A Medicare Update:

Rules-Regs-Reimbursement

Daneen Grooms, MHSA

Director, Health Reform Analysis & Advocacy

ASHA Disclosure

Daneen Grooms, MHSA, Director of Health Reform Analysis and Advocacy

: Paid employee of ASHA

Non : Contributor of for-sale ASHA products on the topic of health plan payments, coding, and payer advocacy. Receives no compensation for product sales.

Agenda

- Treating Patients with Medicare
  - Enrollment
  - Documentation
  - Billing
- Moving from Fee-for-Service to Value
- Health Care Reform and the Affordable Care Act

Who Must Enroll In and Submit Claims Under Medicare?

Anyone who treats a patient who qualifies for Medicare due to:

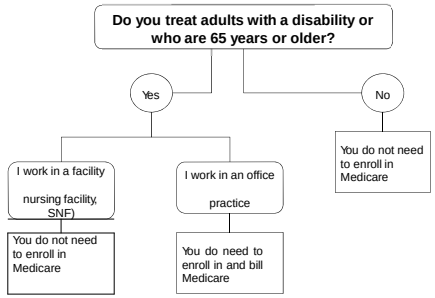
- Age
- Disability

If you are treating a patient who qualifies for Medicare by virtue of age or disability, you are required to enroll in and submit claims to the Medicare program for covered services

- Section 1848 (g)(4) of the Social Security Act

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0908.pdf

Enrollment Decision Tree



What is a Covered Service?

BOTH **Medically Necessary** AND **Skilled**

What is a Covered Service?

Services necessary to…

- Improve
- Maintain
- Prevent (or slow the deterioration of)

…the patient's current condition/function

Covered Services Limitations for Audiology

- Hearing and balance assessments
- Requires a physician order prior to testing
- Reason for test must be to determine a medical condition or the appropriate medical or surgical treatment for a medical condition

"Opt Out"

What does "opt out" mean?

- Essentially "opting out of Medicare" means you see Medicare beneficiaries but you do not enroll in or bill Medicare. In this case the clinician might charge the beneficiary directly.
- Unfortunately, under law, only certain categories of clinicians are allowed to "opt out." Audiologists and SLPs are not included.
- List of providers allowed to opt out can be found at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf

Can an Unenrolled SLP Bill Under the NPI of an Enrolled SLP?

Enrolled clinician **Unenrolled clinician**

Locum tenens is the closest Medicare has to this type of arrangement, and it **does not include audiologists and SLPs**

Locum Tenens

It is a longstanding and widespread practice for ***physicians*** to retain substitute ***physicians*** to take over their professional practices when the regular ***physicians*** are absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for the regular ***physician*** to bill and receive payment for the substitute ***physician's*** services as though he/she performed them. The substitute ***physician*** generally has no practice of his/her own and moves from area to area as needed. The regular ***physician*** generally pays the substitute ***physician*** a fixed amount per diem, with the substitute ***physician*** having the status of an independent contractor rather than that of an employee. These substitute ***physicians*** are generally called "locum tenens" ***physicians***.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf

Incident to Billing: SLP

The Medicare Benefit Policy Manual (Chapter 15, Section 60) describes "incident to" services as:

> "Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness."

For an SLP to deliver the service incident to a physician, he/she must have the direct supervision of the physician.

Incident to Billing: Audiology

Section 1861(II) of the Social Security Act prohibits audiology services from being billed "incident to" the physician.

Free Services

Free services can be given if associated with a written policy that applies to all patients regardless of payer. If Medicare beneficiaries fall under the free services policy, then enrollment and billing is not required.
g. .: All patients making less than $20,000 a year get free services

Citations:

- Chapter 16 §40 of the Medicare Benefit Policy Manual www.cms.gov/manuals/Downloads/bp102c16.pdf
- describes the prohibition against inducing Medicare beneficiaries (such as providing free services) by Medicare providers
- Office of the Inspector General (OIG) issued a Special Advisory Bulletin titled "Offering Gifts and Other Inducements to Medicare Beneficiaries" in August 2002

Is There an Alternative to Enrolling In and Billing Medicare?

