Ensuring Appropriate Placement for Medically Complex Patients

In Surprise Move, CMS OKs Medical Student Documentation for E/M Billing

Hospital Settles Case Over Cataract Surgery Billed Without Lenses

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News Briefs

Congress Ends Therapy Cap, Restores Medical Review for Some Claims Over $3K

The outpatient therapy cap is a thing of the past now that President Trump on Feb. 9 signed a massive budget deal sent to him by Congress that includes a Medicare extenders bill, which ends the cap on physical, speech and occupational therapy. After $3,000 of therapy, however, outpatient rehab providers could face medical review. And in a surprise move, the legislation sets the stage for reduced reimbursement for physical and occupational therapy provided in whole or in part by assistants.

“There is a huge sigh of relief that the fight is over for eliminating the therapy cap,” says Nancy Beckley, president of Nancy Beckley & Associates in Milwaukee.

Hospitals Say LTACHs Cherry-Pick Patients; Questions Arise About Revenue Code Changes

Long-term acute care hospitals (LTACHs) are reportedly refusing patients from short-term acute care hospitals if they don’t generate enough reimbursement, hospital officials say. The LTACHs are cherry-picking patients now that Medicare payment changes are in full force, and short-term acute care hospitals are worried about the compliance and quality implications. For their part, LTACHs say they’re only admitting patients who generate the full payment under the LTACH prospective-payment system, which isn’t cherry-picking, and they’re not required to accept particular patients anyway. It would be better if everyone worked more closely on discharge plans, they say.

Against this backdrop is a disturbing hint of outright noncompliance that is troubling hospital officials.

“We have had more rejections for LTACH stays [since October 2017],” says Vinita Manoraj, medical director of case management at Jersey Shore University Medical Center, which is part of Hackensack Meridian Health in New Jersey. “These are patients who don’t have three-day stays in the ICU or who had respiratory failure but were not on a vent” and now generate less reimbursement for LTACHs than they did recently.

That would coincide with the full implementation of Medicare payment changes in the 2013 Bipartisan Budget Act that were slow-walked for four years. Now that the payment changes are fully effective, LTACHs take a financial hit if they accept fee-for-service patients who don’t meet certain admission requirements. Only patients who have been in the intensive care unit (ICU) in short-term acute care hospitals or who will receive vent care in the LTACH yield LTACHs their full prospective payment system amounts.

“This is a payment issue, not a qualification issue,” Manoraj says.
Compliance also is at stake, says Jessica Fuentes, POD [Process and Outcomes Development] Director of Case Management at Pennsylvania Mountains Healthcare Alliance. Some LTACHs are asking some short-term acute care hospitals to play games with the discharges so they both can benefit. “We’ve been approached by LTACHs to change our revenue codes so that they can be paid by Medicare [at a higher rate] for those complex patients who would be appropriately cared for [in an LTACH],” she says. The payment differential rides on revenue codes, which tell Medicare where patients are treated in a hospital. The revenue code is 020x for intensive care and 021x for coronary care.

But attorney Albert Shay, who represents the National Association of Long Term Hospitals, says LTACHs are not obliged to accept patients when hospitals are just as equipped to take care of them. CMS has cut LTACH payments for all patients—unless they are discharged from ICUs or coronary care units (CCUs) or will be on a ventilator at the LTACH—and it’s squeezing their revenue.

“You will see LTACHs with increasing frequency saying, ‘No, I am not taking that patient,’ ” says Shay, with Morgan Lewis in Washington, D.C. “This should not be an epiphany to acute-care hospitals. Any short-term acute-care hospital that has had a referral relationship with a hospital. The revenue code is 020x for intensive care and 021x for coronary care.

Medicare pays for LTACH stays for inpatients with an average length of stay of 25 days. LTACHs specialize in medically difficult cases, including patients with intractable wounds, acute and chronic respiratory failure, and endocarditis requiring IV medication. Medicare pays for inpatient hospital services for LTACH discharges under the LTACH prospective payment system (PPS). “A hospital generally receives a single payment for the case based on the payment classification, that is, the MS-LTC-DRGs assigned at discharge,” according to an MLN Matters (MM9015 Revised).

