The Year Ahead For Outpatient PT: Payment Policies in 2015

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Learning Objectives

1. Determine the impact on your practice of changes to the Medicare physician fee schedule payment amounts.
2. Understand the latest government activities regarding the therapy cap, quality, the improvement standard, audits, and other initiatives.
3. Takes steps in your practice to comply with Medicare regulations.
Poll

• In which setting do you practice?
  – Private Practice
  – Hospital
  – Skilled Nursing Facility
  – Rehabilitation Agency
  – Comprehensive Outpatient Rehabilitation Facility (CORF)
  – Physician Office
  – Home Health
  – School Based
  – Academic
  – Other
FEE SCHEDULE UPDATES
Outpatient PT Payment Rates for 2015

• Outpatient Physical therapy services are paid under the physician fee schedule
• Values are multiplied by a dollar conversion factor to determine payments. Payment is updated each year by increasing or decreasing the dollar conversion factor
• Due to flawed SGR formula, the dollar conversion factor is projected to be reduced each year significantly
SGR Updates

Practice Cost Increase (MEI Estimate)

SGR Medicare Physician Payment Updates

2007 to 2016's -50% gap between cost increases and payment updates
## Recent Legislation: SGR

<table>
<thead>
<tr>
<th>Year</th>
<th>Legislation</th>
<th>Payment Period</th>
<th>Scheduled Payment Update</th>
<th>Legislated Payment Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>Medicare &amp; Medicaid Extenders Act</td>
<td>2011</td>
<td>-25%</td>
<td>0%</td>
</tr>
<tr>
<td>2012</td>
<td>Middle Class Tax Relief Act</td>
<td>March-Dec. 2012</td>
<td>-27.4%</td>
<td>0%</td>
</tr>
<tr>
<td>2013</td>
<td>American Taxpayer Relief Act</td>
<td>2013</td>
<td>-26.5%</td>
<td>0%</td>
</tr>
<tr>
<td>2014</td>
<td>Pathway for SGR Reform Act</td>
<td>Jan-March 2014</td>
<td>-20.1%</td>
<td>0.5%</td>
</tr>
<tr>
<td>2015</td>
<td>Protecting Access to Medicare Act</td>
<td>April 2014-March 2015</td>
<td>-24%</td>
<td>0%</td>
</tr>
</tbody>
</table>
2015 Fee Schedule

• From January –March 31, 2015 PTs will experience an aggregate 1% increase in payment.

• If Congress does not act before March 31, 2015 a 20.9% reduction in payment will occur.
MPPR/Fee Schedule Resources

• APTA website
  – www.apta.org/medicare (Medicare fee schedule)
  – MPPR calculator
  – MPPR scenarios
  – Fee schedule calculator
  – Summary of Physician Fee Schedule Rule
Future Outlook: Repeal of SGR?

• Cost to Repeal SGR (permanent “doc fix”) is currently $138 billion
• Cost of Congress enacting 17 temporary “doc” fixes to the SGR since 2003= $169.5 billion
• Full Repeal is thought to be more fiscally responsible
• But how do we pay for repeal?
SGR Repeal Bill in Congress

SGR Repeal & Medicare Provider Payment Modernization Act) (HR. 4015/S2000)

• Permanent Repeals the SGR
• 2014-2018 annual updates = 0.5%
• 2019-2023 = freezes updates (0%); providers participating in Alternative Payment Models could get a 5% bonus
• Beginning in 2024, providers participating in APMs will receive a 1% annual update and all others .5% annual updates.
SGR Repeal Bill in Congress

- New Merit-Based Incentive Payment System (MIPS)
- Blended PQRS, Meaningful Use, Value Based Modifier & New Clinical Practice Improvement Option
- Under MIPS would receive a penalty or bonus based on comparison to national mean
Therapy Cap

• Therapy Cap amount for 2015 is $1940 for physical therapy and speech therapy combined & $1940 for occupational therapy (up from $1920 in 2014).
• The therapy cap currently applies to all outpatient therapy settings.
Therapy Cap Exceptions Process: January-March 31, 2015

Claims between $1940-3700: submit KX modifier if services are medically necessary for an exception.