YES!

- Do not accept Medicare beneficiaries
- If a Medicare beneficiary approaches you for treatment and you do not want to enroll in and bill Medicare for the services, then you must turn the patient away
- You are allowed to say no to Medicare beneficiaries
- Even if a beneficiary is willing to pay you out of pocket, you can only see him/her if you enroll in and bill Medicare
- Alternately, SLPs could provide services "incident to" a physician

Is My Obligation to Enroll and Bill Medicare New?

- July 16, 2008 – MIPPA passed
  The Medicare Improvements for Patients and Providers Act (MIPPA) included a provision that allowed SLPs in private practice to directly bill the Medicare program effective July 1, 2009
- June 2, 2009 – The Centers for Medicare and Medicaid Services began accepting enrollment applications
- Not new for audiology

What Is the Enrollment Process?

Step 1: Get your National Provider Identifier (NPI)

Step 2: Enroll as an individual (855-I), enroll as a business (855-B), and/or reassign your benefits to your practice via the 855-R

Step 3: Once approved, submit claims

www.asha.org/practice/reimbursement/medicare/SLPmedicareenroll/

What Are the Consequences for Failure to Enroll and Submit Claims?

- Compliance with mandatory claim filing requirements is monitored by CMS
- Violations of the requirement may be subject to:
  - A civil monetary penalty of up to $2,000 for each violation
  - A 10 percent reduction of a physician's/supplier's payment once the physician/supplier is eventually brought back into compliance
  - And/or Medicare program exclusion
- Medicare beneficiaries may not be charged for preparing or filing a Medicare claim

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0908.pdf

Practical Tips for Medicare Compliance

Billing and documentation requirements

How is Medicare Administered?

How is Medicare Administered?

Medicare Administrative Contractors (MACs) issue local coverage determinations (LCDs):

- CPT and ICD-10 codes are considered medically necessary (may require specific pairing for coverage)
- Impose limitations on coverage
- May be general for clinical specialty or specific to types of services provided (e.g., dysphagia, vestibular)

Medicare Coverage Database:
https://www.cms.gov/medicare-coverage-database/

Medicare Part B

- Known as the Medicare Physician Fee Schedule (MPFS)
- Retrospective payment methodology for outpatient services under Part B of the Medicare program provided in:
  - Private practice
  - CORF
  - SNF (Part B)
  - Home Health (Part B)
  - Outpatient hospital department
- Fee schedule payment tracks to the calendar year (January-December)
- Annual changes required by law or developed by CMS are proposed through a rulemaking process
  - Proposed rule typically issued around July 1 each year
  - 60-day comment period provided
  - Final rule typically issued on or before Nov. 1 each year

Payment Policies: Multiple Procedure Payment Reduction (MPPR) (SLP Services)

- Developed to adjust payment "to more appropriately reflect reduced resources involved with furnishing the service for certain sets of services frequently furnished together"
- Payment reduced for the second and subsequent services within the same MPPR category furnished in the same session/day

Payment Policies: How Does MPPR Work? (SLP Services)

- MPPR **ONLY** reduces the practice expense value; therefore, the entire value of the code is not reduced
- Applicable to "always therapy" services delivered on the same day regardless of therapy discipline
- Code with highest practice value is paid at full amount; each subsequent code is subjected to the MPPR reduction

Payment Policies: Therapy Cap (SLP Services)

- Blunt mechanism for controlling costs associated with therapy/rehab services
- One cap for OT and a separate cap for PT/SLP combined
  - SLP has only been an independent benefit since 2008
- Cap amount for 2017 = $1,980
- Annual cap (January–December) applicable to all services a Medicare beneficiary receives over the course of the year, regardless of treatment setting or diagnosis
  - E.g., patient treated in HOPD in January for a fall; patient treated in private practice for stroke in September – one cap
- Increases each year by approximately $20
- Can exceed the cap by using KX modifier on claims
  - Requirements for billing for services same below and above cap
  - www.asha.org/Practice/reimbursement/medicare/overview_exception/