**Two Payments Set Stage for Showdown**

Because of concerns that short-term acute care hospitals discharged resource-intensive patients quickly to LTACHs, Congress revamped the payment method. That reduced the incentive for LTACHs to take all comers, Shay says. Sec. 1206 of the budget law created two payment buckets under the LTACH PPS:

- Standard payments: To receive payments LTACHs have always received for patients discharged from short-term acute care hospitals, the patient must have been admitted to the LTACH “directly from an IPPS hospital during which at least 3 days were spent in an Intensive Care Unit (ICU) or Coronary Care Unit (CCU), but the discharge must not be assigned to a psychiatric or rehabilitation MS-LTC-DRG in the [LTACH],” or the patient must “have been admitted directly from an IPPS hospital and the [LTACH] discharge includes the procedure code for ventilator services of at least 96 hours (ICD-10-CM procedure code 5A1955Z) but must not be assigned to a psychiatric or rehabilitation MS-LTC-DRG in the [LTACH],” according to the MLN Matters.
- Site neutral payments: If the ICU, CCU or vent circumstances don’t exist, LTACHs receive site neutral payments. They are “the lesser of an ‘IPPS-comparable’ payment amount or 100 percent of the estimated cost of the case.”

In other words, if Medicare patients don’t come to the LTACH from the ICU or CCU or they weren’t on a vent for 96 hours at the LTACH, the LTACH gets paid a lot less. Also, for cost-reporting periods beginning on or after Oct. 1, 2020, LTACHs with fewer than half of their discharges paid at the LTACH PPS rate will be switched to payment at the lower IPPS comparable amount for all discharges in subsequent cost-reporting periods, according to the 2013 law, Shay says.

That has set the stage for the showdown, with LTACHs refusing to take patients when they won’t get standard payments for them or, Fuentes says, allegedly asking hospitals to change the revenue codes so it looks like the patients had been in the ICU or CCU or require continued on p. 4
Ensuring Appropriate Placement for Medically Complex Patients

This policy is designed to help short-term acute care hospitals ensure the proper placement of patients who are medically complex, says Jessica Fuentes, POD [Process and Outcomes Development] Director of Case Management at Pennsylvania Mountains Healthcare Alliance, who developed the policy. “You want to make sure the patient is in the right care at the right time and the right location,” she says (see story, p.1).

PMHA Policy

<table>
<thead>
<tr>
<th>Policy Name: Other Intensive Care Code</th>
<th>Originator: Jessica Fuentes, MSN, MBA-HCA, RN, CCM</th>
<th>Origination Date: 01-19-2018</th>
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<td>Policy Section: Approved By: Approved Date:</td>
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<td>BOARD: Revised Date:</td>
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POLICY:

Identifying critically ill and medically complex patients who require a longer intensive level of care and anticipated longer length of stay (LOS) of greater than 25 days.

PURPOSE:

This policy is to assure appropriate patient placement and level of care, promoting proper utilization of acute care resources, and assist with discharge planning regarding the needs at the next level of care.

GENERAL GUIDELINES:

0209 Other Intensive Care — This code indicates room service charges for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Higher level of care can be assigned to a patient based on the complexity of the patient and the projected LOS exceeds 25 days.

Examples:

1. Vent Wean
   a) May require review by pulmonologist
   b) Goals to liberate from vent
   c) Establish goal for discharge training for home vent or nocturnal vent

2. Respiratory
   a) Significant desaturation
   b) New trach, decannulation
   c) IV Steroids or taper PO steroids
   d) High flow O2, CPAP, BIPAP

3. Medically Complex
   a) Trauma, complex orthopedic, complex neurological
   b) Post op complications
   c) IV medications, Blood, Blood Products
PMHA Policy

d) Complex wound and fistula management

**PROCESS:**

1. CM will assess patients level of care, complexity, and equipment/resource utilization
2. CM will review with physician appropriateness of Long Term Acute Care needs
3. CM will have revenue code changed to support this level of care for the patient
4. CM leadership will perform 100% audit of all patients that have a room charge of 0209 in a Med/Surg unit

**EDUCATION:**

1. CM will have onboarding education and yearly competencies

**RESPONSIBLE PARTIES:**

Hospital Case Management
Hospital UM Committee

vent care. The problem, Fuentes says, is that changing the code is noncompliant—and hospitals shouldn’t do it.

