MEDICARE RULES FOR 2020: IMPLICATIONS FOR THERAPY

December 5, 2019

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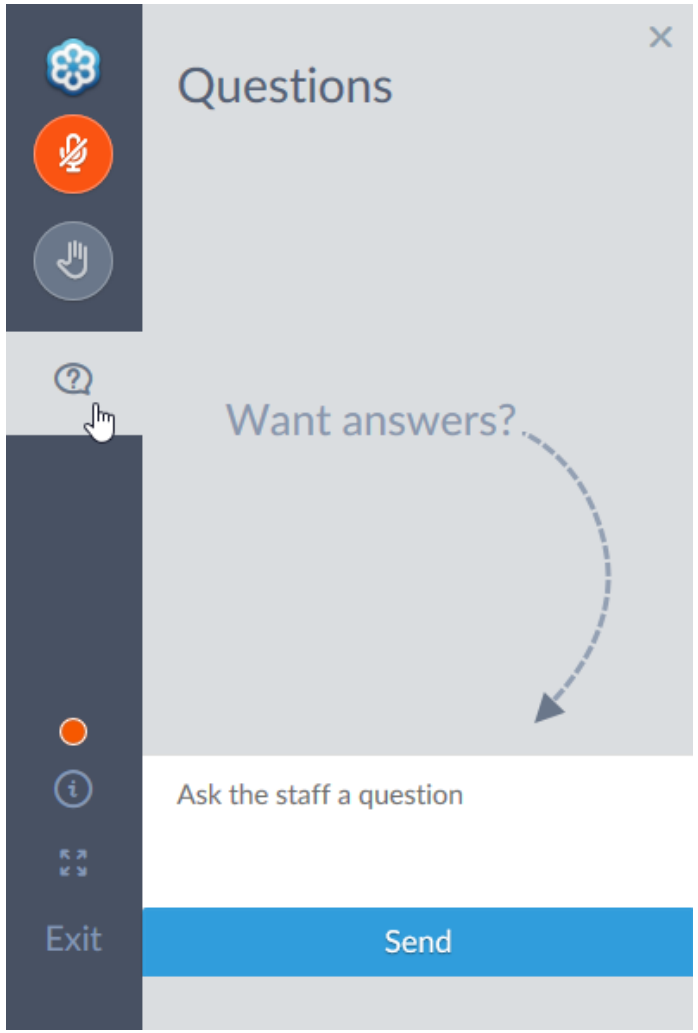

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YOUR HOST

Jerry Henderson, PT

Founder and Vice President of Clinical Strategy
Clinicient, Inc.

Jerry is the founder of Clinicient, and serves as “the voice of the therapist” in all company undertakings. He has deep roots in physical therapy, and brings an immense amount of industry thought leadership to the company’s therapist-facing activities.

Prior to Clinicient, he started three successful private practices and one of the first physical therapy specific EMRs. He has had extensive clinical experience in a variety of settings. He speaks regularly at industry conferences, and is published frequently in professional journals.

jhenderson@clinicient.com

@HendersonPDX

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Audits & Investigations

- External Audit Partner
- Investigations & Audit Representation
- Guidance in OIG Audits
- M & A due Diligence

AGENDA

- 2021 Proposed 8% Reduction
- Assistant Modifiers
- 2020 CPT Code Updates
- Therapy Threshold
- MIPS Changes
- Megatrends
- QA

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2021 PROPOSED 8% REDUCTION

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2021 PROPOSED "8% REDUCTION"

- First appeared: 2019 Final Rule changes to E&M codes
- Budget neutrality: winners/losers
  - ↑ Endocrinology +15%
  - ↑ Hematology/Oncology +12%
  - ↑ Rheumatology +8%
  - ↓ Clinical Psychologist -9%
  - ↓ Ophthalmology -9%
  - ↓ Physical/Occupational Therapy -8%
- Therapy codes -8% is "estimate"
- Implementation: 1/1/2021

