Medicare 201: Beyond the Basics

Rick Gawenda, PT
President
Gawenda Seminars & Consulting, Inc.
October 13, 2022

GAWENDA SEMINARS & CONSULTING

1

Learning Objectives

- Discuss how CMS determines payment for each CPT code
- Describe how the multiple procedure payment reduction policy reduces payment to outpatient therapy providers
- Recognize when to apply the CQ or CO modifier to a CPT code on the claim form
- Identify when it is and is not appropriate to issue an ABN to a Medicare beneficiary
- Recite how the annual Medicare Part B deductible impacts the annual therapy threshold dollar amount

GAWENDA SEMINARS & CONSULTING

2

2

Learning Objectives

- Explain the different Medigap plans, and which plans cover the annual Medicare Part B deductible
- Discuss the Qualified Medicare Beneficiary Program and its impact on your payment for outpatient therapy services
- Describe how Medicare Advantage (MA) plans reimburse therapists who are not enrolled in the MA plan
- Recite when you can bill Medicare for outpatient therapy for a Medicare beneficiary in hospice
- Explain the differences between enrolling as a participating provider vs a nonparticipating provider

GAWENDA SEMINARS & CONSULTING

3

How are We Paid

- **Percent of Charges** – Insurance carrier reimburses a percent of your usual and customary charges. Rare to see this payment system – Least Common
- **Paid a per Diem Rate** – As long as your allowed charges are above the amount the insurance carrier reimburses, you will get the full per diem rate
- **Paid per CPT Code** – Most common form of payment used by insurance carriers, including the Medicare program for outpatient therapy services. Typically called fee-for-service. Essentially, the more units you bill, the more you are paid

GAWENDA SEMINARS & CONSULTING

4

Medicare Payment for Each CPT Code

- The Centers for Medicare and Medicaid Services (CMS) utilizes the Resource Based Relative Value Scale (RBRVS) to determine payment for each CPT under the Medicare Physician Fee Schedule
- RBRVS determines prices based on three separate factors (i.e., relative value units (RVUs)): physician work (51%), practice expense (45%), and malpractice expense (4%)
- Percentages are average percentage contributions of each factor, as computed by the Government Accountability Office in 2005

GAWENDA SEMINARS & CONSULTING

5

Relative Value Units (RVUs) Defined

- **Work RVU** – Relative level of time, skill, training, mental effort, judgment and intensity to provide the service
- **Practice Expense RVU** – Addresses cost of maintaining a practice such as rent, mortgage, equipment, supplies, and non-physician staff costs
- **Malpractice RVU** – Represents payment for the professional liability expenses

GAWENDA SEMINARS & CONSULTING

6

Geographic Price Cost Index: Medicare Part B

- Used by the Medicare Part B program to adjust payment rates that take into account regional and practice-specific factors
- Currently, there are approximately 112 different payment localities under the Medicare fee-for-service program (i.e., MPFS)
- Other insurance carriers may also use a similar index to adjust payment rates based on location and practice-specific factors

GAWENDA SEMINARS & CONSULTING

7

How Does CMS Determine Price of Each CPT Code

- RBRVS Formula is as follows:

  (Work RVU * Work GPCI) + (Practice Expense RVU * Practice Expense GPCI) + (Malpractice Expense RVU * Malpractice Expense GPCI) = Total RVUs

  Total RVUs * Conversion Factor = Fee

- The Conversion Factor is a value used in Medicare's payment formula that turns RVUs into dollar values (i.e., actual fees)

GAWENDA SEMINARS & CONSULTING

8

How are CPT Codes Valued
2022 Example – 97110 Los Angeles County

- (Work RVU * Work GPCI) + (Practice Expense RVU * Practice Expense GPCI) + (Malpractice Expense RVU * Malpractice Expense GPCI) = Total RVUs

  Total RVUs * Conversion Factor = Fee

- (0.45*1.048) + (0.4*1.175) + (0.02*0.757) =
- 0.4716 + 0.47 + 0.01514 = 0.95674
- 0.95674 * 34.6062 = $33.11

