



What's New

We Need Your Input: How Can We Communicate Better?

The Payment and Practice Management Department is looking for ways to improve communication between the component payment chairs and APTA. Please take this [short survey](#), and let us know how you prefer to receive information and resources on payment issues.

Physical Therapy Outcomes Registry Pilot Participation

APTA is pilot testing the Physical Therapy Outcomes Registry, with a limited number of slots remaining for participation. Pilot participants will be fully funded through 2015. If you are interested in participating in the pilot, please e-mail registry@apta.org.

The registry is a data collection system that **will improve practice and support quality compliance requirements such as PQRS**. Registry participants will be able to successfully meet regulatory requirements, and will receive data and benchmark information on performance at individual PT and practice levels that they can use to enhance patient care and justify services to payers. For more information, please visit www.apta.org/registry.

APTA Board Honors State Advocates

Physical therapist leaders from Oklahoma, Washington, Arizona, and Arkansas were honored for their successful efforts dedicated to state legislation that advances the physical therapy profession at the State Policy and Payment Forum in Seattle, Washington. The APTA Board of Directors awarded the 2014 State Legislative Leadership Award to **Brandon Trachman PT, MPT, OCS**, of the Oklahoma Chapter for his work on legislation this year making Oklahoma the 49th direct access state; **Robin Schoenfeld, PT, OMT**, of the Washington Chapter for her work on legislation that removed the 25-year-old prohibition on PTs performing spinal manipulation in Washington; and **Sean Flannagan, PT, DPT, Cert SMT, Cert DN**, of the Arizona Chapter for his work on legislation that added dry needling to Arizona's physical therapy practice act. In recognition of his long-term commitment to their chapters' state advocacy activities over several years, the APTA Board of Directors awarded the 2014 State Legislative Commitment Award to **Steve Forbush, PT, PhD, OCS**, of the Arkansas Chapter. *Be sure to [check out the Storify with video highlights](#) from this year's APTA State Policy Forum.*

Federal Payment

CMS Says Keep Using 59 Modifier for Now

In August, CMS issued a transmittal describing new modifiers—XE, XS, XP, and XU—intended to be used to define subsets of the 59 modifier. However, until you receive further notice, continue using the 59 modifier in reimbursement claims to indicate that a health care common procedural code (HCPCS) represents a service that is separate and distinct from another service to which it is paired under the Correct Coding Initiative (CCI) program. The Centers for Medicare and Medicaid Services (CMS) responded to an inquiry from APTA as to when—and whether—physical therapists should

use the new X-modifiers. CMS has advised that the new modifiers have not been implemented, and PTs should not use them at this time.

ICD-10 Testing Dates Announced

After several delays, the Centers for Medicare and Medicaid Services (CMS) is now ready to test its International Classification of Diseases, 10th Revision (ICD-10) system with providers before the October 1, 2015, startup date for use of the new codes. APTA is encouraging members to participate in the testing program to make sure their own systems, billing companies, and clearinghouses are ready for the changeover.

The testing program will be held over 3 separate weeklong sessions—1 on November 17-21 this year, and 2 in 2015, March 2-6 and June 1-5. Members only need to sign up for 1 session to find out whether their Medicare administrative contractor (MAC) will be able to accept claims with the new codes. The MACs will post information on how to participate in the tests. More information on the program can also be found in a [Medicare Learning Network bulletin \(.pdf\)](#).

Final 2015 Physician Fee Schedule Rule Announces 1% Payment Rise, Increase in PQRS Reporting, Delay of VM for PTs

The final [2015 Medicare physician fee schedule \(PFS\) rule](#) released by the Centers for Medicare and Medicaid Services includes an aggregate increase in payment for physical therapy services of 1%--provided Congress stops implementation of a payment cut due to the flawed SGR formula by March 31. In addition, despite objections from APTA and other organizations, it increases the number of Physician Quality Reporting System (PQRS) measures required for reporting of physical therapists (PTs) in private practice and other health care professionals to as many as 9.

The new PQRS rules were opposed by many other professional health care provider organizations and APTA, which provided CMS with comments when the rule was first proposed. The PQRS change will increase the number of individual measures required to be reported in order to avoid the 2017 2.0% PQRS penalty, from 3 to as many as 9, depending on whether the provider is using claims (6 measures available for 2015), or registry (9 required, or as many as apply to the provider). As in 2014, providers must report on at least 50% of eligible Medicare patients.

While the new reporting requirements are moving forward as proposed, CMS delayed the inclusion of nonphysician eligible professionals (including physical therapists) in the value-based modifier (VM) program until 2018, instead of its proposed 2017 implementation date. The delay is intended to allow the nonphysician professionals to familiarize themselves with PQRS and VM systems.