Take-aways

Budget Neutrality
"PT-OT" not specific target
In same boat w/ all "losers"
"Winners" will fight
Support APTA & AOTA

Reference: 84 FR 62568: Table 127

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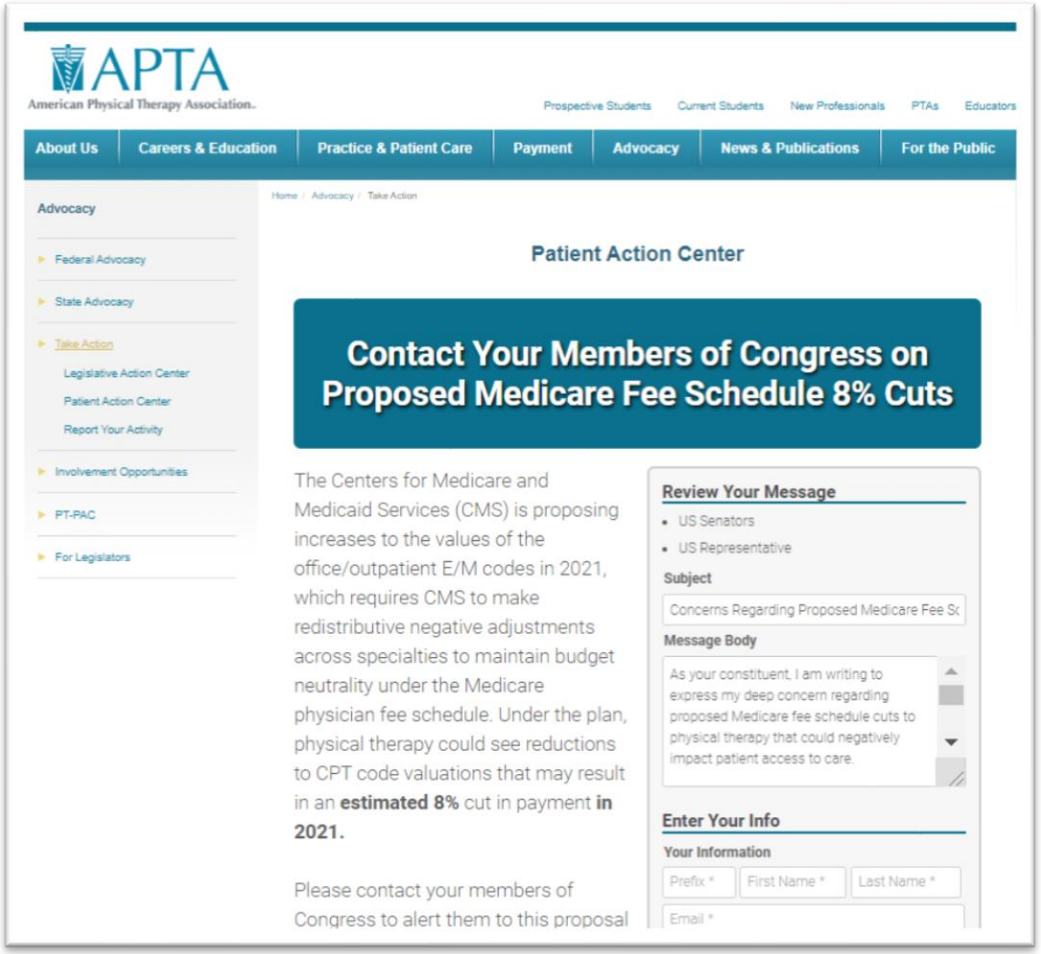
TAKE ACTION ON PROPOSED 8% CUTS

- Contact Members of Congress:
- https://www.govtrack.us/congress/members
- Support APTA efforts



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2020 CPT UPDATES HIGHLIGHTS

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CODE UPDATES: ANNUAL UPDATE TO THERAPY CODE LIST

- Biofeedback
  - 90912 – Initial 15 minutes 1:1
  - 90913 – Each add ’l 15 minutes 1:1
  - “Sometimes therapy” codes
  - Replaces 90911
- Cognition
  - 97129 – Initial 15 minutes
  - 97130 – Each add ’l 15 minutes 1:1
  - “Sometimes therapy” codes
  - G0515 – Deleted 1/1/2020

Take-aways

Update charge master
What is your 2020 coding source?
Review LCD
Cognition: PT? OT? SLP?

