Insider Intel (June 15, 2016)

Welcome (Roshunda)

Good Afternoon and thank you for joining us on APTA's Insider Intel webinar. This call is a free benefit to APTA members is intended to give a brief update on hot topics in federal regulatory affairs within Medicare, Medicaid, fraud and abuse, etc. We will be conducting these calls on a regular basis throughout the year and we encourage you to ask us questions throughout this call and the year on any federal healthcare topic that affects the physical therapy profession.

On the call today we have Roshunda Drummond-Dye (Director, Regulatory Affairs), Heather Smith (Director, Quality), Sharita Jennings (Senior Regulatory Affairs Specialist) and Kyle Levin (Regulatory Affairs Specialist).

Today on the call we will provide a brief overview of the latest information regarding the MACRA proposed rule, IMPACT act, SNF Payroll Based Journal (PBJ), Pre-Claim Home Health Demonstration and Therapy Cap Manual Medical Review. Please feel free to type your questions into the chat function throughout the webinar.

MACRA Proposed Rule (Heather)

Medicare and CHIP Reauthorization Act (MACRA) was passed last spring. It extended the therapy cap through December 2017 and fixed the flawed SGR. It is about to drastically change payment under Medicare part B by tying it to a new value based program called the Merit-based incentive payment system MIPS or through provider participation in alternative payment models which are value based. As part of the creation of the new MIPS program, the PQRS program will conclude its final data collection period this December. The PQRS measures will appear in the new MIPS program. PTs will not be part of MIPS in 2017 or 2018 but will likely be added to the program in the 2019 year. Medicare release the proposed rule for MIPS and APMS in May and will issue a final rule on this programs in the fall. Following the release of the final rule we can provide you with more specific details of the MIPS program and APMs. Today I want to touch on some important highlights of the proposed rule. Here are 5 important impacts that MACRA will have on PT practice:

1. *You can take MIPS for a test drive.* While PTs aren't included in the list of providers who will be required to participate in MIPS beginning in 2017, PTs can report voluntary to get a feel for and better understand the new system before it becomes mandatory.
2. *MIPS may be getting the most attention, but the APM changes are a big deal too.* Participation in APM will grow over time, and APTA will be working hard to ensure that physical therapists are included in these models.
3. *Data collection systems such as the Physical Therapy Outcomes Registry will play a huge role.* Given the complexity of the MIPS program, the ability to collect data and have real time feedback on performance in MIPS will be critical.
4. *You need to get up to speed with EHRs.* PTs are not currently part of the meaningful use program, however, providers in the MIPS program will be included scored on a category

that includes meaningful use of EHRs. APTA has an EHR resource page that we will be updating this webpage throughout the year. http://www.apta.org/EHR/

5. *We're not just talking Medicare.* The policies contained in the MACRA proposed rule will require providers to collect data for Medicare and other payers. Additionally, although APMs are currently focused on Medicare patients, in the future Medicare would like to see providers participate in APMs that focused on Medicare and private payers.

For more details please see our News Now article:
http://www.apta.org/PTinMotion/News/2016/5/6/MACRA/

IMPACT Act (Heather)

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act was passed in 2014. One of the provisions in the Act requires that CMS standardize patient assessment data, quality and resource use measures for PAC providers (HH, IRF, SNF and LTCH). In the fall of 2106 provider will see new items on their existing data collections tools in these setting to begin to the work to standardize the collection of functional information. CMS has training on these new sections:

- *LTCH* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual.html and https://www.youtube.com/playlist?list=PLaV7m2-zFKph4TMS62MeXttvHL5AWfPGv (video recording of training session)
- *IRF* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Training.html
- *SNF* on Tuesday June 21, and Wednesday, June 22, 2016, in Atlanta, further details to follow

SNF PBJ (Roshunda)

The Affordable Care Act (ACA) requires facilities to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data. The data, when combined with census information, can then be used to not only report on the level of staff in each nursing home, but also to report on employee turnover and tenure, which can impact the quality of care delivered. CMS has developed a system for facilities to submit staffing and census information – Payroll-Based Journal (PBJ). This system will allow staffing and census information to be collected on a regular and more frequent basis than currently collected. It will also be auditable to ensure accuracy. All long term care facilities will have access to this system at no cost to facilities. CMS intends to collect staffing and census data through the PBJ on a mandatory basis beginning on July 1, 2016. CMS has posted the latest *Electronic Staffing Data Submission Payroll-Based Journal Long-Term Care Facility Policy Manual* (Version 2). Please note that swing beds are not subject to PBJ reporting requirements and that facilities must include contractors in PBJ reporting, to include therapists.

