Physical Therapy and the Medicare Landscape
CIRCA 2017
So much to talk about and so little time!

- The Very Basics
- IMPACT
- MACRA
- Who is Tom Price?
- MedPac Report 2016
- Opportunities
## TABLE 23: CPT Long Descriptors for Physical Medicine and Rehabilitation

<table>
<thead>
<tr>
<th>New CPT Code</th>
<th>CPT Long Descriptors for Physical Medicine and Rehabilitation</th>
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</table>
| 97161        | Physical therapy evaluation: low complexity, requiring these components:  
  - A history with no personal factors and/or comorbidities that impact the plan of care;  
  - An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions;  
  - A clinical presentation with stable and/or uncomplicated characteristics; and  
  - Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.  
Typically, 20 minutes are spent face-to-face with the patient and/or family. |
| 97162        | Physical therapy evaluation: moderate complexity, requiring these components:  
  - A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care;  
  - An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following body structures and functions, activity limitations, and/or participation restrictions;  
  - An evolving clinical presentation with changing characteristics; and  
  - Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.  
Typically, 30 minutes are spent face-to-face with the patient and/or family. |
| 97163        | Physical therapy evaluation: high complexity, requiring these components:  
  - A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care;  
  - An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions;  
  - A clinical presentation with unstable and unpredictable characteristics; and  
  - Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.  
Typically, 45 minutes are spent face-to-face with the patient and/or family. |
| 97164        | Re-evaluation of physical therapy established plan of care, requiring these components:  
  - An examination including a review of history and use of standardized tests and measures is required; and  
  - Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome.  
Typically, 20 minutes are spent face-to-face with the patient and/or family. |
Thoughts

• Budget Neutral on Eval-against AMA recommendation
• Not Labor Neutral
• CMS did adjust the value of the new code for reevaluation
• Important as severity codes set a faster progression toward outcome driven payment—need to move toward a more uniform assessment
• CMS acknowledged APTA's concerns for adequate time to educate PTs on the use of the new coding system by making no changes to the Medicare benefits policy manual for 2017.
• And therefor medical reviewers won't be able to penalize providers regarding the medical necessity for the new evaluation requirements.
• CMS reminds PTs, however, that they are expected to comply with the current MBPM instructions for evaluation and re-evaluations.
## TABLE 22: Full Definitions for MBPM

<table>
<thead>
<tr>
<th>Therapy Service</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>EVALUATION</strong></td>
<td>EVALUATION is a separately payable comprehensive service provided by a clinician, as defined above, that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities. Evaluation is warranted for example, for a new diagnosis or when a condition is treated in a new setting. These evaluative judgments are essential to development of the plan of care, including goals and the selection of interventions.</td>
</tr>
<tr>
<td><strong>RE-EVALUATION</strong></td>
<td>RE-EVALUATION provides additional objective information not included in other documentation. Re-evaluation is separately payable and is periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, or decline, or change in the patient's condition or functional status that was not anticipated in the plan of care. Although some state regulations and state practice acts require re-evaluation at specific times, for Medicare payment, re-evaluations must also meet Medicare coverage guidelines.</td>
</tr>
</tbody>
</table>
Basic #2- Potentially “Mis-Valued” Codes identified

• The Affordable Care Act requires CMS in its annual physician fee schedule to periodically identify “potentially misvalued” codes and adjust them appropriately.

• CMS identified 10 physical therapy codes: 97032 Electrical stimulation, 97035 Ultrasound therapy, 97110 Therapeutic exercises, 97112 Neuromuscular reeducation, 97113 Aquatic therapy/exercises, 97116 Gait training therapy, 97140 Manual therapy 1/regions, 97530 Therapeutic activities, 97535 Self-care management training, and G0283 Electrical stimulation other than wound.

• In the final rule, CMS confirms that it will include more information in its 2018 physician fee schedule rulemaking on how these codes will be valued. The agency expects to receive valuation recommendations from the AMA RUC in February 2017. In making these recommendations, the AMA RUC will consider input from APTA based on a RUC survey sent to a sampling of members in October 2016.
Basic #3—Other Random Items

• No change to **Telehealth** allowing PT’s as eligible providers. Stated that would require congressional action.

• The Medicare **therapy cap** will be $1980, up from the 2016 cap of $1960.

• **New Prevention Innovative Model for Diabetes.** CMS reaffirms the expansion of the Diabetes Prevention Program (DPP), the first-ever prevention model under the CMS Innovation Center, beginning January 2018. DPP is a structured intervention that includes dietary coaching, lifestyle intervention, and moderate physical activity, all with the goal of preventing the onset of diabetes in individuals who are prediabetic.
Require PAC providers to begin reporting standardized patient assessment data at times of admission and discharge by October 1, 2018, for SNFs, IRFs, and LTCHs and by January 1, 2019, for HHAs.

Require new quality measures on domains beginning October 1, 2016, through January 1, 2019, including functional status, skin integrity, medication reconciliation, incidence of major falls, and patient preference regarding treatment and discharge.

Require resource use measures by October 1, 2016, including Medicare spending per beneficiary, discharge to community, and hospitalization rates of potentially preventable readmissions.

