

## **What's New**

### **Regional Payment Pilot: A new way to work**

It is evident that a change in strategy is needed to impact payment for physical therapist services in the private sector. In 2009, the APTA Board of Directors outlined a framework for consideration to enhance APTAs payment policy efforts. The framework includes setting the standard for payment policy at a national level and providing the support, resources, and strategy to implement effective policy changes to improve payment for physical therapist services at a local and regional level.

Starting in 2012, APTA will engage in a three (3) year Regional Payment Policy Pilot. The timeframe will allow for a full cycle across the jurisdictions and consistency with state implementation timelines for policy outlined in the Patient Protection and Affordable Care Act (PPACA). The pilot will include six (6) states in the New England region: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut. APTA will evaluate and assess the model for its feasibility as a future framework for a national approach to improving payment for physical therapist services.

### **Health Services Research Direct Access Study**

A new Health Services Research Direct Access study found that patients who come to physical therapy on their own have fewer visits and lower costs than patients referred by physicians. The study, published ahead of print in the journal *Health Services Research*, was funded by a grant from APTA, the Private Practice Section and the Health Policy & Administration Section.

The study provides further evidence to support direct access to physical therapists. A summary of key points includes:

- The average allowable amount for physical therapy claims was lower for patients who visited a physical therapist directly-- \$347 compared to \$420 on average for physician-referred patients;
- Patients who visited a physical therapist directly for outpatient care had fewer visits (86% of physician-referred) on average than those who were referred by a physician;
- The removal of a physician gatekeeper did not lead to overuse of care;
- There was no indication that patients who visited a physical therapist directly became disengaged from the overall health care system, and continuity of care was maintained.

Several resources about the study are now available on the APTA Web site:

APTA Toolkit: [www.apta.org/PRMarketing/DirectAccess](http://www.apta.org/PRMarketing/DirectAccess)

Study available at: [www.apta.org/PRMarketing/DirectAccess/FullStudy](http://www.apta.org/PRMarketing/DirectAccess/FullStudy)

APTA press release about the study:

<http://www.apta.org/Media/Releases/Consumer/2011/10/13/>

## **Insurers look to mergers to further growth strategies**

Market saturation and margin-squeezing health care reform have prompted large managed health care companies such as Aetna, Cigna, and Humana to snap up smaller players to keep earnings growth alive, says a Wall St Journal (WSJ) article. See the November 1 [article](#) in PT in Motion: News Now, for more information.

## **Federal Payment**

### **CMS releases 2012 rules**

#### ***Final Physician Fee Schedule rule***

The Centers for Medicare and Medicaid Services (CMS) released the final physician fee schedule rule for Calendar Year (CY) 2012, which sets the therapy cap on outpatient services (except outpatient hospital departments) at \$1,880 beginning January 1, 2012. The therapy cap exceptions process will expire on December 31, 2011, unless Congress acts to extend it.

The [final rule](#) calls for a 27.4% cut in Medicare payments—less than the 29.5% cut estimated earlier this year—for physicians, physical therapists, and other health care professionals based on the flawed sustainable growth rate formula (SGR). However, if Congress intervenes before the January 1, 2012, effective date, the aggregate impact of work Relative Value Units (RVU), practice expense RVU, and malpractice RVU changes for 2012 on physical therapy services is a positive 4% (noted on Table 84 on page 1176 of the rule). According to [CMS](#), the Obama administration is "committed to fixing the SGR and ensuring these payment cuts do not take effect."

CMS also will make changes in how it adjusts payment for geographic variation in the cost of practice. The agency is replacing some of the data sources—such as using data from the American Community Survey (ACS) in place of the Department of Housing and Urban Development (HUD) rental data and also using ACS data in place of the data currently used for non-physician employee compensation. CMS also will adjust its payments for the full range of occupations employed in physicians' office and will make other adjustments called for in prior year public comments.

The CY 2012 final rule also updates or modifies several physician incentive programs, including the Physician Quality Reporting System.

APTA posted a [detailed summary](#) of the final rule on November 14, 2011.

