What's New?

REMINDER: Changes to E-Notes
The Payment Policy and Advocacy E-Notes have moved to the APTA Hub. You will no longer receive an email with the E-Notes, but rather an email alert when they have been posted to the Payment Chairs Hub. Due to Hub settings, component presidents and executives will no longer receive the E-Notes. As the Payment Chair for your component, please share the E-Notes with your component leadership moving forward. If you have any questions about this change or need assistance adjusting your Hub settings, please email advocacy@apta.org.

Anthem's Acquisition of Cigna Continues Insurer Consolidation Trend
Health insurer Anthem's recent announcement that it will acquire Cigna in a $54.2 billion deal is continuing a consolidation trend that could reduce the number of major insurance companies in the US from 5 to 3. And while the nuts and bolts of the deal are plain enough, when it comes to speculation on what it will mean for consumers and providers, there's less consensus.

What's known is this: the multibillion dollar acquisition will make the Anthem-Cigna combination the country's largest private health insurer in terms of members, with an estimated 53 million people covered. Revenues for the new company are projected at $115 billion annually.

Anthem's acquisition comes on the heels of a July 3 merger announcement from insurance giants Aetna and Humana, meaning that if federal regulators approve both deals, the country's 5 major private insurance companies will be reduced to 3, United Healthcare being the third. Pending regulatory approvals, the Anthem-Cigna deal will close in late 2016.

Media coverage of the acquisition generally pointed to pressures applied to insurance companies from the Affordable Care Act (ACA), which put caps on profits that could be made by insurance companies, as the big motivator for the consolidations.

It is imperative PTs remain vigilant and stay abreast of the ever evolving payment environment. As large insurers begin to merge, patient benefits, provider networks, and payment rates all are likely to change and we need to be prepared to demonstrate our concerns in concert with other affected stakeholders.

The APTA will closely monitor the situation to assess how it can intervene and partner with stakeholders should it become apparent medically necessary physical therapy services will be placed at risk. APTA suggests that members notify us at apta@advocacy.org regarding significant policy/benefit changes as they occur.
The Workers’ Compensation Industry prepares for the transition to ICD-10 codes

October 1, 2015 is the scheduled implementation date for the latest version of the International Classification of Diseases codes (ICD). While the workers’ compensation (WC) industry is not a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) and therefore not required to covert from ICD-9 to ICD-10 codes, many in the WC space have heeded the advice of experts and have begun preparing for the transition.

One example of a WC system that has decided to require the transition to ICD-10, is the state run WC system in Ohio. Ohio is requiring providers involved in the WC system to switch to ICD-10 by October 1, 2015. Ohio is one of four states that has special legislation that requires workers compensation coverage be provided exclusively by that State’s Designated Workers Compensation program.

For more information about your state’s workers’ compensation readiness to adopt ICD-10, visit the Workgroup for Electronic Data Interchange’s (WEDI) Property and Casualty ICD-10 State Readiness Resource Center. This website contains an excel spreadsheet highlighting each state’s plan for implementing ICD-10 under its WC plan.

Wellmark Announces Increase in MPPR to 50 Percent

On July 1, 2015, Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, and Wellmark Blue Cross Blue Shield of South Dakota increased its multiple procedure payment reduction policy to 50 percent. Previously, Wellmark applied a 35 percent MPPR reduction to therapy services. Under this policy, the primary procedure will be reimbursed in full, and the practice expense portion of the subsequent procedures will be reduced by 50%. For more information you can view Wellmark’s July 2015 Physical Medicine Guide.

Wellmark Blue Cross and Blue Shield of Iowa and South Dakota represents the largest commercial insurance penetration in their respective states. Seventy percent of the total health insurance enrollment in the state of Iowa and 50 percent of the total health insurance enrollment in the state of South Dakota.

Anthem Contracting with OrthoNet in CA, IN, KY, MO, OH and WI

APTA recently learned Anthem will be using OrthoNet for prior authorization of physical and occupational therapy services in Indiana, Kentucky, Missouri, Ohio and Wisconsin starting on November 1, 2015 for full risk, national, and state exchange plans. Beginning on January 1, 2016 Anthem will be using OrthoNet for prior authorization of its Medicare Advantage plans in KY, MO, OH, and WI, and its Managed Medicaid plans in IN, KY, OH, and WI. Additionally, Anthem Blue Cross in California will be using OrthoNet to implement a physical and occupational therapy utilization management program effective November 1, 2015.