GAWENDA SEMINARS & CONSULTING

9

How are CPT Codes Valued
2022 Example – 97110 Utah

- (Work RVU * Work GPCI) + (Practice Expense RVU * Practice Expense GPCI) + (Malpractice Expense RVU * Malpractice Expense GPCI) = Total RVUs

  Total RVUs * Conversion Factor = Fee

- (0.45*1.000) + (0.4*0.919) + (0.02*0.799) =
- 0.45 + 0.3676 + 0.01598 = 0.83358
- 0.83358 * 34.6062 = $28.85

GAWENDA SEMINARS & CONSULTING

10

How are CPT Codes Valued
2022 Example – 97110 Idaho

- (Work RVU * Work GPCI) + (Practice Expense RVU * Practice Expense GPCI) + (Malpractice Expense RVU * Malpractice Expense GPCI) = Total RVUs

  Total RVUs * Conversion Factor = Fee

- (0.45*1.000) + (0.4*0.877) + (0.02*0.416) =
- 0.45 + 0.3508 + 0.00832 = 0.80912
- 0.80912 * 34.6062 = $28.00

GAWENDA SEMINARS & CONSULTING

11

How are CPT Codes Valued
2022 Example – 97110 Detroit, MI

- (Work RVU * Work GPCI) + (Practice Expense RVU * Practice Expense GPCI) + (Malpractice Expense RVU * Malpractice Expense GPCI) = Total RVUs

  Total RVUs * Conversion Factor = Fee

- (0.45*1.000) + (0.4*0.997) + (0.02*1.622) =
- 0.45 + 0.3988 + 0.03244 = 0.88124
- 0.88124 * 34.6062 = $30.50

GAWENDA SEMINARS & CONSULTING

12

How are CPT Codes Valued
2022 Example – 97110 Alabama

- (Work RVU * Work GPCI) + (Practice Expense RVU * Practice Expense GPCI) + (Malpractice Expense RVU * Malpractice Expense GPCI) = Total RVUs

  Total RVUs * Conversion Factor = Fee

- (0.45*1.000) + (0.4*0.888) + (0.02*0.921) =
- 0.45 + 0.3552 + 0.01842 = 0.82362
- 0.82362 * 34.6062 = $28.50

GAWENDA SEMINARS & CONSULTING

13

End of How You are Paid

GAWENDA SEMINARS & CONSULTING

14

Multiple Procedure Payment Reduction (MPPR) Policy Traditional Medicare

- Effective January 1, 2011, for Medicare Part B services reimbursed under the Medicare Physician Fee Schedule
- **Effects the practice expense (PE) component of always therapy CPT codes**
- CPT code with highest practice expense value will have the **first unit** of that CPT code practice expense reimbursed at 100% of its value
- Remaining units of the same CPT code (if more than 1 unit billed) and all other CPT codes billed that day under the same group number or tax ID number will have their practice expense value reduced by 50%

GAWENDA SEMINARS & CONSULTING

15

Multiple Procedure Payment Reduction (MPPR) Policy Traditional Medicare

- MPPR is not discipline specific, but provider specific. Will cross all disciplines provided on same date of service **by same provider or group practice**
- Negative impact to providers could be up to 18% - 21% in reduced payment during a single visit depending on CPT codes billed and disciplines seen the same date of service

GAWENDA SEMINARS & CONSULTING

16

MPPR Policy Example Disclaimer

- The following slides are examples using **Utah** as the payment locality and used the 2022 conversion factor of 34.6062
- The examples are meant to show how the MPPR policy will be applied and will affect providers and does not guarantee exact payment amounts under Medicare Part B

GAWENDA SEMINARS & CONSULTING

17

17

Multiple Procedure Payment Reduction Policy Example #1

	Work RVU	PE RVU	Adjusted PE RVU	Malpractice RVU	Normal Payment	Payment After MPPR Applied	Sequestration Reduction
1 Unit G0283	0.18	0.17	0.085	0.01	$11.91	$9.21	$9.06
1 Unit 97110	0.45	0.40	0.40	0.02	$28.85	$28.85	$28.39
1 Unit 97110	0.45	0.40	0.20	0.02	$28.85	$22.49	$22.13
1 Unit 97140	0.43	0.35	0.175	0.02	$26.56	$21.00	$20.66
Payment					$96.17	$81.55 (-15.20%)	$80.24 (-16.57%)