Claims exceeding $3700: subject to manual medical review process.
Manual Medical Review

• Recovery Audit Contractors (RAs) responsible for reviewing the medical records and determining whether services are medically necessary.
• Temporary Pause in Manual Medical Review in effect starting February 28, 2014 due to RAC transition.
• New RAC contracts have not been awarded due to protests.
• Existing RAC contracts were extended until December 31, 2014
Manual Medical Review

• CMS plans to have the existing RACs begin “limited” postpayment review of claims exceeding $3700
• New RACs will perform postpayment review on claims exceeding $3700 in 2014 and 2015.
• RACs will not comply with the 10 day turnaround time for review due to the backlog.
• The new RACs will review the therapy claims in the order they were paid.
Collecting Out of Pocket

• If a patient does not qualify for an exception (e.g. services do not considered reasonable and necessary), the provider can collect out of pocket payment from the beneficiary.

• The provider must give the beneficiary an Advanced Beneficiary Notice (ABN) if Collecting Out of Pocket.

• Revised ABN form (Form-R-131) available on the CMS website at: https://www.cms.gov/BNI/02_ABN.asp

• Provider should only give the patient an ABN if there is reason to believe services will be denied as not reasonable and necessary.

• Giving “Blanket” ABNs to every patient exceeding $3700 is NOT acceptable.
Collecting Out of Pocket

• Provider can determine the amount of payment to collect from the patient; it does not have to be the fee schedule amount.
• Submit claim with GA modifier
• Providers should avoid deep discounts or providing services for free as that could violate anti-kickback statutes.
Future Outlook: Therapy Cap
Legislation: Therapy Cap Repeal & Reform (Senate Finance)

- Repeals the Medicare therapy cap
- Retains manual medical review at $3,700 for 1 year
- Transitions to a new medical review system in 2015 with a prior authorization mechanism for approval of blocks of visits
- Replaces current functional limitation reporting with new therapy data collection system (around 2017)
- Starting in 2015, claim form must indicate if the service is provided by a therapy assistant
Legislation: Prior Authorization

• CMS would define services subject to medical review based on factors such as:
  – Providers with unusually high billing patterns;
  – High claims denial percentages
  – Newly enrolled providers
  – Questionable billing practices
  – CMS may establish thresholds for review
CMS: Alternative Payment for Therapy

• CMS is interested in development of an alternative payment system for outpatient therapy.
• Includes discussions of episodic system, per diem systems, hybrid systems.
• DOTPA Research Triangle Institute (RTI) performed a study involving the use of the CARE –C and CARE-F assessment tools at admission and discharge.
• Study was published on website May 1, 2014
APTA Alternative Payment System

• Visit/Session Based System
• Based on clinical judgment of the therapist
• Factors include:
  – severity/complexity of the patient’s presentation
  – intensity of the therapist’s clinical decision making and interventions
CPT coding changes

• AMA Physical Medicine and Rehabilitation Workgroup is currently working on changes to CPT codes in 97000 series (13 specialties)
• Developing per session CPT codes to describe services. Levels based on severity of patient and intensity of service
• APTA and AOTA performed a pilot project to further investigate payment model
PQRS 2015
PQRS: 2015 payment

• If PTs did not report under PQRS in 2013, they receive 1.5% less payment for claims with dates of service from January 1-December 31, 2015. in payment in 2015.

- **CARC 237**
  - Legislated/Regulatory Penalty, to designate when a negative or downward payment adjustment will be applied.

