A New Payment System for Therapy Services and Beyond

2016 Combined Sections Meeting

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Session Type: Educational Sessions
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A New Payment System for Therapy Services and Beyond

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Repeal of the Sustainable Growth Rate Formula

New Payment Model

• Demise of Fee-for-Service and opens the door for value-based payment.

http://hitconsultant.net/2015/05/11/death-fee-service-healthcare/
ILLUMINATION: To Shed Light on.....
Several key trends happening in how healthcare is delivered and paid for:

• Third party payment trends downward across all services and all third party payers
• Third party pay demanding greater accountability and quality
• Continued consolidation of providers, facilities and payers
• Consumers, including aging “boomers”, demanding choice, access, efficiency for their medical needs
Emerging Practice & Payment Models

- ACOs
- Bundled Payment
- Community-Based Care Transitions
- Coordinated Care/Chronic Conditions
- PCMHs
Payment Model Tipping Point

Driven by Fee-for-Service Incentives

- Striving for Clinical Integration
  - Provider Alignment
  - Performance Incentives
  - Service Expansion
  - Meaningful Use
  - Provider Consolidation
  - Volume-Driven Revenue

Driven by Population Health

- Transformation to Accountable Care Principles
  - Clinical Intelligence
  - Data Analytics
  - Joint Contracting
  - Longitudinal Patient Record
  - Cross-Continuum Care Management
  - Health and Wellness Outreach

Patient Quality and Cost Management

Source: KPMG Healthcare, 2011
Volume to Value: Medicare Style

Medicare in 2018

70% Fee-For-Service
30% Medicare Advantage

35% Traditional Fee-For-Service**
35% Alternative Payment Models
30% Medicare Advantage

65% in various APMS

Avalere.com
Value-Based Healthcare

**CMS:** to shift the incentives for payment from volume to value
- Demonstration of value must be communicated through documentation
- Timeline announced January, 2015:
  - 2016: 30% of FFS payments based on value and provided through alternative payment models
  - 2018: 50% of FFS payments based on value and provided under alternative models that base payments on quality of care


**Health Care Transformation Task Force:** Commercial payers to shift 75% of operations to contracts designed to improve quality and lower costs by 2020

http://www.hcttf.org/
Current Fee-for-Service Payment System

The Problem
Care is fragmented instead of coordinated. Each provider is paid for doing work in isolation, and no one is responsible for coordinating care. Quality can suffer, costs rise and there is little accountability for either.

$ $ $ $ $

Hospital Specialist Primary Care Home Health

Patient-Centered Global Payment System

The Solution
Global payments made to a group of providers for all care. Providers are not rewarded for delivering more care, but for delivering the right care to meet patient’s needs.

$ Primary Care Hospital Specialist Home Health

Making the Transition

Source: Recommendations of the Special Commission on the Health Care Payment System, July 2009
PT: Pathway To Payment Reform

Quality Initiatives

Coding Reform

Shaping our Payment Future:
  IMPACT, MIPS, Value Modifier and Delivery Based Reforms (Bundling, Episodic)
Learning from Physician Payment Reform

HOW PAYMENT REFORMS ARE DESIGNED TODAY

Medicare and Health Plans Define Payment Systems

Physicians Have To Change Care to Align With Payment Systems

Patients and Physicians May Not Come Out Ahead
Learning from Physician Payment Reform

**How Payment Reforms Are Designed Today**

1. Medicare and Health Plans Define Payment Systems
2. Physicians Have To Change Care to Align With Payment Systems
3. Patients and Physicians May Not Come Out Ahead

**The Right Way to Design Payment Reforms**

1. Physicians Redesign Care and Identify Payment Barriers
2. Payers Change Payment to Support Redesigned Care
3. Patients Get Better Care and Physicians Stay Financially Viable
Basic Concepts for Payment Reform Models

• More/different payment for redesigning care to achieve higher quality at lower cost
• Create responsibility for controlling/reducing other healthcare costs

