

MPFS Final Rule Summary – Outpatient Therapy

On November 1, CMS released the final rule for the Medicare Physician Fee Schedule effective January 1, 2013. Nearly 60 pages are dedicated to therapy issues.

Conversion Factor and Payment Rates

The fee schedule rule also includes a 26.5 percent across-the-board reduction to Medicare payment rates for physicians, physical therapists and other professionals due to the flawed sustainable growth rate formula. Since 2003, Congress had enacted legislation preventing the reduction every year. If Congress acts by the end of the year, the projected cut would be averted and the aggregate impact on payment for outpatient physical therapy would be a positive 4 percent in 2013.

Physician Quality Reporting System

For 2013 the reporting period for PQRS will be based on a 12 month reporting time frame and the bonus payment amount will be 0.5 percent. Calendar year 2013 will also be used as the reporting period for the 2015 PQRS payment adjustment of -1.5 percent. Successful reporting requirements for the program will remain as they were in 2012 requiring that participants report a minimum of 3 individual measures or 1 group measure via claims based reporting on 50 percent or more of all eligible Medicare patients, or report a minimum of 3 individual measures or 1 group measure via registry reporting on 80 percent or more of all eligible Medicare patients.

Outpatient Therapy Caps for CY 2013

The therapy cap amounts are updated each year based on the Medicare Economic Index (MEI). The annual change in the therapy cap amount for CY 2013 is computed by multiplying the cap amount for CY 2012 by the MEI for CY 2013 and rounding to the nearest \$10. This amount is added to the CY 2012 cap, which is \$1,880, to obtain the CY 2013 cap amount. The MEI for CY 2013 is 0.8 percent, resulting in a therapy cap amount for CY 2013 of \$1,900. The exceptions process to therapy caps expires on December 31, 2012. Renewal depends on congressional action before the end of the year.

Manual Medical Review

The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) requires that CMS apply a manual medical review process as part of the therapy caps exceptions process. Similar to the therapy caps, there are separate \$3,700 thresholds for OT services and PT/SLP services combined. All requests for exceptions to the therapy caps for services after the \$3,700 threshold is reached are subject to manual medical review. The manual medical review process is being phased in over a 3-month period.

Unlike the therapy caps, exceptions are not automatically granted for therapy services above the \$3,700 threshold based upon the therapist's determination that they services are reasonable and necessary. To request an exception to the therapy caps for services after the threshold is reached, the provider sends a request for an exception to the Medicare contractor. The contractor then uses the coverage and payment requirements contained within the Medicare Benefit Policy Manual and applicable medical review guidelines, and any relevant local

coverage determinations to make decisions as to whether an exception is approved for the services. For more information on the manual medical review process, go to www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/TherapyCap.html

Claims-Based Data Collection for Therapy Services

The MCTRJCA requires CMS to implement, beginning on January 1, 2013, “. . . a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services. Such strategy shall be designed to provide for the collection of data on patient function during the course of therapy services in order to better understand patient condition and outcomes.”

In the rule, CMS points out that in 2011, more than 8 million Medicare beneficiaries received outpatient therapy services, including PT, OT, and SLP. Between 1998–2008, Medicare expenditures for outpatient therapy services increased at a rate of 10.1 percent per year while the number of Medicare beneficiaries receiving therapy services only increased by 2.9 percent per year. And the rapid growth in Medicare expenditures for these services has long been of concern to the Congress and to CMS.

Such a claims-based data collection process will be used by the Agency to reform the Medicare payment system for outpatient therapy services. By collecting data on beneficiary function over an episode of therapy services, CMS hopes to better understand the Medicare beneficiary population who uses therapy services, how their functional limitations change as a result of the therapy services, and the relationship between beneficiary functional limitations and furnished therapy.

The long-term goal is to develop an improved payment system for Medicare therapy services. The desired payment system would pay appropriately and similarly for efficient and effective services furnished to beneficiaries with similar conditions and functional limitations that have potential to benefit from the services furnished. Importantly, such a system would not encourage the furnishing of medically unnecessary or excessive services. At this time, the data on Medicare beneficiaries' use and outcomes from therapy services from which to develop an improved system does not exist. This data collection effort is the first step towards collecting the data needed for this type of payment reform.