- **RARC N699**
  - Payment adjusted based on the PQRS Incentive Program.
PQRS: 2015 payment

• In 2015, eligible providers who bill under the physician fee schedule must report successfully under PQRS to avoid a -2.0% reduction in their 2017 fee schedule payment. PTs can report via claims or registry
  – Rehab agencies, outpatient hospitals, SNFs Part B unable to participate in PQRS; use UB-92 (UB-04) or 837I for billing to intermediary
  – No place on claim form for individual NPI
PQRS Successful Reporting

To avoid the penalty in 2017

In 2015, report at least 9 measures OR, if less than 9 measures covering apply to the eligible professional, report 1—8 measures, AND report each measure for at least 50 percent of the Medicare patients to which the measure applies.
## 2015 Individual Measures for PTs

<table>
<thead>
<tr>
<th>#</th>
<th>Measure Description</th>
<th>Claims</th>
<th>Registry</th>
</tr>
</thead>
<tbody>
<tr>
<td>126</td>
<td>Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy: Neurological Evaluation</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>127</td>
<td>Diabetic Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention Evaluation of Footwear</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>128</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>130</td>
<td>Documentation and Verification of Current Medications in the Medical Record</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>131</td>
<td>Pain Assessment Prior to Initiation of Patient Treatment</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>154</td>
<td>Falls: Risk Assessment</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>155</td>
<td>Falls: Plan of Care</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>182</td>
<td>Functional Outcome Assessment</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
## 2015 Individual Measures for PT’s

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<th>Registry</th>
</tr>
</thead>
<tbody>
<tr>
<td>217</td>
<td>Change in Risk-Adjusted Functional Status for Patients with Knee Impairments</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>218</td>
<td>Change in Risk-Adjusted Functional Status for Patients with Hip Impairments</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>219</td>
<td>Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot or Ankle Impairments</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>220</td>
<td>Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>221</td>
<td>Change in Risk-Adjusted Functional Status for Patients with Shoulder Impairments</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>222</td>
<td>Change in Risk-Adjusted Functional Status for Patients with Elbow, Wrist, or Hand Impairments</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>223</td>
<td>Change in Risk-Adjusted Functional Status for Patients with a Functional Deficit of the Neck, Cranium, Mandible, Thoracic Spine, Ribs, or other General Orthopedic Impairment</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Physician Fee Schedule: PQRS Changes in 2015

<table>
<thead>
<tr>
<th>Program Detail</th>
<th>Changes</th>
</tr>
</thead>
</table>
| Successful reporting requirements | • Reporting of 9 measures (or 1-8 as applicable) on 50% of eligible patients will be needed to avoid the -2.0% penalty  
• Requires reporting of 1 cross cutting measures |
| Available measures            | • Elimination of 245 Chronic Wound Care measure  
• Elimination of 148-151 Back Pain Measures Group  
• New category of measure – cross cutting |
| Specific measure changes     | • Measure #130 Medication: to be reported on every visit when billing 97001, 97002 or 97532 (eliminated 97110 and 97140)  
• Measures #126 Diabetes Care: deleted numerator code G8406  
• Measures #217-223 FOTO: added denominator codes G8980, G8983, G8986, G8989, G8992  
• Please review all measures that you are reporting |
| Future changes                  | • Strongly encouraging providers to move away from claims-based reporting |
Should I participate in PQRS in 2015?

I want to avoid the -2.0% penalty in 2017

- Report via claims
  - Report all available individual measures (128, 130, 131, 154, 155, 182)
- Report via registry
  - Select 9 individual measures (or if less available 1-8)
Physical Therapy Outcomes Registry Timeline

2014
Testing and pilot launch

2015
Continued pilot testing and preparation for full launch in 2016

2016 & Beyond
Continued PTOR growth

For further information please visit www.apta.org/Registry
Or email us at registry@apta.org
PQRS: Public Reporting & Future

• Providers who report successfully in the program will have their names listed on the CMS website

• CMS is planning to make:
  – 2015 PQRS GPRO data to be available Physician Compare Website in CY2016 for all groups of 2 or more Eligible Professionals (EPs).
  – 2015 individual EP PQRS data to be available Physician Compare Website in late CY2016 if technically feasible.

http://www.medicare.gov/physiciancompare/search.html
Resources on PQRS

- **APTA website**
  - http://www.apta.org/PQRS/

- **QualityNet Help Desk**

- **PQRS and eRx Incentive Program questions**
  - 866-288-8912 (TTY 877-715-6222)
  - 7:00 a.m.–7:00 p.m. CST M-F or qnetsupport@sdps.org

- **CMS PQRS Website**
The Value-Based Modifier (VM) Program

• VM was mandated by Section 3007 of the Affordable Care Act, to begin by 2015. *This program is separate from PQRS.*

• Physicians are included in this program in 2015 (using CY2013 data).

