After cap’s delay, rehab providers breathe a sigh of relief—for now

The announcement came at the last minute, but it proved such good news that most outpatient therapy providers didn’t mind. CMS delayed the start of the $1,500 therapy cap that was scheduled to kick in January 1 after a two-year moratorium.

However, industry experts advise providers not to sit back and think their worries are over, as CMS gives every indication that it will implement the cap sometime—likely within 2003—unless lobbying efforts for congressional relief prove fruitful in ending the therapy cap.

Many providers may have found it difficult during January to keep track of the flurry of news as CMS released announcements concerning the cap’s delays. Some of these sparked more questions than answers. Therapy providers who want to keep on top of the latest news and issues surrounding the cap should consider the following:

1. CMS announcement of delays. The news broke for the rehab community on the last day of 2002. CMS sent a

CMS provides answers when it comes to billing group therapy

As an outpatient rehab provider, do you know how to determine whether you should bill for group therapy or individual therapy when delivering services to patients? More important, do you know how CMS wants you to bill for the services?

You will know the answer to these and other questions once you read a recently released notice from CMS that answers 11 frequently asked questions (FAQs) about group therapy.

Within the past year, one of the hottest issues for outpatient rehab providers—barring the dreaded therapy cap—concerned accurate submission of group therapy claims. The controversial issue sparked so many questions that CMS held a telephone conference call on the subject in September 2002 that drew more than 700 listeners.

In an effort that appears designed to further clarify its policy and answer several of the billing questions received during the conference call, last month the agency released 11 FAQs and answers on group therapy.
Group therapy

Although analysis remains ongoing, the FAQs contain some important clarifications and few surprises with regard to CMS’ interpretation of policy, industry experts say.

History of the controversy
Group therapy became a hot topic more than eight months ago when CMS released in May 2002 Transmittal 1753, a clarification of group therapy and student therapy billing for insertion into the Medicare Carriers Manual. The transmittal stated providers can’t bill for individual therapy—and receive a higher reimbursement rate—for sessions in which therapists treat more than one patient.

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Although his organization continues to analyze the information contained within the FAQs, Peter Clendenin, executive vice president of the National Association for the Support of Long-Term Care, applauded CMS for the release of the information as FAQs.

“It precludes [CMS] from modifying policy, bringing in

Group therapy policy outlined in transmittal

Those who are still confused when it comes to billing for group therapy should pay special attention to the newly released Transmittal 1872, in which CMS updates the Medicare Intermediary Manual to “reiterate” its billing policies.

This transmittal contains no surprises, as the language is very similar to Transmittal 1753, which was released in May 2002 for insertion into the Medicare Carriers Manual, says David Ross, CPA, director of reimbursement and internal auditing for Kessler Rehabilitation Corporation in West Orange, NJ. Although the clarification of group therapy in the earlier transmittal touched off controversy, this appears to be a recap of that announcement and should be inserted into the manual for fiscal intermediaries.

Those items addressed in the transmittal include the following:

• Group therapy. CMS says that PT, OT, or speech therapies provided to two or more patients at the same time by one practitioner should be billed as group therapy. Those patients can—but do not have to—be involved in the same activity. Although the therapist must be in constant attendance, one-on-one patient contact is not required.

• Therapy students. Only services performed by the therapist are subject to Medicare reimbursement. Services performed by those students in the “line-of-sight” supervision of therapists are not reimbursable. Having a student in the room, however, does not make the service “unbillable,” the agency says.

The transmittal also addresses issues concerning therapist assistants as clinical instructors, services provided under Part A and Part B, and bad debt collection. Go to www.snfinfo.com/ppsrc/#Therapy to read Transmittal 1872.
some new standard, or setting new policy,” Clendenin says. “We’ve always been on guard that it would bring in a new standard that we’d never seen before, and [CMS said] there’s no change in policy.”

Where should you focus?
For the average rehab provider, a quick glance at the FAQs may prove overwhelming. But many of the questions are worthy of special attention, says David Ross, CPA, director of reimbursement and internal auditing for Kessler Rehabilitation Corporation in West Orange, NJ. They include the following:

- **Delivering group and individual therapy on the same day.** One of the FAQs addresses an instance in which one patient receives both types of services on the same day. This question did arise in the past for Kessler—which provides outpatient services at several sites and works with many different fiscal intermediaries (FIs). Many times, the answer depended on the FI’s individual interpretation.

