



# Stroke Survivors and Caregivers Conference

October 6, 2017



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  - Jurisdiction H
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# Acronym List



Acronym	Definition
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedure Coding System
IOM	Internet Only Manual
LCD	Local Coverage Determination
NPP	Non-Physician Practitioner
OT	Occupational Therapy
PT	Physical Therapy
PTP	Procedure to Procedure
SLP	Speech Language Therapy

# Agenda



- Physical and Occupational Therapy Coverage
- Therapy Updates and Reminders
- Common Errors
- Therapy Resources and References
- Medicare Updates
- Novitas Initiatives

# Physical and Occupational Therapy Coverage

# Settings for Physical and Occupational Therapy



- Part A settings are:
  - Hospital inpatient Part B
  - Hospital outpatient
  - SNF inpatient Part B
  - SNF outpatient
  - Outpatient Rehabilitation Facility
  - Comprehensive Outpatient Rehabilitation Facility (ORF)
  - Community Mental Health Center (CMHC)
- Part B settings are:
  - Clinic/Office Setting
  - Patient's Home



# Coverage for Physical and Occupational Therapy



- In order for services to be covered:
  - Must be reasonable and medically necessary:
    - ✓ Type
    - ✓ Frequency
    - ✓ Duration
    - ✓ Patient's functional limitations are documented in terms that are objective and measurable
    - ✓ Relate directly to a written treatment plan

# Requirements for Covered Therapy Services



- Patient is under the care of a physician/NPP:
  - Physician/NPP certifies the plan of care
  - Evidence of physician/NPP involvement examples:
    - ✓ A signed and dated order or referral
    - ✓ Conference notes
    - ✓ Team meeting notes
- Reference:
  - Medicare Benefit Policy Manual, Publication 100-02, Chapter 15, Section 220.3:
    - ✓ <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>

# Medical Necessity of Therapy



- Medical Necessity:
  - Title XVIII of the Social Security Act, section 1862(a)(1)(a). This section allows coverage and payment for only those services that are considered to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Concept of “Reasonable and Necessary”:
  - Restorative/Rehabilitative Therapy:
    - ✓ Goal/Purpose is to improve, restore
  - Maintenance Therapy:
    - ✓ Treatment by therapist is necessary to maintain, prevent or slow further deterioration
    - ✓ Cannot be safely carried out by beneficiary, family member, caregiver or unskilled personnel
    - ✓ <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/mm8458.pdf>

# Factors to Substantiate Medical Necessity



- Some factors that contribute to patient's needs:
  - Patient diagnoses, complicating factors, age
  - Severity, time since onset/acuity, self-effacing/motivation
  - Cognitive ability, prognosis
  - Medical, psychological and social stability

# An Order or Referral



- An order or referral provides evidence:
  - Of the need for care
  - That patient is under care of a physician/NPP
  - Physician is involved in care and available to certify plan
- Payment is dependent on the certification of the plan of care rather than the order

# Establishing the Plan of Care



- Must be established before treatment is begun
- Established when it is developed (written or dictated)
- Signature and professional identity of person who established plan and date established recorded with plan:
  - Physician/NPP
  - PT
  - OT
  - SLP
- Entered into patient therapy record either by person who established or by their staff if a written record of that person's oral orders before treatment begins
- Must document appropriate history, examination, diagnosis, functional assessment, type of treatment including rationale for each specific treatment, body areas to be treated, date therapy was initiated, expected frequency and number of treatments

# Contents of the Plan of Care



- Plan of Care:
  - Diagnoses
  - Long term treatment goals
  - Type of therapy
  - Amount of therapy
  - Duration
  - Frequency of therapy services
- Reference:
  - Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services, Section 220.1.2:
    - ✓ <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>

# Signature and Certification of Plan of Care



- Legible signature and professional identity of individual who established plan and date established
- Physician or NPP must certify and date plan of care
- Certification may be established in the patient's medical record through:
  - Physician's or NPP's progress note or orders
  - Plan of care that is signed and dated by a physician/NPP
  - Documentation must indicate the physician/NPP is aware the therapy service is or was in progress
  - Physician/NPP agrees with the plan or is available in the patient's records to review