18

18

Multiple Procedure Payment Reduction Policy Example #2

	Work RVU	PE RVU	Adjusted PE RVU	Malpractice RVU	Normal Payment	Payment After MPPR Applied	Sequestration Reduction
1 Unit 97162	1.54	1.35	1.35	0.07	$98.16	$98.16	$96.59
1 Unit 97110	0.45	0.40	0.20	0.02	$28.85	$22.49	$22.13
1 Unit G0283	0.18	0.17	0.085	0.01	$11.91	$9.21	$9.06
Payment					$138.92	$129.86 (-6.52%)	$127.78 (-8.02%)

19

19

Multiple Procedure Payment Reduction Policy Example #3

	Work RVU	PE RVU	Adjusted PE RVU	Malpractice RVU	Normal Payment	Payment After MPPR Applied	Sequestration Reduction
1 Unit 97110	0.45	0.40	0.40	0.02	$28.85	$28.85	$28.39
1 Unit 97110	0.45	0.40	0.20	0.02	$28.85	$22.49	$22.13
1 Unit 97110	0.45	0.40	0.20	0.02	$28.85	$22.49	$22.13
Payment					$86.55	$73.83 (-14.70%)	$72.65 (-16.06%)

20

20

Multiple Procedure Payment Reduction Policy Example #4

	Work RVU	PE RVU	Adjusted PE RVU	Malpractice RVU	Normal Payment	Payment After MPPR Applied	Sequestration Reduction
1 Unit 95992	0.75	0.49	0.49	0.04	$42.64	$42.64	$41.96
1 Unit 97110	0.45	0.40	0.40	0.02	$28.85	$28.85	$28.39
1 Unit 97140	0.43	0.35	0.175	0.02	$26.56	$21.00	$20.66
Payment					$98.05	$92.49 (-5.67%)	$91.01 (-7.18%)

21

21

Multiple Procedure Payment Reduction Policy Example #5

	Work RVU	PE RVU	Adjusted PE RVU	Malpractice RVU	Normal Payment	Payment After MPPR Applied	Sequestration Reduction
1 Unit 97110 - PT	0.45	0.40	0.20	0.02	$28.85	$22.49	$22.13
1 Unit 97140 - PT	0.43	0.35	0.175	0.02	$26.56	$21.00	$20.66
1 Unit 97035 - PT	0.21	0.20	0.10	0.01	$13.90	$10.72	$10.55
1 Unit 97530 - OT	0.44	0.64	0.64	0.02	$36.13	$36.13	$35.56
1 Unit 97530 - OT	0.44	0.64	0.32	0.02	$36.13	$25.96	$25.64
1 Unit 97112 - OT	0.5	0.49	0.245	0.02	$33.44	$25.65	$25.24
Payment					$175.01	$141.95 (-18.89%)	$139.68 (-20.19%)

22

22

Multiple Procedure Payment Reduction Policy Example #6

	Work RVU	PE RVU	Adjusted PE RVU	Malpractice RVU	Normal Payment	Payment After MPPR Applied	Sequestration Reduction
1 Unit 92507 - SLP	1.3	0.91	0.91	0.05	$75.31	$75.31	$74.11
1 Unit 97110 - PT	0.45	0.40	0.20	0.02	$28.85	$22.49	$22.13
1 Unit 97112 - PT	0.5	0.49	0.245	0.02	$33.44	$25.65	$25.24
1 Unit 97116 - PT	0.45	0.40	0.20	0.02	$28.85	$22.49	$22.13
2 Units 97530 - OT	0.44	0.64	0.32	0.02	$72.27	$51.91	$51.08
1 Unit 97112 - OT	0.5	0.49	0.245	0.02	$33.44	$25.65	$25.24
Payment					$272.16	$223.50 (-17.88%)	$219.93 (-19.19%)[23]

23

MTPR Policy - UnitedHealthcare

- UnitedHealthcare implemented the Multiple Therapy Procedure Reduction policy (MTPR) effective March 1, 2012
- MTPR will be applied only to claims submitted on a CMS 1500 claim form or its electronic equivalent
- In addition, UHC implemented the MPPR policy to its Medicare Advantage plans and follows Medicare guidelines

