APTA Indiana November 2022 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 and 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)

2023 Finalized Medicare Part B Physician Fee Schedule Summary

- The conversion factor is set to approximately $33.06, a 4.46% cut from 2022.
- Therapy Threshold will increase $2,230. Use a KX modifier when Medicare beneficiaries PT/SLP services are greater than this amount.
- Targeted medical review threshold will remain at $3,000. This does not guarantee a review but increases its likelihood. It is set to remain unchanged through 2028.
- The fee schedule clarifies Remote Therapeutic Monitoring supervision for rehab agencies, comprehensive outpatient rehab facilities, and other institutional providers to general supervision.
- Telehealth: CMS will reimburse for therapy services for 151 days after the end of the public health emergency (PHE) due to COVID-19. Currently the PHE is set to end 1/11/23. As it stands currently, reimbursement for outpatient therapy services delivered via telehealth will end 6/11/23.
- CMS will continue to permit direct supervision of a PTA in a private practice setting through virtual presence by a PT through the end of the calendar year after the PHE ends. As it stands now, this flexibility will end at the end of

the calendar year 2023. At that point, unless there is a change in status, PTA supervision will revert to direct supervision in which the PT must be in the office when a PTA is treating a Medicare beneficiary.

- MIPS
  - No change in the reporting completeness threshold of 70% for 2023.
  - PTs are subject to a reweighted system that includes quality and improvement categories only.
    - For practices with more than 15 MIPS-eligible clinicians, the quality component accounts for 85% of the score; Improvement category makes up the remaining 15%.
    - For small practices of fewer than 15 eligible-clinicians, the distribution is a 50-50 split.
  - Thresholds and payment adjustments for Final Score Points are set at:
    - 0.0-18.75: Negative 9%
    - 18.76-74.99: Negative adjustment on a linear sliding scale between 0-9%
    - 75.0: 0% adjustment
    - 75.1-100: Positive adjustment on a linear sliding scale between 0 - 9%
    - The sliding scale is multiplied by a factor > 0 but not exceeding 3
    - Starting in 2023 MIPS Performance Period, there will no longer be additional payment adjustments for exceptional performance.
  - Improvement Activity Changes: CMS removed six measures and added four measures related to social determinants of health. For a listing of the improvement measure changes, **see Appendix 2 in the final rule (Page 2885)**.
  - Quality Measures Changes: Three new measures were added to the specialty set for PT and OT that address urinary incontinence (048), rheumatoid arthritis functional status assessment (178), and screening for social drivers of health (487). For more information, **see Table B.34 in the final rule (Page 2703)**.
  - Transparency in the Development of MIPS Value Pathways (MVPs)
    - CMS will post draft versions of proposed MVPs that are ready for feedback from the public on the Quality Payment Program website for 30 days.

Resources

- **https://www.apta.org/article/2022/11/03/2023-pfs-article-1**
- **https://www.apta.org/article/2022/11/07/2023-pfs-part-2**
- **https://www.apta.org/article/2022/11/08/2023-pfs-part-3**
- **2023 Medicare Part B Physician Fee Schedule**
- CMS **Fact Sheet** on the CY 2023 Physician Fee Schedule Final Rule CMS
- Fact Sheet on Final Changes to the **CY 2023 Quality Payment Program**

TAKE ACTION!! Change Won't Happen Without Your Help!!

Contact Your Legislators to Ensure Medicare Legislation is Passed by the End of the Year

- Ask your member of Congress to support the Supporting Medicare Provider Act (H.R. 8800), SMART Act (H.R. 5536), and the Expanded Telehealth Access Act of 2021 (H.R. 2168/S. 3193) in any year-end legislative package to respectively:
  - Provide funds to the 2023 fee schedule to offset the 4.5% cut to the conversion factor.
  - Bring supervision requirements for PTAs under Medicare Part B in private practice in line with state licensure laws and preserve access to rural and underserved areas by providing temporary exemption to the 15% payment differential for services by a PTA.
  - Names PTs and PTAs as permanent providers who may deliver and bill for services provided via telehealth.
- Here is the **LINK** to templates of letters addressing these bills and many others for your members of Congress.
- APTA-Supported Bills in the 117th Congress:
  - **Telehealth Beyond COVID-19 (H.R. 4040)**: *Would Extend Current Telehealth Waiver for PTs and PTAs Until December 31, 2024.*
    - Status: PASSED the House. Awaiting vote in the Senate.
  - **Improving Seniors' Timely Access to Care Act (H.R. 3173/S. 3018):** *Addresses Prior Auth Under MA Plans*
    - Status: PASSED the House of Representatives. Awaiting vote in the Senate.
  - **Allied Health Workforce Diversity Act (H.R. 3320/S. 1679)** *Creates New Scholarship Program for PTs/PTAs*
    - Status: H.R. 3320 PASSED out of House Energy & Commerce Cmte; awaiting vote by the full House.
    - S. 1679 PASSED out of Senate HELP Cmte (included in the Prevent Pandemics Act) and is awaiting vote by the full Senate.
  - **The Improving Social Determinants of Health Act of 2021 (H.R. 379/S.104)**