#### ***2012 Home Health final rule***

Payments to home health agencies (HHAs) are estimated to decrease by approximately 2.31% or \$430 million in Calendar Year (CY) 2012, the net effect of a 1.4% payment update, the wage index update, and the case-mix coding adjustment, according to a final rule issued by the Centers for Medicare & Medicaid Services (CMS) that updates the home health prospective payment system (HH PPS) rates effective January 1, 2012.

The Affordable Care Act applies a 1% point reduction to the CY 2012 home health market basket amount. As the CY 2012 market basket is equal to 2.4%, the payment update for HHAs in CY 2012 will be 1.4%. CMS also reduced HH PPS rates in CY 2012 to account for additional growth in aggregate case-mix that is unrelated to changes in patients' health status. CMS has

finalized a 3.79% reduction to the home health PPS rates for CY 2012 and an additional 1.32% reduction for CY 2013.

This rule also finalizes structural changes to the HH PPS by removing 2 hypertension codes from the case-mix system, lowering payments for high therapy episodes, and recalibrating the HH PPS case-mix weights to ensure that these changes result in the same amount of total aggregate payments. These changes are intended to increase payment accuracy and reduce the growth in aggregate case-mix that is unrelated to changes in patients' health status.

Under current Medicare policy, a certifying physician or an allowed non-physician practitioner must see a patient prior to certifying a patient as eligible for the home health benefit. The rule also finalizes added flexibility to allow physicians who cared for the patient in an acute or post-acute facility to inform the certifying physician of their encounters with the patient in order to satisfy the requirement.

Additionally, the rule describes planned improvements to the home health publicly reported quality measures.

APTA posted a [summary](#) of the final rule on November 9, 2011.

## **CMS provider enrollment news**

### ***Revalidation requirements clarified***

Over the coming months and years, Medicare Administrative Contractors (MACs) will be asking physical therapists (PTs) and other providers to revalidate their enrollment by submitting a complete and up-to-date enrollment application. Providers should wait for the request from the MACs before submitting the revalidation. Upon receipt of the revalidation request, providers have 60 days from the date of the letter to submit complete enrollment forms. Failure to submit the enrollment forms could result in the deactivation of a provider's Medicare billing privileges.

A provision in the Affordable Care Act required certain providers who are revalidating to pay an application fee of \$505. This fee does not apply to PTs in private practice who are revalidating. It does apply to all institutional providers who are revalidating (e.g. hospitals, SNFs, rehabilitation agencies, etc).

The most efficient way to submit your revalidation information is by using the Internet-based PECOS, available at the Centers for Medicare and Medicaid Services' (CMS) [Web site](#). If using PECOS, once submitted, you must print, sign, date, and mail the certification statement along with all required supporting documentation to the MAC. More information can be found in a *Medlearn Matters* [article](#) issued by CMS.

### ***CMS posts provider revalidation list***

In response to provider requests, the Centers for Medicare and Medicaid Services (CMS) posted a listing of providers who have been sent a request to revalidate their Medicare enrollment information. The listing contains the name and national provider identifier (NPI) of each provider sent a letter, and the date the letter was sent. To see the listing, click on "Revalidation Phase 1 Listing" in the downloads section of the [Medicare Provider Supplier Enrollment Revalidation Page](#). CMS will update this list monthly.

Providers who are listed but have not received the request should [contact their Medicare contractor](#).

For more information on revalidation of Medicare provider enrollment, see the *MLN Matters* article [Further Details on the Revalidation of Provider Enrollment Information](#), revised on November 1.

### ***Electronic funds transfer***

An October 13 notice from the CMS provider listserv reminds providers that “at the time of enrollment, enrollment change request or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the ACA further expands Section 1862 (a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means. As part of CMS’s revalidation efforts, all suppliers and providers who are not currently receiving EFT payments *will be identified, and required to submit the CMS 588 EFT form with the Provider Enrollment Revalidation application.*

For more information about provider enrollment revalidation, review the Medicare Learning Network’s [Special Edition Article #SE1126](#), titled ‘Further Details on the Revalidation of Provider Enrollment Information.’”

