Centers for Medicare & Medicaid Services
Special Open Door Forum:

Manual Medical Review of Therapy Claims

Tuesday, August 7, 2012
2:00pm – 3:30pm Eastern Time
Conference Call Only

The purpose of this Special Open Door Forum (ODF) is to provide an opportunity for **providers** to ask questions about the mandated manual medical review of therapy services from October 1-December 31, 2012 that was enacted by the Middle Class Tax Relief and Job Creation Act of 2012.

During this Special Open Door Forum, CMS will discuss the implementation of a process to request exceptions from manual medical review, and what the process entails.

CMS requests providers' participation who order or provide therapy services nationally. See below for more background and who will be impacted.

The statutory Medicare Part B outpatient therapy cap for Occupational Therapy (OT) is $1,880 for 2012, and the combined cap for Physical Therapy (PT) and Speech-Language Pathology Services (SLP) is also $1,880 for 2012. This is an annual per beneficiary therapy cap amount determined for each calendar year. Medicare allowable charges, which include both Medicare payments to providers and beneficiary coinsurance, are counted toward the therapy cap. In outpatient settings, Medicare will pay for 80 percent of allowable charges and the beneficiary is responsible for the remaining 20 percent of the amount.

The therapy cap applies to all Part B outpatient therapy settings and providers including:

- private practices,
- skilled nursing facilities,
- home health agencies,
- outpatient rehabilitation facilities, and
- comprehensive outpatient rehabilitation facilities.

Beginning this year, the therapy cap will also apply to therapy services furnished in hospital outpatient departments (HOPDs) until December 31, 2012. Before 2012, therapy provided in hospital outpatient departments did not count towards the therapy cap.

Participants may submit questions prior to the Special ODF to therapycapreview@cms.hhs.gov.

We look forward to your participation.

Special Open Door Participation Instructions:

Participant Dial-In Number(s):

- Operator Assisted Toll-Free Dial-In Number: (800) 603-1774

- Conference ID: 16032541

NOTE: In order to join this conference call, you will be required to provide the Conference ID Number listed above.

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

A transcript and audio recording of this Special ODF will be posted to the Special Open Door Forum website at http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) please visit our website at http://www.cms.gov/opendoorforums/ .

Thank you for your interest in CMS Open Door Forums.

Audio File for Transcript:
http://downloads.cms.gov/media/audio/080712MedReviewTherapyClaimsSODFID16032541.mp3

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: George Mills
August 7, 2012
2:00 p.m. ET

Operator: Good afternoon. My name is (Nicole), and I will be your conference facilitator today. At this time, I would like to welcome to the Centers for

Medicare and Medicaid Services Medical Review for Therapy Claims Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star, then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you.

Mr. Mills, you may begin your conference.

George Mills: Thank you very much. This is George Mills. I am the director of the Provider Compliance Group in the Office of Financial Management, Centers for Medicare and Medicaid Services. The purpose of today's call is to discuss how we're going to implement the manual medical review process for therapy claims above the $3,700 threshold as required by Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012, which was signed into law on February 22nd, 2012.

So, I'm going to go over this briefly. There are a number of people in the room. And at the end, we will take questions.

So, first, I would like to apologize for people. We had a lot of people in the line, getting them in. So, we're starting a few minutes late. But I just wanted to apologize for starting a little bit later than projected. But we wanted to get as many people as possible on to the call.

First I'd like to talk about is the way we discuss internally about possibly implementing this provision, Section 3500 of the Middle Class Tax Relief and Job Creation Act. First of all, we considered doing nothing. But keeping the current status quo as the way the MACs are addressing therapy claims today, we considered conducting just more education about what the MACs are doing today.

We considered implementing this on a pre-payment basis only methodology. We also considered doing a post-pay methodology. And then, we considered allowing for an advance approval of therapy exception.

The issue with most of these areas were that they didn't meet the statutory requirements or there were problems because the beneficiary would be liable. When I say the beneficiary would be liable, the issue would be if we approach this $3,700 manual medical review threshold from our perspective of conducting post-pay review, any claims that we found to be not payable on under Medicare, the beneficiary would be liable for. The same would happen with prepayment because in both of those instances the service had already been provided.

So, the beneficiary liability issue is a complicated legal one. But I'll try to explain it in a way that is relatively simple. Basically, because of the $1,880 cap on therapy services, anything above the cap that's not payable under Medicare is considered beneficiary liable. It's as if – it's as if the service was complete wholly not covered like things like eyeglasses or dental work and things like that.

So, anything above the cap that is denied is beneficiary-liable. The $3,700 is not a cap; it is a threshold which the Section 3005 requires CMS to do review. So, we are going to direct the beneficiary by, at least, alerting the beneficiary up front of the cap and that they are potentially liable for services about the cap.

So, we are going to be sending a mailing approximately September 1st out to any beneficiary that, at the end of August, had $1,700 or more in therapy services – $1,700 or more in therapy services in calendar year 2012 alerting them to the cap and telling them about the manual medical review process and that if there was claims provided above the cap that were medically reviewed, you know, and found out to be not covered by Medicare, that they would be liable.

So, the next issue is how are we going to implement this process? We're going to implement this process by implementing an advance approval of an exceptions process where we're allowing people to come in in advance and get up to 20 days of therapy services approved in advance. For those that do not get an exception approved in advance, all claims will be stopped above the

$3,700 limit and they will be subject to prepayment review, which is why we're sending the beneficiary letter.

There are some questions that people have about the $3,700 limit. There's a separate $3,700 for P.T. and SLP and a $3,700 limit threshold for O.T. So, anyone who will be provided services above the $3,700 will be able to request an advance exception to the therapy cap threshold.

You might be asking, well, "How am I going to know that the individual bene is above 3,700?" We have a change request that will be in effect starting October which will allow, via the HIPAA Eligibility Transaction System, to see the total amount of therapy provided. Those will give providers information as to where the beneficiary stands at that time and will be able to request an exception for services expected to be above.

So, to go over this again, any claim about $3,700, people can request an advance exception. If a claim is not received with an advance exception, it will be stopped for prepay review. If an advance exception is requested, there'll be a 10-business-day review time. And if the contractor (inaudible) does not review the claim in 10 business days, the claim will be deemed to be approved and the provider will receive a notice as such.

Now, when we look at this, we were very concerned about there being very large backlogs come October 1. So, what we are going to do is break therapy providers into three phases. Then, we'll implement the advance approval process in phases.

So, there'll be three phases. Phase one will start October 1, phase two November 1, phase three December 1. People will be – the providers will be notified as to which phase they're in via the CMS website as well as a letter to be mailed via U.S. Mail.

Some people might be saying, well, "Why should I even get an approval for services in advance?" I'd like to notify people that the timeframe for review – for prepayment review – is different than the preapproval exception process. The preapproval exception process is 10 days. The prepayment review, there is a 45-day review time for those types of claims.

For people that are above 3,700 but are not in the phase, the claims will be treated the same as claims above 1,880 but below 3,700, meaning they need to have a (caps) modifier. But they'll still be treated the same way until your specific date goes into effect.

Another question would be, "What would be the policy that's going to be applied to the claim?" And the policy that's going to be applied to the claims review is the current policy being applied by the MACs. So, that would be either the Medicare Benefit Policy Manual or any local coverage decisions related to therapy.