• **Result:** Payer saves money, provider appropriately incentivized, patient benefits
Evolution of Payment Challenges in Outpatient PT

Payment Challenges and New Requirements

2011
- First Application of MPPR (6-7%)

2012
- 2-Tier Cap Exceptions / Inclusion of Hospital OP Department

2013
- MPPR Phase II (6-7%)
- Continuation of 2-Tier Exceptions (Manual Medical Review)
- Functional Measures Requirement
- PQRS Penalty Phase

2014
- IMPACT Act Introduced (IP)

2015
- 0.5% Increase
- IMPACT Act Implementation (IP)
Payment Reform
4 Components

Episodic Payment
Standardization of Data
Quality Programs

Reform Reporting under FFS
First Four Tracks - Coding

1 - Evaluations
• Publication of New Evaluation Codes in 2017 MPFS Rule (July 2016)

2 - Interventions
• Continue to move towards revision of intervention / treatment portion of reporting

3 – Misvalued Codes
• Manage the identified misvalued codes as published in final 2016 MPFS rule

4 – Member Education and Outreach
• Execute a member education and outreach plan per original task force
4 Systems Level Tracks - Scaling From Coding To System Level Reforms

5 – Episodic Models
- Partnerships with Commercial Payers on High Impact Area
- Bundling Programs (CJR / BPCI) – (April 2016)

6 – Quality Initiatives
- PQRS to MIPS
- National Quality Strategy (April 2016)
- Qualified Clinical Data Registry (requirements)

7- Post Acute Care Reform
- Analyze data for creation of functional items on PAC standardized assessment tool
- Assess feasibility of functional items
- Assess unified PAC payment system

8 – Member Education and Outreach
- Member education on new models and initiatives
Coding Reform

Wiring & Plumbing for Payment Reform
A Step to Payment Reform for OP Rehab Services

Reporting PT Evaluation Services
2017 EVALUATION CODES FOR PHYSICAL THERAPISTS
Current Procedural Terminology

• Most commonly used system reporting procedures and services provide to the patient for third party payment
• HIPAA required code set
• Published annually by American Medical Association
CPT Code Process and Structure

*History of 97000 PM&R Family of codes*

- APTA led major (29) revisions in 1994 with over 50 additional updates over last 22 years
  - Time descriptors from 30 minutes to each 15 minutes
  - Descriptors updated and codes added/delete to better describe current practice
  - Evaluation codes first created in 1994
  - Other significant updates: manual therapy, wound care, O&P
  - Another major update needed to move away from procedure based structure/FFS payment model to other payment methodologies
  - Preferred path would be to structure CPT codes to support payment based on patient presentation/severity and clinicians work
Payment Reform for Rehab Services: Timelines and Guidance

- 2012 AMA forms PM&R WG to address changing the reporting methodology consistent with CMS and payment reform efforts,
- 2013-2014 AMA PM&R WG continues its work focusing on evaluation codes as well as intervention codes to continue to progress from reporting timed procedures to a reporting methodology that describes severity/intensity
- 2015, February accomplished revision of evaluation codes to be published 2017
Payment Reform for Rehab Services: Timelines and Guidance

2015
• RUC-Eval codes
  – April: surveyed evaluation codes through RUC process.
  – September: presented survey results to RUC for establishment of Values to be considered by CMS for 2017 Fee schedule
• PM&R WG continues work on severity/intensity model for intervention codes.

2016
• February; reviewing progress achieved and payment environment to inform continued path forward.
Big Picture: Key Factors in Determining Payment

A payment method based on the accurate and complete communication of the following:

• Completed Patient Assessment Instrument
• Evaluation of Clinical Presentation
• Treatment and management options planned and provided
• Demonstration of Value associated with achievement of functional outcomes
2017 Physical Therapy Evaluation & Reevaluation Codes

• Evaluation Codes
  – Three codes: low complexity evaluation, moderate complexity evaluation, high complexity evaluation.
  – 4 Components:
    • Patient history and comorbidities,
    • Examination and the use of standardized tests and measures,
    • Clinical presentation, and
    • Clinical decision making.