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CODE UPDATES: ANNUAL UPDATE TO THERAPY CODE LIST

- Manual muscle testing
  - Deleted for CY 2020:

    95831, 95832, 95833, 95834
- Functional limitation reporting (FLR)
  - Deleted for DOS after 12/31/2019:

    HCPCS G8978-G9158, G9158-G9176, G9186

Take-aways

Update charge master
What is your 2020 coding source?

Claims for 2018 services:
1- year timely filing end 12/31/2019

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CODE UPDATES: DRY NEEDLING

- Dry needling: needle insertion(s)
  - 20560 – without injection(s), 1 or 2 muscle(s)
  - 20561 – without injections(s), 3 or more muscle(s))
  - CMS: “Noncovered” status
- Compliance implications
  - Upcoding
  - Beneficiary Inducement
  - False Claims Act (FCA)
    - Prior to 2020
    - Beginning 2020

Take-aways

Update charge master
What is your 2020 coding source?
Verify practice act
CMS: Voluntary ABN
Verify coverage & payment
Policy: documentation, coding & billing
Understand Compliance Issues

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ASSISTANT RULE

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READING THE FINE PRINT…

§ 410.60 Outpatient physical therapy services: Conditions.

(a) * * *

(4) Effective for dates of service on and after January 1, 2020, for physical therapy services described in paragraphs (a)(3)(i) or (ii) of this section, as applicable—

(i) Claims for services furnished in whole or in part by a physical therapist assistant must include the prescribed modifier; and

(ii) Effective for dates of service on or after January 1, 2022, claims for such services that include the modifier and for which payment is made under sections 1848 or 1834(k) of the Act are paid an amount equal to 85 percent of the amount of payment otherwise

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COUNTING ASSISTANT MINUTES

"We interpreted the references in section 1834(v)(1) and (2) of the Act to outpatient physical therapy "service" and outpatient occupational therapy "service" to mean a specific procedure code that describes a PT or OT service." p 450

"Accordingly, we are revising our final policy in response to comments ***to allow*** the separate reporting, on two different claim lines, of the number of 15-minute units of a code to which the therapy assistant modifiers do not apply, and the number of 15-minute units of a code to which the therapy assistant modifiers do apply." p 466

Apply assistant modifier when assistant performs greater than 10% of a service.

Reporting the assistant modifier on separate claim line items is allowed.

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THE BIG CHANGE

Proposed Rule:

CPT	Assistant Minutes	Total Minutes	Units Allowed	Claim		
	Therapist Minutes			Units	Mod 1	Mod 2
97110	5	49	3	3	GP	CQ
	44					

Final Rule Allowed:

CPT	Assistant Minutes	Total Minutes	Units Allowed	Claim		
	Therapist Minutes			Units	Mod 1	Mod 2
97110	5	49	3	1	GP	CQ
	44			2	GP	--

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"we are finalizing a revised definition of a service to which the de minimis standard is applied to include untimed codes and each 15-minute unit of codes described in 15-minute increments as a service." p 466

The 10% minimum standard also applies to untimed codes

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UNTIMED CODES

CPT	Assistant Minutes	Total Minutes	Units Allowed	Claim		
	Therapist Minutes					
97150	5	35	1	1	GP	CQ
	30					

CPT	Assistant Minutes	Total Minutes	Units Allowed	Claim		
	Therapist Minutes					
97150	5	50	1	1	GP	--
	45					

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COUNTING ASSISTANT MINUTES

"… we are finalizing a policy that only the minutes that the PTA/OTA spends independent of the therapist will count towards the 10 percent *de minimis* standard." p 464