GAWENDA SEMINARS & CONSULTING

24

24

MPPR Policy - Aetna

- Aetna implemented the MPPR policy on November 14, 2011 for the private practice setting
- CPT code with highest practice expense value will have the first unit of that CPT code practice expense reimbursed at 100% of its value
- Remaining units of all CPT codes will have their practice expense value reduced by 50%

GAWENDA SEMINARS & CONSULTING

25

End of MPPR

GAWENDA SEMINARS & CONSULTING

26

PTA & OTA Modifiers

- The Bipartisan Budget Act of 2018 instructed the Secretary, by January 1, 2019, to establish a modifier to indicate (in a form and manner specified by the Secretary), in the case of an outpatient physical therapy **service** or outpatient occupational therapy **service** furnished "i**n whole" or "in part"** by a PTA or OTA, that the **service** was furnished by a PTA or OTA

GAWENDA SEMINARS & CONSULTING

27

PTA & OTA Modifiers

- In a final rule published on November 1, 2018, CMS did release 2 new modifiers that must be appended to services (CPT codes) provided "**in whole" or "in part"** by a physical therapist assistant or occupational therapy assistant beginning with dates of service on and after January 1, 2020

  CQ Modifier: Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant.

  CO Modifier: Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant.

GAWENDA SEMINARS & CONSULTING

28

PTA and OTA Modifiers

- **In Whole or In Part Defined by CMS:**

  CMS finalized their proposal a de minimis standard under which a **service** is furnished in whole or in part by a PTA or OTA when more than 10 percent of the service is furnished by the PTA or OTA. For example, if a Medicare beneficiary received 15 minutes of therapeutic exercise, 2 minutes could be furnished by the PTA or OTA without being subject to the discounted payment rate.

  CMS finalized a revised definition of a service to which the de minimis standard is applied to include untimed codes and each 15-minute unit of codes described in 15-minute increments as a service

GAWENDA SEMINARS & CONSULTING

29

PTA & OTA Modifiers

- Bipartisan Budget Act of 2018 required CQ and CO modifiers to begin with dates of service on and after January 1, 2020
- Payment was not impacted in calendar years 2020 and 2021
- This gave the Centers for Medicare and Medicaid Services 2 years' worth of data prior to the implementation of the payment changes in 2022

GAWENDA SEMINARS & CONSULTING

30

PTA & OTA Modifiers

- Services provided by a PTA or OTA with dates of service on and after January 1, 2022, will be paid at 85% of what a physical therapist or an occupational therapist would be paid for providing the exact same services under the Medicare Physician Fee Schedule when the new modifiers are appended to the CPT code(s) on the claim form

GAWENDA SEMINARS & CONSULTING

31

Modifier Payment Reduction Calculation

- CMS is proposing to apply the 15 percent payment reduction to therapy services provided by physical therapist assistants (PTAs) (using the CQ modifier) or occupational therapy assistants (OTAs) (using the CO modifier), as required by statute
- The volume discount factor for therapy services to which the CQ and CO modifiers apply is: (0.20 + (0.80* 0.85), which equals 88 percent
- Example using $30.00 as the allowed amount for the CPT code

  (6.00 + (24.00*0.85) = 6.00 + 20.40 = $26.40

  26.40/30.00 = 88%

GAWENDA SEMINARS & CONSULTING

32

Modifier Payment Reduction Calculation

Per the CMS final rule, "When therapy claims have more than one unit of a service or two or more "always therapy" codes, and they also have a CQ or CO modifier for each unit or code, the beneficiary's deductible (where it applies) is calculated first, then the MPPR is applied to the Practice Expense relative value unit payment, and then the 20 percent coinsurance is deducted, as per the usual process. After that, the 15 percent reduction is taken for PTA/OTA services, followed by the 2 percent sequestration (when applicable) that is always last".