Other changes include:

- The 2015 therapy cap will be \$1,940, up \$20 from the 2014 cap.
- The \$3,700 manual medical review expires March 31, 2015, consistent with the expiration of the agency's authority to provide therapy cap exceptions. Congress will need to act before March 31 to allow an exceptions process.

In other rules announcements, CMS issued final rules on the methodology for adjusting the DMEPOS fee schedule payment amounts, and the establishment of alternative payment rules for a phase-in of a competitive bidding program. APTA will post detailed summaries of the new rules in the coming weeks.

CMS Eases Reassessment Requirements in 2015 Home Health Rule

Beginning in 2015, the Centers for Medicare and Medicaid Services (CMS) will adopt a change suggested by APTA and others, and replace a requirement that home health therapy reassessments be performed at the 13th and 19th visits

with one that requires a reassessment every 30 calendar days by each therapy discipline. The new requirement is part of a set of finalized changes to the Home Health Prospective Payment System rule announced by CMS on October 30.

Under the [final rule](#), set to be implemented January 1, 2015, physical therapists (PTs) must "perform the needed therapy services, assess the patient, measure progress, and document objectives and goals at least once every 30 calendar days during the home health episode of care." The reassessment policy applies to physical therapy, occupational therapy, and speech-language pathology, and must be conducted by a qualified therapist from each discipline. In the case of physical therapy, "qualified therapists" would be limited to PTs.

CMS had originally proposed that the reassessment be performed every 14 calendar days, but increased the requirement to 30 days after receiving comments from the public, including APTA.

CMS also announced that it will eliminate the mandate for a "narrative" to be supplied by a physician in order to comply with a physician "face to face" requirement. APTA supported this change, expressing concerns that the current rule creates an undue burden on the home health community. The physician (or nonphysician practitioner) will still be required to certify that a face-to-face patient encounter occurred in order to meet the requirements for the home health stay. That encounter must take place no more than 90 days before the start of home health care or within 30 days after it begins.

Final Rule on Outpatient Prospective Payment Includes 2.2% Rate Increase

The [final rule for the outpatient prospective payment system \(OPPS\)](#), released by the Centers for Medicare and Medicaid Services (CMS) on October 31, includes a 2.2% increase in payment rates to hospital outpatient departments beginning January 1, 2015.

The rule includes the packaging of payment for certain ancillary services provided in the hospital as well as comprehensive payments for a list of 25 primary services. The comprehensive payments include adjunctive services and supplies that support delivery of the primary service, which may include some physical therapist services that occur in the perioperative period. Further, the rule requires physician certification for hospital inpatient admissions only for long-stay cases and outlier cases, not short stays.

Except for a small subset of "sometimes therapy" services delivered without a certified therapy plan of care, most physical therapist services provided in the outpatient hospital department are paid under the Medicare physician fee schedule (PFS), not the OPPS. CMS provides an annual update of these "sometimes therapy" services that are paid under the OPPS and subject to direct supervision requirements.

CMS Issues Final 2015 Rules for Inpatient Prospective Payment System

The Centers for Medicare and Medicaid Services (CMS) has issued [final rules](#) for prospective payment systems for acute care and long-term care hospitals (LTCHs), the net effect of which will be to decrease payments to acute care hospitals paid under the inpatient prospective payment system (IPPS) by \$756 million and increase payment to LTCHs by 1.1% under the LTCH prospective payment system.

Despite comments from stakeholders, the rule avoids changing the "2-midnight" policy or policies for short stays. The rule also finalizes the use of 5 readmissions measures for assessing readmission penalties, incorporating methodology changes supported by APTA related to hip and knee arthroplasty.

Among other changes set for 2015:

- Hospitals in the top quartile for the rate of hospital acquired conditions—those with the poorest performance—will have their Medicare IPPS payments reduced by 1%.

- CMS will distribute \$7.65 billion in uncompensated care payments, a decrease from the \$8.56 billion estimate in the proposed rule.
- CMS will assess hospitals' readmission penalties using 5 readmissions measures endorsed by the National Quality Forum (NQF): heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease, and hip/knee arthroplasty. CMS has finalized an updated methodology to take into account planned readmissions for these 5 existing readmissions measures, as well as refinement in the hip/knee arthroplasty readmission measure methodology.
- CMS provides guidelines for implementing the Affordable Care Act's provision requiring transparency in hospital charges. Under these guidelines, hospitals should publish either a list of their standard charges or their policies for allowing the public to view a list of those charges in response to an inquiry.

In addition to the changes for 2015, CMS finalized the addition of 2 quality measures related to function for the 2018 LTCH Quality Reporting Program. APTA supported the measures, titled "Functional Outcome Measure: Change in Mobility among LTCH Patients Requiring Ventilator Support," and "Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function."