“The LTACH is holding the hospital hostage instead of doing what's right for the patients,” she says. “LTACHs shouldn’t dictate how acute care hospitals should bill. We should look at it with revenue cycle and billing.” Revenue codes have to reflect the patients’ severity of illness and intensity of services within the hospital, Fuentes notes.

The issue is not putting patients inappropriately in an ICU or CCU bed so the LTACH will take the patients based on the revenue code, says Chip Giffin, vice president of finance/revenue cycle at Pennsylvania Mountains Healthcare Alliance. “This is why our policy requires a patient need for such level of care” (see box, p. 3).

**Changing Codes Is a ‘Compliance Issue’**

Shay agrees it’s a “compliance issue” if hospitals change codes to get the LTACH a higher payment. “We shouldn’t have LTACHs going to case managers or anyone else saying, ‘Change the code so you can show the patient was in ICU, and we will take them,’” Shay says. But he says this isn’t about LTACHs trying to hold acute-care hospitals hostage. It’s about LTACHs modifying their admission criteria based on how Congress amended the law. “Acute-care hospitals need to be aware of the payment limitations imposed on LTACHs and, when clinically appropriate, put medically complex patients in an ICU. It's not uncommon for patients who should be treated in an ICU to be treated in a less intensive setting or discharged prematurely from the ICU due to capacity issues,” Shay says. “Hospitals have to realize that these capacity issues may have consequences in terms of what patients will be accepted by the LTACH.”

Fuentes notes there is some flexibility. For example, step-down units count as ICUs if they have a three- or four-to-one nurse-to-patient ratio, she says. That could ease the tension somewhat because those patient discharges would qualify as standard patients at the LTACHs, and they would be more receptive.

Capacity is a big concern for short-term acute care hospitals as LTACHs turn away patients, Manoraj says. Patients who stay for weeks or months are tying up beds needed by incoming patients. She found other ripple effects on closer inspection. For one thing, there is an increased risk of readmission when medically complex patients remain in the acute-care hospital instead of going to the LTACH, which is designated by Medicare for them. But patients with, for example, an open abdomen that requires prolonged acute care and long-term IV
antibiotics and severe wounds, who are similar in resource utilization, “can be managed much better over the long term” at LTACHs, Manoraj explained.

She added that the LTACH payment differential is irrelevant for Medicare Advantage Plans. They make no distinction.

Contact Fuentes at jfuentes@pmhalliance.org, Shay at albertain@morganlewis.com and Manoraj at vinita.manoraj@hackensackmeridian.org. ✧

In Surprise Move, CMS OKs Medical Student Documentation for E/M Billing

In a remarkable turnaround, CMS said Feb. 2 that all medical-student documentation counts for evaluation and management (E/M) billing, according to Medicare Transmittal 3971. That means teaching hospitals may charge Medicare for E/M services performed by teaching physicians when medical students they supervise document the exam, medical decision making and other parts of the patient encounter, according to the transmittal, which is effective for Jan. 1, 2018, dates of service.

“E/M Documentation Provided by Students allows the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work,” the transmittal stated.

The new policy came as a big surprise because teaching hospitals have been asking for it for years, but CMS wouldn’t budge. “It’s an astonishing change,” says Jeannine Engel, M.D., physician adviser to compliance services at University of Utah Health in Salt Lake City. “I could not be more excited because starting soon, when we get this operationalized, we will be able to more fully integrate our students into the team because their notes will have more value in a way that is more obvious.”

Until now, only certain documentation by medical students—the review of systems and past family and social history—could contribute to the documentation of E/M services billed to Medicare. Teaching physicians were required to document everything else they performed, including the exam, history of present illness and medical decision making.

But the doors have swung open wide, with some caveats. According to the transmittal, “Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.”