There may be questions about how to request the exception. And there'll be detailed information on everyone's website. So, there'll be more to come on that. But we've got some – we had opened a therapy cap review mailbox and we got a number of questions. And I just wanted to go over them before I open it up for further questions.

The first question was, "Why is CMS doing this?" And the answer is because it's required by Section 3005 of the Middle Class Tax Relief and Job Creation Act.

Another question we received is, "How come CMS has not issued regulations on this process?" I would refer everyone to Section 3005 of the law, which states that the secretary of health and human service shall implement such processing edits and guidance as they may be necessary to implement this provision. Notwithstanding any other provision of law, the secretary may implement the amendments made by this section via program instruction.

So, basically, the law says we don't have to do (inaudible). We can just do a manual guidance, which we will make available to the public on our website.

What is the threshold and how is it determined? Well, the threshold is 3,700. And there's a separate threshold for P.T. and speech language and a separate threshold for O.T.

What does the $3,700 represent? The $3,700 represents the total allowed charges under Part B for services furnished by any type of Part B provider who can provide therapy services other than a critical access hospital.

This would include hospital outpatient departments and skilled nursing facilities course for physicians, independent practitioning physical therapists or occupational therapists.

Does therapy in a CAH count? No. There is – therapy services currently provided by critical access hospitals are not subject to the manual review process review threshold.

What are the phases? Phase one is October 1, 2012 to December 31. Phase two is November 1 to December 31. Phase three is December 1 to December 31.

How do I know which phase I am in? Each provider, subject to the manual medical review process, will be notified via U.S. Mail. They will also post a – making a posting to the cms.gov website which will list all the providers and by phase.

How did CMS come up with the phases? The phases were developed taking into account specific provider characteristics such as claims volume, the historical number of beneficiaries over the cap and total amounts of payment. And then, we adjusted the workload among the contractor to spread it – spread the workload out.

So, in general, it's based on billing characteristics. But there are some exceptions to that rule, whether it's a large number of therapists or other providers who had, in the past, a number of beneficiaries over the cap. In those situations, there could be some equalizing of the distribution of providers across the specific MACs.

What are the guidelines CMS contractors will use when conducting review? The contractors will use the coverage and payment policies contained in Section 2220 of the Medicare Benefit Policy Manual or any local – applicable

local Medicare coverage decisions for making decision on whether to bill a service shall be preapproved.

As I noted the timeliness, contractors have 10 business days from receipt of all requested information to count towards an exception. What happens if the contractor doesn't make an exception in 10 business days? If there is no exception granted in 10 – no decision made in 10 business days, there will be an automatic approval of the request.

If the provider doesn't request an exception and a claim for therapy services is provided, what happens when the claim is submitted? And in that case, the claim will be stopped and prepayment review would be conducted.

We got questions about beneficiary liability and whether for services about the 1,880 cap – whether there's a legal requirement that a provider provides notice – an advance notice – beneficiary's notice.

For services above the 1,880 cap, there's no legal requirement for an issuance of an ABN. However, CMS strongly recommends a voluntary ABN where the provider believes that Medicare may not cover the services.

If I'm in phase two or three, what happens to my claim during the timeframe before the – before the phase kicks into effect? As I indicated earlier, what will happen is those claims will be treated the same as those same above $1,880 but below $3,700, which means they need to have the tax modifier and they'll go through without being subject to the manual medical review process.

If I'm at phase two or three, is – would a contractor be reviewing my claims before the timeframe? The answer is likely no. But a contractor can review any claim at any time. And there might be circumstances where an individual provider put on a provider-specific review. And therefore, that rule would apply as opposed to this general notice of review.

Are claims that are preapproved guaranteed to be paid? The authorization for the exception does not guarantee payment completely. It's not CMS's intention to re-review on a regular basis claims for which exception is granted.

The kinds of situations where I could imagine that a claim might be re-reviewed in some capacity would be if there was some questions such as the request came in for therapy on the shoulder but the bill came in for services provided in another area of the body or other circumstances such as there was a fraud investigation or something else going on by some other entity other than the MACs.

So, how many days can I request an exception for? We will allow people to – providers to request up to 20 therapy days to be approved in advance. So, you can get an advance exception for up to 20 therapy days.

What happens if I don't request preapproval? Or, if I did request preapproval for 20 therapy days but I actually provided 30? Under that circumstance, that claim would be subject to a prepayment review.

What is CMS doing to educate beneficiaries? Like I said, we're doing a mailing between now and the start of the manual medical review process. October 1, there'll be a significant amount of outreach and education conducted locally by the MACs. The MACs will have detailed instructions on how to bill claims once an exception has been provided. So, you'll get more information there.

Another question that we received is, "What if the MACs claim that they don't have all the records? And they should have got a 10-day approval because they didn't do it within 10 days and now they're saying that they didn't get all the records?" Well, that's the same that happens today. It's that there is timeliness standard. We monitor the MACs if there's – if there's evidence that people have that they've been submitting all the request and documentation and the MACs are doing that. We would like to know about it. But we will monitor their adherence to the 10-day timeframe.

So, with that, I'd like to open it up for people's questions, operator. And like I said, we've got a lot of staff in the room and we'll try to address what we can today. And if not, we can add it to our Q&A document that we have on our website.

The other thing I'd like to say before we open it up is that for people who don't get in to ask their question over the line, we do have an e-mail that we will – we're more than willing to accept questions of comments. That address is therapycapreview@cms.hhs.gov . That's therapycapreview@cms.hhs.gov . We won't – we don't necessarily – we might not be able to answer every single e-mail. But we will try to add those things that are in there that look pertinent to the – your Q&A document.

So, with that, operator, if you want to open it up for questions and answers, we can get going now.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your questions to one question and one follow up to allow other participants time for questions. If you require any further follow up, you may press star one again to rejoin the queue.

Your first question comes from the lines of (Darlene Oldman) from Professional Revenue. Your line is open.

(Darlene Oldman): Yes. This is (Darlene Oldman). Thank you for taking my call. I understand the concept of the voluntary ABN. However, since the calculation of the amount of therapy for the beneficiary is based on only what has been billed, there is a good reason to believe there are going to be a lot of residents that – or a lot of facilities that are unaware of what has already been used to date.

My question is, if a voluntary ABN is issued because it is unknown as to the exact amount of therapy that has been given, is there a penalty for that or not?

George Mills: Well, the issue would be we don't allow there to be blanket ABNs.

(Darlene Oldman): Right. I'm (inaudible) …

George Mills: But if you do have suspicion that the service is being provided but might not be covered by Medicare, you can give the voluntary ABN if you're acting in good faith.

(Darlene Oldman): OK.

George Mills: Now, the issue is going to be really, that above the cap 1,880, the beneficiary is liable no matter what.

(Darlene Oldman): Right.

George Mills: If below 1,880 that if the service is being provided, then it might not be covered by Medicare, that the ABN has a legal significance because if you had given them the ABN and then it's not found to be covered by Medicare, then you could bill the bene where the – if that was below 1,880 and you hadn't given ABN, then the provider will be liable.