  According to CMS, the practice is allowed. “This is a clear statement,” Ross says. “You can bill one-on-one and group therapy with use of the -59 modifier. [According to CMS,] it has to be separate and distinct, and you must document it as such. Many of our sites use both one-on-one and group [therapies to treat patients.]”

- **Submitting claims for more than one group therapy session per day.** By addressing whether it’s permissible, CMS addressed an unusual occurrence that may, occur for providers from time to time.

  “This would be one of those rare cases where a patient comes in two separate times during one day. [For example,] the patient may work with two different groups,” Ross says.

  According to CMS, it will allow reimbursement for the practice in facility settings—provided that documentation supports the medical necessity of the sessions.

- **Other items worthy of clarification.** The FAQs also provide clarification on certain circumstances involving group therapy that, while they may appear clear to many, needed to be issued in writing to ensure that everyone operates on the same page, Ross says.

  For example, CMS outlines a situation in which two therapists work on the same patient. Under this circumstance, both therapists can’t bill for the time spent with the patient, according to Ross. And you’re not allowed to submit claims for situations in which patients work on their own without a therapist’s supervision.

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### Group therapy FAQs worthy of notice

CMS released 11 frequently asked questions and answers concerning group therapy on its Web site. The following question is one of the many worthy of notice, according to industry experts:

**Q. Group frequency: How many times can the group therapy code (97150) be billed per patient per day?**

**A.** In private practice settings for physical and occupational therapists, Medicare expects the group therapy code (97150) to be billed only once each day per patient. In the facility settings, the group therapy code could be applied more than once. However, the occasional situation where group therapy is billed more than once each day would require sufficient documentation to support its medical necessity and clinical appropriateness of providing more than one separate session of group therapy.

Source: CMS (go to www.cms.hhs.gov/medlearn/therapy and click on “General Information” to access the entire list of questions).
Therapy cap

On January 17, the agency issued PM B-03-001, an emergency update to the physician fee schedule. On p. 11 of the 12-page document, CMS restated that the therapy cap will be on hold until the agency develops a system to track claims.

1. One-page notice to contractors, dated December 23, 2002, announcing a delay in the January 1 implementation date of the cap. The agency sent the announcement only to carriers and fiscal intermediaries (FIs) and did not post it on the Program Memorandums (PM) section of its Web site.

The brief notice contained few details and attributed the delay to the agency’s lack of a computerized system that would enable it to track claims to see whether they’ve exceeded the $1,500 cap.

Instead, CMS advised that it intended to further information in the form of a PM sometime within the month of January, says Dave Mason, vice president of government affairs for the American Physical Therapy Association.

2. PM’s language sparks questions. While the CMS notice and PM provided few details other than to note the cap is on hold, some of the agency’s language used within the two sparked questions regarding interpretation, Mason says. “It’s something that still doesn’t give us a lot of detail and leaves a lot of the issues unresolved,” Mason says.

In both the December 23, 2002, notice and January 17 PM, CMS indicates that it expects to implement the cap in a “prospective manner.”

Industry to Congress: Overturn the cap

The $1,500 therapy cap—originally slated to kick in January 1—is on hold, but industry efforts to lobby Congress for relief are pushing forward at full throttle. All of the provider organizations continue to press their case that the consequences of the cap would be devastating to both beneficiaries, who may not receive the therapy they need, and providers alike.

In recent weeks, the lobbying effort focused on the U.S. Senate. The Senate adopted legislation that would alleviate the 4.4% decrease to the conversion factor in the 2003 Medicare Physician Fee Schedule without addressing the cap, says Dave Mason, vice president of government affairs for the American Physical Therapy Association.

Some within the Senate were concerned that attempts to reimpose a moratorium on the caps would prove problematic in that it could open the legislation to the attachment of other issues that could ultimately put the whole package at risk, Mason says.

Another possibility is action on a provider and beneficiary package, similar to one considered by the U.S. House of Representatives in the summer of 2002.

However, if such a package is attached to any prescription drug/Medicare reform legislation, the likely debate on those issues could delay action on a moratorium, Mason says.

The key to successfully overturning the cap is convincing legislators. Organizations are in the process of lobbying those who worked with them prior to the congressional break, says Peter Clendenin, executive vice president of the National Association for the Support of Long Term Care in Alexandria, VA.

Therapists interested in joining the lobbying effort should contact their respective state organizations or may want to consider contacting Congress directly.