Engel warned, however, that teaching physicians can’t simply co-sign the medical student’s notes. “That’s not enough for billing,” she says. “We have a responsibility to the patients and to the students to read and edit their notes and get the student’s feedback.”

The policy applies to all students who teaching physicians supervise, including advance practice professionals.

Students ‘Essentially’ Can Be Scribes

There is now sort of a demarcation line between a performance standard and a documentation standard, says Ed Gaines, chief compliance officer of the emergency department division of Zotec Partners in Greensboro, N.C. Before, performance and documentation essentially were the same, and for billing purposes teaching physicians had to do it all. “Under the new rule, the performance standard has not changed, but the documentation standard has changed—in essence the student is permitted to be a scribe for the teaching physician,” Gaines says.

That’s a major change, he notes. Some elaboration is needed, however, and he hopes a forthcoming MLN Matters will do the trick.

The transmittal is part of CMS’s pledge to reduce the regulatory burden on hospitals and physicians (RMC 11/6/17, p. 1). More specifically, CMS is considering an overhaul of the 1995/1997 Medicare Documentation Guidelines, which govern the selection of E/M codes. It dangled the idea in the 2018 Medicare Physician Fee Schedule final regulation.

There’s a long history of what Medicare considers acceptable documentation for billing purposes in the academic arena. “We have a clear line of 15 years of interpretation by CMS in this context,” Gaines says. In a 2002 Medicare Transmittal (1780), for example, CMS drew the distinction between residents, who are licensed physicians, and medical students, who aren’t. As the 2002 transmittal says, “for E/M services, teaching physicians need not repeat documentation already provided by a resident.” It adds that students may document in the medical record but that teaching physicians may rely only on documentation about the patient’s review of systems and past family and social history. “The teaching physician may not refer to a student’s documentation of physical exam findings or medical decision making in his or her personal note. If the medical student documents E/M services, the teaching physician must verify and redocument the history of present illness as well as perform and redocument the physical exam and medical decision making activities of the service,” according
to the transmittal, which has loomed large over teaching physician billing since.

**Consider the Skill Level of Students**

In 2011, Medicare Transmittal 2303 reiterated the limits of medical student documentation’s contribution to billable services. “The teaching physician may not refer to a student's documentation of physical exam findings or medical decision making in his or her personal note,” CMS stated.

Gaines explained there were “bright lines. If the medical student was working under the supervision of the teaching physician and documented the history of present illness, exam or medical decision making, then the teaching physician had to re-document it,” Gaines says. But those are the old rules. “The new rule is the teaching physician may attest to the medical student’s documentation,” he explains. “The attending physicians don’t have to re-document and that’s big.”

Before they jump on the change, teaching hospitals should think about the “skill and competency of their medical students to accomplish these essential elements of service,” Gaines says. “The history of the present illness, nature of the presenting problem(s) and medical decision making are arguably the most important elements of the E/M service, and teaching hospitals should determine at what level the student’s medical education supports that institution’s standard of care.”

A future MLN Matters from CMS may address the expectations of medical student vetting. How far do teaching physicians have to screen medical students for their competence at documenting the history of present illness, exam and medical decision making? “That’s an important discussion for compliance officers to have with academic heads,” he says.

**For Compliance, This Is a Reminder of PATH**

This is no small matter in terms of compliance given the extensive enforcement background of the past 20 years, kicked off by the University of Pennsylvania false claims settlement over teaching physician billing, Gaines says. For many years, teaching hospitals that billed Medicare for services provided by residents without documentation of the personal supervision of teaching physicians were embroiled in false claims lawsuits under a national enforcement initiative, Physicians at Teaching Hospitals (PATH). Although it centered on residents, not medical students, there is similar risk because CMS is now allowing teaching hospitals to bill for E/M services based partly on medical students’ documentation if the teaching physician personally performs the exam and medical decision making.

One outstanding question is how the policy change applies to procedures, Gaines says. “The transmittal is specific to E/M services, but doesn’t say anything about procedures,” he says, although “it is expansive.” For example, patients often show up in emergency departments for a laceration repair and have to receive an EMTALA screening for any other emergency medical conditions—or E/M services and procedures are frequently billed in the ED. Medical students can participate in stitching the laceration if personally supervised by a teaching physician provided the physician documented the procedure for billing purposes, but what now? “Hopefully it will be clarified by the MLN Matters,” Gaines says.