# Changes to the Plan of Care



- Changes are made in writing in the patient's record and signed by the professional responsible for care
- Significant change:
  - Requires physician/NPP certification within 30 days of the initial therapy treatment under the revised plan:
    - ✓ Change in long term goals
- Insignificant change:
  - Report to physician/NPP prior to the next certification:
    - ✓ Change in the frequency or duration due to the patient's illness, or a modification of short-term goals to adjust for improvements made toward the same long-term goals

# Initial Certification



- Physician/NPP certification of plan for duration of plan or 90 calendar days from date of initial treatment (lesser of two)
- Initial treatment includes evaluation that resulted in plan
- Timing – as soon as possible after plan established unless requirements for delay are met
- “As soon as possible” – within 30 days
- Order to certify is verbal – must be followed within 14 days by signature to be timely:
  - Dated notation should be made in medical record

# Recertification



- Should be signed whenever the need for a significant modification of the plan becomes evident
- At least every 90 days after the initiation of treatment under that plan unless delayed

# Documentation of Certification and Recertification



- Dated signature on plan of care or other document indicating approval of plan
- Date signed determines timely or delayed
- Format determined by individual practitioner
- Retained in clinical record and available upon request

# Delayed Certification



- Evidence needed for justification of delayed certifications:
  - For example: not signed, lost
- Delayed certification may include one or more certifications or recertification on a single signed/dated document
- Reference:
  - CMS IOM 100-02 Chapter 15 Section 220.1.3
  - <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>

# Therapy Updates and Reminders

# Therapy Cap Values for Calendar Year (CY) 2017



- Change Request # 9865:
  - Effective: January 1, 2017
  - Implementation: January 3, 2017
- Key Points:
  - Outpatient therapy limits for:
    - ✓ Physical Therapy (PT) and Speech-Language Pathology (SLP) combined is \$1,980
    - ✓ Occupational Therapy (OT) is \$1,980
- Reference:
  - <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9865.pdf>

# Updates on the Therapy Cap



- Exceptions to the therapy cap will remain in effect for claims with dates of service through December 31, 2017
- Hospital outpatient therapy claims will continue to apply to the therapy cap through December 31, 2017
- Reference:
  - <https://www.cms.gov/Medicare/Billing/TherapyServices/index.html?redirect=/TherapyServices>



# New Therapy Evaluation/ Re-evaluation Codes



- Effective for dates of service on and after January 1, 2017:
  - Eight new codes were created to report PT and OT evaluation and re-evaluation services
- The new codes are based on patient complexity and the level of clinical decision-making (low, moderate and high complexity)
- PT Codes:
  - 97161 - PT evaluation, low complexity, 20 minutes
  - 97162 - PT evaluation, moderate complexity, 30 minutes
  - 97163 - PT evaluation, high complexity, 45 minutes
  - 97164 - Re-evaluation of PT established plan of care
- OT Codes:
  - 97165 - OT evaluation, low complexity, 30 minutes
  - 97166 - OT evaluation, moderate complexity, 45 minutes
  - 97167 - OT evaluation, high complexity, 60 minutes
  - 97168 - Re-evaluation of OT established plan of care
- The codes above replaced the four therapy codes 97001-97004
- Reference:
  - <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9782.pdf>

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# Question



- Question:
  - When will the IOM 100-02, Chapter 15, Section 220 Therapy Benefit Policy be updated with additional information on the new evaluation and re-evaluation codes?
- Answer:
  - CMS updates the IOM and when the updates occur the contractors and providers will be notified by a Change Request (CR) and Medicare Learning Network (MLN).
- Reminder:
  - Join Our Email List:
    - ✓ <http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00007968>

# Part B Updated Editing of Professional Therapy Services



- Change Request # 9933:
  - Effective: January 1, 2017
  - Implementation: July 3, 2017
- Key Points:
  - Therapy modifiers:
    - ✓ The new PT and OT codes are added to the current list of procedures that require a specific therapy modifier to identify the plan of care
    - ✓ Therapy modifiers GP, GO or GN are required to report the type of therapy plan of care – PT, OT, or SLP
  - Functional Reporting (FR):
    - ✓ FR requirements are required using G-codes and severity modifiers, when an evaluative procedure is furnished and billed
    - ✓ Eight new codes for PT and OT evaluations and re-evaluations – 97161, 97162, 97163, 97164, 97165, 97166, 97167, and 97168
    - ✓ A severity modifier (CH – CN) is required to accompany each functional G-code (G8978-G8999, G9158-9176, and G9186) on the same line of service
- Reference:
  - <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9933.pdf>