Go to www.house.gov or www.senate.gov to find contact information for your representation.
This seems to indicate that once the agency sets the implementation date, it will monitor those claims received after that date in accordance with the cap, says Mason. This can be contrasted to a possible agency decision to track all claims for services as of January 1, or a monitoring of claims in a retrospective manner.

However, many within the industry want further clarification from CMS that the above interpretation is accurate before they set it in stone, says Peter Clendenin, executive vice president of the National Association for the Support of Long-Term Care in Alexandria, VA.

“There’s some references [within the notices] that you could take comfort in, but it doesn’t state the policy as clearly as it could,” Clendenin says. “You’ve got to rely on some really close reading. My definition and the way that I apply the word ‘prospective’ may be different from others, including [CMS].”

3. Implementation of a per-beneficiary tracking system. In 1999, the last year the cap was in effect, CMS acknowledged that it did not have a system to track therapy expenditures per beneficiary, Mason says.

The agency left the job to providers to track costs for each individual. This time, CMS indicates its plans are to install a system that enables FIs and carriers to monitor the cap per beneficiary, Mason says.

“In the past, a patient went to provider A for some services and provider B for others, and if providers A and B didn’t know where the patient went, they wouldn’t know whether the cumulative value of services was $1,500,” Mason says.

“As we understand it, a per-beneficiary cap means that CMS would track the expenditures, regardless of whether the services are provided. So if a patient is seeing provider A and B, the [system] will add these together and keep track of the beneficiary. Even if provider A is in Minnesota and [provider B is in Utah], theoretically, the services would still be tracked.”

Most presume that the delay results from CMS’ development of instructions to FIs and carriers on the details of such a system. Previous indications from the agency indicate that it intends to give them at least 90 days to get the system up and running, resulting in the implementation, Mason says.

4. What about beneficiary notification? CMS issues a Medicare handbook or booklet to beneficiaries once a year that outlines the guidelines of the program, Mason says. The 2003 handbook does not mention the therapy cap, which prompts questions of whether individual beneficiaries would be aware of the $1,500 limit.

These questions become more salient given the agency’s plans to implement a per-beneficiary tracking system in which patients have the potential to receive services from two or three separate therapy providers that rise above the $1,500 cap.

“Any of these details surrounding how it should be implemented are issues that beneficiaries should be aware of,” Mason says.

“Clearly, they’re not in the handbook. I’m not aware of the type of mechanism that could provide that type of communication until this November [and the release of the 2004] handbook. It’s possible that it could do a separate mailing, or, short of individual notification, ads in newspapers. There may be some other mechanism that may be adequate.”

Editor’s note: BRRR will provide its readers with the latest information on the implementation of the therapy cap in upcoming issues of the newsletter. Go to www.rehabregs.com to subscribe to a free, weekly e-mail newsletter that drops the latest rehab news right in your inbox.

Questions? Comments? Ideas?

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The therapy cap: To track or not to track?

As outpatient rehab providers await word of a new implementation date for the $1,500 therapy cap from CMS, it’s likely the same question is on their minds. Should you keep track of your patients’ therapy costs now?

The question becomes critical when one considers the chances of CMS deciding—once it sets a new date—to implement the cap on a retrospective v. prospective basis.

“[You don’t want providers to be afraid to deliver the therapy because of the cap.]”
—Gail Polanski, RN, BSN

In Program Memorandums and notices, the agency indicates that it plans to implement the cap in a prospective manner—i.e., going forward from the new date—as compared to retrospectively, or tracking claims back to January 1. However, many experts question whether the agency means this definitively and want further clarification on its use of the word “prospective.”

So what should you do when it comes to the cap? Gail Polanski, RN, BSN, president of MG Healthcare Solutions in Buffalo, NY, is advising the rehab providers that she consults with to hold off on tracking the services as though they were subject to the cap.

It’s important that providers place the patients’ needs first, and Polanski is concerned that by tracking the cap now, some patients may not receive the therapy that they require.

“You don’t want providers to be afraid to deliver the therapy because of the cap,” she says. “If the patients need it, they should get it.”

Similarly, Jean Miller Stiles, MS, CCC/SLP, the rehab special projects coordinator with Home Quality Management, says her company—a long-term care and management company in Palm Beach Garden, FL, that owns and manages 54 nursing homes—also decided it would not track the cap retrospectively.