• *CMS is expanding the program in CY2018 (using CY 2016 data) to include:*
  – Nonphysician Eligible Professionals (EPs) *this includes physical therapists*
The Value-Based Modifier (VM) and PTs

• The VM program has a quality tiering methodology that takes into account both quality and cost.
  – *The quality portion of the methodology is based largely on PQRS performance.*
  – The cost portion of the methodology would not typically apply to PTs and PTs would be given an average rating on this section based on CMS guidelines.
Possible Impact of PQRS & VM* for PTs in 2016

<table>
<thead>
<tr>
<th>Reporting Scenario</th>
<th>PQRS Penalty</th>
<th>VM Incentive/ Penalty</th>
<th>Total Impact in 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT practice successfully reports in PQRS</td>
<td>0%</td>
<td>0% to +2.0x (may earn high quality performers)</td>
<td>0% to +2.0x</td>
</tr>
<tr>
<td>PT practice does not report successfully</td>
<td>-2%</td>
<td>-4%</td>
<td>-6%</td>
</tr>
<tr>
<td>PT practice chooses not to participate</td>
<td>-2%</td>
<td>-4%</td>
<td>-6%</td>
</tr>
</tbody>
</table>
Program Integrity: Strategies to Reduce Improper Payments

- Strengthen provider enrollment
- Improve prepayment reviews
- Focus postpayment reviews on vulnerable areas
- Improve oversight of contractors
- Develop a robust process to address identified vulnerabilities

Source: GAO.
Medicare Provider Oversight

• Final rule issued December 5, 2014 (Effective 02/03/15)

• The rule allows CMS to:
  – deny enrollment of providers, suppliers, and owners that have unpaid Medicare debt
  – deny the enrollment or revoke the billing privileges of a provider or supplier if a managing employee has been convicted of certain felony offenses
  – revoke billing privileges of providers and suppliers that have a pattern or practice of billing for services that do not meet Medicare requirements
OMHA Workload

• Extensive jurisdiction for a majority of all appeals under Medicare
• Parts A and B pre and post payment claims (MACs, RACs, ZPICs)
  – This includes therapy cap manual medical review appeals
• Medicare Manage Plans
Impetus for Heavy Workload

- Post-payment audit programs and increasing number of initiatives under the Medicare Office of Program Integrity
- Increased activity in State Medicaid agencies
Volume of Appeals Received

Receipts by Medicare Type

- Part A
- Part B
- Part B IRMMA
- Part C
- Part D
- Part D IRMMA
- Entitlement
- IRMMA
- Unspecified

*The FY14 receipts are based on estimated receipts through June 2014. Includes appeals with both FY13 & FY14 in bond year and does not include reopenings.

Run Date: November 13, 2014
Solutions to Alleviate Backlog

• OMHA held provider forum on October 29th and solicited feedback on how to address the problem
• APTA submitted comments
  – Claims oversight for MMR should be suspended until correction of backlog
  – More scrutiny and streamlined process for Medicare contracted reviewers (number and scope)
  – Increased training and coordination for Medicare contractors for correct and consistent application of the law
Jimmo v. Sebelius Improvement Standard
First Step: Manual Revisions

• Transmittal 179
• Clarifications contained in the Medicare Claims Processing and Benefits Policy Manual (chapters applicable to home health, IRF, SNF and outpatient therapy)
• No rule of thumb application – care depends on whether skilled care is required (reasonable and necessary criteria), not restoration potential
• Inclusion of examples and documentation guidelines for each setting
Second Step: National Education Campaign

- Special Provider Outreach call – December 19th at 2pm
- Target Audience: Skilled Nursing Facilities; Inpatient Rehabilitation Facilities; Home Health Agencies; and providers and suppliers of therapy services under the Outpatient Therapy Benefit.