Minutes of service performed concurrently by an assistant and therapist do not count toward the 10% minimum standard for applying the assistant modifier

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COUNTING ASSISTANT MINUTES

"***We intend to provide further detail regarding examples of clinical scenarios to illustrate our final policies*** regarding the applicability of the therapy assistant modifiers through information that we will post on the cms.gov website." p 465

We're still waiting …

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DOCUMENTATION REQUIREMENTS

"we are not finalizing the proposed documentation requirement to explain in the treatment note, in a short phrase or statement, the application or non-application of the therapy assistant modifier for each therapy service furnished; nor are we finalizing a requirement that the therapist and therapy assistant minutes be included in the documentation. ***Instead, we remind therapists and therapy providers that correct billing requires sufficient documentation in the medical record to support the codes and units reported on the claim,*** including those reported with and without an assistant modifier."

p 469

Boilerplate phrases are not required, but line item documentation of assistant v therapist services are required

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PRACTICAL IMPLICATIONS OF THE ASSISTANT MODIFIER

- Documentation and coding requirements
- Phased implementation
  - CMS “Practice” phase
  - Reimbursement
- Fall out
  - PT and OT assistant employment
  - Any chance of being overturned?
- Supervision and delegation
- Fun with math – the 10% “de minimis” standard

“Untimed codes” is misleading

Now, we have to account for the time spent by assistants!

Time reconciliation just became more complicated

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FUN WITH MATH

Method 1

- Divide assistant minutes by total minutes for the service
- Multiply by 100 to calculate the percentage of service done by the assistant
- Round to the nearest whole percentage
- If percentage is >=11%, apply the modifier

Method 2

- Divide the total time for the service by 10
- Add one minute to identify the de minimis standard
- Apply the assistant modifier to any CPT units that exceed the de minimis number of minutes

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THERAPY THRESHOLD

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THERAPY "THRESHOLD"

"By using the KX modifier, the therapist and therapy provider attest that the services above the KX modifier thresholds are reasonable and necessary and that documentation of the medical necessity for the services is in the beneficiary's medical record." p. 472

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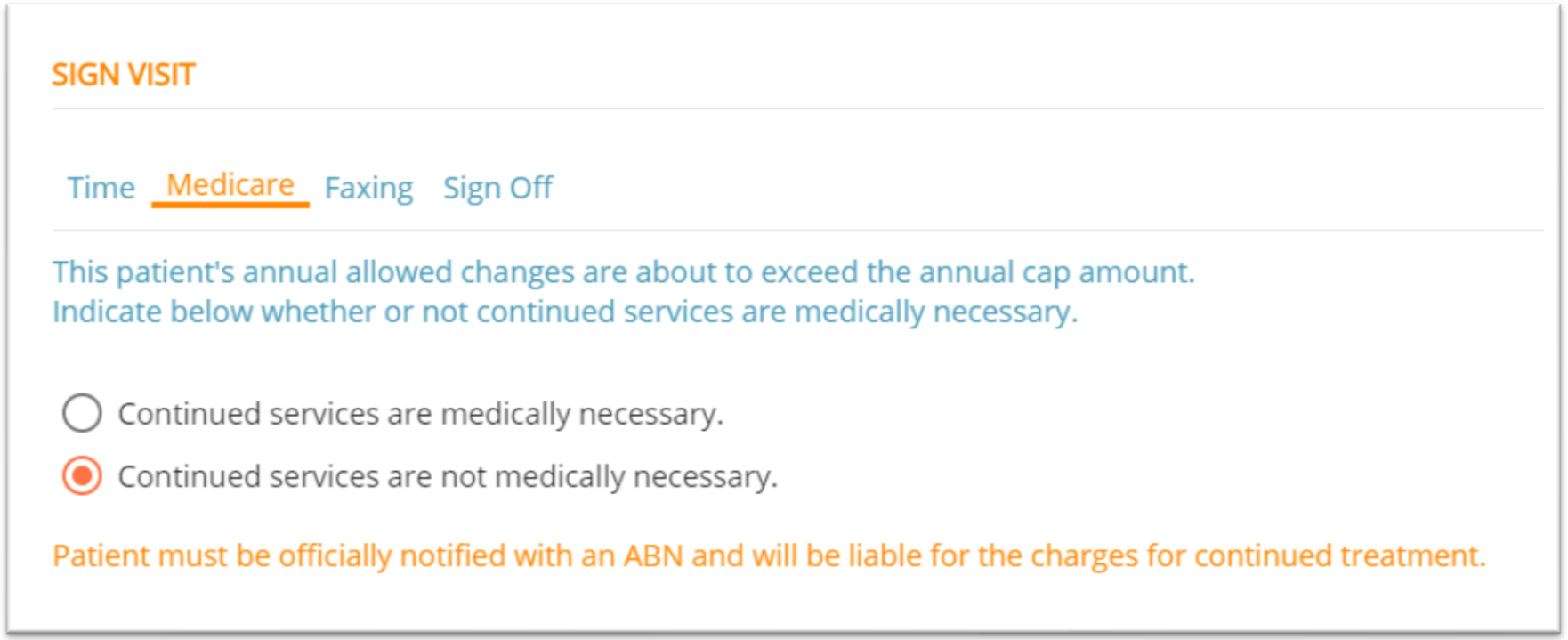
THERAPIST ATTESTATION



