Codify
BY AAPC

Eli's Rehab Report

Outpatient Outlook: Brace for Reimbursement Cuts, Therapy Caps With No Exceptions

But don't give up on petitioning your representatives.

If you were hoping for an extension to the Medicare therapy caps this year, keep hoping. As of press time, Congress failed to pass legislation that would extend the Medicare Part B therapy cap exceptions process and halt the planned 10.6 percent cut to the Physician Fee Schedule beginning July 1.

Nixed too soon: The U.S. House of Representatives passed the Medicare Improvements for Patients and Providers Act (HR 6331) on June 24, which extended the therapy cap exceptions process and dismissed the 10.6 percent cuts, but the Senate would not follow suit. The Senate voted down the legislation 58-40 on June 26, and then recessed for the July 4th holiday.

Official word: "Outpatient therapy service providers should not submit claims with the KX modifier for services furnished on or after July 1, 2008," CMS said in an email announcement to its list serv members. "Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached."

"I'm extremely disappointed that Congress has failed to take action on behalf of Medicare patients and their providers before the July 1 deadline," said American Physical Therapy Association (APTA) President **R. Scott Ward, PT, PhD**, in a June 27 press statement. "The situation is made worse by the fact that the $1,810 cap on therapy care will include services provided to beneficiaries since January 1 of this year, even if those services qualified for an exception to the therapy cap.

Last-Ditch Efforts in Store

Therapist and beneficiary advocates are not about to give up. "We're hoping that after their recess, the Senate will either try to vote on the bill again or come up with a compromise that the Republicans and the Democrats can agree upon," says **Ingrida Lusis,** director of federal and political advocacy for the American Speech-Language Hearing Association (ASHA).

But compromise is a tall order. HR 6331 proposed cutting funds from Medicare Advantage to cover the Physician Fee Schedule cuts and the therapy cap exceptions -- and the Senate Republicans won't have that. Neither will the President, who has threatened veto for that very reason.

"The problem is in politics, not policy," says **Tim Nanof,** legislative representative for the American Occupational Therapy Association (AOTA). "Everyone agrees on avoiding the physician fee schedule cut and extending the exceptions process -- the problem was how to pay for it."

Another possibility: Right before their July 4 recess, Republicans introduced legislation that would offer a one-month extension to all the current Medicare provisions. And the Senate would have an easier time passing that, Nanof believes. But the soonest Congress could address the legislation would be July 7.

AOTA, APTA and ASHA, along with a few other organizations, met with CMS on June 30 to see if the agency would grant an administrative extension to the therapy caps exception process. "CMS listened to our arguments and said they did not have statutory authority to do that," Nanof laments.

Final squeeze: CMS did, however, find a creative way to avoid for a few more days processing claims that would see a 10.6 percent cut and therapy caps. The agency will delay new claims reimbursement for 10 days (on top of their usual

14-day delay), Nanof tells The Coding Institute (TCI). That buys some time until July 15. "But if Congress doesn't act before then, CMS will deny reimbursement for therapy claims above the cap, and it will be up to the beneficiary and the provider to work that out," Nanof says.

Talk to Your Medicare Patients Now

No more wishful thinking -- it's time to be straightforward with all your Medicare beneficiaries. "We're telling members to educate beneficiaries that as of July 1, they need to go to a hospital outpatient department for Medicare to reimburse their therapy above the caps," Lusis says..

Other options: "Patients can pay out of pocket for services above the cap, or wait until the next calendar year, or until Congress enacts a fix," Nanof says.

An Advance Beneficiary Notice (ABN) is recommended, but not required for services that exceed therapy caps, CMS said in its email notice.

A ray of hope: "CMS had a conversation with Congress before the agency decided on this 10-day delay, so it's a good sign that Congress and CMS were working together to find a solution," Nanof points out.

In addition, some groups are considering a lawsuit based on the argument that beneficiaries didn't get enough time and instruction on how to plan for their care, according to Nanof. "AOTA is not one of these groups, but often those suits have the ability to push CMS into quick action," he says.