        - Status: PASSED out of Senate HELP Cmte (included in the Prevent Pandemics Act). Awaiting vote by the full Senate.
    - **Lymphedema Treatment Act (H.R. 3630/S.1315)**
        - Status: PASSED out of House Energy & Commerce Committee; awaiting vote by the full House of Representatives this fall.
    - **FY 2022 Appropriations for Veterans** *Administration Expands Role of PTs/PTAs in the VA*
        - Status: PASSED the House. Awaiting vote by the Senate this fall. Includes APTA language urging the VA to ensure that pain treatment alternatives to opioids, such as physical therapy, are available to veterans. The report language also calls on VA to examine how more competitive pay for PTs and PTAs can help hire and retain them. Urges VA to open its Health Professional Scholarship Program to PTs. Finally, the language calls on the VA to explore ways to expand the role of PTs and PTAs in primary care, rural health, women's health.
    - You may access templates to write members of Congress on these bills at the above link.

Final 2023 Home Health Rule Summary

- Home health will see a 0.7% increase in payment in 2023.
    - CMS opted to phase in a 7.85% cut to maintain budget neutrality over two years. CMS will implement a 3.9% decrease of the 7.85% in 2023 with the remainder in 2024. The decrease is offset by a market basket increase of 4% in 2023 leading to a 0.7% increase for home health services in 2023.
- CMS updates the low-utilization payment adjustment, functional impairment levels, comorbidity subgroups, and case mix weights.
- Adds three new G-codes that identify home health services furnished via real-time audio/visual communications, audio-only communications, and the gathering of data transmitted by the patient through remote patient monitoring technology.
    - HHAs can use the codes voluntarily beginning 1/1/2023, and will be required by July 2023.
- Realignment of the value-based purchasing baseline year to 2022 for those HHAs certified before 1/1/2022. For newer HHAs, the baseline would be the first full calendar year of services after Medicare certification.
- OASIS reporting suspension continues until 2027. At that point, HHAs will be required to submit OASIS data for all patients regardless of payer under the Home Health Quality Reporting Program.

Resources

- **CY 2023 Home Health Prospective Payment SystemRate Update; Home Health Quality Reporting Program Requirements; Home Health Value-Based Purchasing Expanded Model Requirements**
- **Fact Sheet**
- **Final 2023 Home Health Rule Turnaround: From Proposed Cut to Slight Increase**

Medicare Provider Compliance Tips for Physical Therapists in Private Practice

- Updated Improper Payment Rate and Denial Reasons for 2021 Reporting Period
    - For the 2021 reporting period, insufficient documentation accounted for 89.5% of improper payments for physical TPP providers. No documentation (2.4%), coding errors (2.0%), and “other” errors (6.0%) caused other improper payments.
- Preventing Denials reason tips provided in the **LINK**.

WPS

J8 Part B Targeted Probe and Educate Quarter 2 Findings

Our Medical Review team continues to actively review claims and provide education through the Targeted Probe and Educate (TPE) program. Some of the common claim review findings are:

- Physical Therapy (PT) Re-evaluation for CPT 97164 has a trending claim error rate of 70%.
- Wound care services for CPT 11042 have a trending claim error rate of 74%.

For more information, see the **full article** on our website.

Medicare Participation for Calendar Year 2023 – Now Available Online

Medicare Participation for Calendar Year 2023 is now available.

Providers who wish to change their participation status must do so before December 31, 2022.

Providers who want to maintain their current participation status, participating or non-participating, do not need to take any action.