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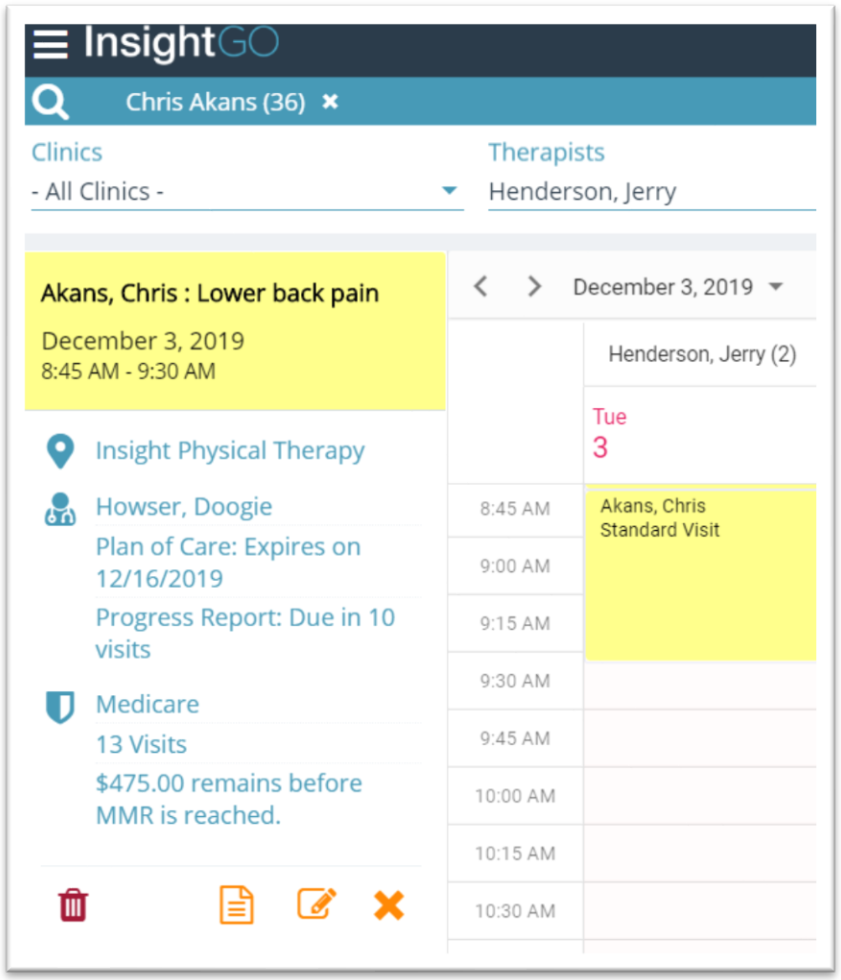
TARGETED MEDICAL REVIEW



