APTA Indiana | Practice & Payment News

APTA Indiana November 2021 Practice and Payment Newsletter

As a benefit of APTA Indiana membership, the Practice and Payment Specialist and Committee serve as a resource for assisting with practice and payment issues and updates. This includes disseminating updates, educating members, answering questions, and hearing from membership about practice and payment concerns. Please reach out to Andrea Lausch, PT, DPT, APTA Indiana Practice & Payment Specialist, at **andrealausch@inapta.org**, with questions or to inform the Committee of payor concerns.

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CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

CY 2022 Part B Medicare Physician Fee Schedule Payment Policy Final Rule

Highlights of the Final Rule:

- **Conversion Factor/Code Valuation**
  - Some physical therapy code values did increase in 2022, including evaluation codes. However, it is estimated, PT reimbursement will likely be reduced by 3.5%, on average, for CY 2022 compared to CY 2021, due to the cut to the conversion factor (CF) by 3.75% to $33.59 in 2022 from $34.89 in 2021.
- **PTA Supervision**
  - CMS did NOT adopt proposed changes for private practice PTs to perform direct supervision to PTAs via real-time audio-visual technology. The flexibility to supervise in this form will expire at the end of the year, in which the public health emergency ends.
- **PTA/OTA Differential**
  - CMS clarified that:
    - The de minimis rule is applied to each 15-minute unit of service, rather than to all the units of a service.
    - A timed service may be billed without the CQ/CO modifier in cases where the PT/OT provides more than the midpoint of a 15-minute code (8 or more minutes) regardless of whether a PTA/OTA participates in the care of the patient.
    - When a PT/OT and PTA/OTA each provide services to a patient between 9 and 14 minutes, independent of one another, with a total time between 23 and 28 minutes, one unit may be billed with the CQ/CO modifier and the other unit without it.

        - The 15% differential will apply to the 80% paid by Medicare. It does not include the 20% the patient is responsible to pay. This reduces the PTA cut to closer to 12%.
- **Remote Therapeutic Monitoring (RTM**)
    - CMS added that PTs and PTAs may bill for RTM codes.
    - The services are designated as "sometimes therapy" codes meaning the codes count toward the annual therapy threshold, but MPPR will not apply. They will require a GP modifier on the claim form.
- **Telehealth**
    - PTs will continue to be able to bill for services delivered via telehealth through the duration of the public health emergency (PHE).
    - CMS did finalize their proposal to retain all services added to the Medicare telehealth services listed on Category 3 basis until the end of the CY 2023. This only permits PTs who bill incidents-to a physician to deliver services via telehealth.
- **Therapy Threshold**
    - The combined PT and SLP threshold for 2022 was increased to $2,150.
- **MIPS**
    - MIPS value pathways are postponed until the 2023 performance year.
    - MIPS 2022 performance threshold is 75 points to avoid a negative payment adjustment in 2024. An increase from 60 points
    - MIPS exception performance threshold is 89 points.
    - MIPS categories will be reweighted.
    - Removed Quality Measure #154: Falls: Risk Assessment from the PT/OT Specialty Set.
    - Small changes in Class 1, 2, and 3 Quality Measures and Scoring Minimums for each measure.
    - Added Class 5 Measures: measures in their first two performance periods in the MIPS program that meet data completeness requirements, but lack a benchmark or do not meet case minimum.

Additional Resources:

- **APTA: Final 2022 Fee Schedule: Cuts, PTA Differential Remain-Focus Turns to Congress**
- **2021 Medicare Physician Fee Schedule Final Rule**

2022 Home Health Prospective Payment System (PPS) Final Rule

Highlights of the Final 2022 Home Health Rule:

- Proposed payments increase to 2.6% for home health agencies (HHAs) that have submitted required quality performance data. Agencies that do not submit the complete package of quality data can expect a 0.6% increase.
- No corrective action on 2020 reduced utilization yet increased payments of more than CMS predicted. CMS reports corrective actions may be needed in 2023 if PDGM does not stabilize next year.
- Home health value-based purchasing model will expand to all states but implementation delayed 1 year to 2023.
    - CMS says during 2022, it will provide technical assistance to HHAs to ensure they understand how performance will be assessed.
    - The system will adjust final payment based on performance across a set of eight measures. For a complete list of these performances see the **Proposed Rule**.
- PDGM case-mix weights, functional levels, and comorbidity adjustment groups are being recalibrated (but won't result in additional spending).
    - Will maintain the 2021 Low Utilization Payment Adjustment through 2022.
- OTs permitted to perform initial assessments.
- More virtual supervision for home health aides.
- Home health quality-reporting changes:
    - Removal of drug education measure.
    - Added two measures related to transfer of health information.
    - Added six categories of patient assessments.
    - Replaced to measures related to hospitalization.