Payment Policies: Manual Medical Review (MMR) (SLP Services)

- $3,700 threshold for OT
- $3,700 threshold for PT/SLP combined
- Administered by the Supplemental Medical Review Contractor (SMRC), Strategic Health Solutions, LLC
- First additional documentation requests (ADRs) issued late April 2016 for services provided July 2015–present
- Same criteria for coverage below and above the threshold – medically necessary, skilled services

REVIEW

Payment Policies: Manual Medical Review (MMR) (SLP Services)

- Who's targeted:
  - Providers with a high percentage of patients receiving therapy beyond the threshold as compared to their peers during the first year of Medicare Access and CHIP Reauthorization Act (MACRA)
  - Providers delivering "a lot" of minutes or hours of therapy per session
  - Therapy provided in SNFs, therapists in private practice, and outpatient physical therapy or speech-language pathology providers (OPTs) or other rehabilitation providers
- MMR process:
  - Request 40 records (ADRs)
  - SMRC has 45 days to review, issue decision on all 40 records at once
  - Compare like providers (e.g., SNF to SNF; private practice to private practice)
  - Informal discussion period, then move to appeals process

Payment Policies: Functional Limitation Reporting (SLP Services)

- Has been in place since Jan. 1, 2013
  - Required for all therapy services (e.g., below and above the cap)
- Use of G-codes primarily tied to evaluation codes
  - Reported at first visit, discharge, every date of service when an evaluation code is billed, and every 10th treatment visit
- Claims without the functional limitation G-codes will be returned unpaid
  - Can resubmit as a corrected claim
  - Documentation must support G-codes submitted
- CMS functional limitation reporting FAQ: https://www.cms.gov/Medicare/Billing/TherapyServices/Downloads/Functional-Reporting-PT-OT-SLP-Services-FAQ.pdf

Payment Policies: Functional Limitation Reporting

Practical Tips:

- **Report one treatment goal at a time**

  Ongoing reporting (but not treatment) is limited to one condition/disorder/functional limitation at a time, even for those patients who qualify and will be treated for multiple categories. The primary functional limitation should be chosen, and, after the treatment goal is achieved for the primary, a subsequent functional limitation should be reported.

- **Include the -GN modifier**

  The therapy modifier -GN is required on the claim form to indicate the therapy service is furnished under the SLP plan of care. The -GN modifier is also required for all of the G-codes reported on the claim.

Physician Quality Reporting System (PQRS)

- PQRS applies to both audiologists and SLPs
- No reporting in 2017 or 2018
- Payment adjustments for 2016 reportinwill still be imposed in 2018
- Voluntary reporting under Merit-Based Incentive Payment System (MIPS) is an option but CMS has provided no guidance.
- Mandatory reporting under MIPS TBD- probably 2019
- Many of these measures moving to new quality reporting program- MIPS

Medicare Documentation Requirements: SLP

Plan of care

- Diagnoses
- Long-term treatment goals
- Type (PT, OT, SLP)
- Amount (# of times/day therapy delivered)
- Duration (# of weeks or treatment sessions)
- Frequency (# of times/week therapy delivered)

Medicare Documentation Requirements: SLP

Progress note

- Assessment of improvement, extent of progress (or lack thereof) toward each goal
- Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions should be documented in the clinician's Progress Report
- Changes to long- or short-term goals, discharge, or an updated plan of care that is sent to the physician/non-physician practitioner for certification of the next interval of treatment

Medicare Documentation Requirements: SLP

Daily treatment note

- **Date of treatment**
- **Each intervention/modality**

  Identification of each specific intervention/modality provided and billed, for both timed and untimed codes, in language that can be compared with the billing on the claim to verify correct coding. Record each service provided that is represented by a timed code, regardless of whether or not it is billed because the unbilled timed services may impact the billing.
- **Length of time of treatment**

  Total timed code treatment minutes and total treatment time in minutes.