GAWENDA SEMINARS & CONSULTING

33

Modifier Payment Reduction Calculation

- 3 units of 97110 are billed and the allowed amount is $30.75 per unit
- 1st unit remains at $30.75 and the allowed amount for the other 2 units is each $23.79
- Total allowed amount is $78.33
- (15.67 + (62.66*0.85) = 15.67 + 53.26 = $68.93 prior to sequestration reduction and $67.86 after sequestration

GAWENDA SEMINARS & CONSULTING

34

2022 MPFS Final Rule

CO and CQ Assistant Modifier Application Examples

- CMS finalized their proposal to modify their policy so that the CQ/CO modifiers would not apply when the PT/OT provides enough minutes of the service on their own to bill for the last unit of a timed service, (more minutes than the midpoint or 8 minutes of a 15-minute timed code) regardless of any additional minutes for the service provided by the PTA/OTA
- **Example**

  PT/OT provides 23 minutes of 97110 and PTA/OTA provides 10 minutes of 97110. Total timed minutes is 33 and allows for 2 units to be billed. Since PT/OT provided an entire 15 minutes, first unit is billed without CO/CQ modifier. Since PT/OT spent an additional 8 minutes providing 97110, a second unit could be billed without using any of the minutes provided by the PTA/OTA. This means the second unit is also billed without the CO/CQ modifier

GAWENDA SEMINARS & CONSULTING

35

PTA & OTA Modifier Example
2022 MPFS Final Rule

- PT or OT spends 20 minutes providing manual therapy and then the PT or OT provides 12 minutes of therapeutic exercise and then the PTA or OTA provides 14 minutes of therapeutic exercise
- The total time of 15-minute time-based CPT codes is 46 minutes and allows for 3 units to be billed
- The billing would be 1 unit of 97140 **without** the CQ/CO modifier since the entire time was provided by the PT or OT
- Two units remain to be billed and the PT/OT and the PTA/OTA each provided between 9 and 14 minutes independent of one another with a total time between 23 and 28 minutes – in these “two remaining unit” scenarios, one unit is billed with the CQ/CO modifier for the PTA/OTA and the other unit is billed without it for the PT/OT

GAWENDA SEMINARS & CONSULTING

36

PTA & OTA Modifiers Example
15- Minute Time-Based CPT Codes

- PT or OT spends 30 minutes providing therapeutic exercise and then the PTA or OTA provides an additional 15 minutes of therapeutic exercise
- The total time is 45 minutes, and this allows three units of CPT code 97110 to be billed
- Since the PTA or OTA provided an entire 15 minutes of therapeutic exercise, 1 unit of 97110 would be billed **with** the CQ/CO modifier
- Since the PT or OT provided an entire 30 minutes of therapeutic exercise, 2 units of 97110 would be billed **without** the CQ/CO modifier

GAWENDA SEMINARS & CONSULTING

37

37

PTA & OTA Modifiers Example
15- Minute Time-Based CPT Codes

- PT or OT spends 15 minutes providing manual therapy and then the PTA or OTA provides 20 minutes of therapeutic exercise
- The total timed minutes are 35 minutes, and this allows 2 time-based units to be billed
- Manual therapy would be billed **without** the CQ or CO modifier since the PT or OT provided the entire 15 minutes of manual therapy
- Therapeutic exercise **would require** the CQ or CO modifier since the PTA or OTA provided the entire 20 minutes of therapeutic exercise

GAWENDA SEMINARS & CONSULTING

38

38

PTA & OTA Modifiers Example
15- Minute Time-Based CPT Codes

- PT or OT spends 7 minutes providing manual therapy and then the PTA or OTA provides 15 minutes of therapeutic exercise
- The total time of 15-minute time-based CPT codes is 22 minutes and allows for 1 unit to be billed
- Since therapeutic exercise was provided for the most amount of time, CPT code 97110 would be billed on the claim form and **would require** the CQ or CO modifier since the PTA or OTA provided the entire 15 minutes of therapeutic exercise

39

PTA & OTA Modifiers Example
15- Minute Time-Based CPT Codes

- PT or OT spends 10 minutes providing manual therapy and then the PTA or OTA provides 10 minutes of therapeutic exercise
- The total time of 15-minute time-based CPT codes is 20 minutes and allows for 1 unit to be billed
- Since the minutes spent providing each intervention are the same, the code furnished by the PT/OT would be selected to break the tie and billed **without** a CQ/CO modifier because the PT/OT furnished that service independently of the PTA/OTA