• Re-evaluation Code
  – Single Code
  – All incorporate standardized tests and measures and patient assessment instrument or functional outcome measure.
Overview of New Evaluation Structure: Defining Process

**Process:** Patient presentation upon evaluation includes determining their overall severity and complexity:
- History (medical, functional)
- Examination
  - Physical impairment
  - Impact on the patient ability to function
  - Cognition
  - Living environment
Overview of New Evaluation Structure: Defining Process

• 3 levels of complexity:
  – Low
  – Moderate
  – High

• The level of the PT evaluation dependent on clinical decision making and the nature of the condition (severity)
Overview of New Evaluation Structure: Defining Process

• Also part of the evaluation process:
  – Development of plan of care
  – Coordination, consultation and collaboration of care with physicians, other QHP’s or agencies
Overview of New Evaluation Structure: Defining Process

• Clinical Judgment
  – To achieve good outcomes, therapist uses clinical judgment to determine the overall severity of their complaints/condition and make appropriate decisions regarding interventions to use in treatment based on this patient assessment, at each encounter or session supported as much as possible by current best evidence.
Overview of New Evaluation Structure: Defining Process

History:

• Assists in supporting level of evaluation by addressing;
• Comorbidities that impact function and ability to progress through a plan of care
• Previous functional level, context of current functional abilities and
• Treatment approaches in past if applicable and other factors that may impact patients ability to progress and reach goals
• Provides rationale: Medical necessity for level of evaluation reported
Overview of New Evaluation Structure: Defining Process

**Personal Factors:** Contextual Factors that influence how disability is experienced by the individual

- Include sex, age, coping styles, social background, education, profession, past/current experience
- Overall behavior patterns, character
- Other factors that influence how disability is experienced by the individual
- **IF NO IMPACT ON PLAN OF CARE, SHOULD NOT BE CONSIDERED WHEN SELECTING LEVEL OF SERVICE**
Overview of New Evaluation Structure: Defining Process

• **Body Regions:** Head, neck, back, lower extremities, upper extremities, and trunk

• **Body Structures:** Structural or anatomical parts of body, such as organs, limbs and their components classified according to body systems

• **Body Systems:** Musculoskeletal, neuromuscular, cardiovascular pulmonary, and integumentary

Review of Body Systems would include.........
Overview of New Evaluation Structure: Defining Process

- 4 primary elements that will inform your choice of the level of evaluation:
  - History
  - Examination
  - Presentation
  - Clinical Decisions Making

- Must communicate information regarding these elements and then decide what level of Evaluation to report
CPT Code Revisions
PT Re-evaluation

• Single level
• Established Plan of Care
• An examination including a review of history and use of standardized tests and measures is required
• Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome
Reporting Levels of Evaluations: Reflecting Physical Therapists Clinical Decision Making

• Reflect complexity of patient in order to better determine the management path
• Assessment tools at the front end, outcomes reported at the back end begin to differentiate how patients are managed for potential development of reformed payment model
• Address issue of variation in care
Goal: Decrease the Variation in Care
Payment and the RUC Process: Timeline for Evaluation codes

Evaluation RUC Survey Analysis
- July 2015: Survey closed
- July through August 2015: Data analysis w/ member experts
- September 2015: RUC recommendations due to AMA

Evaluation Code Launch
- October 2015: Recommendations presentation to the RUC
- July 2016: MPFS proposed rule (comment period)
- January 2017: Potential implementation

Refinement of Intervention Codes
- Currently regrouping and strategizing on next steps
- RUC process will impact in some way either current codes or revised codes
The RUC Process