(Darlene Oldman): Right. Which is trying to avoid …

George Mills: Right. But …

(Darlene Oldman): … providing services and you know, (inaudible).

George Mills: Right. But the point – right. But like some people had said, we had talked to – it's like, why just don't you deny claims because for anybody that didn't get an exception. And you bring up an excellent point here. It's that you could check today and you could see for patient X, "Oh, they've got $2,000 of therapy." And then, you provide 23 med days and then you go to bill Medicare and then you look at the – look at the system and it shows $8,000 because …

(Darlene Oldman): Exactly.

George Mills: Now, the next day after you've looked at the system, all these therapy claims went through. Now, we don't – based on our data, we don't see that occurring frequently. But it is a possibility. And that's why if there was not an exception gained, we would ask for a prepay review or we're going to conduct prepay review just because of that situation.

(Darlene Oldman): Yes.

George Mills: But we'll add this to FAQs about the – about the ABN. Is that (inaudible) – I don't have – I don't see an ABN expert from our appeals area. So, I'll make sure to get that on FAQs for you, OK?

(Darlene Oldman): OK. Thank you very much.

George Mills: Thank you.

Operator: Your next question comes from the line of (Jane Moffat) from (Casamba). Your line is open.

(Jane Moffat): Hi. Thanks. My question is related to the MPPR adjustment. Are we basing our 3,700 cap on the post-MPPR adjustment or the pre-MPPR adjustment? And regardless of the answer to that, at what point can the facility request the exception prior to a patient hitting the 3,700?

George Mills: I'll turn it over to our payment policy people to answer the first part and I – we can handle the second.

(Pam West): OK. This is (Pam West). And the MPPR adjustments are taken prior to payment. So, it is incurred – the expenses are incurred for – as a total expenses up to 1,880 to be considered. So, everything that's prepaid and the (inaudible). So, the MPPR is taken prior to the payment being made.

George Mills: And in terms of when you can request an exception, it's when you think your services that you're going to provide in total will go over. So, if you had a beneficiary that was in that $3,000 and your services that you're going to provide would take them above $700, you can put in a request for an exception because as soon as the …

(Jane Moffat): Great. Thank you.

George Mills: Yes. As soon as the aggregate hits 3,700 in total, it's going to flag in the system and it's going to stop. So, we'll have that in advance.

(Jane Moffat): But we should have asked for that exception well in advance of reaching that so that we don't have to interrupt …

George Mills: Yes. Up to 20 treatment days.

(Jane Moffat): Great. Thank you.

Operator: Your next question comes from the line of Barbara Love from the University of Rochester. You line is open.

George Mills: Hello.

Male: Let's move to the next caller, (Nicole).

Operator: Your next question comes from the line of (Marla Hunt) from (Inaudible) Medical. Your line is open.

(Marla Hunt): Yes. Thank you very much. I was wondering, is there any type of special modifier you're going to be requiring on the claims if we do have the exception?

George Mills: Yes. Well, that will be in the detailed instruction. We're still working on finalizing them. I don't have them right out of the top of my head. But you'll get that from the MAC because there is DDE systems and things like that. So, that will be in the instructions provided by the MACs.

(Marla Hunt): OK. Thank you.

George Mills: Yes. Your local contractor. I'm sorry. Your local – whoever you bill, you'll check their instructions and it will be there.

(Marla Hunt): OK.

George Mills: OK.

(Marla Hunt): Thank you.

George Mills: Thank you.

Operator: Your next question comes from the line of (Deborah Farley) from (Bill Probe) Management Systems. Your line is open.

(Deborah Farley): Yes. I understand the three phases. How is CMS going to determine – or are these letters going to every provider? Or, just select providers, say …

George Mills: They're going – well, every person who in 2011 provided therapy service will get a letter. And we will be using the addresses based on the most recent updates in the (paycos) file. And so, if – and then, anybody who is new or not listed because they didn't have anything in 2011 and we don't see any billings in early 2012 will be listed in phase three.

(Deborah Farley): OK. Thank you.

George Mills: So, if you're not – yes. So, I'm going to put up a list. And it's going to show everybody in phase one and everybody in phase two. And if you're not in phase one or phase two, then you're in phase three, which would include like somebody who just got a provider number a week ago. So, that way, they are automatically put in phase three.

(Deborah Farley): Right. But any provider in 2011 who didn't bill, say any therapy codes, they're not going to be receiving a letter.

George Mills: No. If they didn't – if they didn't get one – but if they are …

(Deborah Farley): Right.

George Mills: If they didn't bill any therapy and then, let's say, starting last month they expanded into therapy services, they would be in phase three.

(Deborah Farley): OK. Thank you.

George Mills: Bye.

Operator: Your next question comes from the line of Mark Williams from TruCare Solutions. Your line is open.

Mark Williams: Yes. Will the information from this call be available through transcript on your website?

George Mills: Yes. I'd have – I'm not sure of that. We need to check with the operator.

Male: It actually will be available. Usually, a week turnaround. One week turnaround.

Mark Williams: OK. All right. Thank you.

Male: Yes.

Operator: Your next question comes from the line of (Alicia Smith) from (Epoch). Your line is open.

(Alicia Smith): Thank you. I was just wondering if the provider or beneficiary has any appeal rights if the preapproval is not granted or it's denied on prepay review.

George Mills: Yes. Appeal rights are the same. So, what will happen is if – I'm sorry. I should have – I skipped over that in my notes. I apologize.

But if the – you submit an advance approval and it's not approved, you can do one of two things. You can come back again with more information because one of things we want to do is make sure people understand why we think we're not going to approve it. So, we want the contractors to give a letter saying, well, "You're missing this or you're that or you don't. You're not showing the need for skilled care" or whatever the reason is.

So, you can either resubmit it or you can provide the service. And then, if we did said, "No, we're not approving it," then we'll deny it and then you can go right into the appeal process. And if you receive a prepayment denial, you have the right to go through the normal appeal process like you would at any claim today.

(Alicia Smith): Just as a follow up to that, we're accustomed to the Medicare administrative contractors often simply identifying that the claim does not show evidence of skilled care being provided.

George Mills: Yes.

(Alicia Smith): Will the contractors be required to provide more detail in terms of what they mean by that?

George Mills: Yes. Yes. We want a detailed response letter. Yes. That's in our instructions.

(Alicia Smith): Thank you.

Operator: Your next question comes from the line of (Julie Larson) from Orthopedic Rehab. Your line is open.

(Julie Larson): Yes. I have a question. You mentioned earlier about providers being told where patients are at in the cap and I didn't catch where we're going to see that information. Is it through the C-SNAP or is it though the IDR? What system?

George Mills: Well, it's in the HETS system. And if – are you an institutional provider?

(Julie Larson): No.

George Mills: With DDE. There's the HETS system, that's the eligibility system is being modified so you'll be able to see it through there. I don't know – well, (inaudible) here. Maybe he can ….

Will Gehne: Yes. It will be available two ways, either if you're submitting the (inaudible) standard eligibility transaction, it will be available through the HETS system or if you have access online through your MACs to the – what it's called – your institutional providers, the ELGA inquiry screen.

(Julie Larson): We're not an institutional providers.

George Mills: So, it's the HIPAA 270, 271.