40

PTA & OTA Modifiers Example
15- Minute Time-Based CPT Codes

- PTA or OTA spends 32 minutes providing therapeutic exercise and then the PTA or OTA provides 14 minutes of therapeutic activities
- The total time of 15-minute time-based CPT codes is 46 minutes and allows for 3 units to be billed
- Since all of the services were provided by the PTA or OTA, the 2 units of 97110 and 1 unit of 97530 would be billed **with the** CQ/CO modifier appended to them on the claim form

GAWENDA SEMINARS & CONSULTING

41

CQ/CO Modifiers & Other Insurances

What other insurances have implemented CQ/CO Modifiers?

- Humana
- Cigna – Not through ASH
- TRICARE
- UnitedHealthcare
- My opinion – more to come in 2023!

GAWENDA SEMINARS & CONSULTING

42

Humana and CQ/CO Modifiers

- Humana announced they will require CQ/CO modifier with their Commercial and Medicare Advantage policies beginning January 1, 2020
  - Follows CMS implementation guidelines
- Policy applies to every charge for outpatient OT or PT service reported on professional or institutional claim except for an institutional TOB 85x claim
- Effective for DOS beginning 1/1/2022, Humana allows a charge for outpatient OTA or PTA service at 85% of contracted rate or base maximum amount payable under the member's plan

GAWENDA SEMINARS & CONSULTING

43

End of CQ/CO Modifiers

GAWENDA SEMINARS & CONSULTING

44

Advance Beneficiary Notice of Noncoverage

- Providers **can't** issue:

1. ABNs to all Medicare beneficiaries on their first visit
2. Generic/blanket ABNs to Medicare beneficiaries
3. ABNs to a Medicare beneficiary simply because they have reached/exceeded the annual therapy dollar threshold
4. ABNs to a Medicare beneficiary simply because they have reached/exceeded the $3000 dollar threshold
5. ABNs to a Medicare beneficiary receiving maintenance therapy that requires the skills of a therapist to provide

GAWENDA SEMINARS & CONSULTING

45

Advance Beneficiary Notice of Noncoverage

- Providers **can** issue an:

1. ABN when the services they are going to provide are not covered by their Medicare Administrative Contractor (i.e., laser, iontophoresis)
2. ABN when they feel the services are not medically necessary and will not be paid by the Medicare program
3. ABN to a Medicare beneficiary is receiving home health services and also wants to attend outpatient therapy

GAWENDA SEMINARS & CONSULTING

46

Advance Beneficiary Notice of Noncoverage

- An ABN is **not required** to be issued to a Medicare beneficiary or their representative for services that are statutorily non-covered by the Medicare program
- Examples include theraband, selling hot and cold packs, post therapy services focused on wellness, prevention, fitness, yoga, Pilates, etc.
- No minimum or maximum dollar threshold to issue an ABN
- Annual therapy dollar threshold and $3000 Targeted Medical Review threshold has nothing to do with issuing an ABN

GAWENDA SEMINARS & CONSULTING

47

Issuance of a Voluntary Advance Beneficiary Notice

- Issued when the service is statutorily a non-covered service by the Medicare program (care that is never covered)
- The voluntary ABN serves as a courtesy to the beneficiary in forewarning him/her of impending financial obligation
- When an ABN is used as a voluntary notice, the beneficiary should not be asked to choose an option box or sign the notice

GAWENDA SEMINARS & CONSULTING

48

2022 Therapy Threshold

- The therapy threshold for calendar year 2022 is $2,150 for physical therapy and speech-language pathology combined and a separate $2,150 for occupational therapy
- Services provided that are above the annual therapy threshold dollar amount in a calendar year would require the KX modifier be appended to them on the claim form ($2,150 PT and SLP combined and a separate $2,150 for OT in 2022)
- Application of KX modifier will attest services above $2,150 in 2022 and beyond are still medically necessary