Stiles cited two reasons for this, including an analysis of her company’s Part B costs, which revealed that most charges do not exceed $750 per patient, which is well below the $1,500 cap.

Also, the late arrival of the Medicare Physician Fee Schedule—published on December 31, 2002, and scheduled to go into effect March 1—makes tracking costs problematic.

Therapy providers bill according to the fee screens published in the fee schedule, and this year they must bill the first two months at the old 2002 rate, before transitioning into the 2003 rate.

However, should you decide to keep track of the $1,500 therapy cap, providers must keep the following in mind:

- **Keep current on the fee schedule.** Therapists should keep the most up-to-date CPT codes and corresponding fees for the year 2002 within their system and keep track of patient costs daily.

  They need to remember that they need to change those fees and codes in March to the 2003 schedule, as they continue to track costs, Stiles says. Her company developed a software program that tracks the amount of therapy on a daily basis.

- ** Deliver care appropriately.** Since the cap is not in place, providers must make sure that they don’t limit care to patients because they’re afraid of going over the cap.

- **Develop a plan.** If providers haven’t done so already, they need to develop plans and fixes for scenarios in which services delivered to patients exceed the cap.
CMS addresses licensing issues in fee schedule

If you were an outpatient rehab provider who held your breath as you awaited the release of the 2003 Medicare Physician Fee Schedule, you likely turned a bit blue during those last few weeks of December 2002.

The fee schedule, which was published on December 31, 2002, after a two-month delay and goes into effect March 1, contains the following provisions that therapists should pay special attention to, according to industry experts.

Providers practicing in physician offices
The fee schedule gives fiscal intermediaries (FI) and carriers the green light when it comes to issuing provider numbers to PTs and OTs employed in physicians’ offices, says Dave Mason, vice president of government affairs for the American Physical Therapy Association (APTA).

Both the American Occupational Therapy Association (AOTA) and APTA supported the policy change.

“We’re very pleased with the policy change where CMS is supporting [OTs] in private practice working for physician practices and other types of organizations,” says Judy Thomas, director of reimbursement and regulatory policy for AOTA.

“It’s a benefit to everyone. Now carriers know who is performing PT and OT services—if it’s an OT in a private practice, they’re actually enrolled in part of the group. When people are working incident to a physician, you really don’t know who it is, as physicians can actually use people other than qualified therapists.”

Although the move is a positive one, APTA believes that CMS did not fully address concerns about fraud and abuse with regard to the potential for inappropriate referrals or referrals for profit, Mason says.

“Our concerns mainly rest on the issue of self referral and the nature of the referral if they have someone set up in the office,” Mason says. “While there are safeguards already in place that are supposed to prevent inappropriate referrals, we’re concerned this could lead to abuses of the situation.”

E-stimulation codes
The agency also published new G codes for electrical stimulation of wounds within the fee schedule. The codes can be found on p. 49 and p. 50, the Physical Medicine and Rehabilitation section of the fee schedule (see related story on p. 8).

The fee schedule still contains the controversial 4.4% reduction in the conversion factor, which affects physician reimbursement rates. This reduction may prove less painful for PTs and OTs, as the schedule boosts the practice expenses for physical codes, Thomas says.

“The conversion factor isn’t having as big of an effect on the physical medicine codes as it is on having other codes because of the increase in practice expense values” Thomas says.

Throughout the two-month wait for the release of the fee schedule, CMS pinpointed the delay back to problems in the listed anesthesiology codes.

It disavowed the speculation of those who said the agency did not want to release the yearly update—which contained the decrease—until after the November elections.

The agency maintained that it is unable to increase the conversion factor without congressional legislation that mandates it to do so.

It’s expected that a bill will be introduced to Congress within the next few months that corrects the conversion factor, industry experts say.

Editor’s note: Go to www.rehabregs.com/psr/ #Medicare to see the entire 2003 Medicare Physician Fee Schedule.
E-stim updates for 2003

By David Lane

Within the last few months, CMS made several announcements that will affect how you receive Medicare reimbursement for wound care in 2003. The agency released a new wound-care coverage decision concerning electrical stimulation, as well as corresponding HCPCS codes in the 2003 HCPCS Level II Code Book. The agency also provided instructions on reimbursement for CPT 97602—which covers removal of devitalized tissue from wound(s)—when it released the 2003 Medicare Physician Fee Schedule.

On November 8, 2002, CMS released Program Memorandum (PM) AB-02-161, which details the provision and coverage of electrical stimulation services for chronic wounds. According to the memo, the agency covers and reimburses electrical stimulation to treat chronic stage III or stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers.

