRJCA, the following key therapy cap changes go into effect for services provided on or after October 1, 2012, through the end of the year:

- Cap threshold amount increases from $1,880 to $3,700. This increase does not, however, negate the need to use the KX modifier to request an exception to the cap for claims when the $1,880 threshold is reached.
- Hospital outpatient therapy services, with the exception of critical access hospitals, will no longer be exempt from the cap. For hospitals new to the cap process, claims paid for services from January 1, 2012, will be used to determine the threshold amount.
- The individual Type I National Provider Identifier (NPI) of the physician or nonphysician practitioner (NPP) certifying the therapy treatment plan must be reported on all claims.
- Pre-approval manual medical review process for claims which will exceed the $3,700 threshold. Medicare Administrative Contractors (MACs) will have 10 *business* days to respond to a request. A failure of the MAC to respond within the designated time frame is deemed an approval to provide services beyond the $3700 threshold. Pre-approval requests will be required for each increment of 20 treatment days. A failure to submit a pre-approval request will result in payment ceasing when the $3,700 threshold is reached and the initiation of a prepayment review for the claims at issue. The pre-payment review period is anticipated to be approximately 60 days.

Data Collection Requirements in 2013

Additionally, the MCTRJCA requires CMS to implement an outpatient therapy claims-based data collection strategy designed to assist in reforming the Medicare payment system for outpatient therapy services. The specific data collection required by the MCTRJCA will not affect current payment for the submitted claims; rather, it is designed to assist in understanding patient conditions, anticipated goals, and therapy outcomes to establish a revised payment methodology. CMS included the proposed rules for this required outpatient therapy services data collection when it published the proposed Physician Fee Schedule for 2013.

The proposed changes, if finalized without further revisions, would likely require: (1) *significant changes* in software used for claims submission, and (2) *substantial education* for therapists who will need to report the required codes and modifiers. The following provides a brief overview of this proposed claims-based data collection:

- The reporting would occur at the time of the initial evaluation, intermittently throughout the course of treatment, and at discharge. For the intermittent reporting requirement, CMS has proposed to require reporting once every 10 treatment days or at least once during each 30 calendar days, whichever time period is shorter. CMS did note that the claims reporting requirement should align with the progress note documentation requirement for therapists and specifically sought comments on whether an established number of visits would be a better options for both requirements.
- G-codes would be used to identify what is being reported — current status, goal status, or discharge status.
- Modifiers would be used to indicate the extent of the severity/complexity of the functional limitation being tracked. CMS proposed 12 modifiers that essentially would require the therapist to identify the percentage of the impairment limitation in increments of 10%, with no limitation and 100% limitation for the other two modifiers.
- In addition to having a G-code and modifier combination for reporting on the primary or most clinically relevant functional limitation at the time of the initial evaluation, CMS has provided for reporting a secondary G-code and modifier combination, to account for situations in which a therapist is treating two separate and distinct clinical conditions each with its own treatment plans, such as a speech language pathologist treating a patient with both dysphagia and aphasia or a physical therapist treating a patient with a fracture hip and frozen shoulder. CMS is seeking comments on whether the reporting of data on a secondary functional limitation should be required or optional.
- Although the reporting system is proposed to be implemented on January 1, 2013, claims submitted in the first 6 months would be processed even in the absence of the G-code and modifier combination. Beginning July 1, 2013, however, claims would be required to have these functional limitation code-modifier combinations.
- CMS proposes to amend existing regulations establishing the conditions for payment of outpatient therapy services to add this claims-based data reporting requirement.

CMS acknowledged that the data collected by this proposed system would fall "far short of the data needed for developing a new payment system," noting that "a significant limitation of this proposal is that it would not provide data by type of functional limitation involved." CMS included a suggested approach to require reporting by functional limitation categories. CMS provided an example that described the G-code / modifier combination for the two most frequently reported functional limitations by each of the three therapy disciplines during its Development of Outpatient Therapy Payment Alternatives project. Should CMS decide to move to a category-specific functional limitation reporting system, it would expect to include such a requirement in the 2013 Physician Fee Schedule final rule. Therefore, CMS is additionally seeking input from therapists on categories of functional limitations.

Ober|Kaler's Comments

Hospitals that have been exempt from the therapy cap financial limitations in the past need to be *preparing for the October 1, 2012* changes. ALL OUTPATIENT THERAPY SERVICE PROVIDERS have the opportunity **to submit comments** by the *September 4, 2012* deadline. Particular attention should be paid to submitting comments addressing CMS' specific questions, as well as to comments to the proposed claims-based data collection requirements, as these requirements will likely demand significant operational and claims software changes if adopted as proposed.