It is unclear if the programs only apply to private practice occupational therapists and physical therapists, or if physician owned and outpatient hospital based services are also included. The Anthem notice to CA providers indicates that OrthoNet will be using “Anthem UM guidelines and OrthoNet’s proprietary guidelines for medical necessity review.” If Anthem is using OrthoNet’s definition of medical necessity it may have a significant impact on access to medically necessary physical therapy services. This may also raise issues of transparency if consumers are not informed of the possible change in benefit administration.

APTA held initial discussions with the CA Chapter on August 10, 2015. We will be scheduling a follow up call with all of the affected chapter payment chairs to find out what they may be hearing from members and what action the individual states may be taking.
Federal Payment

Quick Take on Proposed 2016 Physician Fee Schedule
In the first physician fee schedule rule to come out since the repeal of the sustainable growth rate formula, the Centers for Medicare and Medicaid Services (CMS) proposes revisions to payment policies, establishes 2016 payment rates for Medicare-billed services, and updates quality provisions. The rule also begins implementation of the new merit-based incentive payment system, applicable for now to physicians and other designated providers (not physical therapists).

How will the rule impact physical therapists (PTs) and physical therapist assistants (PTAs)? Below are some key highlights from APTA's initial look at the proposed rule.

2016 Payment Rates. The payment rate for physical therapy services is estimated to increase approximately 0.5%. This is based on:

- The proposed 2016 conversion factor of $36,1096, which reflects the 0.5% increase and budget neutrality adjustment of 0.9999 called for under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); and
- A zero impact on the relative value units—the work values, practice expense values, and malpractice expense values related to physical therapy services. The actual impact of payment rates for individual physical therapy practices will depend on the mix of services provided.

Misvalued Codes. Ten CPT codes that PTs typically report were identified by CMS for review to determine if they are "misvalued" and need to be updated based on possible changes in physician work and direct practice expense inputs, as these codes haven't been reviewed since 2009 or earlier. The codes are 97032 (electrical stimulation), 97035 (ultrasound therapy), 97110 (therapeutic exercises), 97112 (neuromuscular reeducation), 97113 (aquatic therapy), 97116 (gait training), 97140 (manual therapy), 97530 (therapeutic activities), 97535 (self-care management training), G0283 (electrical stimulation other than wound). They are among 118 total "high expenditure" codes (with Medicare allowed charges of $10 million or more) that CMS identified for review, with a target of a 1% reduction in expenditures for misvalued codes in 2016.

Quality Provisions. Reporting requirements and the measures that PTs report in 2016 under the PQRS program will be largely unchanged from 2015. PTs who do not successfully participate in PQRS in 2016 will face a 2.0% reduction in payment in 2018. In other quality reporting provisions:

- CMS had planned to make all 2015 PQRS measures for individual eligible professionals available for public reporting, and this rule would continue to make all PQRS measures available for public reporting annually.
- PTs are again not part of the value-based modifier program in 2016, although the program will expand to a limited group of other eligible non-physician professionals.

Physician Self-Referral. CMS proposes some major provisions related to the physician self-referral law (i.e., Stark Law) and its exceptions. CMS states the purpose of these proposals is "to accommodate delivery and payment system reform, to reduce burden, and to facilitate compliance," and "to expand access to needed health care services."

For more information, view the detailed summary on APTA's Medicare Physician Fee Schedule website. APTA will submit comments on the proposal by September 8th.
Medicare to Test Bundled Payments for Hip, Knee Replacements in Selected Cities

Hip and knee replacement surgery—which is nearly always partnered with rehabilitation including physical therapy—is the target of a proposed Medicare test of a bundled payment model, which will hold acute-care hospitals in 75 areas around the US accountable for their costs and quality of care. It's yet another signal that health care reform is moving away from fee-for-service payment models and toward paying for value and outcomes.

The chosen areas include Los Angeles and New York City as well as smaller markets, and would affect more than 800 acute-care hospitals. Unlike similar tests of the past, there's no voluntary sign-up; all facilities must participate.

The 5-year test period would begin January 1, 2016, and end December 31, 2020. Participating hospitals would bear the financial risk of the episode of care, which would begin at admission to the hospital and end 90 days after discharge, to include all related care covered under Medicare Parts A and B—the procedure, inpatient stay, hospital care, post-acute care, and provider services.

During the 5-year test period, Medicare would continue to pay using the current fee-for-services system. But at the end of every year, separate payments related to each episode would be bundled to calculate the total "episode payment" and reconciled against an established target price. If the episode payment is lower than the target and the hospital meets quality-performance thresholds, Medicare would pay the hospital the difference. If the episode payment is higher than the target, the hospital would have to repay Medicare the difference. The repayment responsibility would be waived the first year, and other policies in the proposal would limit the financial risk a hospital would be responsible for during the entire test period.