Require the Secretary of HHS to provide confidential feedback reports to providers. The Secretary will make PAC performance available to the public in future years.

Require MedPAC and HHS to study alternative PAC payment models, with reports due to Congress 2021-2022 for HHS.

Require the Secretary to develop processes using data to assist providers and beneficiaries with discharge planning from inpatient or PAC settings.
IMPACT: The Road to 2022

**Timeline**

**FY 2017**
- Standardized resource use measure and some quality reporting begins.
  - 10/1/16

**FY 2018**
- Confidential feedback provided on previous year's reports.
  - 10/1/17

**FY 2019**
- Standardized assessment data required. Public quality data available. Penalties take effect for those not reporting.
  - 10/1/18

**FY 2022**
- CMS & MedPAC reports on PAC prospective payment.
- Study on hospital assessment data.
  - 10/1/21
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- QUALITY PAYMENT PROGRAM
- MACRA is the first tangible step toward mandating a payment system that bases reimbursement on quality of care and outcomes and begins the phase-out of fee-for-service
- Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)
- PT’s left out in 2017 but most regulatory heads indicate we will be looped in by 2019
- Primary focus should be outcomes reporting (test drive MIPS)...http://www.apta.org/MIPS/FAQ/
- and drive for inclusion in APMs (alternate payment models)
MACRA CONTINUED...

- CURRENT APMs
  - Medicare Shared Savings Program (MSSP) (also known as Medicare ACOs)
  - Next Generation ACOs
  - Comprehensive Care Joint Replacement Model
  - Bundled Payment Care Initiative
- 2017 APMs
  - Comprehensive End-State Renal Disease Care
  - Next Generation ACO Model
  - Comprehensive Primary Care Plus
  - Oncology Care Model – Two-Sided Risk
  - Medicare Shared Savings Program – Track 2
- Also in 2017—MIPS and APMs co-participants
Who is Dr. Price?

BACKGROUND:
• Graduated from Medical School Michigan 1980
• Practiced as an Orthopedic Surgeon 20 years in Atlanta. He was partner and founding board member of Resurgens Orthopedics (100MD’s) until he was elected to Congress in 2004.
• A long history of working with the AAOS:
  • Dr. Price has decades of leadership on health care policy issues and firsthand experience caring for patients for nearly twenty years. He has worked closely with AAOS on issues including repeal of the Medicare sustainable growth rate formula, oversight of mandatory bundled payment models, increasing flexibility within electronic health record programs, defending important in-office ancillary services, and protecting the patient-physician relationship. He has been an indispensable voice within the House Republican Doctors Caucus, making significant contributions to health policy reform and furthering the interests of patients. And he has been one of the most important champions in improving the care of patients in the specialty, rural, and small or solo practice settings.

POLICY POSITIONS:
• Strongly opposed to the mandatory nature of the Comprehensive Care Joint Replacement (CJR) program. This position might benefit orthopedic groups because hospitals manage the CJR bundle whereas physicians manage the BPCI bundle as part of that optional program.
• Strongly favors tort reform to raise the burden of proving negligence and limiting awards in medical malpractice cases.
• Favors allowing health insurers to sell across state lines
• Opposed to CMS using comparative effectiveness or patient-centered outcomes research to deny or limit coverage
• Favors making it more difficult for CMS to require reporting and use of performance-based quality measures. This may result in a delay and/or modification of the CMS’s Merit-Based Incentive Payment System (MIPS) which is set to begin in 2017
• Favors a federal antitrust waiver that would allow otherwise unaffiliated physicians and other providers to collectively negotiate payment rates with insurance companies.
MedPac Report 2016 aka The Perfect Storm

SNF
• Patients receiving intensive therapy (RU and RVU) in SNF has continued to increase since 2011-2014.
• During the same time period there has been minimal change in the functional limitations of patients being admitted to SNF.
• Also during this time no correlation has been found in the risk-adjusted improvement of functional limitations and ADLS with the increase in RU and RVU levels.
• As a result of this information MedPac has recommended a change in the SNF PPS system in regard to payment based on rehab utilization to a system based on acuity level and disease process.

Home Health
• MedPac has recommended in 2018 moving away from the current system that weights therapy utilization as a payment factor in the current HH PPS.
• MedPac believes the current system has shifted focus away from the patient characteristics and skewed the POC.
• Eliminating this system would base the payment solely on patient characteristics (similar to DRG).
• Overall MedPac believes that this would reduce spending but would impact agencies financially in 1 of 2 ways—those who provided less therapy would have higher margins and those who provided more would have lower margins...Hmmmm
OPPORTUNITIES

ACUTE

• Early Mobility and the Financial Impact
• Appropriate Discharge Disposition and Financial Impact
• Appropriate DME for Success
• Improved Coordination with Next Sight on FUNCTIONAL STATUS (IRF?)

Post Acute Care

• APMs
  • CCJR
  • BBPCI
  • ESRD
• SHARED SAVINGS MODELS/ACO
• VALUE BASED PURCHASING ➔ functional progression
• Our Language? Section G/GG and the M1800s
• MEDICAL attrition