Medicare Physician Fee Schedules effective January 1, 2023 through December 31, 2023 as of November 15, 2023:

- **Download PDF**
- **Download Excel File**

For term definitions and additional resources click **HERE.**

FAMILY AND SOCIAL SERVICES ADMINISTRATION (FSSA)

Updated Telehealth and Virtual Services Manual

Telehealth and Virtual Services

- Updated Practitioners Eligible to Provide Telehealth Services
- Removed References to "Telemedicine," Including in the Document Title
- Revised Notice About Special Policies and Procedures During the COVID-19 Public Health Emergency
- Updated the Introduction Section
- Updated the Telehealth Services Section and All Subsections
- Added the Nonhealthcare Virtual Services Section
- Added the Special Considerations for Certain Services and Providers Section
- Updated the Originating Site Services Section
- Updated the Telehealth Services for FQHCs and RHCs Section
- Added the Intensive Outpatient Treatment via Telehealth Section
- Added and Updated the Remote Patient Monitoring Services Section and Subsections
- Added the Telehealth Services That Require Electronic Visit Verification Section

IHCP Announces Changes to Future HIP Reimbursement Rates

- **BT202277**: Outlines a reimbursement policy change mandated by CMS, in which by 2024, Indiana must transition to a reimbursement model with consistent rates across all FSSA's programs.
    - Currently HIP pays professional and ancillary providers for services through at the Medicare rate or 130% of Medicaid.

UnitedHealthcare (UHC)

Prior Authorization for Home Health Services

Starting Feb. 1, 2023, for UnitedHealthcare® Medicare Advantage and Dual Special Needs Plans (D-SNP), you'll need to request prior authorization for home health visits for all visits after the start of care (SOC) visit.

The visit types included in the prior authorization requirement are as follows:

- Continuation of Care
- Resumption of Care (ROC)
- Additional Services
- Recertification

Note: SOC visits do not require prior authorization.
Click **HERE** for more information.

CIGNA

Cigna PTA Differential and 4 Unit Max Advocacy

Cigna has recently implemented a **4 unit per visit limitation and a 15% payment reduction** for services provided by a PTA, effective October 15, with TX, KY, CO, and OH starting on November 1.

APTA and Chapters are advancing the advocacy effort to challenge the implementation of the PTA differential. As there is an exception procedure in place for the 4 unit per visit limitation, our effort is focused on the PTA differential. In addition, we have communicated and consulted with AOTA and the Private Practice Section on the situation to gain insights and assist with our actions.

Our next steps are to ask you, our membership, to assist in advocacy efforts. As APTA members and physical therapists, physical therapist assistants, student physical therapists, and student physical therapist assistants, we need you to take action.

Here are the things you can do now to advocate against the PTA differential policy to ensure your voice is heard:

1. ***Provider Letters****:* Write a letter to Cigna addressing how this new policy will affect your clinic setting and your ability to deliver care to Cigna beneficiaries. **To ensure the greatest impact, please be sure to customize the letter and add specific examples from your practice.**
2. ***Patient Letters to Payer****:* Encourage your patients that are Cigna beneficiaries to write letters expressing their concern on how this policy will adversely impact their care. **Please encourage the patient or guardian to customize the letters and to share their personal experience.**
3. *Patient Letters to Employer*: Ask the patient to send a copy of the **payer letter** to their employer. You can also suggest they call the HR Department to inform them of their concern on losing access to PTA/PT team services.
4. ***Patient Postcard****:* We've also developed a patient postcard that is intended for larger clinics.
   - Have the patient sign the postcard, apply a stamp and mail the card. The postcard is already addressed to the dedicated Cigna contact.
5. *Talk to Your Legislator:* While legislative action may not be possible at this time, you can still notify your legislators and make them aware of this Cigna policy change and how it will negatively affect enrollee health, the delivery of physical therapy care, and the other adverse downstream effects. The sooner they hear about it and the greater the frequency, the more likely they will explore action to challenge the policy.

The power of the APTA can be leveraged if you act. The collective strength of our members does matter if we all advocate for our profession and the health of the patients that we serve. Please encourage any non-member colleagues to act and ask them to consider membership as there is strength in numbers.

APTA INDIANA PAYER REPORTING PORTAL

- An **APTA Indiana Payer Reporting Portal** has been developed for providers to use as they experience a payer issue in real time. Please use the free text box to share the negative impact of the issue on the patient.
  - If the reason you submit a payer complaint to the portal is due to an issue with a peer-to-peer review or call to the payer, it is advised that the payer, time of call, and name of the payer representative be logged.
  - Please share the link with staff! Analytics state that it may take 4-6 minutes to complete the portal per submission.
    - Staff may bookmark the link to the portal on their web browser. They do not need to be a member of APTA Indiana to complete the payer reporting issue.
    - The link may also be accessed by phone. Feel free to voice record the issue for easy reporting.