The Year Ahead For Outpatient Physical Therapy: Payment Policies in 2016
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Learning Objectives

Upon completion of this course, you will be able to:
1. Determine the impact on your practice of changes to payment policies.
2. Cite the latest government activities regarding the therapy cap, quality, audits, refinements to payment, and other initiatives.
3. Take steps in your practice to comply with Medicare regulations.
Poll: What is your primary practice setting:

1. Private practice
2. Outpatient hospital facility
3. CORF/ ORF
4. Skilled nursing facility (part B)
5. Other

Poll: What is your primary role (select one):

1. Clinician
2. Manager
3. Administrator
4. Educator
5. Other
PAYMENT UPDATES

Medicare Physician Fee Schedule Payment Update

• Projected conversion factor of $35.8279 (a reduction of .1 percent from 2015)
• Accounts for SGR permanent solution and statutory adjustments for misvalued codes
• Overall PT services impact is 0 percent
• Individual impact will depend upon the mix of services being billed
Therapy Cap

• 2016 cap is $1960
• Exceptions process is extended until December 31, 2017
• *Still awaiting specifics for implementation of targeted manual medical review*

Targeted Manual Medical Review

• MACRA replaced the manual medical review process for Medicare Part B therapy services that exceed a $3,700 threshold with new medical review process that became effective in July 2015
• CMS will determine which therapy services to review by considering:
  – aberrant billing practices
  – high claims-denial percentages or issues with compliance
  – newly enrolled providers
  – Treatment of specific medical conditions that warrant increased scrutiny
  – groups that includes another therapy provider identified for medical review.
Potentially Misvalued Codes Initiative

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97032</td>
<td>Electrical stimulation</td>
</tr>
<tr>
<td>97035</td>
<td>Ultrasound therapy</td>
</tr>
<tr>
<td>97110</td>
<td>Therapeutic exercises</td>
</tr>
<tr>
<td>97112</td>
<td>Neuromuscular reeducation</td>
</tr>
<tr>
<td>97113</td>
<td>Aquatic therapy/exercises</td>
</tr>
<tr>
<td>97116</td>
<td>Gait training therapy</td>
</tr>
<tr>
<td>97140</td>
<td>Manual therapy l/&gt; regions</td>
</tr>
<tr>
<td>97530</td>
<td>Therapeutic activities</td>
</tr>
<tr>
<td>97535</td>
<td>Self-care management training</td>
</tr>
<tr>
<td>G0283</td>
<td>Electric stimulation other than wound</td>
</tr>
</tbody>
</table>

“Incident To” Billing

- Clarification – physician who bills must be the physician that provides service or directly supervises
- Changes definition of “auxiliary personnel” to exclude physicians who have had Medicare billing privileges revoked
Pay for Performance and Alternative Payment Models

Shifting from Volume to Value

- HHS measurable goals and timeline
- Tying payment to alternative payment models and pay for performance
- 30 percent by the end of 2016 to APM
- 50 percent by the end of 2018 to APM
- 85 percent to quality by end of 2016 and 90 percent by 2018
### Payment Taxonomy Framework

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Category 2:</th>
<th>Category 3:</th>
<th>Category 4:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee-for-Service — No Link to Quality</td>
<td>Fee-for-Service — Link to Quality</td>
<td>Alternative Payment Models Built on Fee-for-Service Architecture</td>
<td>Population-Based Payment</td>
</tr>
</tbody>
</table>

**Description**
- Payments are based on volume of services and not linked to quality or efficiency.
- At least a portion of payment varies based on the quality or efficiency of health care delivery.
- Some payment is linked to the effective management of a population or an episode of care. Payment will be triggered by delivery of services, but opportunities for shared savings or risk shared.
- Payment is not directly triggered by service delivery to volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., 2+ years).

**Medicare FFS**
- Linked to Medicare fee-for-service.
- Majority of Medicare payments are not linked to quality.
- Hospital value-based purchasing.
- Physician Value-Based Modifier.
- Bundled payment incentives.
- Accountable care organizations.
- Medical homes.
- Bundled payments.
- Comprehensive primary care.
- Comprehensive EHRs.
- Medicare-Medicaid Financial Alignment Initiative Fee-for-Service Model.
- Eligible Physician accountable care organizations; in years 3–5.


### Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

#### 2016
- All Medicare FFS (Categories 1-4): 85%
- FFS linked to quality (Categories 2-4): 30%
- Alternative payment models (Categories 3-4): 50%

#### 2018
- All Medicare FFS: 90%
- Alternative payment models (Categories 3-4): 50%

Health Care Payment and Learning Action Network

- Serve as a convening body to facilitate joint implementation of new models of payment and care delivery,
- Identify areas of agreement around movement toward alternative payment models and how best to report on new payment models,
- Collaborate to generate evidence, share approaches, and remove barriers,
- Develop common approaches to core issues such as beneficiary attribution, financial models, benchmarking, quality and performance measurement, risk adjustment, and other topics raised for discussion, and
- Create implementation guides for payers, purchasers, providers, and consumers.