### **CMS changes claim adjustment reason codes for MPPR payments**

CMS [notified contractors](#) to use “Code 59: Processed based on multiple or concurrent procedure rules” on remittance advices when claim payments are subject to the Multiple Procedure Payment Reduction (MPPR). The change is intended to make it easier to identify payment adjustments on remittance advices.

### **New version of ABN required beginning January 1, 2012**

While you are currently able to use the 2008 version of the Advanced Beneficiary Notice (ABN), effective January 1, 2012 you will be required to use the 2011 version. According to CMS, the 2008 and 2011 versions are identical except the release date “3/11” is printed in the lower left corner of the new version. ABNs issued on the 2008 version prior to January 1, 2012 are effective for the length of time specified on the notice.

Information and a copy of the 2011 version of the ABN (form CMS-R-131) are available online at <http://www.CMS.gov/BNI> under the “FFS Revised ABN” link.

### **Version 5010 deadline news**

The Centers for Medicare & Medicaid Services (CMS) recently announced a 90-day enforcement discretion period for all HIPAA covered entities regarding the Version 5010 (ASC X12 Version 5010) transition. The compliance deadline for the implementation of Version 5010 is still **January 1, 2012**; however, CMS will not initiate enforcement action until **March 31, 2012**. CMS made this decision based on industry feedback that many organizations and their trading partners were not yet ready to finalize system upgrades for this transition.

CMS encourages you to continue internal testing and external testing of Version 5010 transactions with trading partners to ensure compliance for Version 5010. Although enforcement action will not be taken prior to March 31, 2012, it is important that you continue to move forward to meet Version 5010 requirements as soon as possible.

During the 90-day enforcement discretion period, the Office of E-Health Standards and Services (OEHS) will continue to accept complaints associated with compliance with Version 5010, NCPDP D.0 and NCPDP 3.0 transaction standards beginning January 1, 2012. HIPAA covered

entities that are subject to these complaints must produce evidence of either compliance or an established plan to become compliant within the enforcement discretion period. In addition to testing, if you have not yet created a transition plan for Version 5010, you should do so in order to meet these compliance deadlines.

Please visit the CMS ICD-10 Website [Latest News](#) page for additional resources and more information on this [enforcement discretion period](#). And, visit [the ICD-10 website](#) for the latest news and resources to help you prepare, and to download and share the implementation [widget](#) today.

### **Pulmonary rehab program pricing decreased by CMS**

On November 30, 2011, the Centers for Medicare and Medicaid Services (CMS) published the final rule for the Hospital Outpatient Prospective Payment System (OPPS) in the *Federal Register*. The rule finalized a significant cut to reimbursement for the comprehensive pulmonary rehabilitation program billed under HCPCS code G0424. Physical therapy services provided through this program must be billed under G0424, so the reimbursement cut will affect physical therapists in these settings. APTA submitted comments on the proposed rule on August 30, 2011, addressing concerns that this drastic cut to reimbursement could decrease access to medically necessary services provided by a physical therapist. We explained to CMS that if hospitals are not able to compensate for medically necessary services delivered by the physical therapist under the G0424 comprehensive pulmonary rehabilitation program, these hospitals may choose not to utilize physical therapists. Despite these comments, CMS finalized the proposed reimbursement cut to the comprehensive pulmonary rehabilitation program.

## **Component Advocacy News and Tips**

### **Looking for successes to share**

The New Jersey copayment podcast averaged 63 clicks per day for 5 days in September, nearly double any other item featured on the homepage marquee that month. Thank you to New Jersey chapter leaders for participating in this podcast.

If you have a success story that you think would be helpful for APTA members, please send a suggestion to [advocacy@apta.org](mailto:advocacy@apta.org).

### **Newly formed Utah chapter reimbursement committee addressing copays, PTA payment**

Utah reimbursement chair Aaron Hackett reports the formation of Utah's first reimbursement committee. They already have a variety of issues to tackle. The chapter is considering legislation to list PTs as non-specialty providers so patients do not have to pay specialist copayments. [Aaron](#) asks that you please pass on any examples of model language for this that you have available. He also notes that despite chapter efforts, the Utah Workers' Compensation Commission is likely to lower payment for services delivered by PTAs.