CPT Editorial Panel Adopts Coding Changes

Specialty Society Advisors Review New and Revised CPT Codes

Codes Do Not Require New Values

No Comment

Comment on Other Societies’ Proposals

Survey Physicians; Recommend Values

RVS Update Committee

Specialty Society RVS Committee

Centers for Medicare and Medicaid Services

Medicare Payment Schedule
Misvalued Codes

• CMS began to identify & request RUC review of certain codes in 2008 with a goal of reducing payment for misvalued services

• The Affordable Care Act made misvalued code initiative part of the law (around 16 categories).
  – Review fastest growing services
  – Harvard (original) codes never reviewed
  – Codes frequently performed together
  – Low Value High Volume Services
  – And More...(categories expanded by PAMA)
Misvalued Codes

• ABLE legislation (enacted December 2014)
• Target for Misvalued Codes equal to a reduction of 1% of allowed expenditures under the fee schedule for 2016; followed by 0.5% targets in 2017 and 2018.
• If the yearly target is not met by revaluing certain codes, then here will be across-the-board cuts to all codes to meet the goal.
## Misvalued Code List (CMS)

### Misvalued code list in 2016 Medicare Physician Fee Schedule FINAL rule:

<table>
<thead>
<tr>
<th>Potentially Misvalued Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97032 – Electrical Stimulation</td>
</tr>
<tr>
<td>97035 – Ultrasound</td>
</tr>
<tr>
<td>97110 – Therapeutic Exercise</td>
</tr>
<tr>
<td>97112 – Neuromuscular Reed.</td>
</tr>
<tr>
<td>97113 – Aquatic Therapy</td>
</tr>
</tbody>
</table>
Misvalued Code List (AMA screens)

- G0283 (unattended estim)
- 97016 (vasopneumatic devices)
- 97112 (neuromuscular reeducation)
- 97140 (manual therapy)
- 97530 (therapeutic activities)
- 97532 (cognitive skills)
- 97542 (wheelchair management)
RUC Process:
Components of Relative Value

FIGURE
How a CPT code’s Medicare allowable is determined*

Adjustments for Geographical Practice Cost Index

CMS

RUC

Work RVU
- time • technical skill • effort • judgment • stress on doctor, etc.
48.3% average weight
[Example: 0.97]

Practice Expense RVU
- use of nonclinical personnel • office space • supplies, etc.
47.4% average weight
[Example: 1.10]

Professional Liability Insurance RVU
4.3% average weight
[Example: 0.07]

RVU × CMS Conversion Factor ($34.0230 for 2013) = Medicare Payment

[Example: 2.14 × $34.0230 = $72.81]

Abbreviations:
CMS = Centers for Medicare & Medicaid Services
RUC = American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee
RVU = Relative Value Unit
*Example based on CPT code 99213
Source: American Medical Association

APTA
American Physical Therapy Association
What is the RUC and What Does It Do?

- The AMA Specialty Society Relative Value Scale Update Committee (RUC) makes recommendations to the Centers for Medicare and Medicaid Services (CMS) for the provider \textit{work} and \textit{practice expense} values of CPT codes.

- The RUC HCPAC (Health Care Professionals Advisory Committee) is composed of non-physician providers and makes recommendations to CMS for CPT codes that are primarily reported by non-MD/DO providers.
What is the RUC and What Does It Do?

• In order to make these recommendation, specialty societies (e.g. APTA and AOTA) submit recommendations for these values, and present their recommendations at the RUC meetings.

• How do societies develop their recommendations?
  – Survey
  – Expert Panel
Survey Process

Qualified Health Care Provider Work RVS Update Survey

*How we want you to feel...*

I’m so excited.

*How you actually felt...*
Survey Process

*Components of Provider Work*

- The survey is designed to obtain estimates of the amount of work and time required by a qualified health provider, such as a physical therapist, to provide a service that will be identified by a new or updated CPT code.