Medicare Shared Savings New Rule

- June 6, 2015, CMS released new ACO rulemaking
- The rule:
  - Allows health care providers to gain more incentive payments and innovative methods for care coordination
  - Gain access to real time information patients from Medicare
  - Waives 3-day SNF rule for certain ACOs
ACOs in Your State

https://www.cms.gov/Medicare/Medicare‐Fees‐for‐Service‐Payment/sharedsavingsprogram/ACOs‐in‐Your‐State.html

CMMI: Bundled Payment for Care Initiative

Model 1: Inpatient Stay Only (Physician services paid separately)

Model 2: Inpatient and PAC Stay (30 or 90 days)

Model 3: Discharge from Inpatient stay and PAC 30 days after

Model 4: Inpatient Stay (all services including physician)
PQRS AND MIPS

Poll: True or False: At the end of 2016, the PQRS program will end.
<table>
<thead>
<tr>
<th>Health Care Setting</th>
<th>Reporting Level</th>
<th>Program Details/ Data</th>
<th>Payment Incentive/ Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient (Acute Care Hospitals)</td>
<td>Facility</td>
<td>IQR, Readmissions &amp; VBP</td>
<td>P4R Penalty -2% &amp; P4P</td>
</tr>
<tr>
<td>Long Term Care Hospitals (LTCH)</td>
<td></td>
<td>LTCH-CARE, claims, NHSN</td>
<td>P4R Penalty -2%</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facilities (IRF)</td>
<td></td>
<td>IRF-PAI, claims, NHSN</td>
<td>P4R Penalty -2%</td>
</tr>
<tr>
<td>Skilled Nursing Facilities (SNF)</td>
<td></td>
<td>MDS 3.0, claims, NHSN, VBP</td>
<td>P4R Penalty -2%, P4P</td>
</tr>
<tr>
<td>Home Health</td>
<td></td>
<td>OASIS, HH CAHPS, claims, VBP</td>
<td>P4R Penalty -2%, P4P</td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
<td>Hospice item set (HIS)</td>
<td>P4R Penalty -2%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Individual or Group (TIN/NPI)</td>
<td>PQRS</td>
<td>P4R Penalty -2%</td>
</tr>
<tr>
<td>Innovative Models (ACOs, BPCI, CJR)</td>
<td>Organization, Facility</td>
<td>Quality reporting requirements for each model</td>
<td>P4P (ACO), P4R (BPCI), P4P with threshold (CJR)</td>
</tr>
</tbody>
</table>

ACO= Accountable Care organization; BPCI= Bundled Payments for Care Improvement; CJR= Comprehensive Care for Joint Replacement
NHSN= National Healthcare Safety Network
P4R= Pay for Reporting
P4P= Pay for Performance

### Functional Limitation Reporting

- No changes to FLR
- All ongoing cases that cross the calendar year will continue reporting as scheduled
  - Cases do not need to restart reporting as of January 1, 2016
**Physician Quality Reporting System (PQRS)**

- PQRS is a quality reporting program that encourages individual eligible professionals (EPs) – including PTs - to report information on the quality of care to Medicare.
- In 2016, EPs- including PTs in private practice- who bill under the physician fee schedule must report successfully under PQRS to avoid a -2.0% reduction in their 2018 fee schedule.
  - *Rehab agencies, outpatient hospitals, SNFs Part B unable to participate in PQRS; use UB-92 (UB-04) or 837I for billing to intermediary* 

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**Physician Fee Schedule: PQRS Changes in 2016**

<table>
<thead>
<tr>
<th>Program Detail</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful reporting requirements</td>
<td>Same as 2015: Reporting of 9 measures (or 1-8 as applicable) on 50% of eligible patients will be needed to avoid the -2.0% penalty</td>
</tr>
<tr>
<td>Available measures</td>
<td>No new measures/ no measures removed</td>
</tr>
<tr>
<td>Specific measure changes</td>
<td>No coding changes to report</td>
</tr>
<tr>
<td></td>
<td>Additional clarifying details added to some measures</td>
</tr>
<tr>
<td></td>
<td>Please review all measures that you are reporting</td>
</tr>
<tr>
<td>Reporting Mechanisms</td>
<td>No changes</td>
</tr>
</tbody>
</table>
PQRS Participation 2016

Should I participate in PQRS in 2016?