Will Gehne: All right. HIPAA eligibility transaction. Yes.

(Julie Larson): OK. So, there are going to be more information available out because what you're talking about is …

Will Gehne: Yes, we will. We'll make sure we – the MACs emphasize that on a local level about how you get that.

(Julie Larson): OK. (Inaudible) …

Will Gehne: (Inaudible) inquires, transactions that you use to determine whether a patient has Part A or Part B coverage, what their enrollment dates and things like that. That's a different – that a different screen within the same system.

(Julie Larson): OK.

George Mills: OK. We'll make sure the MACs alert people on that, OK? Thank you.

(Julie Larson): OK.

Operator: Your next question comes from the line of (Bonnie Nether) from (Global Living). Your line is open.

(Bonnie Nether): Yes. I have a question about the therapy cap related to hospital outpatient departments. I understand beginning 10/1, they are going to be held to the cap limitation as well. Will the therapy provided in those institutions, then, only be applied into the eligibility system beginning 10/1?

George Mills: Well, the issue is – I mean, it's that the total is from start of January, which includes the outpatient department. So, anything under – basically, under Part B other than CAH is going to be captured in the total. The issue would be if the person – they could have $6,000 of therapy through the end of June.

But then, we don't go back to people unless they're getting more services beyond October 1. So, everything before October 1 counts. But what gets in the manual medical review would be if there are services above the $3,700 on or after October 1.

(Bonnie Nether): OK. So, the eligibility files that have that Part B total today, it does have what has been provided in the hospital setting since January 1?

George Mills: No, it will be (inaudible) …

Will Gehne: Not yet. Unfortunately, we are not able to go back in and pull all the history from January 1 to the present into the system and that we're actually going to do it all at once on October 1. So, you'll see – on September 30, you'll see, you now, one amount of dollars has been applied towards beneficiaries cap and then you'll see it updated on October 1 to add in the hospital outpatient amount.

So, I'm encouraging folks to, you know, check again, you know, first thing after October 1 …

George Mills: Yes.

Will Gehne: … on all their patients.

George Mills: That's the date that the system releases – the Medicare standard system goes in effect in October 1, which is another reason why we're not just going to deny because you might be looking and not see the person having a lot of therapy that they got in outpatient department. And then, come October 1, they're, you know, way over the threshold.

(Bonnie Nether): Right. That was my concern.

George Mills: Yes.

(Bonnie Nether): Thank you for that information.

George Mills: Yes. And now, when we look at it, though, you know, we don't see people like jumping around that much. I mean, I'm not to say that it never happened. But it's very rate that people are hospital outpatient and you know, for huge amounts of services.

So, it seems like – based on our data, you know, that – it's not going to be as frequent as you would think. But it is going to happen. That's why we're not just going to automatically deny, you know, and get an advance approval because we're aware of that limitation until October 1.

(Bonnie Nether): OK. Thank you.

Operator: Your next question comes from the line of (Georgia Farris). Your line is open.

(Georgia Farris): Hi. I was just wondering how this affect home health agencies. I see that it's listed in some of the papers. But I thought home health is paid under Part A.

George Mills: Yes, it is. But if the – there are Part B services that can be supplied. So, I'll turn it over to (Pam).

(Pam West): Yes. So, home health benefits covers Part A and Part B services. But any service for someone in the home that a home health agency would provide who is not already under a home health plan of care would be services in the outpatient benefit. So, those would be covered.

George Mills: Yes. So, basic way to think about it is if you're billing under Part B and you're an HHA, it would be subject. If it's a Part A bill, it's not.

(Georgia Farris): OK. So, I – as far as I know, we're Part A.

George Mills: I screwed it up. OK.

Will Gehne: Well, it's better to say that if the services are being billed under the home health prospective payment system …

George Mills: OK.

W: … it's not covered.

(Georgia Farris): Right.

Will Gehne: Whether that's part – that may be paid under Part A or Part B depending on (inaudible).

George Mills: OK.

Will Gehne: But if it's being billed under (inaudible) 34X so that it's somehow services outside of a home health plan of treatment and paid on the physician fee scheduled basis then it would be applied (inaudible).

(Georgia Farris): OK. So, if it's a PPS episode, then this is not effected to us at all.

Will Gehne: Correct.

George Mills: Correct.

(Georgia Farris): OK. And then – so, then, do our visits – we're a department of a hospital, a home health agency? Do our visits affect the outpatient therapy as a PPS episode?

George Mills: No.

(Georgia Farris): No. OK.

George Mills: The therapy, like in a SNF, that was paid under Part A or under the home health as described, doesn't count here.

(Georgia Farris): OK. All right. Thank you so much.

Operator: Your next question comes from the line of (Sofia Morton) from (National). Your line is open.

(Sofia Morton): Hi, George. Thanks for holding this call today. I want to kind of build on a couple of questions you got a couple of callers ago. You're going to be able to show in your computer system on 10/1 the dollar amounts of all previous Part B therapy for this new provider to see what was in the past so they'll know if they're getting close to the 3,700 in order to request preapproval.

But let's say that a patient is in the facility and you know, ongoing therapy every day, how are you going to deal with that last of September of first couple of days of October where everybody is going to be looking it up on October 1 yet therapy has to happen every day. And if the facility requests preapproval on, say October 1 or October 2, it will – they may not hear from the MACs for the full 10 days, especially for that first round.

George Mills: Well, (inaudible).

(Sofia Morton): How are you going to handle that initial period that could go a little messy? Thank you.

George Mills: Well, yes. That's why we're going to start allowing requests to start coming in in mid-September so that they are in advance of October 1. You know, the issue is going to be you're not going to have the complete information necessarily. And that's why we're not going to just deny if there's not an exception.

You know, the way the law is read and sort of assumes that everything is ordered and convened exactly the way it was provided. And we know that it's – with the 12-month claims filing limit, we could get claims in December of 2013 that really changed where a person is in the cap. It's not going to be ideal at September 15.

But we're – we would say if you look at what you provided because I know (Pam) and others have talked about this, usually people say with one therapy prior they're not bouncing around that frequently. And again, don't – I'm not saying that people don't move around. But I'm just saying it seems more apt than not that if you get therapy it's from one entity. But I think people, from their own billing, can have an idea based on their own record until the system comes up.

So, it's not going to be perfect for the first – the two weeks before October 1. But after October 1, you'll have everything. But then, even within there, that's only as good as the day you look at it because other claims could come in from going back to January 1 that could affect that number.

So, it – that's why we set it up the way we did because we didn't want that there'd be a bunch of appeals just because people did the right thing, looked at the system, saw that somebody was way under the threshold but then, all of a sudden, there was claims that they had no idea or provided. And so, that's exact reason we're not just denying but we'll do reviews.

So, we'll take the – that will be in the detailed instruction at the MAC and so basically a couple of weeks ahead of time because of the 10 days plus some time for getting it and responding. So, there'll be detailed instructions of when and where you'll be able to submit your requests.

Hello?

(Sofia Morton): Thanks, George.

George Mills: OK. Thank you.

Operator: Your next question comes from the line of (Sandra Lockwood) from (Rocket City) Regional. Your line is open.

