APTA INDIANA MARCH 2025 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 AND MEDICAID SERVICES (CMS)

Physical Therapy CPT Code 97110 – CERT Errors

Indiana's Medicare Administrative Contractor (WPS) communicated that recent Comprehensive Error Rate Testing (CERT) reviews have shown significant improper payments due to missing required elements of documentation to support physical therapy services.

To avoid audits, Targeted Probe and Educate, and denials ensure you note the errors assessed and make sure you are in compliance.

Errors were assessed due to:
- Missing physician/non-physician practitioner (NPP) signed and dated plan of care.

- Lacking clear documentation in minutes of the total treatment time to support the number of units billed for each treatment day.
- Lack of documentation to support the required specific 10-day progress note, to be completed on the tenth day of treatment.

We closely monitor our CERT errors to identify problem areas contributing most significantly to improper payments. Providers with error findings may be the subject of additional review and educational contacts by WPS or other CMS-affiliated contractors.

To learn more about Medicare requirements for therapy services see **Complying with Outpatient Rehabilitation Therapy Documentation Requirements**.

Medicare Physician Fee Schedule Pay Cut Update and Advocacy Call

The House of Representatives failed to include a package to address the 2.8% cut to the Medicare Physician Fee Schedule. This is unacceptable! We must act by contacting our House of Representative member ASAP and urge them to include legislative language to reverse the payment cuts that occurred on January 1.

Go to **house.gov** and type in your zip code to find your U.S. House of Representatives contact information and write today, then visit the **APTA Patient Action Center** for a sample customizable script to guide your call. Be sure to explain how these cuts affect your patients, business, and community.

Resources

- **#FixMedicareNow**
- **Medicare Physician Fee Schedule Cuts**

MARKETPLACE/MEDICAID BENEFICIARY SCAM

APTA Indiana was Recently Made Aware of a Marketplace Plan Scam

How This Affects Medicaid/MCE Patients and Providers:

- Individuals with Medicaid were enrolled into a Marketplace plan by bad acting independent advisors and brokers without consent.
- When an individual with Medicaid is enrolled in a Marketplace plan, CMS recommends the patient chooses one product. In the situation of the scam, the beneficiary does not know they are enrolled in the Marketplace plan.
- When the brokers/advisors enrolled individuals in the Marketplace plan, beneficiaries were attested to have a low income which made them have a $0 premium.
- This may cause surprise taxes for the individual at tax time if their income is actually higher than what was reported because they received too much premium assistance.
- This may have also affected their Medicaid coverage or resulted in their providers being out of network with the Marketplace plan, unbeknownst to them.
- For providers, patients do not know they have the Marketplace plan and they communicate they have a Medicaid plan.
    - As a result, the provider may get a claims denial when Medicaid/MCE is billed as the Marketplace plan is shown to be the primary insurance.
    - Once Medicaid/MCE determines the primary payer is the Marketplace plan, they have been known to ask for a recoupment and advise the provider to file the claim with the primary insurance.

FAQ:

- If a provider checks the beneficiary insurance before each visit, is Medicaid's eligibility file up-to-date?
    - MCE/Medicaid eligibility files may have a lag time. There is not a guarantee the eligibility file is up-to-date at the time it was reviewed.
- Since a PA is required before treatment for most Medicaid/MCEs, would the provider get notified through the UM company that the patient does not have Medicaid when they try to get the PA?
    - At the minimum, they have verification that the provider attempted to obtain the prior authorization which may be helpful during an appeal.

What You Can Do:

- Be vigilant about documenting Medicaid benefits before therapy visits.
- Review CMS's **communication** on this Alert advising beneficiaries what to do if they discover they have a potential problem with their coverage.

INDIANA MEDICAID

Home Health Care

IHCP provides updated guidance for home health services prior authorization documentation. See **BT202525** for more details.

Telehealth Billing Requirements

IHCP reminds providers about reimbursement requirements for billing. See BT **202510** for details.

