APTA INDIANA MAY 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.

CONTENTS

INDIANA HEALTHCARE LEGISLATIVE PAYMENT HIGHLIGHTS

APTA Indiana actively collaborated with legislators and provided testimony on two key bills (SB 480 and HB 1003) during the 2025 session, with a strong focus on prior authorization reform. Below are highlights on how these bills impact the physical therapy profession. See the resources for details.

SB 480: Indiana Prior Authorization Reform: APTA IN WIN!

The 2025 Indiana legislation SB 480 reduced administrative burden and improved timely access to care—related to prior authorization (PA) practices by Utilization Review (UR) entities, effective July 1, 2025.

Key Highlights:
- **Physical Therapy PA WIN:** For all plans except Medicaid and the Indiana State Employee Health Plan, UR entities may not require prior authorization for the first 12 physical therapy visits for each new episode of care—a significant step toward improving patient access and reducing administrative delays.
    - Big win for APTA IN. Indiana is the third state in the US to pass such language!!

The following wins within SB 480 apply to all healthcare providers and services, including the PT profession:
- No Claims Denial for Prior Authorized Services: Once a service is prior authorized, UR entities may not later deny claims for those services, with limited exceptions.
- Unanticipated Services Without PA: Sets expectations for how UR entities must handle services that could not reasonably be anticipated and were delivered without prior authorization.
- Shortened Peer-to-Peer Review Timeframes: Requires 48-hour turnaround for peer-to-peer review requests.
- Policy Change Notification and Reporting: UR entities must report and provide transparency around policy changes, and report approval/denial rates.
- Adverse Determination Process: Clarifies requirements UR entities must follow when issuing adverse determinations, ensuring providers and patients receive timely and clear information and requires denials or appeals to be performed by a clinical peer.
- Utilization Management Timelines: Specifies how quickly UR entities must respond to PA requests or appeal and how quickly providers must respond to adverse determinations.

    - Completes process between 48 hours (for approval following initial PA submission) to 10 days if an appeal process is completed.
- Authorization Stability: Once authorized, a UR entity cannot revoke, limit, or restrict that authorization if services are initiated within 45 days (excluding weekends and holidays). An authorization for a health care service shall be valid for at least one (1) year after the date the healthcare provider receives the authorization.
- Portability of Authorizations: Requires that a prior authorization from one UR entity must be honored by another entity for up to 90 days or a health plan must honor a PA from another product within the same health plan.

Resources:
- **IGA Senate Bill 480**
- **2025 SB 480 Highlights**

HB 1003

- **Site-Neutral Billing**
    - Mandates qualified providers (individuals or an entity employed by an Indiana nonprofit hospital system) working in an office setting to not bill health care services with a place of service code 21 (Inpatient Hospital) or 22 (Outpatient Hospital Campus) beginning 7/1/2025.
        - Beginning 1/1/2026, a payor shall pay the claims incurred by an in-network qualified provider based on the physician fee schedule (the negotiated agreement between a payor and a qualified provider specifying reimbursement for services furnished in an office setting and billed on a CMS 1500 for or its electronic equivalent).
        - An office setting is defined as a location of a qualified provider where healthcare services are provided that are located more than 250 yards from the main hospital building owned in full or part by the Indiana nonprofit hospital system and where a qualified provider routinely provides care.
- **Prior Authorization Reform**
    - Empowers the Department of Insurance to collaborate on best practices for prior authorization and mandates reporting on PA disputes between healthcare providers and health plans to the general assembly before 12/1/2026. The section expires 7/1/2027.
- **Mandatory Disclosure During Contract Negotiations**
    - Requires the health carrier and the provider or facility to share 25%, 50%, and 75% reimbursement amounts that the health provider facility or provider receives for each covered service under a proposed health provider contract. The carrier must also provide the current fee schedule and the proposed fee schedule.