(Sandra Lockwood): My question was just asked and answered. I guess my only follow up to that would be what happens when a facility is a couple of months behind in getting their physical therapy and the patient moved to a new location? I understand that you're saying it doesn't happen very frequently. But it will happen. So, what happens when the patient comes to the new place, gets their services, the claim goes in, two month later, the old facility gets theirs sent in? What happens to my payment?

George Mills: Well, let's say that somebody was going to a facility and got a bunch of outpatient services at the start of the year. And the bene, for whatever reason, doesn't tell you about it and then starts getting services from you and you get paid by Medicare. And now, all of a sudden, after you got paid, the claims from the institution came in and had they been billed and processed sequentially, you would have been over the cap.

We're not going to go back and make you redo this. We won't do anything. But if the claims go through and there is no issue, we're not going to go back and do post-pay just because they're over the 3,700 as a matter of process.

So, that's actually in our guidance to the MACs. And that could – that will happen. And we understand that. But so, in your claim went through, then – and you got paid, then it's not like we're going to say "Now, that we got this

new claim, we see you're over the cap and we're going to do manual medical review." So that's not our instruction.

(Sandra Lockwood): Are you still following (inaudible) …

George Mills: But what I'll do is add it to an FAQ because we actually do have it in the instructions for the MAC. But we'll add that because that – I'm sure people will be worried about that. You know, you got paid, you think everything is fine. And all of a sudden, there is $5,000 for – from facility that you didn't even know the beneficiary was in.

(Sandra Lockwood): Will you be following the (inaudible) …

George Mills: I will add that to the FAQ. Yes.

(Sandra Lockwood): Will you be following the repetitive billing rule?

George Mills: Yes.

(Sandra Lockwood): So, is there a care where my claim won't be paid because you're looking for months May and June from another facility that haven't submitted claims yet?

George Mills: No, because we wouldn't – we'd have not way of knowing what we don't know. I mean, there's nothing in the computer that says, you know, George Mills went to, you know XYZ Hospital in Michigan and now he's in Maryland. And we don't even know that those services were provided until we actually get the claim.

Will Gehne: I think the distinction is that repetitive billing in the sense that a month's services for the providers that are subject service repetitive billing need to be billed together. But sequential billing, where the month has to be billed in sequence, is not of course. So, repetitive billing applies sequential billing does not. I think that helps with it.

George Mills: Yes. Yes. So well what – but just to – because it's kind of tricky, we'll definitely put an FAQ. But the issue would be if your claims went through and if other people would have billed and their – they would have put the bene

over the 3,700, but your claims have already gone through and their claims come later, are you going to be reviewed? And the answer is no. Not in general.

(Sandra Lockwood): Thank you.

Operator: Your next question comes from the line of Johanna Murphy from MedStar Georgetown. Your line is open.

Johanna Murphy: Thank you. Yes. I was just wondering if this just going to be only rehab codes that the cap is applied to. The reason I'm asking is we provide wound care therapy here and do a treatment of missed therapy or low-frequency noncontact ultrasound. And this has a 01832 code. And we had heard some rumors that this code may not be applied to the cap.

George Mills: I deter to my policy expert in terms of what's in the – we might have to go back and look at it. But (Pam), you might …

(Pam West): Yes. Yes. 01832 is actually on the therapy code list as a sometimes therapy service.

Johanna Murphy: OK.

(Pam West): But it – but it's also on the what we call the sometimes OPPS service code. So, if the service is done not under a therapy plan of care, then the claim would be submitted through the OPPS rather than through the physician fee schedule. So, unless the code 0183T comes in with a therapy modifier on it, it will actually be processed through the OPPS system and paid under the hospital – the hospital payment amount.

Johanna Murphy: And what modifier are you specifically talking about?

(Pam West): All therapy claims must come in with a GNGO or GNP therapy modifier.

Johanna Murphy: OK. OK. Yes. OK. All right. Thank you.

(Pam West): OK.

George Mills: Thank you.

Operator: Your next question comes from the line of (Laura Bates). Your line is open.

(Laura Bates): Yes. We have a question. We provide services in a hospital. So, we don't get individual letter from Medicare. So, will our hospital be notified what phase we are in? And the second part of that question is if we are in phase three but we know someone is getting close, say in October, should we put in for our preauthorization for the 20 treatment days?

George Mills: Basically, for phase three, you can start submitting about November 15 for services on or after December 1.

(Laura Bates): OK. So, the hospital …

George Mills: Yes. And the hospital will be that – whatever the NPI mailing address is for the NPI, that is where the mailing would be – so, there's a mailing associated with the NPI. That is where we're going to be mailing it. And if there's multiple addresses, we're going to mail it to multiple address, just to make sure that – but the other thing is, we're going to put it – the list – a way to look it up on the Internet to, say look up here at NPI on the XYZ hospital – I'll look in my NPI and it will show that I made it in phase one or phase two. But if you're not listed, you're in phase three.

(Laura Bates): OK. And this will all be on the CMS website? It will be easy to find?

George Mills: Yes. And we'll send tweets out and ListServ notices and all sorts of stuff. Yes, definitely, it will be there on our therapy page.

(Laura Bates): OK. Thank you.

Operator: Your next question comes from the line of (Evelyn Stones) from (Inside) Services. Your line is open.

(Evelyn Stones): Hello.

George Mills: Yes. You're on.

(Evelyn Stones): My question – hi. My question is will the MACs be required to have therapist on staff to review these requests?

George Mills: No. They will have the regular medical review staff which in – well, could include therapists as well as their medical director. The way we've – our requirement is they have to have licensed clinicians to review claims. So, our requirements aren't changing.

We're not necessarily saying that they have to hire 10 physical therapists to do this. But they'll use Medicare guidelines like they do for any other medical review we do. But …

(Evelyn Stones): Right. So, that …

George Mills: But along that line – but along that line, we're having – we're working with the MACs to make sure that we're all reviewing claims, basically, the same way. And then, in addition to that, we're going to have another open door forum for which we don't have the date yet.

But it will be way before the prior approval process starts where we're going to go over how we're going to look at these claims at what's the process we use looking at what's a valid order, what's a valid plan of care, what, you know, how do we look at whether something is skilled care and that there is a need for skilled care. So, we're going to go over that with everybody.

The MACs we're going to train to make sure they're following that. If they do this work now, they have their (LCDs) in every single MAC on therapy right now. They are doing therapy reviews now. So, that isn't changing (inaudible).

(Evelyn Stones): Right. OK. That's good. Somebody else should drive the point that sometimes in the MAC (action) letters, it just says that, you know, skilled care is not – is not described. And that's about all the explanation that they give. So, that's helpful to know that there will be some additional training and open door forum so we'll kind of understand the criteria you're using.

George Mills: Right. And then – and the latter, I know people have brought up the sort of ubiquitous denial that comes because it's not (denied) reasonable and necessary letter. And that's one of things we're trying to address. Part of it is systems issue about how much detail we could give. But that's what we're going.

It's that we want to explain to people when we do a denial what's missing. So, if something is wrong in the order like the orders just got a stamp from the physician not their signature, well it'll say, you know. Rather than just saying "Invalid order," it'll say, "It's an invalid order because there's a stamp rather than a signature," or, you know, something is missing in the plan of care or whatever. We want to get people detail because we want to process to be a feedback mechanism so that we don't having the same issues over and over again.

