**PRACTICE & PAYMENT COMMITTEE NEWS**

**IN Anthem Survey Results**

Our committee had conducted a member survey in December regarding AIM/Anthem. 30 members responded and the summary is as follows**:**

* 72% responded that the first approval was 6 visits
* 58% said that the phone wait times are 5 to 30 minutes and about 25% said over 30 minutes
* Average of 3 visits granted the second time
* portal functionality as a problem reported by a few
* Extended duration for number of visits allowed
* Problem with visits vs units
* Great administrative burden. Only 9% said that their administrative staff was able to complete paperwork without the help of a therapist.
* 69% of respondents were satisfied with the number of visits allowed
* Gaps in care due to limited visits allowance by a few
* Reassessments are required but not enough time in between to assess progress
* Too many submissions for too few visits

If you want details of this survey, please [email me](mailto:info@inapta.org) and I will be happy to send you the survey results.

These problems were reported to Anthem and AIM, not only by IN, but other states as well.

**Planned Program Improvements/Updates for AIM**

* Updated women’s health pathway
* Tweaked post op pathway
* Enhancements for peds, developmental delay, complex neuro, comorbidities, complex conditions. AIM made changes to the algorithm to allow higher visit allocation or more time to treat.
* AIM has reported that they are allowing more visits with Initial approval: 7 visits; 2nd approval in 5 visit range, 3rd approval 4-5 visit range but is dependent on review by their PT. Approval % is very high for 1st and 2nd request- intentional to facilitate up front care
* Effective November 1, 2019 in the states of Indiana, Kentucky, Missouri, Ohio and Wisconsin, prior authorization is not required for PT, OT, or ST outpatient therapy services when receiving skilled treatment for Autism Spectrum Disorder or Pervasive Developmental Delays for members with Anthem commercial plans. You may file your claims without a prior authorization number if you are billing with one of the following ICD-10 codes: F84.0, F84.2, F84.3, F84.5, F84.8, or F84.9. Please note that benefit limits, if applicable, will still be applied

**AIM Rollout for Anthem Medicare Advantage Plans**

* IN will go live w/rollout scheduled for 4/1/20. Web portal will go live for prior auth on 3/19 for dates of service 4/1 forward
* Prospective auth for all patients including those continuing treatment after 4/1
* Will do education and training in Feb/March. Once enrollment in a session reaches 100, a 2nd session is opened. Recommend providers attend training.
* AIM provider portal has FAQ, program criteria/guidelines and training dates. Go to: <https://aimproviders.com/rehabilitation/>.
* Use of eval code taken into account in decision making process. Need to use high level complexity code if complex; will also calculate a functional tool score.
* AIM authorizes PT at the grouper level - not on individual codes - providers can use whatever code combo they deem appropriate unless the service/code is not covered under the plan. However, for Medicare clients NCDs and LCDs trump even clinical guidelines - need to know LCD rules for your market; some have unique requirements. Example: E. stim for wound care. Those codes will be listed. NCD is National Coverage Determination and LCD is Local Coverage Determination.
* As AIM is using eval code tier as one of the parameters for decision making in the MA program, please use the appropriate eval code. Resources are found here: <http://www.apta.org/EvalCodes/>
* Training sessions can be found here: <https://aimproviders.com/rehabilitation/webinar/>

**Important Links**

Link to the current AIM Provider Portal – FAQs: <https://aimproviders.com/rehabilitation/getting-the-answers-you-need/frequently-asked-questions/>

APTA and various Chapter Payment Chairs have virtual meetings with AIM/Anthem at the beginning of each month. If you are still experiencing problems, please let me know so that I can report it and hopefully get an answer for you. If I don’t hear from you, I assume everything is going fine.

**Advocacy Tools**

* <http://www.apta.org/Payment/Medicare/Advantage/ProblemResolution/>  (APTA webpage w/ MA advocacy tools)
* <https://www.medicare.gov/MedicareComplaintForm/home.aspx> (Link that providers can give to patients if they encounter issues)

**Pain Management Policy**

The Pain Management Best Practices Inter-Agency Task Force, a federal advisory committee established by the Comprehensive Addiction and Recovery Act of 2016, released its final report in May 2019 on acute and chronic pain management best practices, calling for a balanced, individualized, patient-centered approach.

To ensure best practices for the treatment of pain, the Task Force final report underscores the need to address stigma, risk assessment, access to care and education. It also highlights five broad categories for pain treatment: medications, interventional procedures, restorative therapies, behavioral health, and complementary and integrative health approaches.

Here is a link to that report: <https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf>

**Update on IN Licensure Board**

Currently, the Governor's office has not made a move on changing any of the individuals on the Board or appointing the PTA Member. The Governor's office has been in communication with Steve Beebe, our Chapter Lobbyist, to ask about a PTA whom the Chapter recommended, but no progress in that yet.

The Board is working on the Rules to accompany the Statute. Currently the language for the Rules is with the AG who is assigned to the Board.

**Medicare Update**

Medicare Administrative Contractors for CMS have been notified of the agency's decision to [reverse coding methodology decisions](http://www.apta.org/PTinMotion/News/2020/01/24/NCCIDecision/) that prevented PTs from billing an evaluation and therapeutic activities or group therapy activity delivered on the same day, and to apply that decision to claims made back to the beginning of the year. Providers may check with their MAC about claim adjustments, appeal claims denied due to the [Procedure-to-Procedure, or PTP] edits to the appropriate MAC, or resubmit claims due to the PTP edits after implementation of the replacement edit file with January 1, 2020, retroactive date, as permitted by the MAC.

**Coding Updates**

**Some of the changes are as follows:**

**Dry Needling Codes**

20560: Needle insertion without injection 1 or 2 muscles

20561: Needle insertion without injection 3 or more muscles

These codes are non-covered services per CMS so you can bill the Medicare patient directly after providing them with an ABN, using the code on the claim as well as GX modifier. For commercial insurance patients, please check with their insurance company.

**Biofeedback Codes**

90911: This code has been deleted and replaced with 90912 and 90913. 90912 for initial 15 minutes and 90913 for each additional 15 minutes.

90912: BFB training; perineal muscles, anorectal and urethral sphincter, including EMG and/or manometry when performed initial 15 minutes of one on one contact.

90913: Same definition but each additional 15 minutes.

This code is deemed sometime therapy code which means that it can be provided by other providers outside the therapy plan of care. However, when provided by a PT it should be appended by GP modifier.

This is not an all-inclusive list of update and changes.

Please feel free to contact our committee by email [info@inapta.org](mailto:info@inapta.org).

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APTA Indiana Practice and Payment Committee Chair