- [http://www.eventsvc.com/blhtechnologies](http://www.eventsvc.com/blhtechnologies)
Third Step: Accountability

- Re-review of previous denials
- Retroactive January 2011
- Appeal rights lie with beneficiary
- Claims review through established protocol of sampling of QIC claims
- Bi-annual meeting with plaintiffs counsel on claims review findings
- Expedited review and resolution of errors and denials

[APTA Learning Center](http://www.apta.org/learningcenter)
What Happens When Services Are No Longer Medically Necessary?

**Rights of the patient**
- Periodically meet with your health care providers (i.e. therapist, physician, SNF) to understand treatment options
- Can continue to receive services and pay out of pocket
- Seek aid through local assistance programs (national Elder Locator program 800.677.1116)
- Right to appeal denied Medicare claims

**Rights of the provider**
- Furnish patient with an ABN
- Establish a maintenance program to be carried out by non-skilled individuals
- Can continue to collect payment out of pocket
- Coordination of services with physician and other health care providers to ensure a consistent message to the patient
- Right to appeal Medicare denied claims
Medicare Resources

- Medicare Therapy Services webpage: http://cms.gov/Medicare/Billing/TherapyServices/index.html
APTA Resources

• APTA Medicare Coverage Page
  http://www.apta.org/Payment/Medicare/CoverageIssues/SkilledMaintenance/
  Technical briefs on lawsuit and settlement
  – Summary of manual provisions
  – Tips and highlights for physical therapists
  – Podcasts: overview of manual provisions and documentation
  – Setting specific tools and clinical application resources
Impact of ACA on Medicare Advantage

- Affordable Care Act cuts may have large impacts on beneficiaries
  - 2014 payments adjusted for differences in diagnostic coding intensity between Medicare Advantage plans and traditional Medicare
- Medical Loss Ratio 85% requirement implementation in 2014
- Sequestration cuts from Budget Control Act
MA Plan Costs Are Rising

• Kaiser Family Foundation study indicates the following for 2014:
  – Higher premium payments for beneficiaries
  – No large changes in availability of plans
  – High out-of-pocket maximums for plans
    • Further cost sharing (co-payments, coinsurance) for beneficiaries
Medicare Advantage: Cost Sharing

- Unreasonably high co-payments for therapy services from many MA plans
- APTA’s advocacy efforts

  - Call for high co-payment examples
  - Comment letters
  - Meeting with CMS

- Emphasis on patient impact and access to therapy services
2015 Medicare Advantage Call Letter

• Cost Sharing Changes:
  – **$40 copay limit for physical therapy services**
  – Refine plan offerings so that beneficiaries can easily identify the differences between their options

• Provider Networks:
  – Notification to enrollees regarding any changes to provider networks
  – Potential future rulemaking
Provider Network Adequacy

• MA plans narrowing networks to cut costs
• Federal judge in Connecticut temporarily blocked UnitedHealthcare from dropping an estimated 2,200 physicians from its Medicare Advantage plan
  – Potential national implications
Implementation of Traditional Medicare Policies

• Multiple procedure payment reduction adopted by many MA plans since 2011 CMS implementation

• Implementation issues by Humana
  – Retroactive overpayment letters issued
  – Incorrect calculations
  – APTA advocacy efforts → Humana no longer applying policy retroactively

• Functional Limitation Reporting also being adopted by MA plans
Provider Tips for MA Issues

Review Contracts
- Determine risk for payment cuts (through sequestration, MPPR, etc.)
- Seek legal counsel as needed

Monitor MA Plan Websites
- Many MAOs issue policy updates only via their websites
- Notice requirements in contracts

Encourage Patients to Get Involved
- Emphasis on patient impact with cost sharing issue
- Patient advocacy more meaningful
Veteran’s Choice Program

• Interim Final Rule effective November 5, 2014
• Establishes eligibility standards for patients and providers
• Sets payment rates with deference to Medicare Fee schedule and special provisions for care in rural areas
• Streamlined claims processing system
• http://www.apta.org/Payment/TRICAREVA/