Any other use for electrical stimulation in wound care is not covered, nor will the agency reimburse for the service when used as an initial treatment modality. Coverage only begins after “appropriate standard” wound care has been rendered for 30 days without measurable signs of healing, according to the memo.

In conjunction with this PM, as well as one released earlier in the fall of 2002, CMS published three new HCPCS Level II codes to use when coding electrical stimulation on Medicare claims.

These codes—effective January 1, with the publication of the annual HCPCS Level II Code Book—include the following:

- **G0281**—Electrical stimulation (unattended), to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care

- **G0282**—Electrical stimulation (unattended), to one or more areas, for wound care other than described in G0281

- **G0283**—Electrical stimulation (unattended), to one or more areas, for indication(s) other than wound care, as part of a therapy plan of care.

When CMS released the 2003 Medicare Physician Fee Schedule on December 31, 2002, it indicated the work, practice expense, and malpractice values for CPT code **97014**—application of a modality to one or more areas; electrical stimulation unattended—are now cross-walked to these new G codes.
However, the agency will not cover CPT code G0282. Also, CPT code 97032—application of a modality to one or more areas: electrical stimulation (manual), each 15 minutes—should not be used to describe any electrical stimulation modalities provided as a component of a wound care treatment.

CMS also changed CPT 97014 from a covered service to a non-covered service in PM AB-02-161. In addition, the 2003 Physician Fee Schedule notes that 97014 does not appear as a reimbursable code. The new G code—G0283—replaces the use of 97014 on Medicare claims.

According to CMS, providers can use the G codes when they file either the UB-92 or 1500 form, and the codes apply to both PT and OT services. Providers may also want to pay attention to the “comments” section of the Physician Fee Schedule, in which CMS makes note of reimbursement for CPT code 97602—removal devitalized tissue from wound(s); non-selective debridement, without anesthesia, i.e., wet-to-moist dressings, enzymatic, abrasion, including topical applications(s), wound assessment and instruction(s) for ongoing care, per session.

CMS received a Health Care Professionals Advisory Committee (HCPAC) recommendation, as well as many comments calling for the revision of the work relative value units associated with the code. The HCPAC recommended a revision in the work value from 0.00 to 0.32.

The agency, however, disagrees with the recommendation. In the fee schedule, the agency says the typical services described by 97602 are bundled into those of CPT 97601—wound care; selective debridement and CPT 97022—whirlpool.

Therefore, CPT 97602 will remain a bundled services and not separately reimbursable to Medicare beneficiaries.

Go to www.rehabregs.com/pps/src/#Medicare to find the 2003 Medicare Physician Fee Schedule.

Go to www.rehabregs.com/pps/src/#Therapy to find the PMs. All coding changes as described must be in effect by April 1, 2003.

Editor’s note: David O. Lane, PT, MHS, is president of CBL Solutions, Inc. in Edinburg, TX.
These questions were answered by Nancy J. Beckley, MS, MBA, president of Bloomingdale Consulting Group in Brandon, FL. To submit a question, e-mail Anne Scadding, BRRR managing editor, at ascadding@hcpro.com or complete the form on p.11 and fax it to 781/639-2982.

**Q** When does the new fee schedule for outpatient therapy go into effect? How do I get a copy? We did not get anything from our Medicare payer and are anxious to know whether we are billing the correct amount to Medicare.


The MPFS sets a new conversion factor of $34.5920, which is a 4.4% reduction from the 2002 conversion factor of $36.1992. As it has in the past, the Web site PTManager.com published a free “rehab calculator.” This calculator, which contains the rehab codes in an Excel spreadsheet format, allows you to enter your geographic locality to determine specific Medicare payment rates.

As a point of reference you should bill Medicare based on your practice’s fee schedule. Your Medicare payer will automatically adjust the bill and pay you the correct Medicare reimbursable amount according to the MPFS.

To use this tool most effectively, take your historical Medicare reimbursement amounts and compare them to future reimbursements, given the same set of circumstances. This is a valuable exercise that allows you to determine, from a marketing perspective, whether you want to increase your Medicare business within the coming year; decrease the number of Medicare patients you may treat, or retain your practice’s status quo.