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# Updated Editing of Always Therapy Services - MCS



- Change Request # 10176:
  - Effective: January 1, 2018
  - Implementation: January 2, 2018
- Key Points:
  - Applies as “always therapy” must always be furnished under an SLP, OT, or PT plan of care, regardless of who furnishes them
  - Codes must always be accompanied by one of the therapy modifiers:
    - ✓ The GN modifier for six codes, the GO modifier for four codes, and the GP modifier for four codes
  - The table indicates the appropriate/acceptable modifier to be used with the therapy codes
  - The GN, GO, GP therapy modifier is specific to the SLP, OT, PT plan of care, therefore only one of these modifiers is allowed per code
  - Claims will be rejected if any line on the claim contains more than one therapy modifier GN, GO, GP
- Reference:
  - <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3814CP.pdf>

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# Therapy Multiple Procedure Payment Reduction (MPPR)



- Medicare applies a MPPR to the practice expense component of certain therapy services
- Since April 1, 2013, this MPPR rate is 50 percent for both office and institutional settings
- The “MPPR Rate File” was updated for CY 2017 and can be found in the Downloads section of the CMS webpage:
  - <https://www.cms.gov/Medicare/Billing/TherapyServices/index.html>

# Changes to the Payment Policies for Reciprocal Billing Arrangements and Fee-For-Time Compensation Arrangements (formerly referred to as Locum Tenens Arrangements)



- Change Request # 10090:
  - Effective: June 13, 2017
  - Implementation: June 13, 2017
- Key Points:
  - The term “locum tenens,” which has historically been used in the CMS manual to mean fee-for-time compensation arrangements, is being discontinued:
    - ✓ This is due to the title of section 16006 of the 21st Century Cures Act uses “locum tenens arrangements” to refer to both fee-for-time compensation arrangements and reciprocal billing arrangements
  - Outpatient physical therapy services furnished by physical therapists in a Health Professional Shortage Area (HPSA), a Medically Underserved Area (MUA), or in a rural area can be billed under reciprocal billing and fee-for-time compensation arrangements in the same manner as physicians bill effective June 13, 2017

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# Additional Information on Change Request # 10090



## ■ Key Points:

- The Q5 and Q6 must be submitted on the claim:
  - ✓ Q5 - Service furnished by a substitute physician under a reciprocal billing arrangement
  - ✓ Q6 - Service furnished by a locum tenens physician:
    - Note: The Q5 and Q6 modifiers' descriptors will be amended to include physical therapists in addition to physicians in the near future in a HCPCS quarterly update
- The Medicare Claims Processing Manual will be clarified that when a regular physician or physical therapist is called or ordered to active duty as a member of a reserve component of the Armed Forces for a continuous period of longer than 60 days, payment may be made to that regular physician or physical therapist for services furnished by a substitute under reciprocal billing arrangements or fee-for-time compensation arrangements throughout that entire period

## ■ References:

- <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3774CP.pdf>
- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10090.pdf>

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# Diagnosis



- Should be specific and as relevant to problem to be treated as possible
- Both a medical diagnosis (from physician/NPP) and treatment diagnosis (from the Therapist) are relevant:
  - Both are appropriate for the claim



# Medicare Updates

# Social Security Number Removal Initiative



- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019
- Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards:
  - 11-characters in length
  - Made up only of numbers and uppercase letters (no special characters)
- Transition period:
  - Will begin no earlier than April 1, 2018 and run through December 31, 2019:
    - ✓ Either the HICN or the MBI can be used
    - ✓ Use the MBI or the HICN to check Medicare eligibility, after transition period ends use only the MBI
    - ✓ Use the beneficiary identifier (MBI or HICN) you used to submit the claim that's under appeal, even after the transition period

# What Providers Need to Know on The Social Security Number Removal Initiative



- How will providers get MBIs?:
  - During the transition period, the MBI will be on the remittance advice when you submit a claim using your patient's HICN
  - In the message field on the eligibility transaction responses it will let you know when a new Medicare card has been mailed to each person with Medicare
  - Your systems must be ready to accept the MBI by April 2018:
    - ✓ No earlier than April 2018 Medicare cards will be sent, people new to Medicare will only be assigned an MBI
- Claim forms:
  - Not changing:
    - ✓ During the transition period, you can use either the HICN or the MBI
    - ✓ Once the transition period ends, you must use the MBI
- Get more information about the SSNRI:
  - <https://www.cms.gov/Medicare/SSNRI/Index.html>