### **Colorado chapter considers equal pay legislation**

As you are aware from the request for content on this issue, the Colorado chapter is considering legislation to mandate equal pay across all settings. If you have any information regarding similar efforts in your component, please share them with [Jeanette Hrubes](#).

## **Vermont chapter gets 97116 reinstated as a covered code for BCBSVT**

Reimbursement chair Julie Adams reports that Blue Cross Blue Shield Vermont (BCBSVT) has recently agreed to cover 97116 (gait training) and denials are being paid retroactively. Julie attributes the success to member and chapter efforts to help BCBS understand the difference between gait analysis (which is not covered) and gait training (which is covered). For more information, contact [Julie](#).

Julie also noted that she has met with Department of Vermont Health Access consultants at Pacific Health Management Group to discuss the potential implications of a provider tax (which would include physical therapists) on physical therapists and its effect on access to physical therapy services.

## **Texas chapter addressing Medicaid cuts**

Reimbursement chair Mary Daulong reports that the Texas Physical Therapy Association has formed an informal coalition with the Texas Occupational Therapy Association to address proposed Medicaid rate reductions. For more information, check out this member e-blast:

### ***2012 Proposed Medicaid Rate Reductions - Contact Your Legislators TODAY***

*The Texas Health & Human Services Commission (HHSC) released proposed Medicaid rate reductions on November 8, 2012 and held a hearing on November 21. HHSC is still considering rate reductions and we need everyone to contact their legislators. [Click here](#) to learn more about the proposal, access the Rate Calculator Spreadsheet, and get involved.*

## **APTA Resources**

### **Medically Necessary Physical Therapy Services resources now available**

A new podcast discusses how and why APTA adopted a position on medically necessary physical therapy services and provides physical therapists with a framework for using the definition to demonstrate and evaluate the value of physical therapy services.

APTA's position is modeled after Model Contractual Language for Medical Necessity, developed by the Center for Health Policy at Stanford University. The key pillars of the concept presented in this model and discussed in detail in the [podcast](#) are authority, purpose, scope, evidence, and value. Additional information is available [here](#).

### **Physician Quality Reporting System resources updated**

Beginning in 2015, physical therapists and other health care providers who do not successfully participate in the Physician Quality Reporting System (PQRS) program will be subject to payment penalties. The Centers for Medicare and Medicaid Services finalized the use of the calendar year 2013 as the reporting period to inform the 2015 payment adjustment. Eligible providers, including physical therapists, who do not satisfactorily report data on quality measures for the reporting period between January 1, 2013, and December 31, 2013, will be subject to a 1.5% reduction in their fee schedule amount in 2015.

APTA created new resources for members to assist them in their participation in the PQRS program. A new [podcast series](#) reviews PQRS basics, including information on [getting started](#), [teaching physical therapists the program](#), and [billing and tracking performance](#). A November 16 [audio conference](#) provided an update to changes to the PQRS program for 2012.

The Medicare PQRS program began in 2007 as a voluntary, incentive-based program for practitioners, such as physical therapists in the private practice setting, as a means to ensure high quality health care services for their beneficiaries. In 2012, and continuing through 2014, providers who successfully participate in the PQRS program will receive a 0.5% bonus payment.

## CMS Resources

### Recently released Medicare Learning Network materials

#### ***Predictive Modeling Analysis of Medicare Claims***

The new MLN Matters® Special Edition Article (#SE1133) [Predictive Modeling Analysis of Medicare Claims](#) is designed to provide education on the predictive modeling system that CMS uses to analyze Medicare FFS claims for potentially fraudulent activity. It includes an overview of the predictive analytics system that CMS implemented on June 30, 2011. This system uses algorithms and models to examine Medicare claims in real time to flag suspicious billing.