  Total treatment time includes the minutes for timed code treatment and untimed code treatment. Total treatment time does not include time for services that are not billable (e.g., rest periods).
- **Signature and professional identification**

  Of the qualified professional who furnished or supervised the services and a list of each person who contributed to that treatment
  (E.g., the signature of Kathleen Smith, PTA, with notation of phone consultation with Judy Jones, PT, supervisor, when permitted by state and local law)

Medicare Documentation Requirements: Audiology

Physician order

- Obtained **prior to delivery** of services
- Must include **date of request** by ordering provider and NPI of ordering provider on claim
- Can be issued by:
  - Physician
  - Nurse practitioner
  - Clinical nurse specialist
  - Physician assistant
- Does not need to list specific services; can be determined by audiologist independently
- Can be:
  - Signed, written document
  - Telephone call (as documented by both the audiologist and physician)
  - Securely transmitted email
  - Note in the medical record (if the audiologist and physician work in the same practice)

Medicare Documentation Requirements: Audiology

Reason for test

- Failure of hearing screening
- Identification of cause of suspected hearing loss, tinnitus, or balance disorder
- Patient report of suspected change in hearing, tinnitus, or balance
- Re-evaluation because of changes in hearing, tinnitus, or balance status
- Monitor effect of medication, surgery, or other treatment
- Analyze and program cochlear or brainstem implant
- Evaluation from implant of prosthetic device or periodic evaluation following implantation

Medicare Documentation Requirements: Audiology

Justification of procedures billed

- Include code and procedures performed in a note along with the results of each procedure
- Include time spent with patient performing evaluation and time spent writing report
  - Must spend at least 31 minutes to bill for hour-long codes

THE FUTURE IS OURS TO CREATE

Healthcare Delivery and Payment is Transforming

Quantity **Quality**

- Fee-for-service = payment for ***quantity*** of care
- Value-based = payment for ***quality*** of care
- The trend is **moving toward value-based**
  (As a result of the Affordable Care Act in 2010)

Value: Improved quality at reduced cost

Medicare Payments are Transitioning

The Centers for Medicare and Medicaid Services (CMS)

- Mandated (and funded) by ACA to find other sorts of payment models that might work
- Formed the Center for Medicare and Medicaid Innovation (Innovation Center)
- Develops and tests various payment and delivery models

Alternative payment models are a means of achieving the goal of value-based care

CMS's Triple Aim

- **Better care**
  - Coordinated care, alternative payment models
- **Smarter spending**
  - Evidence-based care and eliminate duplicative services
- **Healthier people**
  - Patient-centered, incentive for outcomes

CMS Payment Framework

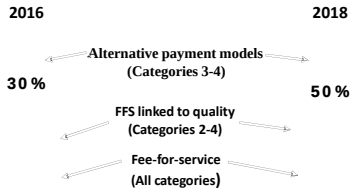
Fee-for-Service (volume) → Value (quality + cost)

	Category 1: Fee for Service—No Link to Quality	Category 2: Fee for Service—Link to Quality	Category 3: APMs Built on Fee-for-Service Architecture	Category 4: Population-Based Payment
Description	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of healthcare delivery	Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk	Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (i.e., >1 yr)
Medicare FFS	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician value-based modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable care organizations • Medical homes • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD • Medicare-Medicaid financial alignment initiative fee-for-service model	• Eligible Pioneer accountable care organizations in years 3-5

Source: CMS

Why This Matters

The percentage of Medicare FFS payments linked to quality and alternative payment models is growing!