Hip and knee surgeries were chosen because they are the most common inpatient surgery for Medicare patients, and they tend to be high-cost, high-utilization procedures with a wide variance in spending.

The initiative comes from CMS's Center for Medicare and Medicaid Innovation, whose purpose is to test innovative payment and service delivery models in search of those that reduce expenses while preserving or enhancing quality of care by making providers more accountable for both costs and patient outcomes.

Previous tests of payment models have been voluntary, but CMS implied in the proposed rule that participation hasn't been as high, or among as broad a cross-section of providers, as the agency felt it needed to evaluate the models, and so this program would be mandatory for hospitals within the chosen geographic areas, with limited exceptions.

APTA will submit comments on the proposal (.pdf), which are due September 8.

SNF Final Rule Includes 1.2% Increase, Sets the Stage for Increased Quality Reporting

Skilled nursing facilities (SNFs) will see a Medicare rate increase next year, although it won't be quite as much as originally proposed by the Centers for Medicare and Medicaid Services. While news about next year's payment adjustment almost always gets attention, some of the most notable parts of the new rule are more focused on the future beyond 2016, and what SNFs will be expected to do if they want to avoid penalties—or pursue incentives.

As for payments, the rule rolled out last week by CMS includes a rate increase of 1.2% for 2016, a bump that's down about $70 million from the 1.4% increase proposed earlier this year. Overall, CMS projects aggregate payments to increase by $430 million in 2016.

Other parts of the rule are worth noting because of the ways they will change reporting requirements over the next few years. These changes apply to 3 main areas:
• **Staffing reports.** Beginning next year, SNFs will be required to submit detailed staffing information to the Department of Health and Human Services (HHS). That information will cover both agency and contract staff, and will include salary and staff turnover data, as well as reports on hours worked, resident case-mix, and hours of care provided per-resident per-day.

• **Functional measures on resident status.** Beginning in 2018, if SNFs want to avoid a 2 percentage point penalty in payment updates, they will need to supply data on several resident quality measures that include skin integrity, percentage of residents with new or worsened skin ulcers, incidence of major falls, and changes to functional and cognitive status.

• **Value-based purchasing (VBP).** Not set to take effect until 2019, the SNF VBP program will tie payment incentives to 30-day hospital readmission rates. The measure that will be used initially focuses on risk-standardized rates for all-cause readmissions, but CMS says it will replace that measure with one that reflects the "potentially preventable hospital readmission rate."

The reporting changes are designed to comply with specific mandates in the Affordable Care Act, the Protecting Access to Medicare Act, and the IMPACT Act, but CMS believes the combined effect of the new requirements will be to move the ball closer to the goal of value-based payments. "The final rule includes policies that advance that vision and support building a health care system that delivers better care, spends health care dollars more wisely, and results in healthier people," CMS states in a fact sheet on the changes as proposed in April.

APTA submitted comments on the proposed rule, and will develop a summary and highlights guide during the coming weeks.

**Medicare Extends 5-Star Ratings to Home Health Agencies**

Home health agencies are now part of the Centers for Medicare and Medicaid Services 5-star rating system, which incorporates evaluations of patient mobility in its assessment of an agency’s overall effectiveness.

Released through its Home Health Compare website, the star ratings are based on 9 of the 27 quality measures included in that program. The measures included are patient wait for a first visit, thoroughness of explanations of drugs to a patient or caretaker, administration of a flu shot, hospital stays, and improvements in walking, getting in and out of bed, breathing, and movement with less pain.

Of the 9,359 agencies rated (out of 12,261 total agencies), only 239 received 5 stars, while 2,218 received 4 or 4.5 stars. Nearly half of all agencies—46%—landed in the middle of the pack, receiving 3 or 3.5 stars, with 28% receiving lower ratings of 1.5 to 2.5 stars. Of all agencies rated, 6 received a single star.

The 2,902 agencies not included in the rating system either had low patient volume, did not provide enough data, or had recently opened for business.

In a state-by-state analysis conducted by Kaiser Health News, Rhode Island and Florida reported the largest percentages of 4- to 5-star rated agencies—albeit based on markedly different volumes. While Rhode Island, with 46% of its agencies earning 4-5 stars, technically had the best rate, those numbers reflected 24 rated agencies. The 43% of facilities that earned 4 to 5 stars in Florida were identified from a pool of 949 rated agencies.

