APTA Indiana August 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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THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

CY 2022 Part B Medicare Physician Fee Schedule (PFS) Payment Policy Proposed Rule

- The conversion factor (CF) is proposed to drop 3.75% to $33.58 in 2022. In 2021 the CF is $34.89, In 2020 the CF was $36.09. CMS is required by Congress to maintain a budgetary balance, so payment reductions for therapies and other procedural providers are subject to decreases resulting from the increases in payment for Evaluation & Management (E/M) Services in 2021 that were offset by funds directed to CMS by Congress in 2021.
    - Some CPT codes commonly used in physical therapy, such as evaluation codes, are proposed to increase for FY 2022. However, APTA shares that payment, on average, will likely be reduced by 3.5% for CY 2022, compared to CY 2021.
    - How you may help fight the Medicare cuts:
        - Send your comments to CMS. Click **HERE** for APTA templates.
        - On Sept. 1: Join APTA staff, association leaders, and fellow PTs, PTAs, and students in a one-day **#FightTheCut Virtual Rally**.
        - Be on the lookout for congressional advocacy opportunities.
        - Please share advocacy opportunities with colleagues, patients, friends, family, etc., and encourage them to send comments on their own.

PTA Supervision
Proposed changes for private practice PTs to supervise PTAs via real-time audio-visual technology. During the PHE, PTAs are permitted to be supervised through "virtual presence." CMS is proposing to make this permanent.

- APTA continues to advocate for general supervision via telecommunication across all settings.

PTA/OTA Differential
CMS is proposing to move forward in 2022 with the PTA/OTA differential. They are proposing to revise the *de minimis* standard established to determine whether services are provided "in whole or in part" by PTAs or OTAs. Specifically, CMS is proposing to revise the *de minimis* policy to allow a timed service to be billed without the CQ/CO modifier in cases when a PTA/OTA participates in providing care to a patient with a PT or OT, but the PT/OT meets the Medicare billing requirements for the timed service without the minutes furnished by the PTA/OTA by providing more than the 15-minute midpoint (also known as the 8-minute rule).

In addition to cases where one remaining unit of a multi-unit therapy service is to be billed, this revision to the policy would apply in a limited number of cases where more than one unit of therapy, with a total time of 24-28 minutes is being furnished. For these limited cases, CMS is proposing to allow one 15-minute unit to be billed with the CQ/CO assistant modifier and one 15-minute unit to be billed without the CQ/CO modifier, in billing scenarios where there are two 15-minute units left to bill when the PT/OT and the PTA/OTA each provide between 9 and 14 minutes of the same service. See the **CMS Fact Sheet** or the **Proposed 2022 PFS** for more information.

- APTA is asking CMS, who is bound by legislation, to implement the PTA Differential, to:
    - Delay implementation to Jan. 1, 2023, to give providers time to recover from the pandemic and CMS time to provide education and technical assistance to providers;
    - Reduce the current burdensome direct supervision requirements of PTAs in private practice settings;
    - Provide an exemption to the 15% payment differential for rural and underserved areas.
- Please help advocate for these changes. APTA has provided a **template** to be used to advocate toward these efforts.

Telehealth
PTs will continue to be able to bill for services delivered through telehealth for as long as the public health emergency is in place. Once the emergency has ended, however, they will no longer be considered eligible providers of telehealth. As for the list of telehealth services commonly used for physical therapy services, CMS proposes to allow codes to continue to be authorized through 2023, given the unpredictability of when the health emergency will end, but PTs won't be able to use them after current waivers are lifted.

- APTA continues to advocate that CMS add the list of covered telehealth services PT often uses to the Medicare telehealth list, to ensure a seamless transition when additional practitioners, such as PTs, become eligible to furnish and bill for telehealth services under Medicare.
- To Congress, APTA advocates for permanent adoption of its temporary waiver of restrictions on payment for telehealth delivered by PTs and PTAs, OTs and OTAs, SLPs, and audiologists. The Expanded Telehealth Access Act (H.R. 2168), now in the U.S. House of Representatives, would instruct CMS to do this. Please write to your members of Congress and urge them to support this bill. Templates may be accessed **HERE**. For more information from APTA, please click **HERE**.