Description of Alternative Payment Models

Alternative Payment Models (APMs)

- Accountable care organizations
- Episode of care
- Bundled payment
- Patient-centered medical home

Accountable Care Organizations (ACOs)

ACOs

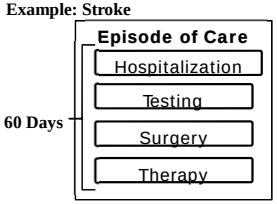
- Assume accountability for the cost and quality of care for a **defined population of patients**
- Coordinate the services of its providers in various healthcare settings to manage patients' needs
- Health information technology is integral
- Can be hospital-driven or hospital/provider arrangements
- Medicare and private sector ACOs exist

www.beckershospitalreview.com/lists/100-accountable-care-organizations-to-know-2015.html

Episode of Care

Encompasses all services provided to a patient with an **identified condition** within a **specific period of time** across a continuum of care in an integrated healthcare system (e.g., Stroke)

Example: Stroke



- Did services improve outcome?
- Was spending reduced?
- Was treatment completed within the required timeframe?

Bundled Payment

- Represents a single fixed payment for an identified condition
- Better coordination of care for patients
- Works really well for procedures/services with a **discrete stop/end time**
- Can also be implemented for **chronic conditions**

Patient-Centered Medical Home (PCMH)

- A model, not a "home"
- The PCP coordinates care with other providers ("gatekeeper")
- Enhanced care coordination and communication, particularly useful for chronic conditions
- Intended to minimize fragmentation of information between providers
- Can be integrated into ACOs

Patient

APMs under MACRA

Medicare Access and CHIP Reauthorization ACT (MACRA)

- Transitions Medicare outpatient payment to payment based on quality, outcomes, and efficiency
- Repeals sustainable growth rate (SGR)
- To learn about the Quality Payment Program: **https://qpp.cms.gov/**

Merit-Based Incentive Payment System (MIPS) or Alternative Payment Models (APMs)?

Chart Courtesy of MedPAC

Who Is a MIPS-Eligible Clinician (EC)?

Included in MIPS:

- 2019-2020: Restricted to physicians, physician assistants, nurse practitioners, clinical nurse specialists, nurse anesthetists, and group practices
- **2021+: Others, including SLPs and audiologists**
  - **Can participate as early as 2017 to "gain experience"**
- Participants in non-advanced APMs

Excluded from MIPS:

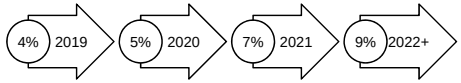
- Newly enrolled clinicians (in Medicare)
- Qualifying and partial qualifying APM participants
- Clinicians who do not exceed the low-volume threshold (charge less than or equal to $30,000 ***OR*** care for 100 or fewer Part B-enrolled beneficiaries)
- Unlikely for facility-based providers

Merit-Based Incentive Payment System (MIPS)

- Composed of four categories
  - Quality (PQRS)
  - Clinical Practice Improvement Activities (CPIA) (new)
  - Advancing Care Information (ACI) (meaningful use)
  - Cost (value modifier)
- Beyond pay for reporting
  - Scores compared to a benchmark to compare quality
  - "High" quality, positive adjustment
  - "Low" quality, negative adjustment

MIPS Performance Category Weights (2019 Adjustment)

MIPS Adjustment Factor



What Qualifies as an Advanced APM?

Chart Courtesy of MedPAC

Why Should Providers Participate in an Advanced APM?

Audiologists and SLPs who are qualified Advanced APM participants will receive a 5% bonus payment for covered Part B Medicare payments from 2019-2024

Advanced APM Requirements

The clinician:

- Participates in an APM that requires use of certified EHR technology
- Uses quality measures comparable to the Merit-Based Incentive Payment System (MIPS)
- Either bears financial risk for monetary losses in excess of a nominal amount or is a PCMH under section 1115A

Requirements for Participation in an Advanced APM

Payment Threshold (% of payments)
That must be attributable to services furnished through an advanced APM

Payment Threshold	2019-2020	2021–2022	2023 and beyond
Medicare only	25%+	50%+	75%+
Combination all-payer and Medicare	N/A	50% (all-payer) 25% (Medicare)	75% (all-payer) 25% (Medicare)