States with the highest percentages of agencies with 2.5 stars or lower include Arkansas (45%), Wyoming (48%), Texas (52%), and Minnesota (52%). Other states and territories with high percentages in this category included the District of Columbia, Alaska, and the US Virgin Islands, but relative numbers of agencies rated were small.

The ratings were drawn from data from fall 2013 through the end of 2014. Medicare will update the ratings quarterly.
Value-Based Payment Model Introduced in Proposed 2016 Home Health Prospective System

In addition to its annual payment update, the recently released CMS proposed rule for the 2016 Medicare home health prospective payment system (HH PPS) includes policy changes for home health agencies and a new value-based home health model to encourage quality.

Below are some key highlights of the rule that impact physical therapists and physical therapist assistants. APTA has posted a detailed summary on the Medicare Payment and Policies for Home Health webpage.

Payment Policy. Taking into account all the policy changes, CMS estimates that overall Medicare payments to home health agencies will be reduced by $350 million or 1.8% in 2016 compared with 2015. This decrease reflects a 2.9% market-basket update and 0.6 percentage point cut for productivity, which is mandated by the Affordable Care Act. The rule also includes a 1.72% cut in each of 2016 and 2017 to account for estimated case mix growth 2012-2014, which the agency believes is unrelated to patient acuity, and a scheduled -2.5% rebasing adjustment, the third of a 4-year phase-in. In addition, the proposed 2016 national, standardized 60-day episode payment rate would be $2,938.37. If a home health agency (HHA) does not submit the required quality data, that rate would drop by 2% to $2,880.92.

Home Health Quality Reporting Program. CMS will add 1 standardized cross-setting measure to the Home Health Quality Reporting Program for 2015, as required by the IMPACT Act of 2014. The law requires HHAs, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals to submit standardized patient assessment data and standardized data on quality measures and recourse use. The proposed new measure, the National Quality Forum (NQF)-endorsed measure: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678), addresses changes in skin integrity. Also new for 2016, all HHAs will need to submit both admission and discharge OASIS assessments for at least 70% of all patients whose episodes of care occurred during the reporting period starting July 1, 2015. The threshold will increase by 10% in each of 2016 and 2017 to reach 90%.

Home Health Value-Based Payment Model. HHAs in 9 states will participate in a new value-based payment model beginning January 1, 2016. These HHAs will receive a payment increase or reduction in a future year based on quality performance in the designated earlier year, and CMS projects an estimated $380 million in total savings 2018-2022 from reductions in unnecessary hospitalizations and skilled nursing facility usage. The states, chosen randomly from within designated geographic groupings, are Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington. Among the details of the program:

- The first payment adjustment, in 2018, will be based on 2016 performance data. The maximum increase or decrease will be 5% in 2018 and 2019, 6% in 2020, and 8% in 2021 and 2022.
- A total performance score, determined using the higher of either the HHA's achievement score or improvement score for each measure, will determine the payment adjustment in a given year.
- The proposed rule includes a detailed discussion of the initial set of proposed measures, which include both process and outcome measures, and the scoring and payment adjustment methodologies.

Component Advocacy News and Tips

WV Public Employee Insurance Agency Removes Barriers to Direct Access to PT

Since 1984, West Virginia has had direct access. Unfortunately, patients have not been able to fully take advantage of this policy because many of the large payers in WV will not reimburse providers for their services without a referral from a physician. However, at WV’s Payer Forum last fall, chapter representatives had a discussion with payers about the savings and efficiencies of direct access. Ted Cheatham, the CEO of the WV Public Employee Insurance Agency
(PEIA), was intrigued by the concept and reported he would give it some thought. In July, PEIA notified the WV Chapter of a policy change, stating that PEIA would no longer require a physician’s referral for the first 20 physical therapy visits. This is a big win for the Chapter, physical therapist in WV, and patients.

**CO Medicaid Rates Increase**
The Centers for Medicare and Medicaid Services (CMS) has approved Colorado’s recent Medicaid State Plan Amendment to pay significantly higher rates beginning July 1 to PT clinics providing out-patient therapy services to Medicaid clients.

This formal CMS approval follows passage during the 2015 state legislative session of Senate Bill 15-234 that authorizes $3.6M in new funds to the State Department of Health Care Policy & Financing to pay six therapy codes higher rates.

APTA Colorado took the lead last fall in requesting these substantial Medicaid rate increases for Physical Therapy to meet the rehabilitation needs of thousands of new recipients under the Medicaid program expansion under the Affordable Care Act. The chapter’s legislative initiative began with testimony before the Joint Budget Committee (JBC) in December. The JBC heard the plea and allocated $3.6M in new funds for therapy services beginning July 1, 2015.