To Engel, the payoff in this change will be the opportunity for teaching physicians to spend more time teaching. Over the years, she says, as reimbursement pressures have intensified, teaching physicians may not have been “spending as much time reviewing student notes due to time pressures. I’m hopeful this will change when their documentation can be used for billing.”

At the same time, medical and allied health students may feel “marginalized” because their documentation is cordoned on the grounds that it can’t contribute to E/M billing. For example, Epic, the electronic health record system, may be customized so it has a separate tab for documentation by medical and other allied health students. If that’s the case, their notes don’t necessarily appear in the patient’s documentation, Engel says. But that will be different.

“The time we save doing our own documentation, we need to spend teaching,” she says. “Students are not our slaves. They are our responsibility.”

Contact Engel at jeannine.engel@hsc.utah.edu and Gaines at egaines@zotecpartners.com. View the new transmittal at https://tinyurl.com/ya8sqpmx.

**Hospital Settles Case Over Cataract Surgery Billed Without Lenses**

Seton Medical Center in California agreed to pay $27,227 to settle allegations it violated the civil monetary penalty law when it billed Medicare for cataract extraction surgery without supplying specialized intraocular lenses (IOLs), the HHS Office of Inspector General said.

Seton Medical Center self-disclosed the problem to OIG in October 2016 and was accepted into the Self-Disclosure Protocol in November 2016.

According to the settlement, OIG contends Seton billed Medicare for items or services that were not provided as claimed and were fraudulent. From Sept. 1, 2010, to Sept. 1, 2016, Seton “submitted 121 claims for
CATARACT EXTRAC TION PROCEDURES TO MEDICARE WHEN RESPONDENT DID NOT SUPPLY THE SPECIALIZED INTRAOCULAR LENS (IOL) AND SHOULD NOT HAVE BEEN REIMBURSED FOR THE IOL SUPPLY,” THE SETTLEMENT STATES.


AFTER INFORMING HIM WHAT WENT DOWN, TEPLITZKY SAYS HE RECOMMENDED A SELF-DISCLOSURE.

“IT WAS A SIMPLE FILING,” HE SAYS. “THE LAW IS PRETTY CLEAR: IF YOU ARE IN POSSESSION OF PAYMENTS TO WHICH YOU ARE NOT ENTITLED, YOU HAVE AN OBLIGATION TO REPAY, AND THE AMOUNT OF MONEY WAS NOT A FACTOR.”

SETON DID NOT ADMIT LIABILITY IN THE SETTLEMENT.

CONTACT TEPLITZKY AT STEPLITZKY@BAKERDONELSON.COM.

CONGRESS ENDS THERAPY CAP FOREVER

CONTINUED FROM P. 1

THE TWO-YEAR BUDGET AGREEMENT WAS NOT FINALIZED IN TIME TO FUND THE FEDERAL GOVERNMENT WHEN THE MONEY RAN OUT AT MIDNIGHT FEB. 8, SO IT INCLUDES A SHORT-TERM FUNDING MEASURE TO KEEP THE GOVERNMENT OPERATING THROUGH MARCH 23. MEANWHILE, THERE WAS A BRIEF GOVERNMENT SHUTDOWN.


THE BILL ALSO DELIVERS MONEY TO FIGHT THE OPIOID EPIDEMIC, EXTENDS FUNDING FOR THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)—AN ADDITIONAL FOUR YEARS ON TOP OF SIX YEARS ALREADY APPROVED—AND PUTS OFF CUTS TO MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR TWO YEARS, AMONG OTHER THINGS, ACCORDING TO THE AMERICAN HOSPITAL ASSOCIATION. THE INDEPENDENT PAYMENT ADVISORY BOARD CREATED BY THE AFFORDABLE CARE ACT WAS ELIMINATED BY THE BILL.

AND THEN THERE IS THE ELIMINATION OF THE CAP, WHICH IS A BIGGIE FOR OUTPATIENT PROVIDERS.