#### ***Contractor Entities at a Glance – who will contact you and why***

MLN Matters® Special Edition Article #SE1123, *Contractor Entities at a Glance: Who May Contact You About Specific CMS Activities*, which describes the current Medicare contracting environment and lists the entities responsible for CMS activities, is available at <http://www.CMS.gov/MLNMattersArticles/downloads/SE1123.pdf>. This article also explains why certain entities may contact providers, and announces the availability of a new Medicare Learning Network® publication, *Contractor Entities At A Glance: Who May Contact You About Specific CMS Activities*. This educational tool, which is available in downloadable format at [http://www.CMS.gov/MLNProducts/downloads/ContractorEntityGuide\\_ICN906983.pdf](http://www.CMS.gov/MLNProducts/downloads/ContractorEntityGuide_ICN906983.pdf), includes a chart that outlines each entity by type, definitions, responsibilities, and reasons for contacting providers. This product will be available in hard copy format from the MLN® at a later date.

#### ***Medicare Pilot Project for Electronic Submission of Medical Documentation***

MLN Matters® Special Edition Article #SE1110, *Medicare Pilot Project for Electronic Submission of Medical Documentation (esMD)*, which provides information about Medicare's Electronic Submission of Medical Documentation pilot project, is available at <http://www.CMS.gov/MLNMattersArticles/Downloads/SE1110.pdf>. The esMD project is designed to reduce provider costs and cycle time by minimizing and eventually eliminating paper processing and mailing of medical documentation to review contractors.

#### ***Advance Beneficiary Notice of Non-coverage (ABN) Part A and Part B***

The revised [Advance Beneficiary Notice of Non-coverage \(ABN\) Part A and Part B](#), booklet is now available from the Medicare Learning Network. This booklet is designed to provide education on the ABN. It includes information on when an ABN should be used and how it should be completed.

#### ***Skilled Nursing Facility Prospective Payment System***

The [Skilled Nursing Facility Prospective Payment System](#) fact sheet has been revised. It includes the following information: background and elements of the Skilled Nursing Facility Prospective Payment System.

#### ***Outpatient rehabilitation services documentation fact sheet revised***

The [Outpatient Rehabilitation Services: Complying With Documentation Requirements](#) fact sheet is designed to provide education on Comprehensive Error Rate Testing program errors related to outpatient rehabilitation therapy services. It includes information on the documentation needed to support a claim submitted to Medicare for outpatient rehabilitation therapy services.

### **Medicare Secondary Payer**

The [Medicare Secondary Payer](#) fact sheet is designed to provide education on the Medicare Secondary Payer (MSP) provisions. It includes information on MSP basics, common situations when Medicare may pay first or second, Medicare conditional payments, and the role of the Coordination of Benefits Contractor.

## **APTA Activities / Calendar of Events**

### **APTA audio conferences provide valuable resources**

Register today for the next audio conference in APTA's monthly Payment Policy & Advocacy audio conference series:

- [Accountable Care Organizations: Opportunities and Challenges for Physical Therapists](#) will be presented on December 8, 2011 by Roshunda Drummond-Dye, JD, Heather Smith, PT, MPH and Nancy White, PT, DPT, OCS.
- [Medicare 2012: The Year Ahead for Outpatient Physical Therapy](#) will be presented on December 15, 2011 by Gayle R. Lee, JD and Stephen Levine, PT, DPT, MSHA.
- Additional courses are planned, but not yet open for registration at <http://www.apta.org/thesource/>. Check the website for registration information at a later date.
  - January: Basic essentials for physical therapist coding and compliance.

### **APTA coding seminars**

Save the date for the [2012 Coding & Payment Seminars](#). These seminars will provide you with the latest coding and payment updates. Our expert speakers will answer all your questions about CPT coding, Payment Reform for Outpatient Physical Therapist Services, Medicare trends and compliance, documentation, audits, and appeals. New for 2012 will include a session on Quality Reporting Overview and Keys for Successful Reporting in Physician Quality Reporting Systems. Expert speakers are Helene Fearon, PT, Steve Levine, PT, DPT, MSHA, Gayle Lee, JD, Roshunda Drummond-Dye, JD, and Heather Smith, PT, MPH.

January 20-21	Fort Lauderdale, FL
February 24-25	Baltimore, MD
March 16-17	Kansas City, MO
April 20-21	San Francisco, CA

Remember: Coding seminar registration is complimentary for reimbursement chairs. To register, call Member Services at 800/999-2782 x3395 with your name and the component for which you serve as reimbursement chair.