# New ABN Form Updates



- ABN form (CMS-R-131) has been approved by the Office of Management and Budget (OMB) for renewal:
  - Effective: June 21, 2017
  - New expiration date on the form:
    - ✓ Be sure to use the form with the date 3/20/20 at the bottom
  - Rehabilitation Act of 1973 (Section 504) revises the form to include language informing beneficiaries of rights to CMS nondiscrimination practices and how to request alternative format if needed
  - No other changes to the form
- ABN form (CMS-R-131):
  - <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-Forms-English-and-Spanish.zip>
- ABN form instructions:
  - <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-Form-Instructions.pdf>
- Questions regarding the ABN can be emailed to:
  - [BNImailbox@cms.hhs.gov](mailto:BNImailbox@cms.hhs.gov)

# New ABN Form



This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:
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Form CMS-R-131 (Exp. 03/2020)

Form Approved OMB No. 0938-0566

# Novitas Initiatives

# Novitasphere



- Free, secure Web-based portal
- Part A – Access to Eligibility, Medical Review Record Submission, Claim Submission with File Status, and Audit and Reimbursement Cost Reports Submission
- Part B - Access to Eligibility, Claim Information and Remittance Advice, Claim Submission with File Status, Electronic Remittance Advice (ERA), Claim Correction, Secure Messaging and a MailBox
- Live Chat feature
- Dedicated Help Desk- 1-855-880-8424
- For demonstrations and more information:
  - JH Providers:
    - ✓ [http://www.novitas-solutions.com/webcenter/portal/Novitasphere\\_JH/](http://www.novitas-solutions.com/webcenter/portal/Novitasphere_JH/)
  - JL Providers:
    - ✓ [http://www.novitas-solutions.com/webcenter/portal/Novitasphere\\_JL/](http://www.novitas-solutions.com/webcenter/portal/Novitasphere_JL/)

# Novitasphere Claim Correction Feature



- Common clerical errors can be corrected on finalized claims:
  - Number of services or units
  - Diagnosis code (Primary)
  - Eligible modifiers
  - Procedure code
  - Date of service
  - Place of service
  - Billed amount
- Novitasphere Claims Correction Guide:
  - [http://novitas-solutions.com/cs/idcplg?IdcService=GET\\_FILE&RevisionSelectionMethod=LatestReleased&dDocName=00086496&allowInterrupt=1](http://novitas-solutions.com/cs/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&dDocName=00086496&allowInterrupt=1)



# Automated Claim Correction Using the IVR



- New feature for all Part B providers allowing an unlimited number of claims to be corrected using the IVR:
  - Adding, changing or deleting a modifier
  - Changing a primary diagnosis code
  - Changing an ordering/referring provider
  - Changing a procedure code (and billed amount)
  - Changing the quantity billed (and billed amount)
  - Changing a date of service
  - Completing a history correction
- Correct claims within one year of finalized date using the IVR
- Claims billed in error must be corrected using:
  - Return of Monies to Medicare Form
  - Part B Redetermination and Clerical Error Reopening Request Form
- Claim corrections not accepted via IVR may use:
  - Novitasphere
  - Part B Redetermination and Clerical Error Reopening Request Form

# Automated Claim Correction Using the IVR Resources



- User Guide:
  - <http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00086538>
- Frequently Asked Questions:
  - <http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00132381>

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**The survey will take 2-3 minutes, and will appear at the conclusion of your visit.**

*This survey is conducted by an independent company ForeSee, on behalf of the site you are visiting.*

**No Thanks**

**Yes, I'll Help!**



# Customer Contact Information



- Providers are required to use the IVR unit to obtain:
  - Claim Status
  - Patient Eligibility
  - Check/Earning
  - Remittance inquiries
- Jurisdiction H:
  - Customer Contact Center- 1-855-252-8782
  - Provider Teletypewriter- 1-855-498-2447
- Patient / Medicare Beneficiary:
  - 1-800-MEDICARE (1-800-633-4227)
  - <http://www.medicare.gov>

# Thank You



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