CARESOURCE

Caresource Prior Authorization Update

Caresource recently changed their policy following APTA Indiana advocacy to allow PT/OT/ST health partners to submit prior authorization requests within two business days from the date of the initial evaluation and treatment.

Resource

- **Caresource PT/OT/ST Prior Authorization Update**

ANTHEM

Billing Modifier 59, XE, XP, XS, and XU Update

Certain modifiers for outpatient claims will receive prepayment coding review. Beginning April 1, 2025, Anthem will update their **prepayment coding validation** review process for outpatient claims to include claims submitted with modifiers **59, XE, XP, XS, and XU** and other less used therapy modifiers.

Anthem will evaluate the use of modifiers in conjunction with the edits they bypass (such as the NCCI) to determine whether it is appropriate for the modifier to bypass the edit.

See **Anthem's** announcement for more information and what you should do if you believe a claim reimbursement decision should be reviewed.

TRICARE WEST

Referral Waiver and Transition Challenges

On January 1, 2025, TriWest Healthcare Alliance (TriWest) became the contractor for the TRICARE West Region adding six states formerly in the East Region and resulting in significant challenges. In response, the Defense Health Agency (DHA) **waived** the requirement to obtain approval for referrals to outpatient specialty care for TRICARE Prime enrollees from January 1 – March 31, 2025.

Providers do not need to submit referral or authorization requests for TRICARE Prime enrollees for outpatient care during the temporary waiver period and referrals issued are valid for services rendered through June 30, 2025. Additional information including how to contact TriWest is provided at **TRICARE West Region Transition**.

DHA also acknowledges other **operational challenges** including payment set up. APTA is engaging congressional partners to address these issues on behalf of the physical therapy profession and will keep you informed of developments.

UNITED HEALTHCARE

Home Health Care

Commercial Plans

Effective for dates of service on or after May 1, 2025, the following PT/OT/ST and Nursing home health HCPCS with a CMS Status Indicator of E, I or X:

- G0299, G0300, G0490, G0493-G0496, G0529, G2168, G2169, S0274, T1030, T1031, T1002, T1003, T1021.
    - These HCPCS codes will not be considered for reimbursement when submitted by physicians and physician groups.
    - These HCPCS codes will be considered for reimbursement when appropriately submitted by home health providers.

Indiana Community Plan

Effective May 01, 2025, for dates of service on or after July 1, 2024.

In alignment with CMS, home health services billed in place of service 12 will not be reimbursed if the dates of service overlap with an inpatient stay. The date span criteria will exclude the date of admission and discharge.

NEW APTA PAYMENT RELATED RESOURCES

- **APTA Public Policy Priorities for 2025-26 Focus on Increased Payment and More**
    - APTA's updated legislative and policy agenda.
- **APTA State Payer Advocacy Resource Consortium** (SPARC): Look here for resources from direct one-on-one aid for solo practices to overarching support to improve national payer policy including Model Contract Language, Denials and Appeals, MPPR, State Medicaid Payment Guides, Administrative Burden, and The Economic Value of PT in the US report.
- Free Webinars on Payer Contracting Education:
    - **PRIVATE PRACTICE - Strategic Contracting Series - Module 1: Yes You Can (even if you're a small practice) & No They Can't!**
    - **PRIVATE PRACTICE - Strategic Contracting Series - Module 2 - What Do Different Types of Plans Mean for Your Practice**
- **The Latest Patient Care Resources for APTA Members**

APTA INDIANA PAYER REPORTING PORTAL

Having payer concerns or barriers impacting patient care or creating administrative burdens?

The **APTA Indiana Payer Reporting Portal** has been developed for providers to use as they experience a payer issue in real time related to prior authorization, credentialing, claims payment, contracting issues or other related payment concerns.

- This portal will remain available until further notice, to be used as reportable events occur. You may save this link permanently on your desktop and/or access this portal on your mobile device for future use.
- Please share the link with staff.
    - 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.