Requirements for Participation in an Advanced APM

Patient count threshold (% of patients) That must be attributable to services furnished through an advanced APM			
Patient Count Threshold	**2019-2020**	**2021–2022**	**2023 and beyond**
Medicare only	20%+	35%+	50%+
Combination all-payer and Medicare	N/A	35% (all-payer) 20% (Medicare)	50% (all-payer) 20% (Medicare)

Health Care Reform and the Affordable Care Act

The ACA and Medicare

- The law includes many provisions affecting the Medicare program related to provider payments, benefit improvements, and delivery and payment system reform
  - https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7948-02.pdf

The ACA requires coverage of 10 benefit categories

1. Ambulatory Patient Services
2. Emergency Services
3. Hospitalization
4. Maternity and Newborn Care
5. Mental Health and Substance Use Disorder Services
6. Prescription Drugs
7. **Rehabilitative and Habilitative Services and Devices**
8. Laboratory Services
9. Preventive and Wellness Services and Chronic Disease Management
10. Pediatric Services, including Oral and Vision

Rehabilitative and Habilitative Services and Devices

- Individual and small group (50 or fewer employees) health plans operating inside and outside of the Marketplace have to cover these services
- **Does not apply** to Medicare, traditional Medicaid or private insurance plans that are self-funded and/or large group health plans (more than 50 employees)
- States expanding their Medicaid programs must provide EHBs

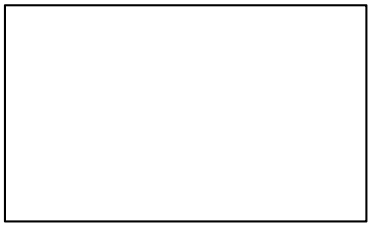
EHBs: Snapshot of Medicaid Expansion by State

Uniform Definition and Separate Visit Limits

- Habilitation services and devices:

  Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
- Separate visits limits for rehabilitation and habilitation services in 2017

Recent ACA Repeal/Replace Efforts



American Health Care Act (AHCA)

- American Health Care Act proposed to:
  - Eliminate Medicaid expansion
  - Eliminate EHBs
  - Limit federal contribution to Medicaid on a per capita basis (i.e. elderly, blind and disabled, children, non-expansion adults, expansion adults)
- GOP leaders pulled the AHCA bill for vote in the House on March 24, 2017 so the ACA remains and is still the law

ACA still faces challenges

- **Regulatory:** Sec Tom Price has been a critic of EHBs and the ACA.
  - The ACA gives significant authority to the Secretary to implement law.
  - CMS has waiver authority regarding States' implementation of Medicaid
- **Legislative:** Congress can introduce another ACA repeal/replace bill
- **Executive:** President Trump asked federal agencies to minimize impact of the individual mandate

Acronyms

- **ACA:** Affordable Care Act (Obamacare)
- **APMs:** Alternative Payment Models
- **CMS:** Centers for Medicare and Medicaid Services
- **CPIA:** Clinical Practice Improvement Activity
- **CPT:** Current Procedural Terminology
- **EHR:** Electronic Health Record
- **EC:** Eligible Clinician
- **ICD:** International Classification of Disease
- **LCD:** Local Coverage Determination
- **MMR:** Manual Medical Review
- **MACRA:** Medicare Access and CHIP Reauthorization Act
- **MAC:** Medicare Administrative Contractor
- **MEI:** Medicare Economic Index
- **MedPAC:** Medicare Payment Advisory Commission
- **MPFS:** Medicare Physician Fee Schedule
- **MIPS:** Merit-Based Incentive Payment System
- **MPPR:** Multiple Procedure Payment Reduction
- **NPI:** National Provider Identifier
- **PQRS:** Physician Quality Reporting System
- **QPP:** Quality Payment Program
- **RVU:** Relative Value Unit
- **SNF:** Skilled Nursing Facility
- **SGR:** Sustainable Growth Rate

ASHA Staff Contacts

reimbursement@asha.org will get you to the right person!

OR

Questions regarding:

- **Health Reform/APMs:**
  Daneen Grooms, dgrooms@asha.org
- **Medicare:**
  Sarah Warren, swarren@asha.org

72