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DAILY NEWS

Finance SGR Package Replaces Therapy Caps With Prior Authorization

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The Senate Finance Committee proposes to repeal Medicare therapy caps and institute a new medical review process in its place as part of the extenders package tied to the committee's replacement of the flawed Medicare physician payment formula, released Tuesday (Dec. 10). Providers say including a repeal of the caps -- which Congress has overridden 10 times since the caps were enacted -- in the package to repeal the Sustainable Growth Rate is a good starting point, though one therapy advocate said they would like to see the language in the proposal tightened up before it is passed to better mirror congressional intent.

Senate Finance and House Ways & Means plan to each mark up their respective SGR packages at the end of the week. The Ways & Means package, also released Tuesday, does not include extenders. Mandy Frohlich, the senior director of government affairs at the American Physical Therapy Association, said she expects therapy caps to come up at the Ways & Means mark-up.

Providers are still reviewing the Finance package, but said the direction the committee takes is a good start, and some provider advocates said Finance's approach is very thoughtful. The Therapy Caps Coalition, which includes therapy and chronic disease lobbyists, and other stakeholders have been pushing lawmakers to add a long-term Medicare payment alternative to the therapy caps to alleviate the uncertainty of renewing the exceptions process every year.

The Finance Committee's newly unveiled bill proposes to immediately repeal the cap, which is currently set at $1,900 a year for occupational therapy and $1,900 for a year for physical therapy and speech pathology, but keep the $3,700 threshold for manual medical reviews through the end of 2014.

Starting in January 2015, HHS would start a new medical review program with prior authorization. The program would look to review therapy providers using appropriate factors, a committee summary says, which could include those new to the Medicare program, with higher billing patterns than peers, and a high percentage of claim denials. The committee also suggests those with questionable billing practices, such as billing medically unlikely amounts in a day, also could be reviewed. Practices that include these types of providers could be reviewed as well.

Services identified by reported data elements could also be reviewed, the committee says, as well as "Services furnished to treat a type of medical condition."

Tim Nanof, director of health care policy and advocacy for the American Speech Language Hearing Association, said Finance's inclusion of the repeal and replacement is a good sign for now, but added that the language is really broad and could capture everything, as all therapy treats a medical condition. Nanof said ASHA would like to see the language tightened up before a final bill is passed to make sure the measure really captures congressional intent.

Finance's therapy caps replacement plan calls for HHS to use prior authorization medical review for therapy services above certain thresholds, whether a dollar threshold or by type of service or setting. The package doesn't specify what that threshold should be, however, and it also says that HHS could review services under whatever threshold is set with pre-payment or post-payment reviews. One provider said they were surprised by the lack of specificity on setting the thresholds for review.

Nanof said there is a danger with the open language that the reviews could create an administrative burden that is beyond CMS' ability to handle in a timely manner. But if the language is tightened up to focus on outliers, this could prove a positive step, Nanof said. An appropriately targeted focus on outliers is necessary to make sure that providers won't get punished for treating sick or

more clinically challenging patients, he added.

Frohlich said the thresholds will require therapy advocates to work with CMS to make sure the right type of claim is considered for review.

If a provider has a low denial rate, CMS could end prior authorization, Finance's summary says. If the improper payment rate for therapy is 50 percent or less of the fee-for-service improper payment rate, CMS would have to reduce the amount of medical review conducted.

Frohlich said this goes back to the concept of targeting the right providers, and shows the committee really thought out the repercussions a new policy might have.

Prior to the Senate Finance package's release, some providers had indicated that prior authorization could be an acceptable replacement for the caps and manual medical review process, provided safeguards were included like tightening up the 10-day time limits on reviews, though others expressed reservations, saying CMS had tried prior authorization with the MMR process when it was fist instituted, and it didn't go well.

The National Association for the Support of Long Term Care released a survey last week that showed at least 33 percent of MMR claims submitted by members since the beginning 2013 are still waiting to be processed, and providers said a fast turnaround is necessary for a successful review process.

The Finance package says: "The Secretary would make a prior authorization determination within ten business days of receipt of the necessary medical documentation or; otherwise, be deemed to have found the services to meet the applicable requirements for Medicare coverage."

Frohlich said this is a really positive step, and the most direct language requiring a quick turn-around for claims reviews that she has seen so far.

Finance also calls for electronic submission for reviews as soon as it's practical, and says it shouldn't take longer than two years, a provision applauded by advocates. Therapy advocates had also pushed for electronic submission, as Nanof said an electronic receipt allows providers to know exactly when the 10-day review period starts.

Frohlich noted that although Finance's package is a good start, it is unlikely to be passed by the end of the year, so APTA is still hoping an extension of the therapy cap exceptions process will be included with any cap to hold providers over until the permanent policy can be put in place. -- *Michelle M. Stein* (*mstein@iwpnews.com*)

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