MIPS Proposed Changes

- MIPS Value Pathways are postponed. CMS still wants to transition from its Merit-based Incentive Payment System to what it calls a MIPS Value Pathways System, but CMS is putting that move on hold until the 2023 performance year.
- MIPS thresholds to increase - Beginning with the 2024 MIPS payment year, a clinic's performance threshold must be either the mean or median of the final scores for all MIPS-eligible clinicians for a prior period. CMS would establish the performance threshold using the mean and the 2017 performance period, which was reflected in 2019 MIPS payment, resulting in a performance threshold of 75 points and an exceptional threshold of 89 points.
- MIPS categories will be re-weighted so that cost and quality each account for 30% of a score, while improvement activities and promoting interoperability will remain at 15% and 25%, respectively. Currently, PTs are only eligible for the quality and improvement categories.
- New MIPS Quality Measures - CMS also stated its intent to update the MIPS quality measure inventory for a total of 195 proposed measures, and to establish five new cost measures and seven new improvement activities for the 2022 performance period.

ADDITIONAL RESOURCES

- **CMS Fact Sheet**
- **Medicare Program - CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies: Medicare Shared Savings Program Requirements; Provider Enrollment**

Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements
(proposed rule)
Effective Date: Jan. 1, 2022
Comment Deadline: Sept. 13, 2021

CMS To Restart the Targeted Probe and Educate (TPE) Program
CMS has announced via a **MLN Connects article**, that the agency is restarting the TPE Program, which is a process that a Medicare Administrative Contractor (MAC) can utilize when providers are selected by Medical Review. The TPE review process may include up to three rounds of a prepayment or post-payment probe review with education. If there are continued high denials after the first three rounds of reviews, the MAC will refer the provider and results to CMS and CMS will determine additional action, which may include additional rounds of review, 100 percent prepayment review, extrapolation, referral to the Recovery Auditor (RA), or referral for revocation.

Should you receive an audit from your MAC, CMS encourages you to take advantage of the TPE education, and get up to 3 rounds of educational claim review to help you bill accurately.

Click **HERE** for additional information.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Renewal of Determination That A Public Health Emergency Exists

National PHE Extension
On July 19, 2021, Xavier Becerra, Secretary of Health and Human Services renewed the **COVID-19 National PHE** declaration, effective July 20, 2021. It will last for 90 days (October 18, 2021).

TELEHEALTH

Please see the following updated link for commercial temporary and/or permanent payer policy revisions on telehealth: **Commercial Payers.** Indiana Medicaid: See Bulletins **BT202142** and **IHCP Telemedicine and Telehealth Services Policy**.

Reminder, PTs are eligible to bill Medicare for certain services provided via telehealth for the duration of the public health emergency.

SCHOOL BASED PHYSICAL THERAPY UPDATES

School Psychologist Referrals
Indiana House Enrolled Act No. 1405, a recent revision of both the PT and School Psychology practice acts, now allowing (effective 7/1/2021):

- A licensed school psychologist, employed by a school corporation, to refer a student for mandated school PT services (ie, school services required per the Individuals with Disabilities Education Act/IDEA and/or Section 504 of the Rehabilitation Act of 1973) provided by a school's licensed PT.
- A licensed PT, employed by a school corporation, to provide mandated school services, upon the referral of a licensed school psychologist.

Please refer to **Indiana's School Psychology practice act, see 6(c) and Indiana's Physical Therapy practice act, see sections 2 (b) and (e).**

Medicaid Billing Tool Kit
The Medicaid Medical Billing of Health-related Individualized Education Program Services Provided by Indiana Public School Corporations Tool Kit was updated July 2021 to reflect changes in new legislation. Click **HERE** for this information.

CIGNA

Ayres Sensory Integration Coverage for Diagnosis of Autism Spectrum Disorder
Effective July 15, 2021, Cigna will now cover Ayres Sensory Integration for a diagnosis of Autism Spectrum Disorder. The criteria that must be met is detailed in their new policy. Click **HERE** to access the policy.

UNITED HEALTHCARE (UHC)

UHC Exchange Modifier 96 and 97 Requirements
Effective for professional and facility claims, with dates of service on or after 09/01/2021, a new reimbursement policy is being created for the use of Modifiers 96 and 97. The modifiers will be utilized to support the differentiation between Habilitative and Rehabilitative Services.

Providers should bill with the appropriate CPT/HCPC Code(s) and append Modifier 96 to indicate that the service is Habilitative or append Modifier 97 to indicate that the service is Rehabilitative. Claim lines for CPT/HCPCS codes that require the use of modifiers 96 or 97 that are billed without the modifiers will be rejected as incorrect coding. Please click **HERE** to review the policy.