(Evelyn Stones): Thank you.

Operator: Your next question comes from the line of (Lorry Clark) from (Inaudible) Sports Medicine. Your line is open.

(Lorry Clark): Hi. I was wondering if somebody has already reached their $3,700 cap for the year and they'll be getting therapy with us for the first time. We've never seen them. Are we – should we – we're required to do a medical – manual review. Correct?

George Mills: No. What will happen is if they're above 3,700 and you're going to provide – and you know they're above $3,700 in therapy services for the year, from October – for services being provided depending on what phase they're in. But assuming you're in phase one, from October 1 to December 31, you have the advance – request the advance exception to provide up to 20 treatment days in advance. If you don't get the exception request, then what will happen is the claim will come in and we'll do prepay medical review.

(Lorry Clark): OK. So, we request an advance exception ahead of time for 20 treatment days.

George Mills: Right. Up to 20 treatment days.

(Lorry Clark): And that treatment is not consecutive days. It's just 20 visits or plain treatment.

George Mills: Treatment days. Yes.

(Lorry Clark): OK.

George Mills: Well yes, which there could be many services on one day. But it's 20 treatment days.

(Lorry Clark): OK. Thank you.

George Mills: Bye. Thank you.

Operator: Your next question comes from the line of (Danielle Allen) from Atlantic Orthopedic. Your line is open.

(Danielle Allen): Hi.

George Mills: Hello.

(Danielle Allen): We wanted to know if we have 20 different therapists in our group, when they do the phases, will we all be in the same phase. Or, is it done by NPI number and our providers could all be in different phases?

George Mills: By NPI.

(Danielle Allen): OK. So, we could have some providers in one phase and some providers in another phase?

George Mills: Yes. Or you could have them all in the third phase.

(Danielle Allen): OK. OK.

George Mills: Yes. But like I said, part of it is that – what we're trying to avoid is, come October 1, we get a hundred thousand record requests or advance exception requests or more just come pouring down at the MACs. So, this is really just a way to try to manage the workload so that we don't create a huge backlog

because we don't believe that's the purpose of the statute and what Congress intended.

So, we're just trying to make up the backlog. So, like I – going back earlier, somebody said, well, what if there's a new provider that just got their NPI a couple of months ago and they just enrolled? Well, they're going to be in phase three. So, like in your practice, you might have a new therapist or – providing services.

Well, they would be in phase three, where be it somebody that did a lot of therapy and have a lot of people that were way above the cap and above 3,700, they might be in phase one. So, yes, you might have different people. But you know, the option is having everybody and you know, we're trying to be thoughtful of you, too.

(Danielle Allen): Sure. I know. I understand. We just like to know if it'd be scattered or everyone was going to be (inaudible) …

George Mills: It is going to be scattered.

(Danielle Allen): OK.

George Mills: It's based – it's going to be based on the NPI, really.

(Danielle Allen): OK. All right. Thanks so much.

George Mills: Bye.

Operator: Your next question comes from the line of (Fatima Sonido) from Performance. Your line is open.

(Fatima Sonido): Hi. My question is – so, when we request the advance exception, normally we would just get the 20 days of treatment up front. If we needed to use – do you initially just give out 20? Or, if we needed beyond 20 days, can we also get that as well? (Inaudible) another request.

George Mills: Yes. You can get it – an unlimited amount of exception. The issue is just you'd have to get them approved in advance or there'll be – or we will do prepay review on the claims you submit.

(Fatima Sonido): OK. So, automatically, you would just give out the 20 days to start off it, whether or not we use …

George Mills: Well, no. You're going to have to submit the plan of care, the order and some documentation for it. But then, we'll look at it. And assuming that everything's fine, you get approval and your 20 days. But you figure – it's conceivable that you can have somebody getting therapy every day and they're in phase one.

So, they're going to get each day as a treatment day well there's 90 days between October 1 and the end of the year. So, people can request multiple increments of 20. It's just you have to do it in advance. Or, otherwise, if the claim comes in, we'll do prepay review.

(Fatima Sonido): OK. Thank you.

George Mills: Yes. Thanks.

Operator: Your next question comes from the line of (Michael Adams) from Reston Hospital. Your line is open.

George Mills: Hello.

(Michael Adams): Hello.

George Mills: Yes. We're here. Go ahead.

Male: (Nicole), I think we lost him. Let's move on to the next caller.

Operator: Your next question comes from the line of (Sue More) from Center for Rehab. Your line is open.

(Sue More): Hi. I was just wondering how long it will be or when you expect the instructions and the list of providers to be posted to the CMS website.

George Mills: I expect the list of providers to be posted no later than August 15. And our manual guidance to the contractors is currently in the process of being published and going through the internal process. And on our website, we have factsheet. And then, all the MACs were asking that they had materials up no later than September 1 about how the local process would work in terms of like, you know, if you're going to fax the request, what's the number? If you've got questions, who to call. Those kinds of things.

(Sue More): OK. And I'm sorry I missed …

George Mills: Most of the – most …

(Sue More): If you do need to exceed 20 additional visits, what is the – (inaudible) call?

George Mills: You can – you can just – you can just request an additional exception beyond 20.

(Sue More): OK. Thank you.

Operator: Your next question comes from the line of (Pam Huda) from Orthopedic and Support. Your line is open.

(Pam Huda): Yes. Hi. My only questions is, whenever you request the advance exception, is there a form or something that we have to fill out?

George Mills: No. But we're going to have a cover sheet which will be part of the instruction which will be just, basically, demographic information about the beneficiary. All that detail will be provided in the detailed materials for whoever you bill, whatever medical contractor you bill. All that information will be there. But it will basically just be like a cover page identifying you, the bene. And then, attached to that will be things like the order, the plan of care and medical documentation to support the request.

(Pam Huda): OK. And one more thing while I have you. We have a facility that once our patients reach their cap, we send them to the hospital because we're affiliated with the hospital. But what you're saying is now our cap is going to be – they're going to have a cap, too. So, we can't …

George Mills: The patient – yes. The cap was going to be everybody. The cap is going to be your total outpatient Part B services regardless of who provided that unless that facility is a CAH, critical access hospital.

(Pam Huda): OK. Got you. OK. I thank you.

Operator: Your next question comes from the line of Ingrid Gilbert from Naples Community. Your line is open.

Ingrid Gilbert: Yes. The question we have is there has been some other documentation about functional status in outpatient. Can you response to what type of functional status programs you will be anticipating at having to use? Or, is this just what we've documented in our note?

(Pam West): CMS currently has a proposal for the inclusion of functional information on claims for therapy services. It is part of the notice and proposed rulemaking for the physician fee schedule. And those – the criteria outlined in that proposal is not applicable to this manual medical review process.

George Mills: Yes. That proposal would not be in effect until January 1, 2013. So, this is just based on whatever – the normal materials you use to bill. And I would just – it's in the proposed rule on outpatient PPS. There's a whole description of the proposed information collection activity. (Pam) said that that's to get it in the claim form and that's totally separate than this.

Ingrid Gilbert: OK.

