Requests for Exceptions to the Therapy Threshold:

Manual Medical Review Process

Why is CMS doing this?

This process is required by Section 1833(g)(5)(C) of the Social Security Act, as added by Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJA), which was signed into law on February 22, 2012.

Why has CMS not issued regulations on this process?

Section 3005(d) of the MCTRJA requires implementation in a timely manner and authorizes implementation of this process via program instruction.

(d) IMPLEMENTATION.—The Secretary of Health and Human Services shall implement such claims processing edits and issue such guidance as may be necessary to implement the amendments made by this section in a timely manner. Notwithstanding any other provision of law, the Secretary may implement the amendments made by this section by program instruction.

What is the manual medical review threshold?

$3,700

What does the $3,700 threshold represent?

The threshold represents the total allowed charges under Part B for services furnished by independent practitioners, and institutional services under Part B (hospital outpatient departments, skilled nursing facilities).

Does therapy provided in a critical access hospital (CAH) count?

No. Services provided in a CAH are not counted and CAHs are not subject to the manual medical review provision.

What are the Phases?

Phase I	October 1, 2012 to December 31, 2012
Phase II	November 1, 2012 to December 31, 2012
Phase III	December 1, 2012 to December 31, 2012

How do I know what Phase I am in?

Each provider subjected to a phase will be notified via US Mail. There will also be a posting to www.CMS.gov with the providers in phase I and II.

How did CMS come up with the phases?

The phases were developed taking into account specific provider characteristics (e.g., claims volume and payment) and then adjusted to distribute workload evenly at the Medicare Administrative Contractor.

What are the guidelines CMS contractors will use when conducting the review?

The contractors will use the coverage and payment policy requirements contained within Section 220 of the Medicare Benefit Policy manual and any applicable local coverage decisions when making decisions as to whether a service shall be preapproved.

How long will a contractor have to make a decision on a pre-approval request?

10 business days.

What happens if a contractors decision about request for an exception is not made within 10 business days?

If a manual medical review decision is not made within 10 business days, the request for exception will be deemed to be approved.

If a decision was made within 10 business days and the request for an exception was denied, and the the provider furnishes the service to the beneficiary and submits a claim, what happens?

The claim is not payable under Medicare, the claim will be denied, and the beneficiary will be liable for the services.

Why is the beneficiary liable?

Medicare only covers therapy services up to $1,880 cap in 2012. For services between $1,880 and $3,700, if the conditions for an exception are not met, the beneficiary is financially responsible. For services above the $3,700 threshold, if a request for an exception to the $3,700 threshold is not met, the beneficiary is finanancially responsible.

Am I required to provide the beneficiary an Advanced Beneficiary Notice (ABN) for services above the therapy cap of $1,880?

There is no legal requirement for issuance of an ABN. However, CMS strongly recommends a voluntary ABN where the provider believes that Medicare may not cover the services.

How is the $3,700 calculated?

The $3,700 is calculated using all outpatient therapy services provided (except those provided in Critical Access Hospitals) within the category of physical

therapy/speech language therapy and then a separate category for occupational therapy services.

If I am in Phase III, what happens to my claims during the timeframe of October 1, 2012 to November 30, 2012?

Phase III is scheduled to begin for services expected to be furnished on or after December 1, 2012. Claims for services furnished before this time will be treated in the same manner as claims for services below the $3,700 threshold.

If I am in Phase III would a Medicare contractor conduct review of my claims from October 1, 2012 to November 30, 2012?

Medicare contractors have the authority to review any claim at any time.

How to I know where to submit my request for exception?

Please check the website of the Medicare contractor to whom you submit your claims for processing for detailed information on where to submit your request for exception for therapy services above the $3,700 threshold.

Will claims that are pre-approved be guaranteed payment?

Authorization does not guarantee payment. Retrospective review may still be performed.

Why would a Medicare contractor review therapy that has been pre-approved?

There are many reasons retrospective review would be needed after a pre-approval:

- clinically inappropriate modalities;
- patient's clinical therapy needs do not match what was reported, e.g.
    - Patient's functional level is greater than reported,
    - Patient reached functional independence more quickly than predicted.
- Excessive or inappropriate therapy was furnished, e.g.
    - therapy more often or of longer duration than is medically r/n;
    - therapy provided to clinical treatment area not reasonable and necessary, e.g. therapy to shoulder when knee is the issue

What happens if I request pre-approval and gain approval for 20 treatment days and I actually furnish 30 treatments?

The claim will be subject to prepayment medical review.

What is CMS doing to educate beneficiaries about the therapy cap and the threshold?

CMS will be conducting a mailing in September to beneficiaries who have received therapy services at or near the cap. The mailing will inform them of the cap and of the fact that if services above the cap are denied, that they will be financially liable.