- I want to avoid the - 2.0% penalty in 2018
  - Report via claims
  - Report via registry

- Report all available individual measures (128, 130, 131, 154, 155, 182)
- Select 9 individual measures (or if less available 1-8)

PQRS: Errors to Avoid

- Failing to include PQRS data on an original claim
  - Make sure PQRS codes are included on all eligible initial claims
  - Claims cannot resubmitted for the sole purpose of adding a PQRS code

- Placing invalid modifiers on the PQRS codes including GP or KX
  - Placing a GP or KX modifier will cause the PQRS to reject form the system
  - You cannot resubmit the claim to correct PQRS code errors

- Failing to meet 50% reporting rate for all selected measures
  - Consistently report PQRS measures on all eligible patients throughout the year
  - Do not select different measures for each patient; report selected measures on all patients
  - Report on all eligible visits including 97002 and 97532

Access your feedback reports throughout the year at Quality Net:
https://www.qualitynet.org/portal/server.pt/community/pqri_home/212
MACRA and the Future of PQRS

MIPS (2017)

PQRS Physician Quality Reporting System
MU Meaningful Use
VM Value-based Modifier
MIPS Merit-based Incentive Payment System

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PQRS and MIPS: Impact for PTs

- **2016**: Report PQRS data. Subject to 2.0% penalty if you failed to report PQRS data successfully in 2014.
- **2017**: Subject to 2.0% penalty if you failed to report PQRS data successfully in 2015.
- **2018**: Subject to 2.0% penalty if you failed to report PQRS data successfully in 2016.
- **2019**: Report MIPS data?? (Secretary has ability to add PTs to program in 2017)
- **2020**: Report MIPS data.
- **2021**: Report MIPS data. Subject to potential incentive or penalty based on reporting in MIPS program in 2019 (3.0% to -7.0%).
Poll: True or False: The Comprehensive Care Joint Replacement (CJR) model begins on April 1, 2016 and mandates that all hospitals in selected metropolitan regions participate.
Comprehensive Care for Joint Replacement Payment Model

- Proposed CJR Model focused on elective primary hip and knee replacement patients begins on April 1, 2016 and will run for 5 years
- Model includes inpatient stay and post discharge care 90 days after discharge
- Unlike other innovative models, CJR requires that all IPPS hospitals in the selected MSAs must participate
- The average Medicare payment for hip and knee procedures ranges from $16,500 to $33,000, according to the CMS
- Medicare estimates a cost savings of $153 million over the 5 years of the model
CCJR Quality Measures

- Required:
  - Hospital-level Risk-Standardized Complication Rate following elective primary THA and/or TKA (NQF #1550), an administrative claims-based measure
  - HCAHPS Survey measure

- Optional:
  - Patient reported outcome measures
    - PROMIS Global or VR (Veterans RAND) 12 AND
    - HOOS Jr or HOOS Pain AND Function, Daily Living Subscales / KOOS Jr or Stiffness, Pain AND Function, Daily Living Subscales
Financial Arrangements: Gain Sharing

• Providers are still paid under FFS payment models as they are today (may share in savings)
• Hospitals may have certain financial relationships with collaborators (can share reconciliation payments and internal cost savings with collaborators)
• Must furnish services during episode to be collaborator
• Collaborators may include:
  – Physicians and nonphysician practitioners
  – Home Health Agencies
  – Skilled Nursing Facilities
  – Long Term Care Hospitals
  – Physician Group Practices
  – Inpatient Rehabilitation Facilities
  – Providers or suppliers of therapy services

Beneficiaries

• Beneficiaries may still select any provider of choice with no restrictions.
• May still receive any Medicare covered service with no restrictions.
• No copayment change
• Hospitals may offer certain items and services to beneficiaries during episode (may not be inducements)
Waivers

• Fraud and abuse law waivers will be promulgated separately by OIG and CMS
• Can waive the SNF 3 day rule if SNF is rated 3 stars or higher on Nursing Home Compare
• Can waive “incident to” rule for physician services to allow clinical staff of a physician to furnish home visits. (only for non HHA covered patients)
• Telehealth- waives originating site requirements so service may be originated in patient’s home

What’s Next?

• APTA is planning to update webpage with resources including:
  – Basic information on the model
  – Contracting considerations
  – Clinical practice guidelines, best practices
  – Functional tools
  http://www.apta.org/BundledModels/CCJR/
Resources

• Fee Schedule:
  http://www.apta.org/Payment/Medicare/CodingBilling/FeeSchedule/
  http://www.apta.org/Payment/Medicare/2015/Changes/

• CJR:
  http://www.apta.org/BundledModels/CCJR/

• PQRS:
  http://www.apta.org/PQRS
  https://www.cms.gov/PQRS/
  https://www.qualitynet.org/

QUESTIONS

If you have additional questions on PQRS please feel free to contact us at
800 999 2782 ext 8511 OR
advocacy@apta.org