For example, you may determine that you will receive less Medicare reimbursement in 2003 for the same amount of business as compared to 2002 (the 4.4% conversion factor decrease in the 2003 MPFS makes this more likely). Therefore, it may make sense to replace some of your Medicare business with private payers whose reimbursement rates are higher.

Go to www.ptmanager.com and click on the “2003 PTManager Medicare Physician Fee Schedule Calculator” link to access the calculator.

**Q** The recent article in the November 2002 issue of BRRR, “How preventive therapy can beef up reimbursement,” prompted several questions. In the state that I practice in, my understanding is that only a home health agency can provide home health. How can therapists travel to people’s homes without having home health involved? Also, OT doesn’t work alone in home health, as there must be other skilled needs. Can we get paid for the services described?

This is an excellent question. People often confuse the provision of therapy services in the patient’s home with “home health therapy.” In order to receive Medicare reimbursement for home health services, they must be done under the guidelines for “home health.” You are correct in saying that OT—or speech therapy or PT—can’t be an “independent” provider for home health services for a particular patient if there is not a home health plan of care for the patient.

However, a patient can have a rehab plan of care, and services can be delivered in the patient’s home. Many rehab providers do not elect to provide services at the patient’s home under a rehab plan of care because there is no additional reimbursement for travel time.

You should note a couple of items. First, a patient...
can’t be under a rehab plan of care and a home health plan of care at the same time. In other words, a patient can’t receive home health services and receive Part B services for rehab from a rehab provider simultaneously. Also, you must code the site of services on your bill. As you would not be providing OT or PT in your clinic setting, it would have to be properly coded for the offsite location.

I work in an outpatient clinic in an area where there is a lot of managed care. We are fortunate enough to have most of the health maintenance organization (HMO) contracts that are available, including Medicare. One issue troubling us concerns the copayments that the managed care plans require us to collect for every patient visit. This proves a particular hardship for many of our seniors who have chosen a Medicare HMO and are reluctant to continue their scheduled therapy because they may not be able to afford the copayments.

Is it ethical for us to recommend that these seniors change out of their Medicare HMO and back into traditional fee-for-service Medicare so that they can receive the therapy they need, or can we waive the copayments without getting in trouble?

It’s important to look at an example of copayments. A Medicare patient visits your office and incurs a routine charge totaling $120. The Medicare fee schedule for your locality sets reimbursement at $90. Therefore, the patient is responsible for the 20% copay—in this example, $18. In an HMO scenario, the reimbursement per visit may be based either on a per-visit rate or a percentage of the fee schedule.

If the copay in the Medicare HMO is less than the $18 copay the patient would pay under traditional Medicare, the patient comes out ahead by staying in the HMO. This assumes the person does not have coinsurance or a supplemental Medicare policy. Many patients choose a Medicare HMO because they do not have a supplemental policy.

The bottom line is that, under most circumstances, the patient is responsible for a copay on every visit, and in all likelihood the HMO’s copay is less than the one under traditional Medicare.

As to the ethical issue, Medicare-eligible individuals must choose the type of Medicare plan to participate in during scheduled, open enrollment periods. You can’t, therefore, change coverage on a whim to take advantage of what may be perceived as differing benefits.

**BRRR Q&A**

My question is: ___________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Name: ___________________________ Rehab setting: _______________________

Please tell us how to contact you in case we need more information.

Fax this form to BRRR Managing Editor Anne Scadding at 781/639-2982.

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CMS issues HIPAA documents

On December 19, 2002, CMS released two documents to help therapists comply with the transactions and code sets rules, important requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).


Medicaid cuts may affect therapy reimbursement

Therapists who receive Medicaid reimbursement for the treatment of some patients may notice a dip within the coming year, no matter what state they practice in.

A study by the Kaiser Commission on Medicaid and the Uninsured released last month showed that an estimated two-thirds of the 50 states plan to cut patient benefits, restrict or reduce eligibility, or increase patient copayments, according to the New York Times. Among the first services to be cut will include PT and OT—as well as dental care, eyeglasses, and hearing aids, the report stated.

HealthSouth’s Scrushy back at helm

More than four months after he stepped down, Richard M. Scrushy reassumed his position as chief executive officer (CEO) of the embattled HealthSouth Corp. in Birmingham, AL. The move by Scrushy—who remained as chair of the company’s board after stepping down in August 2002—pushed current CEO William T. Owens back into his former position as chief financial officer. The switch was designed to strengthen the company’s financial leadership, HealthSouth noted in a release.

We want to hear from you...

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