[APTA participated in the comment period](#) for the 2015 rules when they were proposed by CMS earlier this year, and will publish a summary of the changes online in the coming weeks.

SNF, IRF Final Rules for 2015 Released by CMS

Rule changes for skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs) will increase payments by 2% and 2.2%, respectively, in 2015. In addition to the increases, the new rules issued from the Centers for Medicare and Medicaid Services (CMS) will make changes to a host of reporting, coding, and data collection models, as well as establish definitions of various therapy models in IRFs.

The payment increases amount to an additional \$750 million for SNFs, and an increase of \$180 million for IRFs.

[IRF rules changes \(.pdf\)](#) include the following:

- Removal of 10 status post-amputation diagnoses codes from the list of codes that meet presumptive compliance criteria
- Beginning October 1, 2015, addition of an item in the IRF patient instrument (PAI) to record the amount and mode of therapy delivered by each therapy discipline for the first 2 weeks of the IRF stay
- Creation of definitions for "individual therapy," "co-treatment," "concurrent therapy," and "group therapy" to align with current SNF Part A definitions
- Addition of a yes/no check-off in IRF-PAI that would indicate whether prior treatment and severity requirements have been met for patients with arthritis
- Addition of IRF quality reporting measures that would include outcome measures related to MRSA and clostridium difficile infection (CDI)

The [final rule changes for SNFs \(.pdf\)](#) involve a provision that will allow SNFs to use a "change of therapy other Medicare required assessment" (COT OMRA) to reclassify residents formerly but not currently in a therapy resource utilization group (RUG) into a new RUG. CMS will continue to prohibit the use of the COT OMRA for initial classification of patients into a therapy RUG.

Additionally, the SNF final rule includes a statement from CMS that acknowledges the comments it received around the development of an alternative therapy payment model. The agency states that several models are being explored, and that the changeover to a new model must be timely and incorporate stakeholder feedback that addresses problems in the current SNF payment structure. CMS has not set a date for implementation and is still accepting input on the issue.

Component Advocacy News and Tips

Wisconsin Chapter Works With DHS on Medicaid Prior Authorization

The Wisconsin Physical Therapy Association (WPTA), Wisconsin Occupational Therapy Association (WOTA), Wisconsin Speech-Language Pathology & Audiology Association (WSHA), Wisconsin Association of Family & Children's Agencies (WAFCA), Children's Hospital of Wisconsin, and UW Hospital & Clinics have been meeting with representatives from the Wisconsin Department of Health Services (DHS) and Representative John Nygren, co-chair of the Joint Committee on Finance, to discuss concerns regarding the Medicaid prior authorization (PA) process. This dialog has been continuing for a little over a year and has resulted in positive feedback from DHS representatives. The above provider organizations continue to meet with DHS and Rep Nygren, and have recommended the following reforms to the prior authorization process. If you are facing similar obstacles in your state, these recommendations maybe be useful as you engage with state representatives.

- Develop criteria for coverage that is applied consistently.
- Eliminate prior authorization for the initial evaluation with physician referral.
- Require providers to develop a care management plan for patients requiring many services. The plan would be submitted annually to the department for prior authorization.
- Base Medicaid fee-for-service prior authorization on an existing Medicaid or commercial HMO model. Some HMOs allow an initial evaluation and a set number of visits without prior authorization. Prior authorization can be obtained beyond the initial visits by submitting the evaluation and clinical notes – no extra forms to fill out.
- Create a review team that has experience with care management models to review the more complex populations with chronic, ongoing therapy, and mental health needs.
- Create an advisory group with representatives from each therapy association who would act as consultants for the Medicaid review team. The collaborative process would address policy, current best practices, and care delivery models for target populations based on identified issues that arise. This is similar to how Medicare manages its local coverage determination process in Wisconsin (Wisconsin Contractor Advisory Committee).
- Provide specific rationale for any denial in writing at the time of denial to both the family and provider. The denial letter should include more information for families regarding their appeal rights and how to file an appeal.
- Develop a case management approach based on a previously submitted 3-tier PA process. This would essentially allow an annual PA to be submitted for review and would also include a mechanism for auditing those PAs and the providers submitting them.
- Revise the process used to appeal PA denials so it is more transparent to both the Medicaid member/family and the provider.
- Establish a preferred provider status that would allow certain providers to use a less complex PA process for requesting services.

Legislation Passed in Alaska Converting the Worker's Compensation Fee Schedule

On Tuesday, July 8, Alaska Gov Sean Parnell signed House Bill 316, which changes the Alaska worker's compensation fee schedule. Alaska currently uses a usual, customary, and reasonable (UCR) fee schedule, set at the 90th percentile, and reflective of the geographic area where services are rendered.