MUCH TO THE CHAGrin OF THE REHAB COMMUNITY, A HARD CAP WENT INTO EFFECT JAN. 1, 2018, WHICH MEANS MEDICARE LIMITS THE AMOUNT IT PAYS PER BENEFICIARY FOR OUTPATIENT PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY (RMC 1/22/18, P. 1). THE ANNUAL CAP FOR 2018 IS $2,010 FOR PHYSICAL THERAPY AND SPEECH-LANGUAGE PATHOLOGY SERVICES COMBINED.

CMS TRANSMITTL S

FEB. 2–8

LIVE LINKS TO THE FOLLOWING DOCUMENTS ARE INCLUDED ON RMC’S SUBSCRIBER-ONLY WEBPAGE AT HCCA-INFO.ORG. PLEASE CLICK ON “CMS TRANSMITTL S AND REGULATIONS.”

TRANSMITTL S

(R) INDICATES A REPLACEMENT TRANSMITTAL.

PUB. 100-04, MEDICARE CLAIMS PROCESSING MANUAL

• QUARTERLY UPDATE FOR CLINICAL LABORATORY FEE SCHEDULE AND LABORATORY SERVICES SUBJECT TO REASONABLE CHARGE PAYMENT, TRANS. 3973 (FEB. 8, 2018)

• UPDATE TO THE FEDERALLY QUALIFIED HEALTH CENTER (FQHC) PROSPECTIVE PAYMENT SYSTEM (PPS) FOR CALENDAR YEAR (CY) 2018 - RECURRING FILE UPDATE, TRANS. 3972 (FEB. 8, 2018)

• DIAGNOSIS CODE UPDATE FOR ADD-ON PAYMENTS FOR BLOOD CLOTTING FACTOR ADMINISTERED TO HEMOPHILIA INPATIENTS, TRANS. 3974 (FEB. 8, 2018)

• QUARTERLY HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) DRUG/BIOLOGICAL CODE CHANGES - APRIL 2018 UPDATE, TRANS. 3966 (FEB. 2, 2018)

• REINSTATING THE QUALIFIED MEDICARE BENEFICIARY INDICATOR IN THE MEDICARE FEE-FOR-SERVICE CLAIMS PROCESSING SYSTEM FROM CR 9911, TRANS. 3965 (FEB. 2, 2018)

• SUPERVISED EXERCISE THERAPY (SET) FOR SYMPTOMATIC PERIPHERAL ARTERY DISEASE (PAD), TRANS. 3969 (FEB. 2, 2018)

• E/M SERVICE DOCUMENTATION PROVIDED BY STUDENTS (MANUAL UPDATE), TRANS. 3971 (FEB. 2, 2018)

• QUARTERLY UPDATE TO THE NATIONAL CORRECT CODING INITIATIVE (NCCI) PROCEDURE-TO-PROCEDURE (FTP) EDITS, VERSION 241, EFFECTIVE APRIL 1, 2018, TRANS. 3963 (FEB. 2, 2018)

PUB. 100-02, MEDICARE BENEFIT POLICY MANUAL

• NEW “K” CODE FOR THERAPEUTIC SHOE INSERTS, TRANS. 241 (FEB. 2, 2018)

PUB. 100-20, ONE-TIME NOTIFICATION

• IMPLEMENTATION OF AUTOMATING FIRST CLAIM REVIEW IN SERIAL CLAIMS FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS), TRANS. 2029 (FEB. 2, 2018)

PUB. 100-15, MEDICAID PROGRAM INTEGRITY MANUAL

• UPDATE TO THE MEDICAID PROGRAM INTEGRITY MANUAL (PIM), TRANS. 3 (FEB. 2, 2018)

PUB. 100-03, MEDICARE NATIONAL COVERAGE DETERMINATIONS

• SUPERSIZED THERAPY THERAPY (SET) FOR SYMPTOMATIC PERIPHERAL ARTERY DISEASE (PAD), TRANS. 204 (FEB. 2, 2018)
and $2,010 for occupational therapy services. A cap is nothing new, but it was always paired with an exceptions process, which allowed rehab providers to exceed the cap when it was medically necessary with the understanding that therapy was subject to medical review. But the exceptions process expired Dec. 31, 2017, leaving only the cap in place. That was a thorn in the side of outpatient rehab providers because patients with certain conditions, such as strokes, will exhaust their Medicare benefits early in the year, Beckley says.

