Eli's Rehab Report

Outpatient Outlook: Catch the Finer Details of MACRA Legislation Before They Catch You

...and refresh your therapy cap knowledge, while you're at it.

A big victory was won this spring when Congress did away with the sustainable growth rate (SGR) that threatened to tank your Medicare payments each year. Now, however, you have a few new challenges to expect on the road to proper reimbursement.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), signed into law on April 16, is what thankfully made the SGR history. This legislation, however, also laid groundwork for the transition away from volume-based to quality-based reimbursement.

Bottom line: Get ready for some changes as early as July.

MMR to Get More Targeted

The most important thing you need to know now is that the MACRA legislation changed the manual medical review (MMR) process for therapy dollars exceeding $3,700.

"Instead of reviewing all claims that exceed $3700, CMS can determine which claims they would like to target for review," says **Gayle Lee, JD,** director of health finance and quality for the **American Physical Therapy Association** (APTA).

Determining factors for targeted review would include providers who:

1. Have patterns of aberrant billing practices compared with their peers;

2. Have a high claims denial percentage or who are less compliant with applicable Medicare program requirements;

3. Who are newly enrolled;

4. Who treat certain types of medical conditions; and

5. Who are part of a group that includes another therapy provider identified by the above factors.

The question: Does this mean you could be triggered for MMR long before your patients hit $3700? A lot is up for speculation until CMS and the major rehab advocacy groups discuss the topic in more detail.

"We believe MMR will trigger in a targeted manner over $3700," says **Tim Nanof,** director of health care policy and advocacy for the **American Speech-Language Hearing Association** (ASHA). "We don't have details on what that looks like if a provider is targeted for one of the possible areas and whether other claims below $3700 could be reviewed under this program."

In addition, the question lies as to how the **Centers for Medicare and Medicaid Services** (CMS) will implement the new, targeted process of review on backlogged claims versus those submitted from the date of enactment. "We have more questions than answers," Nanof says. "A meeting with CMS has been requested."

"We have very few details yet from CMS regarding implementation of this provision and have reached out to them to meet," Lee says.

Timeframe: The change to MMR is effective 90 days after enactment of the MACRA legislation. That's July 2015.

Tackle Therapy Caps While They're Still Around

While the therapy caps are still in play, you might as well hone your skills of managing them. For the next two years, therapists have a grace period of therapy cap exceptions.

Therapy caps are $1940 for OT and $1940 for PT and Speech combined. For any service above this amount that is reasonable and necessary, simply apply the KX modifier on your claim form as usual; then, watch for manual medical review after $3700 (and per the new factors mentioned above).

"Currently, all states are under post-payment review," Lee says.

Facility-based settings: In January, CMS announced a temporary approach for reviewing therapy claims over $3700 in facility-based settings, but "the review had been put on hold temporarily as a result of challenges with transitions to new Recovery Audit Contractors," Lee says. "Under the review process, claims will be reviewed in chronological order based on the month in which they were paid. To prevent providers from being overburdened with requests for claims to review, CMS established limits on the number of additional documentation requests (ADRs) that can be sent to the provider at once."

"We are encouraging members to discuss services with their patients as they approach $3700 and to be sure documentation meets all standards for skilled care including connecting skilled services to goals for the patient," Nanof says.

Have an Advance Beneficiary Notice (ABN) ready if your beneficiary chooses to continue treatment but does not qualify for a therapy cap exception. You can find a copy of the form appropriate to your setting at cms.gov/Medicare/Medicare-General-Information/BNI/index.html. For a list of FAQs regarding the form check out cms.hhs.gov/Medicare/Billing/TherapyServices/Downloads/ABN-Noncoverage-FAQ.pdf.

"An ABN would be required if the physical therapist is going to collect cash. If an ABN is not given, then the therapist cannot collect from the patient," Lee says.

If the patient becomes cash-pay, as long as you have first given the patient an ABN, you can charge your practice's own rate. "However, be aware that provision of free or deeply discounted services can potentially be a violation of the anti-kickback statutes," Lee warns.

Protect yourself: "When charging patients out of pocket, it is very important to have a set fee schedule that applies to all patients regardless of their insurer (Medicare or private insurance)," Lee says. "Additionally, any discounts offered should also be offered to all patients regardless of their source of insurance coverage, and all discount policies should be established in writing."

Example: A therapist may have a policy that offers a 20 percent discount to patients with income less that a certain dollar amount in a given year or for patients with medical costs that exceed a set limit in a given year, Lee says.