Resource:
- **IGA HB 1003**

CMS

Proposed FY 2026 SNF and IRF Rule Highlights

SNF-Specific Highlights Proposed
- SNFs could see a 2.8% payment increase.
- CMS is rolling back social determinants of health (SDOH) and health equity measures finalized last year—these changes may impact how patient needs related to social context are documented and addressed by PTs.
- CMS is inviting comments on regulatory relief, including streamlining quality reporting and reducing provider burden—potentially affecting PT administrative workload.
- Removal of the Health Equity Adjustment from the Value-Based Purchasing (VBP) Program, impacting SNFs serving high proportions of dually eligible patients.
- Future scoring methodology changes for Within-Stay Potentially Preventable Readmission (PPR) measures proposed to be the same as for the SNF Value-Based Purchasing measure.
- Proposed changes to the PDPM ICD-10 code mapping.

IRF-Specific Highlights Proposed
- Proposed payment rate increase by 2.6%.
- No expansion of early transfer payment policy to include home health yet, though it's under consideration.
- Wage index adjustments continue phased reduction for facilities losing rural status; impacts may vary regionally.
- IRF-PAI changes under review, including potential for pediatric version and reduced burden via “skip patterns”—this affects PT documentation workload.
- Updates on the IRF QRP pay-for reporting program.

- Request for Information on approaches and opportunities to streamline regulations and reduce burden on those participants in the Medicare program.

Quality Reporting Program (QRP) Changes Across SNFs and IRFs

- Removal of COVID-19 vaccine measures from QRP starting FY 2026.
- Elimination of four SDOH patient assessment items scheduled for FY 2028: living situation, food insecurity (2), and utilities.
- CMS requests input on new QRP focus areas, including interoperability, well-being, nutrition, and delirium—topics highly relevant to holistic PT care.
- Considering shortening assessment data submission deadlines from 4.5 months to 45 days.
- Reconsideration policy changes would limit appeals to only "exceptional circumstances" (e.g., natural disasters), tightening options for contesting penalties.

Resources:

- **Proposed FY '26 SNF and IRF Rules: Payment Increases, Roll Back of SDOH Items**
- **Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2026**
- **Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2026 and Updates to the Inpatient Rehabilitation Facility Quality Reporting Program**

Telehealth Waiver Extension

Congress has extended the waivers that allow outpatient therapy services, including those provided by physical therapists, occupational therapists, speech-language pathologists, and audiologists, to be delivered via telehealth. The waiver is extended through September 30, 2025.

Resources:

- **Fact Sheet: Telehealth Waiver**
- **Telehealth, PT Compact Legislation Reintroduced in U.S. Congress**
- **CMS Telehealth**

NCCI Edits

Click **HERE** for the updated NCCI Edits of the most common edits for Physical Therapy services: 4/1/2025-6/30/2025.

Wheelchair Seating: Prevent Claims Denials

Wheelchair seating improper payment rate was nearly 30% in 2024. Review the **Wheelchair Seating** provider compliance tip sheet for more information on how to avoid denials, including:

- Billing Codes
- Denial Reasons and How to Prevent Them
- Example of Improper Payments Due to Insufficient Documentation
- Additional Resources

APTA NEWS AND CALLS FOR ADVOCACY

APTA Annual Report: 2024 Member Benefit Highlights and Achievements

- KPI Summary of federal and state advocacy and profession wins.
- Numerous highly valuable links such as:
  - **PT-member exclusive Find a PT Directory** (1M consumers used the directory to find a PT in 2024!).
  - **Digital Health Practice Tools**
  - **APTA Digital Health App Formulary, ORCHA**
  - Business Owner Employee Benefit Offerings Through APTA
    - **401(k) plans**
    - **Insurance plan options**
  - **APTA Co-Branding/Marketing** Resources
  - **Membership Engagement Group** Communities
  - **APTA Community**
  - House of Delegates Highlights
  - Treasurer Report
  - Strategic Plan

Log into the **Legislative Action Center** to add your voice urging your member of Congress to support these bills and others that impact your practice!

- H.R. 1614 Permanent Medicare Telehealth Coverage for PT
- H.R. 879 Support the Medicare Fee Schedule Fix for Providers

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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.