H.B. 316 changes from a UCR fee schedule to a Resource Based Relative Value Scale based on the Centers for Medicare and Medicaid Services, with a conversion factor set by the Medical Services Review Committee. H.B. 316 requires the Commissioner of Labor to approve the conversion factors before they adopted into regulation. Fees are expected to be submitted by July 1, 2015.

Maine Chapter Working to Reduce Prior Authorization Burdens

The Maine Chapter of APTA has been working with officials at MaineCare regarding the prior authorization process. After receiving calls from members who were having issues with the process, the chapter polled its members to further clarify the difficulties they were experiencing with the MaineCare website, e-mail blast, and consultant inquiries. After collecting this information, the chapter initiated regular phone calls with MaineCare. The chapter worked with MaineCare to design and send an e-mail blast to its members soliciting feedback for improving the prior authorization process.

As a result, MaineCare is improving its training and protocols, so information and processing is consistent. MaineCare is also making changes to its online portal to allow for more direct communication. Lastly, the chapter, in conjunction with MaineCare, is organizing a series of meetings throughout the state to help educate physical therapists on the prior authorization process.

The chapter will continue to work with MaineCare, and is hoping to have a greater impact in the near future when the rule-making process opens up for comments and redesign.

New Delaware PT Law Includes Telehealth, Dry Needling

Delaware physical therapists (PTs) have a new scope of practice that includes telehealth, dry needling, and an updated definition of the practice of physical therapy, now that a significantly revised physical therapy licensing law has been signed by Gov. Jack Markell. Markell signed the bill on August 12.

Advocated for by the Delaware Physical Therapy Association, the legislation ([H.B. 359](#)) faced opposition from other provider groups, including acupuncturists who were opposed to the inclusion of dry needling in the new definition for physical therapy. In addition to the dry needling and telehealth provisions, the new law includes temporary exemptions to licensure for PTs licensed in another state who are in Delaware for educational purposes, accompanying travelling sports team or performance groups, or responding to declared emergencies.

"The legislative process was very arduous, and I am grateful for all of our chapter members who attended hearings, met with legislators, and sent e-mails or made phone calls in support of H.B. 359," said George Edelman, PT, OCS, MTC, president of the Delaware Chapter. "We are thrilled that Delaware now has a physical therapy statute that reflects 21st century practice."

The Delaware State Examining Board of Physical Therapists and Athletic Trainers—the state's licensure board—is expected to begin work on developing board rules related to the new law this fall.

APTA Resources

Upcoming Insider Intel Call

Watch for an announcement on the next Insider Intel call which will feature information on the physician fee schedule (PFS), home health prospective payment system (HHPPS), outpatient prospective payment system (OPPS), and the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) rules.

Federal Resources

CMS Fact Sheets on PFS, HHPPS, OPPS and DMEPOS Rules Available

APTA will post detailed summaries of the physician fee schedule (PFS), home health prospective payment system (HHPPS), outpatient prospective payment system (OPPS), and the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) rules in the coming weeks. In the meantime you can view the CMS fact sheets on the final rules [here](#).

APTA Activities / Calendar of Events

State Policy & Payment Forum Delivers Advocacy Information

This year's State Policy and Payment Forum in Seattle, Washington, once again informed and recharged physical therapists (PTs), physical therapist assistants, and physical therapy students from across the country to help them continue to advocate for the physical therapy profession at the state level.

Cohosted by APTA and the Washington Chapter, the 2014 forum gave more than 200 attendees the opportunity to learn from influential public policy makers and other physical therapy advocates; collaborate with colleagues in developing and improving their components' state advocacy efforts; and network with other professionals from across the country. Topics included fair physical therapy copay legislation; a debate on the merits of "any willing provider" legislation, issues surrounding network adequacy, and emerging scope of practice issues; PTs' ordering of x-rays and imaging studies; dry needling; state licensure issues; and more. The forum's luncheon keynote speaker was Mark McClellan, MD, PhD, a senior fellow and director of the Health Care Innovation and Value Initiative at the Brookings Institution.

APTA Webinars and Virtual Programming Provide Valuable Resources

Register today for these upcoming audio conferences:

2014 Postacute Care Compliance Seminar: The program will be presented by Ellen Strunk, PT, MS, GCS, CEEAA, Cindy Krafft, PT, MS, COS-C, Roshunda Drummond-Dye, JD, and Anita Bemis-Dougherty, PT, DPT, MAS, on November 15, 2014, from 8:00 am to 4:30 pm. Participate in person at APTA's headquarters or via virtual live stream, and earn 0.9 CEUs.