"the MR threshold is $3,000 for PT and SLP services and $3,000 for OT services. For purposes of applying the targeted MR process, we use a criteria-based process for selecting providers and suppliers that includes factors such as a high percentage of patients receiving therapy beyond the medical review threshold as compared to peers."

p. 444

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MIPS UPDATES

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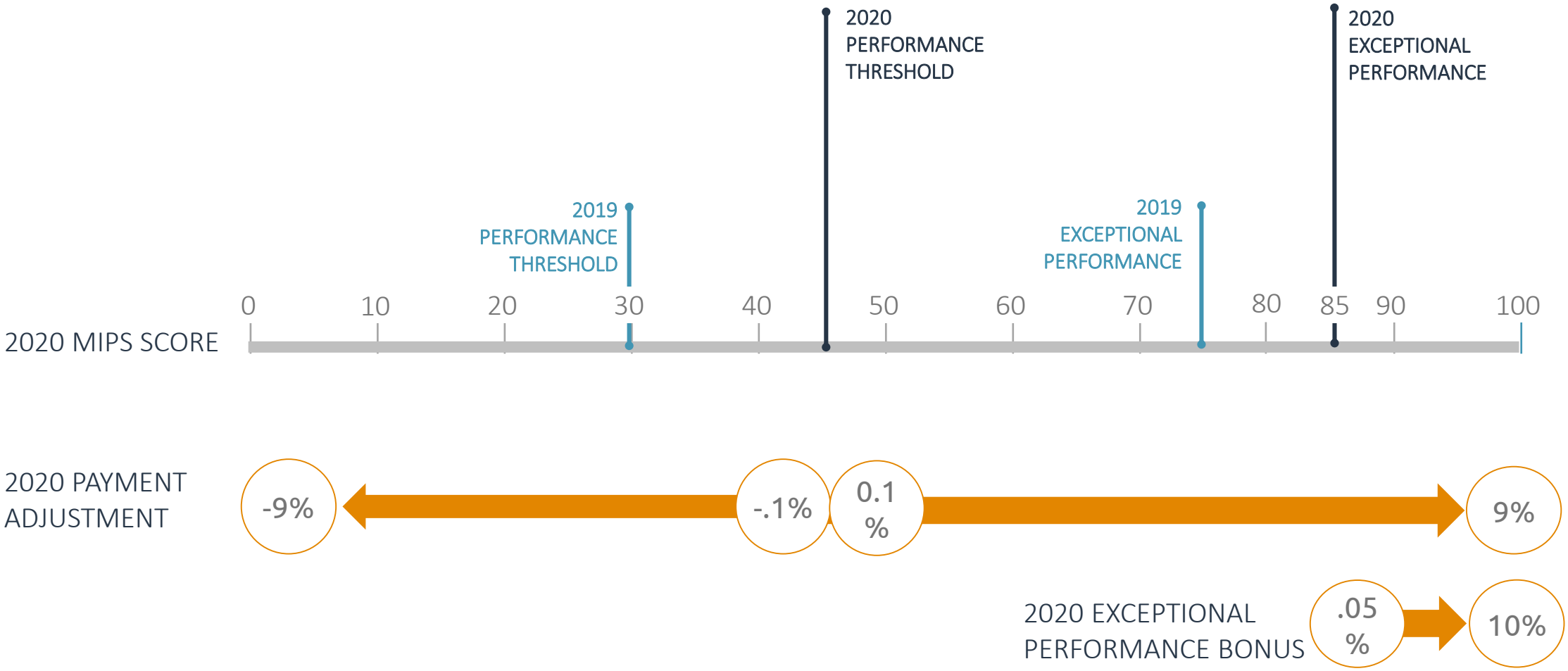
MIPS PARTICIPATION