Pre-Claim Review Demonstration for Home Health Services (Roshunda)

The Centers for Medicare and Medicaid Services (CMS) is implementing a three-year Medicare pre-claim review demonstration for home health services in the states of Illinois, Florida, and Texas beginning in 2016, and in the states of Michigan and Massachusetts beginning in 2017. CMS is testing whether pre-claim review improves methods for the identification, investigation, and prosecution of Medicare fraud occurring among Home Health Agencies (HHAs). CMs also wants to assess the impact on the quality of care. The pre-claim review demonstration does not create new clinical documentation requirements. HHAs will submit the same information they currently submit for payment, but will do so earlier in the process. The HHA (or the beneficiary) may submit a pre-claim review request after a Request for Anticipated Payment (RAP) is submitted by the HHA. The pre-claim review process must occur within the first 30 days after a RAP is processed and before the claim is submitted by the HHA. HHAs will begin submitting pre-claim review requests in: Illinois beginning no earlier than August 1, 2016; Florida no earlier than October 1, 2016; Texas no earlier than December 1, 2016; and Michigan and Massachusetts no earlier than January 1, 2017. If HHAs in the demonstration states do not utilize the pre-claim review process, those claims submitted for payment will be stopped for prepayment review and may be subject to denial. After the first three months of the demonstration in a participating state, CMS will reduce payment by 25 percent for claims that are deemed payable but did not first receive a pre-claim review decision.

A CMS special Open Door Forum (ODF) was held Tuesday, June 14, 2016. For more information and ODF updates, visit our website at http://www.cms.gov/OpenDoorForums.

Therapy Cap Manual Medical Review (Roshunda)

Additional Documentation Requests (ADRs) have started to go out from the Supplemental Medical Review Contractor (SMRC). The name of the SMRC is Strategic Health Solutions. Here is a link to a sample ADR and SMRC website: https://strategichs.com/smrc/current-smrc-projects/. The focus from a setting perspective falls into three buckets: SNFs, private practice and outpatient facilities. They will not review any home health Part B claims in the targeted MMR process. They are specifically looking at providers who have provided a high amount of hours and/or minutes of therapy to a patient in a day. We don't have specific guidelines on what constitutes a "high amount of hours or minutes of therapy". The ADRs will be limited to 40 claims per provider and some may be upheld and some may be denied. But, each of the 40 claims will be assessed individually for accuracy in billing. Strategic Health (SMRC) has 45 days to respond with their decision after that no further action by SMRC to the provider and it may be turned over to the MAC for further action/review. Providers are afforded a discussion period to fix small administrative errors or provide inadvertently omitted documentation. SMRC discussion period is a time where denials can be undone if the provider submits additional documentation. Providers will be compared to their peers to determine aberrant or outlier billing patterns (i.e. PTPPs compared to other PTPPs, etc.) CMS Program Integrity staff will be re-reviewing a sub-sample of the denials for accuracy.

Question and Answer Period

Will MIPS only apply to private practice outpatient therapy practices or will it also include hospital based outpatient therapy practices?

Under the PQRS program only PTs in private practice can participate. CMS has not yet provided clarification on the inclusion of facility based providers under MIPS. APTA will be asking for clarification on this issue from CMS staff.

Does the time of a non-patient care rehab or therapy aide need to be included in the PBJ reporting?

Generally, no. The time of these staff would not be included. Direct care does not include individuals whose primary duty is maintaining the physical environment of the SNF. Table 1 in the Policy Manual provides a list of direct care staff that should be included.

Please provide more information about MIPS. I am not familiar with this.

The MIPS program will replace existing quality reporting programs under Medicare Part B beginning in 2017, this includes the PQRS program. Under MIPS there are 4 categories in which providers will be evaluated. The first category is quality measures and this will likely include many of the existing measures that are in the PQRS program today. Currently, providers in PQRS get credit for simply reporting measures, however, under MIPS these quality measures will have national benchmarks by which providers will be evaluated. For instance, Medicare will be evaluating whether or not you performed a pain assessment or falls risk screening. The second category looks to see if providers are performing quality improvement activities in their practice. This could include things such as participation in a registry, or managing specific types of patient populations. The third category is resource and cost use measures. Up until this point, PTs have not had these measures, but Medicare is in the process of creating new measures around specific patient conditions such as joint replacements, spine surgery and stroke. PTs will get information on the costs for these episodes. The last category is accessing patient information which is meaningful use. Meaningful use looks at the adoption and utilization of standardized EHR in patient care. Providers will receive a total score each year under the MIPS program based on these categories that will determine whether they receive an incentive payment, remain neutral, or are subject to a penalty. Again, APTA will provide more details on this program after the final rule is released.

In regards to the Manual Medical Review- are all private practice physical therapy offices subject to manual medical review at any point, or do they become subject to review when patients go over the $1960 cap and $3700 threshold?

Targeted manual medical review is still triggered at the $3700 threshold but is now targeted to those providers who had a high claims denial percentage or is less compliant with applicable requirements; the therapist has a pattern of billing that is aberrant compared to peers or otherwise has questionable billing practices, such as billing medically unlikely units of services in a day; the therapist is newly enrolled or has otherwise not previously furnished therapy services; the services are furnished to treat a type of medical condition; and/or the therapist is part of a group that includes another therapist identified using the factors used by CMS for targeted review.

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