George Mills: But that was in the same area of the law but it required us to do that. But this is the manual medical review section. That's the data collection section.

Ingrid Gilbert: Right. Thank you.

George Mills: OK. But I think, well, we should maybe add an FAQ to make sure that it's clear as to this – what that is and what this is. But thank you for the question.

Ingrid Gilbert: Yes. I am just thinking about budgeting for something if I have to do that that's all.

George Mills: Right. OK.

Operator: Your next question comes from the line of (Jules Van Newton) from Care Centers Management. Your line is open.

(Jules Van Newton): Yes. I have just a quick question. In transmittal 2457 that was sent out in April regarding all the changes, it says that (after) Congressional action manual medical review expires with the exception process – expires for date of service after December 31. Is that saying that essentially for three months, we're going to jump into this and then, if Congress doesn't act – then, after December 31, this will all go away? Is that what you all are saying there?

George Mills: Well, it's for – it's for services provided from October 1 to December 31. A review, theoretically, could go a little bit beyond that. But yes, the review period is limited to those three – dates of services for those three months.

Now, that doesn't mean Congress doesn't come by and change the rule and make it permanent, which is something that it could always do. But right now, it's just that for a three-month period. But that doesn't mean we'll only do review for those three months. But it's focusing on those services provided during those days.

(Jules Van Newton): So, the question – the follow up question, then, is as Congress is wanting to do it in the past, (present it is), they come back after that deadline and retroactive rulemaking and everything goes back into effect retroactive. If that occurs, even though after December 31, this manual exception process expires but they retroact. That means that would continue on just like it normally would. Is that correct?

George Mills: Yes. And it's hard to expect that I know what they would do. All I know is that, you know, the tally would start again coming up January 1.

(Jules Van Newton): OK.

George Mills: So, even though you had people that were over $3,700 – let's say on December 31 then comes January 1, the tally starts again. So, you probably

wouldn't face it immediately in the first few months. So, you know, we do have people that are above $3,700 in January. Don't get me wrong. But a majority of people are more later in the year because the majority of people are not getting the services every single day.

(Jules Van Newton): Yes. And in Congress, this wait is longer than just a couple of months to do this before in the past. So, I guess the question – could you tell us where the website is for the FAQ and the other information? I think I must have missed that.

George Mills: It's on cms.hhs.gov. And if you put in – just put in search for therapy, you'll get the webpage that talks about the payment policy. And there's link over to our page for medical review.

(Jules Van Newton): All right. Thank you.

George Mills: But we'll add that – we'll make sure that people will get it out to everybody again too. There was just a (tweet) the other day that had it. And so – but OK.

The exact one, just to be sure is – w w w . cms . hhs – cms . gov / medicare / billing / therapyservices / index . html So, that's what I say. Just go to our website and put it in therapy.

(Jules Van Newton): All right. Thank you.

George Mills: Thanks.

Operator: Your next question comes from the line of (Steve Sprouts) from (St. Paul's) Hospital. You line is open.

(Steve Sprouts): Hi. I direct an outpatient P.T., O.T., speech department and a couple of things related – it seems that proponents or referrals comes in for – come in for P.T., will there be a time, do you believe, when P.T. and speech will be separated from one another? And there's a myth that it was just a comment that was missing in the original legislation. True or not true?

George Mills: I can't speak to that. All I know is that's the way the lawyers say that speech and P.T. are combined and O.T. is separate. And I have no idea whether that will all eventually be three separate categories or not.

(Steve Sprouts): It just doesn't seem to fit very well in practice. The other follow up was, as an outpatient hospital department, someone new to this, I know you're talking about the review, the $3,700. Tell me more about $1,880 therapy cap for those two different groups, P.T. and speech and O.T.

George Mills: Well, OK – so, again, there is – there's two different numbers here. And I apologize because sometimes I slip and use the same word. There is a – we have an $1,880 therapy cap. Another cap applies to P.T. and speech language, as well as a separate $1,880 cap for O.T.

And now, what we have is a threshold for – of $3,700 for P.T. and speech language. And then, another $3,700 threshold for O.T. So, what happens is under – if you're above $1,880 and you don't have a KX modifier on the claim, between $1,880 and $3,699 in services, the claim will just automatically be denied because you don't have the KX modifier.

The KX modifier is, basically, the supervisor attesting that they – the services are medically necessary above the cap and they have their medical reports on file to support the medical necessity. What the difference is is that we don't necessarily look at the records to support that assertion. We go on the modifier primarily.

That doesn't mean we would never audit between $1,880 and $3,699. It just means that it's not our normal procedure for all claims. What happens, though, is that Congress put the $3,700 threshold in. And for any services above $3,700, the providers are being asked to get an exception approved in advance.

So, what it means is just putting the KX modifier on the claim above $3,700. That does not mean the claim is going to be paid. You're either going to have to request an advance exception or the claim will be subject to prepayment review.

And so, a human being will be looking at the records and making a determination, whereas below the $3,700, the computer is basically making that determination based on the KX modifier.

(Steve Sprouts): OK. And then, when you receive a claim, what's the turnaround time, roughly for that to appear in real-time eligibility systems?

George Mills: It gets updates as the process – as the batch process. It's virtually every night. It depends on the processing and payment scale timing of the MAC. Most people are almost daily now.

(Steve Sprouts): OK. Thank you.

Operator: Your next question comes from the line of (Kathy Engels) from North Mississippi. Your line is open.

(Kathy Engels): Yes. I'd like to know how or if this will affect the critical access hospital therapy outpatient department. And a follow up to that is the therapy that we provide at the critical outpatient therapy department, will it affect the patient's cap if they go to another outpatient therapy sometime during that year?

George Mills: No. Claims for services provided by CAH are not excluded from this completely. They're not counted against the cap. And they're not counted as if – even if the patient goes to some other therapy providers. So, it's like – for the purposes of the cap and the therapy threshold, it's as if the person never gotten any services.

(Kathy Engels): OK. Thank you.

George Mills: At least today. Now, of course, Congress could come back tomorrow and change that one. But that's the policy in effect today.

(Kathy Engels): Thank you.

Operator: Your next question comes from the line of (Pam Jenkins) from (Inaudible). Your line is open.

(Pam Jenkins): Hello. I just have a question. We've got a – so, we have a patient that we've discharged that they were at the $3,700. Between either October through December, they come back with a new incident like surgery and what not. Should we, at that point, than turn in our request for the extension for either 20 or 40 days?

George Mills: Yes. When you – when you're going to provide services above – that you know is above $3,700, request up to 20 therapy days in advance through the end of December.

(Pam Jenkins): OK. Thank you.

Operator: Your next question comes from the line of (Jill Barr) from (Barn) Associates. Your line is open.

(Jill Barr): Yes. I have a question. Our connection is a little bad. So, some of the responses I wasn't hearing. But let's say that we've got a patient that is new to us in the last three months. And when we look, they are at their dollar amount. But we're doing the eval to establish the plan of care. For whatever reason, let's say the MAC says, "No, we don't agree with it." Are we, at least, paid for eval?

And then, my second question is – and this is what I couldn't hear. You said something about a stamped script would not be accepted. So, am I to assume then that the signatures that are coming over EHR you will not accept?