Specifically, G-codes will be used to identify what type of functional limitation is being reported and whether the report is on the current status, projected goal status or discharge status. Modifiers will indicate the severity/complexity of the functional limitation being tracked. The difference between the reported functional status at the start of therapy and projected goal status represents any progress the therapist anticipates the beneficiary would make during the course of treatment/episode of care.

These claims-based data collection requirements will apply to services furnished under the Medicare Part B outpatient therapy benefit and PT, OT, and SLP services under the Comprehensive Outpatient Rehabilitation Facilities (CORF) benefit, to therapy services furnished personally and “incident to” the services of physicians or nonphysician practitioners (NPPs). This broad applicability includes therapy services furnished in hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), CORFs, rehabilitation agencies, home health agencies (when the beneficiary is not under a home health plan of care), and in private offices of therapists, physicians and NPPs.

The G-codes, and their long descriptors, that will be used for reporting functional limitations of beneficiaries are listed in Table 21 of the final rule. There are 11 G-codes that describe categorical functional limitation, including seven for SLP services, and three more general G-codes for functional limitations that do not fit within one of the 11 categories. The general categorical codes would be used when none of the specific categories apply or when an assessment tool is used that yields a composite score that combines several or many functional measures, such as is done with the FOTO Patient Inquiry tool, for example. Two of these general G-code sets are to be used for “other” PT and OT services and one for “other” SLP services.

G-Codes for Claims-Based Functional Reporting

G-Codes for Claims-Based Functional Reporting for CY 2013 will include the current status, the projected goal status and the status upon discharge for the following categories:

- Mobility: Walking & Moving Around
- Changing & Maintaining Body Position
- Carrying, Moving & Handling Objects
- Self Care
- Other PT/OT Primary Functional Limitation
- Other PT/ OT Subsequent Functional Limitation
- Swallowing
- Motor Speech
- Spoken Language Comprehension
- Spoken Language Expression
- Attention
- Memory
- Voice
- Other SLP Functional Limitation

Severity/Complexity Modifiers

Each functional G-code used on a claim, a modifier will be required to report the severity/complexity for the functional limitation. A 7-point scale will be used to report the severity or complexity of the functional limitation involved. The scale identifies modifiers for zero and 100 percent impairment and separate modifiers for roughly each 20th percentile of impairment/function.

Therapists will be able to choose from the many valid and reliable measurement and assessment tools to inform their clinical decision-making and to quantify functional limitations, including the four assessment tools CMS identified in CY 2011 PFS rulemaking that produce functional scores – namely, the Activity Measure – Post Acute Care (AM-PAC) tool, the FOTO Patient Inquiry, OPTIMAL, and NOMS. These four tools are recommended for use by therapists, but not required. The scores from these and other measurement tools already in use by therapists that produce numerical or percentage scores are to be crosswalked to the 7-point severity modifier scale. CMS plans to make information about the severity/complexity scale, as well as other aspects of this new system, widely available to therapists. But it will be incumbent upon individual therapists to learn how to translate the score from a singular assessment tool or the combined results from multiple tests/measures along with other information regarding their patient’s functional limitation to the Medicare scale.

Therapists will be required to report FS data with claims submission in conjunction with the initial service at the outset of a therapy episode, at least every ten visits, and at discharge.

Additionally, functional reporting is also required at the time the beneficiary's condition changes significantly enough to clinically warrant a re-evaluation such that a HCPCS/CPT code for a re-evaluation or a repeat evaluation is billed.

Documentation of the information used for reporting under this system must be included in the beneficiary's medical record. Thus, the therapist will need to track in the medical record the G-codes and the corresponding severity modifiers that were used to report the status of the functional limitations at the time reporting was required.

These requirements are effective on January 1, 2013, with a six-month testing period from January 1, 2013 until July 1, 2013. Required reporting begins July 1, 2013, after which claims without the appropriate G-codes and modifiers would be returned unpaid.