But it looks like relief is moments away, Beckley says it’s almost certain that budget legislation will include a Medicare extenders bill, which has numerous provisions for providers, and the therapy cap is one of them. In exchange for torpedoing the cap, the bill implements a $3,000 therapy “threshold,” Beckley says.

When therapy reaches $3,000 combined for physical and speech therapy or $3,000 for occupational therapy, providers are required to affix the KX modifier to their Medicare claims, Beckley says. “By affixing the KX modifier, the therapist is making an attestation that the therapy is medically necessary and there’s documentation in the medical record to support this,” she explains. “Therapists need to be careful—they are making an attestation.”

Cap Elimination Is Probably Retroactive

CMS will use the modifier information to select some therapy claims for medical review. Beckley says the reviews probably will be conducted by CMS’s supplemental medical review contractor, which is StrategicHealthSolutions, but there won’t be 100% review of outpatient therapy claims over the threshold. Recovery audit contractors did that in 2013 and 2014, when there was both a cap and an exceptions process.

The $3,000 is fixed until 2028, and after that it will be incrementally increased according to the medical economic index, she notes.

The outpatient therapy cap expired on Dec. 31, 2017, for short-term acute care hospitals, so the cap hasn’t applied to them anyway. But they are still subject to the medical review process moving forward, Beckley says. She assumes that for critical-access hospitals, the $3,000 will be calculated as if they were on a fee schedule.

It looks like the expiration of the cap will be retroactive to Jan. 1.

Congress also took a big step toward identifying Medicare services provided by physical therapy and occupational therapy assistants. The bill directs CMS to create a modifier for tracking use of therapy assistants in 2019, with an eye toward collecting enough data in 2020 to come up with a Medicare fee schedule rate that’s 85% of the fees paid to physical, speech and occupational therapists by 2022, Beckley says. It’s supposed to be subject to the rulemaking process, so it will take some time and allow the industry to comment.

“It is likely to affect different sectors differently,” with facilities that rely most on assistants, such as skilled nursing facilities, high on the list, Beckley says.

Contact Beckley at nancy@nancybeckley.com. ✦

**NEWS BRIEFS**

◆ The University of Michigan Health System in Ann Arbor was overpaid $6.1 million, according to a Medicare compliance review. The HHS Office of Inspector General reviewed 181 inpatient and outpatient claims paid to the health system in 2014 and 2015 and found 73 errors. That resulted in $1,294,130 of overpayments. “On the basis of our sample results, we estimated that the Hospital received net overpayments totaling at least $6,162,201 for the audit period,” OIG contended. Errors included incorrectly billed inpatient rehabilitation, claims paid in excess of charges, claims billed with the wrong high-severity-level DRG codes, unreported manufacturer credits for replaced medical devices, billing errors on outpatient claims, and misuse of modifier 59, OIG says. In a written response, the University of Michigan Health System’s corporate compliance department disagreed with some of OIG’s findings, notably its “position regarding purposed billing errors pertaining to inpatient rehabilitation claims” and the use of extrapolation in this area. Where the University of Michigan Health System agreed, the health system said it repaid the overpayments or made adjustments. It also implemented some controls. Visit https://go.usa.gov/xnsqX.

◆ A ransomware attack at electronic medical records provider Allscripts wiped out access for 1,500 clients in January, and the EMR provider has been hit with a class action lawsuit as a result. The suit, filed by Surfside Non-Surgical Orthopedics, a sports medicine and pain practice in Boynton Beach, Fla., alleges that Allscripts knew of the problems before the ransomware hit. Allscripts was attacked by SamSam, a strain of ransomware that has been a known threat since early 2016, according to the lawsuit. Learn more about the attack and lawsuit at http://bit.ly/2EADuYq.