The increase brings Medicaid rates up to 90 percent of what Medicare pays for six important and useful codes. The new rates were effective on July 1 but there will be several months’ delay in actual payment of the new rates because CMS must officially approve any Medicaid payment increase.

**Telehealth Legislation Signed by CT Governor**
On June 23, Connecticut Governor Malloy signed legislation that establishes new requirements for the delivery of healthcare services via telehealth to patients within the state, and requires certain insurance coverage of those services. The new law specifically includes PTs as “telehealth providers.” These telehealth provisions will provide patients with greater access to physical therapy services, especially those in underserved rural and urban areas. See details [here](#).

**IA Passes Legislation Limiting Copays for Physical Therapist Services**
On July 2, Iowa Governor Branstad signed SF 505 into law. This Health and Human Services appropriations bill included provisions that limit patient copays for physical therapy services. Provisions in the language specify that patient copays imposed by certain third-party payers for services provided by physical therapists, occupational therapists, and speech-language pathologists may not exceed those imposed for services provided by physicians for the same or similar condition. With support from APTA and the Private Practice Section, Iowa Chapter members led effective grassroots advocacy efforts to educate legislators. For additional details about this effort, read the issue brief [at this link](#).

**PTs in MO Can Certify Individuals Requiring a Disability Parking Placard**
On July 13, 2015 Missouri Governor Nixon signed SB 254 into law. This bill, which addresses several motor vehicle-related issues, adds licensed PTs to the list of licensed health care providers who can certify an individual with a disability for the purposes of obtaining a Missouri permanent or temporary disability parking placard. The law goes into effect August 28, 2015. Read the issues brief [at this link](#).
Strapping vs. Taping
Recently, APTA has received several questions regarding the difference between strapping and taping. To clarify, strapping is the application of adhesive in overlapping strips in order to immobilize a body part, whereas taping is typically applied in a specific manner to control and/or guide motion rather than to immobilize a body part. You can find more information about strapping, taping, and casting in APTA’s Orthotics, Prosthetics, Casting, Strapping, and Taping FAQ. Providers should also review payer polices regarding strapping and taping to ensure proper billing.

Summaries of Key Provisions in Final and Proposed Rules Released by CMS
CMS has released several final and proposed rules impacting physical therapists. Below are two charts that summarize the key provisions:

FINAL RULES:

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<thead>
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<th>Setting</th>
<th>Payment</th>
<th>Quality</th>
<th>Other</th>
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<tr>
<td>Inpatient hospital</td>
<td>0.09%</td>
<td>✓ New measures added to quality programs</td>
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<tr>
<td>Long-term care hospital</td>
<td>4.6%</td>
<td>✓ New functional measures (IMPACT)</td>
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<tr>
<td>Inpatient rehabilitation facilities</td>
<td>1.8%</td>
<td>✓ New functional measures (IMPACT)</td>
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<tr>
<td>Skilled-nursing facilities</td>
<td>1.2%</td>
<td>✓ New functional measures (IMPACT)</td>
<td>✓ New requirements on detailed staffing reports</td>
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<tr>
<td></td>
<td></td>
<td>✓ New value based purchasing program</td>
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ICD-10 Webinar Now Available for Free Download

ICD-10: Final Steps for Successful Implementation is now available to APTA members for free. This 90-minute presentation provides a brief history of ICD-10, an overview of how it is different from ICD-9, and strategies for using the system set to begin on October 1. More information on ICD-10 is available on APTA’s ICD-10 webpage.

Federal Resources

MLN Connects Provider eNews Lists Resources to Help Providers with ICD-10 Transition

The recent edition of MLN Connects Provider eNews, the weekly newsletter released by the Centers for Medicare and Medicaid Services, provides several resources to help providers prepare for the October ICD-10 deadline. The newsletter provides links to an ICD-10 FAQ, a provider webpage, as well as a guide to ICD-10. You can view the newsletter on the CMS website.

APTA Activities / Calendar of Events

Preventing Fraud, Abuse, and Waste: A Primer for Physical Therapists

APTA’s fraud, abuse, and waste course is now available to members for free. This course reviews laws, written regulations, and policies introduced by the federal government and other payers designed to crack down on the prevalence of health care fraud, abuse, and waste.
2015 Medicare Post-Acute Care Seminar
The 2015 Medicare Post-Acute Care Seminar will be held on November 14, 2015 at APTA headquarters in Alexandria, VA. Members can attend the seminar live or view the seminar virtually. For more information and to register for the seminar, visit APTA’s Learning Center.