Additional Resources:

- **2022 Home Health Final Rule**
- **CMS Fact Sheet**
- **https://www.apta.org/article/2021/11/05/final-home-health-rule**
- DMEPOS, SNF, IRF (and others) - **https://www.apta.org/article/2021/08/10/final-snf-irf-rules**

COVID Vaccination Rule

Highlights of the CMS Coronavirus Vaccination Rule:

- CMS requires vaccination for staff associated with any facility regulated by Medicare conditions of participation or conditions of coverage.
    - Applies to all current and future staff including clinical and nonclinical staff, students, trainees, and volunteers and anyone who provides services under contracts or other arrangements with the facility.
        - Among the facility types covered by the rule are hospitals, ambulatory surgery centers, dialysis facilities, home health agencies, long-term care facilities and clinics, rehabilitation agencies, and public health agencies as providers of outpatient physical therapy and speech-language pathology services.
    - Does not include outpatient private practices that are not subject to Conditions of Participation (an easy way to figure this out is if you are required to perform direct supervision of PTAs, then you are not subject to the Conditions of Participation)
    - There is an exclusion for individuals who provide services 100% remotely.
- First shots need to be received by 12/5/21, and the second before 1/4/22.
- There are limited exemptions.
- For noncompliance providers and suppliers may be subject to enforcement remedies that depend on the level of noncompliance including civil monetary penalties, denial of payment for new admissions, or termination from the Medicare and Medicaid program as a final measure.
- If you aren't subject to this mandate, you may still be required to comply with state or local requirements. In addition, you may be subject to the recent rule released by the **Occupational Safety and Health Administration**.

Additional Resources:

- **OSHA Website**
- **CMS Interim Final Rule**
- **FAQs**
- **CMS Press Release**
- **APTA Practice Advisory**

WPS GOVERNMENT HEALTH ADMINISTRATORS (GHA)

Medicare Participation for Calendar Year 2022

Medicare Participation for Calendar Year 2022 is now available to providers who wish to change their participation status. This must be done by January 31, 2022. No action needed to maintain your current status.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

Public Health Emergency Extension

Secretary of Health and Human Services, Xavier Becerra, renewed the Public Health Emergency (PHE) due to COVID-19, effective October 18, 2021. The new expiration date of the PHE is the end of the day on January 16, 2022.

CIGNA

Cigna Updated Their Preventative Care Services to Include:

Fall Prevention for Community Dwelling Adults Age 65 Years and Older With Risk Factors

The following codes represent services that are NOT for treatment of illness or injury and should be submitted with a designated wellness or maternity diagnosis code in the primary position on the claim form. Select a Designated

Wellness Code from pertinent Code Group. Some services may require precertification or other reasonable medical management technique or practice depending on benefit plan design.

Use the following diagnosis codes only in combination with CPT codes: 97110, 97112, 97113, 97116, 97150, 97161, 97162, 97163, 97164, 97530, G0159, S8990, S9131

ICD-10-CM Diagnosis Codes:

- M62.81: Muscle Weakness (generalized)
- R26.81: Unsteadiness on Feet
- R54: Age-Related Physical Debility
- Z91.81: History of Falling

UNITED HEALTHCARE COMMUNITY PLAN (INDIANA)

Coverage Determination Guideline Updates: (Scroll to **Outpatient Therapy Services**)
Changes Effective December 1, 2021

- Title Change
- Removed notation language pertaining to code benefit applicability.
- Revised Description For: HCPCS code G0281, Revenue codes 0430, 0431, 0432, 0433, 0434, 0439, 0420, 0429, 0440, 0441, 0442, 0443,0444, 0449, 0943, 0948, and 0979, and removed list of ICD-10 diagnosis codes for the Habilitative Services Benefit Only.

APTA PATIENT ACTION CENTER

Please take a few minutes to write to your members of Congress regarding:

- The Medicare 2022 Fee Schedule Cuts,
- Support for Making Telehealth Permanent for PTs and PTAs (H.R. 2168/S. 3193),
- To Delay Implementation of PTA Differential to 2023, Provide Exemption to the Differential for Rural and Underserved Areas, and to Allow General Supervision of PTAs in Outpatient Settings Under Medicare (H.R. 5536).

Click **HERE** to be directed to letters focused on the patient impact of these federal issues and bills.