GAWENDA SEMINARS & CONSULTING

49

Use of KX Modifier in 2022

- Targeted medical review dollar amount for 2022 is $3,000 for physical therapy and speech-language pathology combined and a separate $3,000 for occupational therapy
- For services exceeding $3,000 in 2022 for physical therapy and speech-language pathology combined, those services would require the KX modifier be appended to them on the claim form
- For claims exceeding $3,000 in 2022 for occupational therapy, those services would require the KX modifier be appended to them on the claim form

GAWENDA SEMINARS & CONSULTING

50

2022 Medicare Part B Deductible

- Part B deductible is $233.00
- How does the Part B deductible impact the dollar amount that is applied towards the annual therapy threshold dollar amount in 2022?
- It depends on whether the therapy visits were provided prior to or after the annual Part B deductible was met

GAWENDA SEMINARS & CONSULTING

51

Part B Deductible: Impact on Therapy Threshold

- If Part B deductible **has not been met** prior to the Medicare beneficiary receiving outpatient therapy services, the Medicare allowed amount up to the Part B deductible would count towards the annual therapy threshold dollar amount
- If Part B deductible **has been met** prior to the Medicare beneficiary receiving outpatient therapy services, then the Medicare beneficiary would have the full annual therapy threshold dollar amount available assuming they have not had any therapy yet in that calendar year

GAWENDA SEMINARS & CONSULTING

52

Therapy Threshold Calculation

- Therapy threshold dollar amount is based on the Medicare allowed amount for each CPT code **after** the Multiple Procedure Payment Reduction policy is applied **and before** the governments 2.0% (net 1.6%) sequestration reduction is applied, not what you charge or are paid by the Medicare program

GAWENDA SEMINARS & CONSULTING

53

What Amount Counts Towards the Therapy Threshold?

	Work RVU	PE RVU	Adjusted PE RVU	Malpractice RVU	Normal Payment	Payment After MPPR Applied	Sequestration Reduction
1 Unit G0283	0.18	0.17	0.085	0.01	$11.91	$9.21	$9.06
1 Unit 97110	0.45	0.40	0.40	0.02	$28.85	$28.85	$28.39
1 Unit 97110	0.45	0.40	0.20	0.02	$28.85	$22.49	$22.13
1 Unit 97140	0.43	0.35	0.175	0.02	$26.56	$21.00	$20.66
Payment					$96.17	$81.55 (-15.20%)	$80.24 (-16.57%)

54

Criteria For Targeted Medical Review

- CMS has tasked Noridian Healthcare Solutions, LLC as the Supplemental Medical Review Contractor (SMRC) with performing this medical review on a **post-payment basis**
- The SMRC will be selecting claims for review based on the following:

1. The therapy provider has had a high claims denial percentage for therapy services
2. The therapy provider has a pattern of billing for therapy services that is aberrant compared to peers or otherwise has questionable billing practices for such services, such as billing medically unlikely units of services in a day

GAWENDA SEMINARS & CONSULTING

55

Criteria For Targeted Medical Review

- The SMRC will be selecting claims for review based on the following (cont.):

3. The therapy provider is newly enrolled under this title or has not previously furnished therapy services under this part
4. The services are furnished to treat a type of medical condition
5. The therapy provider is part of group that includes another therapy provider identified

GAWENDA SEMINARS & CONSULTING

56

Medicare Supplement Plans

- Known as Medigap
- Due to passage of the Medicare Access and CHIP Reauthorization Act (MACRA), newly enrolled Medicare recipients beginning January 1, 2020, and after will not be able to enroll in Medigap Plan C or Plan F
- Medigap Plans C and F would cover the annual Medicare Part B deductible
- A newly enrolled Medicare recipient is defined as "people who are 65 years of age or become first eligible for Medicare because of age, disability or end-stage renal sickness on or after January 1, 2020

GAWENDA SEMINARS & CONSULTING

57

57

Medigap Plans

Medigap Benefits	A	B	C	D	F
Part B coinsurance or copayment	Yes	Yes	Yes	Yes	Yes
Skilled nursing facility coinsurance	No	No	Yes	Yes	Yes
Part A deductible	No	Yes	Yes	Yes	Yes
Part B deductible	No	No	Yes	No	Yes
Part B Excess charge	No	No	No	No	Yes
Out-of-pocket limit	N/A	N/A	N/A	N/A	N/A