- 98% of eligible clinicians participated in 2018
- 818,000 clinicians will be MIPS eligible in 2020
- Nearly 360,000 are expected to submit for MIPS via a Registry or QCDR
- Equivalence in negative and positive payment adjustments in 2020- $584M
- Up to $500M additional available in exceptional performance pool

MIPS SCORE AND PAYMENT ADJUSTMENT



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PROPOSED RULE 2020

The Shift to Value Continues

All providers will be required to participate in the QPP by 2022

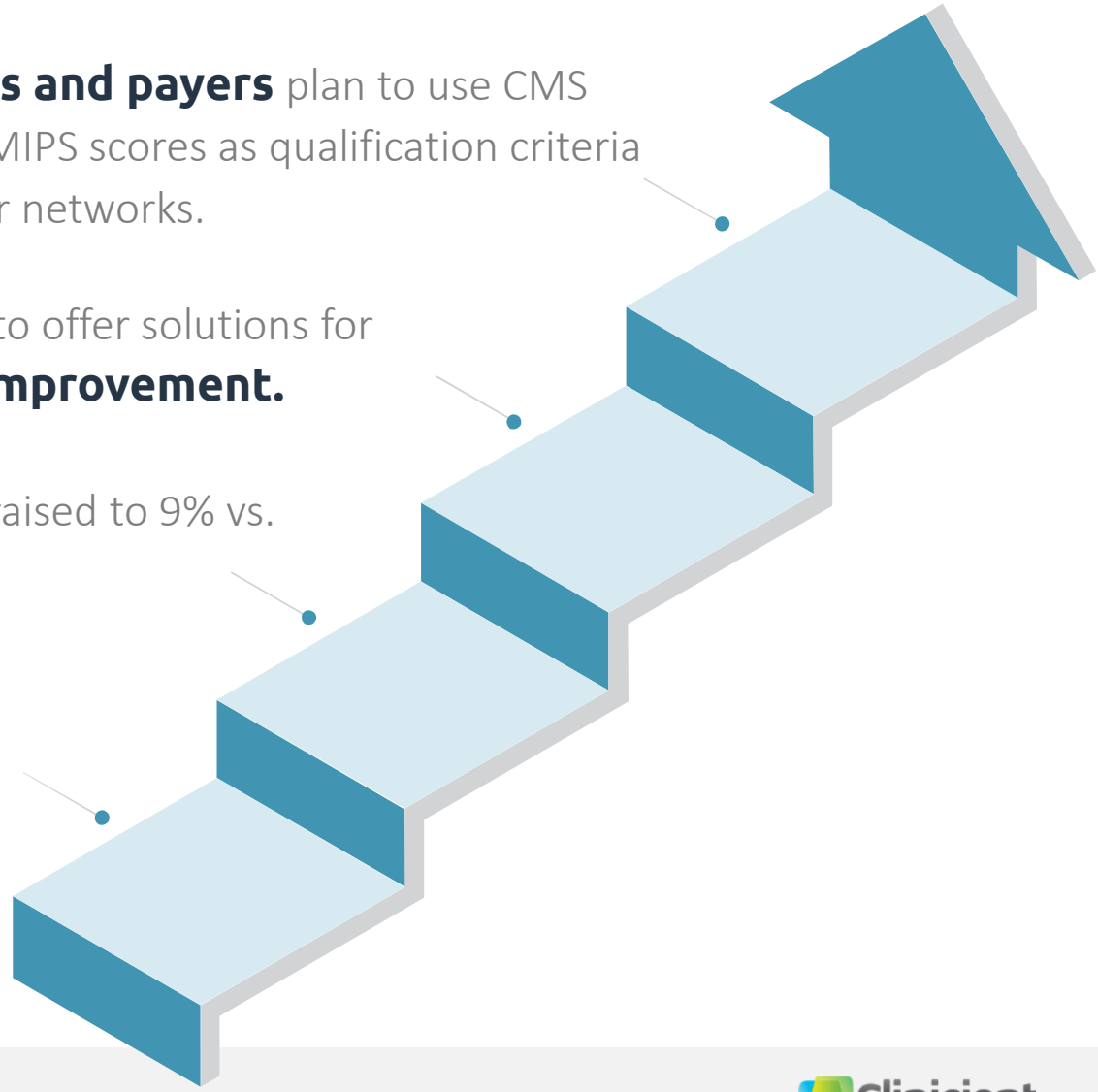
Employers and payers plan to use CMS published MIPS scores as qualification criteria for provider networks.

