MEDICAL SYSTEMS
HELPING DOCTORS BE DOCTORS

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THE BILLING BULLETIN

Medicare Therapy Services Update

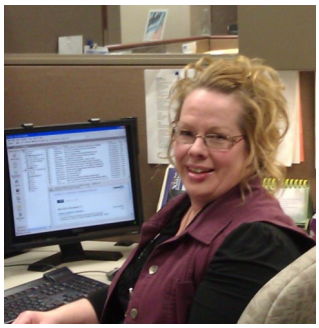
There will be significant changes this year to the Medicare outpatient therapy benefit. **The American Taxpayer Relief Act of 2012** extends the Medicare Part B Outpatient Therapy Exceptions Process through December 31, 2013. No automatic exceptions will be granted this year, however exceptions will be based on a manual review process. The annual therapy cap amount for this year amounts to $1900 for physical therapy and speech language pathology services combined and a separate $1900 for occupational therapy services. This marks an increase from the $1880 allowed in 2012.

Also **effective April 1, 2013**, the 20% payment reduction to the practice expense of "always therapy services" will increase to 50%. The code with the highest practice expense will be reimbursed at 100% and the practice expense values for the second and subsequent codes will be reduced to 50%. This reduction applies when multiple therapy services are billed on the same date under the same NPI, regardless of whether the services take place during the same therapy session. This applies across all therapy disciplines.

The **Middle Class Tax Relief and Jobs Creation Act of 2012** will require the use of function related **G codes** and modifiers on claims submitted for therapy services. These non-payable **G codes** will be submitted at the time a therapy episode of care is initiated, at specified points during treatment, and at the time of discharge. For the period of **January 1, 2013 through June 30, 2013**, a testing period will take place to allow practitioners time to learn these codes. For therapy services on and after July 1, 2013, claims without this information will be returned or rejected. You can get more information on the **Centers for Medicare and Medicaid Services (CMS) website at www.cms.gov.**

Meet Our Experts

Kelly Merry ~ Head of Monitoring and Auditing Team



How long have you been employed at CRT? 6 years

Education/Certifications: CPC Certified, Completing Compliance Certification at the present time

Personal: Married for 19 years with two children, Brandon and Dylan

Hobbies/Personal Interests: Active in my church, reading, learning sign language, being with my family

What do you find most challenging about your job at CRT? Staying abreast of the insurance changes

CMS Updates Recordkeeping Principles

CMS amended their recordkeeping principles regarding corrections and delayed entries in **January** of this year. They explicitly state that when making review determinations they will **NOT** consider any entries that **"do not comply"** with the following principles, regardless of whether documentation submission originates from and **EHR** (Electronic Health Record) or from a paper record. Documents containing amendments submitted for correction or reconsideration must;

1. Clearly and permanently identify any amendment, correction or delayed entry as such.
2. Clearly indicate the date and author of any amendment, correction or delayed entry, and
3. **NOT** delete but instead, clearly identify all original content

When correcting a paper medical record, these principles are accomplished by using a single line strike through so that the original content is still readable. The person who makes the alteration to the record must also **sign and date** the revision. Amendments or delayed entries to the paper records must also be signed and dated upon entry into the record.

Amendments within an **EHR** receive special considerations, however, the principles still apply. Records sourced from an **EHR** must also distinctly identify any amendment, correction or delayed entry and provide a reliable means to clearly identify the original content, modified content and the date and owner of each modification in the record.