- Elements of Provider Work:
  - Technical Skill & Physical Effort
  - Mental Effort & Judgment
  - Psychological Stress
  - Time to Perform the Service
### Survey Process

**Components of Provider Work**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Work RVU</th>
<th>PE RVU</th>
<th>Pre-Service</th>
<th>Intra-Service</th>
<th>Post-Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>97001&lt;br&gt;PT Evaluation</td>
<td>1.20</td>
<td>0.87</td>
<td>4</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>97110*&lt;br&gt;Therapeutic Exercise</td>
<td>0.45</td>
<td>0.44</td>
<td>1</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>97113*&lt;br&gt;Aquatic Therapy</td>
<td>0.44</td>
<td>0.76</td>
<td>1</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>97140*&lt;br&gt;Manual Therapy</td>
<td>0.43</td>
<td>0.40</td>
<td>2</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>97150&lt;br&gt;Group Therapy</td>
<td>0.29</td>
<td>0.19</td>
<td>-</td>
<td>10</td>
<td>-</td>
</tr>
</tbody>
</table>

*Potentially Misvalued Code*
Survey Process

*Work RVU*

- The survey includes clinical vignettes and a reference code list. Survey takers are asked to review the vignettes and the description of the proposed code, and then select a code from the reference list that is “most similar” to the code being surveyed.

- At the end of the survey you are asked to estimate the work RVU for the proposed code.
Survey Process

*Time*

- **Pre-Service:** Includes services provided before the service and may include preparing to see the patient, reviewing records, and communicating with other professionals.
- **Intra-Service:** Includes the services provided while you are with the patient and/or family.
- **Post-Service:** Includes services provided after the service, e.g. arranging further services, documentation of evaluation or reevaluation and POC, communicating further with patient and/or family and other professionals.
Survey Process

**Note:** Physician/qualified health care provider work RVU DOES NOT include services provided by staff who are employed by your practice and cannot bill separately, including physical therapist assistants and physical therapist aides.

*If you receive a survey in the future, do not hesitate to call APTA if you have questions or need clarification.*
# Practice Expense

*Clinical Staff Time*

<table>
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<td>0.43</td>
<td>0.40</td>
<td>2</td>
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<td>2</td>
</tr>
<tr>
<td>97150 Group Therapy</td>
<td>0.29</td>
<td>0.19</td>
<td>-</td>
<td>10</td>
<td>-</td>
</tr>
</tbody>
</table>

*Potentially Misvalued Code*
Practice Expense

• Portion of resources used in furnishing the services that reflects the general categories of physician and practitioner expenses:
  – Medical Equipment and Supplies
  – Administrative Supplies
  – Salaries (including PTA and other clinical labor)
  – Electricity, Water, Rent, Etc.
Key Documents
Alternative Payment Methodology

• Familiarity with these key documents and resources will be helpful as coding and payment methodology reforms are discussed and developed
  – **International Classification of Function, Disability and Health**, WHO, classifies health domains describing Body structures/functions, activities/participation and environmental context
CPT/RBRVS Resources

• AMA CPT Process:
  – AMA CPT MANUAL 2016 and 2017

• Medicare RBRVS: The Physician's Guide
  – Mastering the Reimbursement Process, 4th edition
Resources
Alternative Payment Methodology

• Institute of Medicine, *Crossing the Quality Chasm. A New Health System for the 21st century*, National Academy Press 2001


• [http://www.ama-assn.org/ama](http://www.ama-assn.org/ama)

Payment Reform

If you have any questions about APTA's resources related to payment reform, contact advocacy@apta.org.

Physical Therapy Classification and Payment System (PTCPS)

APTA's goal is to reform payment for outpatient physical therapist services to improve quality of care, recognize and promote the clinical judgment of the physical therapist, and provide policymakers and payers with an accurate payment system that ensures the integrity of medically necessary services.
A New Payment System for Therapy Services and Beyond

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QUESTIONS?

TRANSFORMATION  MOVEMENT  BETTER TOGETHER