George Mills: No. No. EHR, we will accept them. But a rubber stamp is not an acceptable signature.

(Jill Barr): OK.

George Mills: Unless that's on letterhead of the provider and there's a type in – there's detailed instructions that are manual on that.

(Jill Barr): OK.

George Mills: But in general, like if – like imagine a script like you take to a pharmacy which has stamp on it, we won't accept that. We want a legible signature. But I'll – maybe, (Pam) – the first part, maybe (Pam) can address …

(Pam West): OK. Your question about whether or not you can do and be paid for an evaluation. Currently, I believe that is our policy for that, that the evaluation would be covered. But we are going to have to make sure that we can apply that policy to this threshold. So, we will post back answer to that question on FAQ.

(Jill Barr): OK. (Inaudible).

(Pam West): Thanks for asking that question.

George Mills: That's an excellent question. So (inaudible) for the evaluation.

(Jill Barr): OK.

George Mills: And why don't we – yes. OK. Very good. Thank you.

(Jill Barr): Yes.

Operator: Your next question comes from the line of (Ryan) (Inaudible) from (Optimal) Hospital. Your line is open.

(Ryan): Good afternoon. Thanks for taking my call. My question, at the facility I work, our billing practice is to bill for a month at a time. So, for instance, if we were in phase one of the program, will we be submitting our September billing sometime in early October? Would that billing be, I guess, underneath this program? Would that be all acceptable to the program when it goes in in early October? Or, would it only affect the date of service in October – therapy provided in October?

George Mills: It's date of service, not when you submit the claim.

(Ryan): OK.

George Mills: So, it's therapy provided on or after October 1 through December 31, 2012, not when you – just because you have to submit the claim. The only significance of claims before that would be any therapy services provided before October 1 count against the threshold but not – but are not necessarily subject to review.

(Ryan): OK. Thank you.

Operator: Your next question comes from the line of (Maria Kirsten) from (Civilian Group) Hospital. Your line is open.

(Maria Kirsten): Hi. I am – about the cap applying to wound care about physical therapy?

Female: Yes. What's your question?

(Maria Kirsten): Does the cap apply to wound care by physical therapy?

Female: If the wound care services are provided under a physical therapy or occupational therapy plan of care, then – and they're submitted with a therapy modifier on the claim done by therapists, then yes, they would apply to the therapy money counted towards the threshold and the cap.

Are you in an outpatient hospital?

(Maria Kirsten): We are in an outpatient hospital. And we are still trying to figure out if we fall under the critical access hospital.

Female: Well, of course, we have a different payment policy for wound care – wound care provided in hospitals. But if it is a wound care is under a therapy plan of care even in a hospital, then it does apply to the therapy caps and threshold.

(Maria Kirsten): OK. Thank you.

George Mills: So, I think the key is how it's coded, right? So, if it's coded that as part of therapy, it counts for the therapy. And if it's just regular wound care in outpatient department, it's not. So, you've got to make sure because this – it's got to have the modifier, the G.N., the GEO and G.P. (for it to go). So, if it doesn't have that, it doesn't count.

(Maria Kirsten): OK. All right. Thank you.

George Mills: Thank you.

Operator: Your next question comes from the line of (Sheila Capitosi) from Functional (Café). Your line is open.

(Sheila Capitosi): Yes. I was wondering if there is going to be a defined record set that providers will submit when they're requesting an exception. Will that be part of the detailed instruction?

George Mills: Yes. Yes. And you know, just in general, just right now, it will be the order, the plan of care and then supporting documentation. But how you'll do that and where will you submit it and all the details will be on the MAC websites.

(Sheila Capitosi): Thank you.

Operator: Your next question comes from the line of (Georgia Patel) from (Inaudible) Physical. Your line is open.

(Georgia Patel): Yes. Somebody already asked the question that I was going to ask. Thank you, though.

George Mills: Yes. I'm sorry. OK. Great. Next question.

Operator: Your next question comes from the line of (Karen Willy) from IU Health Bloomington. Your line is open.

(Karen Willy): Good afternoon. I just wanted to clarify. If we check the common working file for a therapy patient today, we will only be able to see the dollar amounts that have applied against their cap if done in a not hospital outpatient department. But then, after – or just on October the 1st, that's when the hospital dollar amounts are going to be pulled in and added to that – to the amounts in the common working file. Did I understand that correctly?

George Mills: Yes. The aggregate total which the big changes including the hospital outpatient, that won't be available for display until October 1.

(Karen Willy): OK. All right. Thank you very much.

George Mills: Yes. But it will be there. And again, that's why, you know, when we were looking at this, a lot of people were saying, "Oh, you know, anything that doesn't get a preapproval, you should just deny." But we don't – (A), we don't believe that people necessarily bill all the time in the exact order that the services are provided and that people acting in good faith could look at that when it's available, look inside – well, they're not even close to being over the threshold. Think they don't need to submit advance request for an exception. But then, all of a sudden, provides services and then they look and then get a notice like the bene is way over the threshold.

(Karen Willy): Yes.

George Mills: And you know – so, that's why we wanted to do that instead. We felt that was equitable.

(Karen Willy): Well, the gentleman who just called in a moment who's facility bills therapies on a for – on a series patient, that's how many of the facilities do it.

George Mills: That's right.

(Karen Willy): So, that's going to affect that a lot.

George Mills: I think it's going to be – yes. And but remember, it's only for services on or after October 1.

(Karen Willy): Correct.

George Mills: So, anything before then – so, like I said, anybody that's over the threshold, it's not like we're going to be and find then and go back and ask for records. But it's only if they are getting services after October 1.

(Karen Willy): Yes. Thank you.

George Mills: OK. Thank you.

Operator: Your next question …

Male: Can we have one more call? One more call.

George Mills: Yes. That would be good because we're running short on time. But you know, all I'd like to do is remind people that they could submit questions via e-mail. So but – yes. Take one more call. And then, we'll give the e-mail address at the end right before we close.

Operator: Your next question comes from the line of (Kristen Traynold). Your line is open.

(Kristen Traynold): Hi. I just had one more question about the advance approval process. If we have somebody coming in that we know it's, you know, right around October 1 and we know that they have hit the $3,700 cap but we have a new provider that's in phase three of the approval process so they can't submit the advanced approval …

George Mills: Yes.

(Kristen Traynold): … how are we supposed to handle that?

George Mills: Well, that would only be in a – if you are – the provider is in phase three, than we would only be worried about getting an advanced approval for services on or after December 1. Again, that's the way the phases (are about). If service is provided on or after the start of the phase. So, you would only need to worry about that come mid-November if that specific provider in your group was going to provide services on or after December 1.

(Kristen Traynold): OK.

George Mills: OK.

(Kristen Traynold): All right. Thank you.

George Mills: So, OK. Thank you.

But let me just give out the e-mail address again. It's for – I know there were a lot of people on the phone. And we appreciate all the interest and all the great questions we got today.

The e-mail address where you can send questions that may not have been answered or any comments you want us to consider is therapycapreview@cms.hhs.gov . And like I said, that's our general mailbox. And we might not be able to give you a one-for-one response but we'll try to add that – any questions we get to the FAQs.

That's it here, operator.

Operator: This concludes today's conference call. You may now disconnect.

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