QCDR's are now tasked to offer solutions for **continuous quality improvement.**

Increased thresholds – Bonus/penalty raised to 9% vs. 7%. Performance threshold to 45 vs. 30.

CMS implementing **MIPS Value Pathway (MVP's)**, with the stated goal of accelerating the transition to APM's.

Patient Reported Outcomes are named as the "gold standard" for MVP's.



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QUALITY REPORTING MECHANISMS FOR MIPS

	CLAIMS BASED	QUALIFIED REGISTRY	QUALIFIED CLINICAL DATA REGISTRY (QCDR)
AVAILABLE QUALITY MEASURES	National Quality Forum (NQF) measures	NQF measures, or previously approved registry measures	NQF measures and approved QCDR measures
GROUP SIZE	Only available for practices with 15 or fewer therapists	No group size limitation	No group size limitation
CLINICAL UTILITY	Low	Varies	High
SUBMISSION	Special procedure codes on claims forms	CMS approved Registry	CMS approved QCDR
RELATIVE VALUE	Lower value	Varies	Generally higher value

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MEGATRENDS

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OPPS/ASC – OUTPATIENT HIP AND KNEE REPLACEMENT

- CY 2020 OPPS/ASC Payment System Final Rule
  - Removed Total Hip Arthroplasty (THA) from the Inpatient Only (IPO) list
  - Added Total Knee Arthroplasty (TKA) to the ASC CPL

Take-away

THA/TKA Hospital OP:
No SNF qualifying stay
Fast track HHA/OP?
TKA ASC:
No SNF qualifying stay
Fast track OP?
Opportunities for strategic collaboration
What are your Outcomes?

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DOWNSTREAM EFFECTS OF PDPM AND PDGM

- Patient-Driven Payment Model (PDPM)
  - Implemented 10/1/2019
  - Replaces RUGs
  - “Minutes” of therapy no longer $ driver
  - Staffing adjustments & reductions
- Patient-Driven Groupings Model (PDGM)
  - Change from 60-day to 30-day episodes
  - Removes therapy visits thresholds
  - Allows PTAs/OTAs to perform maintenance therapy

Take-away

Opportunities?
CMS Resources
APTA/AOTA Resources
PT, OT, SLP in market for employment
Social media – what is your policy?

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PATIENTS OVER PAPERWORK: BURDEN REDUCTION

- Good news for Rehab Agencies & CORFs:
  - Emergency Preparedness (EP) CoP – Reduced requirements (11/20/2019)
- Good news *didn't happen* for therapy requests:
  - POC certification

Take-away

Modify existing EP Policies & Procedures
If no survey since 11/2016: you are target for survey

If AAAASF Accredited: obtain updated Standards

Respond to CMS comments via APTA/AOTA/ASHA model letters

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HOW CLINICIENT HELPS WITH MEDICARE

SINGLE SYSTEM FOR EMR AND BILLING

ANNUAL MEDICARE CODE UPDATES

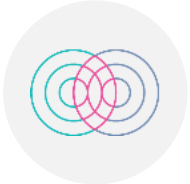
THERAPY-SPECIFIC CHART TEMPLATES

WORKFLOW PROMPTS, ALERTS AND NOTIFICATIONS

GOAL TRACKING

PRE-AUDIT AT VISIT SIGN OFF

WEBINARS AND EDUCATION



MIPS - KEET HEALTH

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POLL QUESTION

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Q&A

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FINAL THOUGHTS

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