58

58

Medigap Plans

Medigap Benefits	G	K	L	M	N
Part B coinsurance or copayment	Yes	50%	75%	Yes	Yes
Skilled nursing facility coinsurance	Yes	50%	75%	Yes	Yes
Part A deductible	Yes	50%	75%	50%	Yes
Part B deductible	No	No	No	No	No
Part B Excess charge	Yes	No	No	No	No
Out-of-pocket limit	N/A	$6,620 In 2022	$3,310 In 2022	N/A	N/A

59

59

End of ABN, Therapy Threshold and Medigap Plans

GAWENDA SEMINARS & CONSULTING

60

60

Opting Out of Medicare

I Know It Makes You Sad, But

YOU CANNOT OPT OUT OF MEDICARE

61

Who Can't Opt-Out of Medicare?

- Chiropractors
- Physical Therapists in Private Practice
- Occupational Therapists in Private Practice
- Speech-Language Pathologists in Private Practice

62

Mandatory Claims Submission

- The Social Security Act (Section 1848(g)(4)) requires that claims be submitted for all Medicare patients for services rendered on or after September 1, 1990
- This requirement applies to all physicians and suppliers who provide **covered services** to Medicare beneficiaries
- If physical therapists want to treat Medicare beneficiaries for covered services, they must enroll in Medicare if they are practicing in a private practice
- Must submit a claim to your respective Medicare Administrative Contractor for services that are a **covered** Medicare benefit
- You are **not required** to file a claim for a service that is categorically **excluded** from coverage (Fitness, wellness, injury prevention)

GAWENDA SEMINARS & CONSULTING

63

Participating vs Non-Participating Provider

- When non-private practices enroll in the Medicare program, they must select to be a participating provider (i.e., Rehab Agency)
- When private practices enroll in the Medicare program, they have the option of selecting to become a participating provider or a non-participating provider

GAWENDA SEMINARS & CONSULTING

64

Medicare Participating Provider

- Participating provider agrees to accept assignment for all services furnished to Medicare patients
- By accepting assignment, the provider agrees to accept the amount approved by Medicare as total payment for covered services
- Medicare program pays 80% of the allowed amount and the patient's secondary insurance (Medigap), if they have it, will pay the other 20%
- If the patient does not have a secondary insurance, the patient is responsible for the other 20%; possibly (will explain later)

GAWENDA SEMINARS & CONSULTING

65

65

Medicare Non-Participating Provider

- Non-Participating provider may choose to accept or not accept assignment on a claim-by-claim basis
- If you choose **to select assignment** on a claim, the Medicare allowed amount is set at 95% of the Medicare allowed amount for participating therapists
- By choosing **not to select assignment**, you may charge the Medicare beneficiary up to 115% of the limiting charge based on the Medicare allowed amount; however, the Medicare allowed amount for a non-participating provider is 95% of the Medicare allowed amount for participating providers

GAWENDA SEMINARS & CONSULTING

66

66

Participating vs Non-Participating Provider
The Payment Difference – Example #1

	Participating	Non-Participating Assigned Claim	Non-Participating Unassigned Claim
Medicare Visit – Allowed amount is $100.00	Allowed amount is $100.00	Allowed amount is 95% of $100 which is $95.00	Allowed amount is 95% of $100 which is $95.00
Medicare pays 80%	Medicare pays $80.00 to clinic	Medicare pays $76.00 to the clinic	Patient pays $76.00 to the clinic and CMS pays $76.00 to patient
Secondary or patient pays 20%	Secondary or Patient pays $20.00 to clinic	Secondary or Patient pays $19.00 to clinic	Patient pays $19.00 to clinic and insurance pays $19.00 to patient
Limiting amount of 115% of the Medicare allowed amount	Not Applicable	Not Applicable	115% multiplied by the Medicare allowed amount of $95 equals $109.25. Take the $109.25 and subtract the $95.00 that was paid and that leaves a balance of $14.25 that the non-participating provider can collect from the patient
Total Payment	$100.00	$95.00	$109.25 is paid by patient at time of visit to clinic

67

67

Participating vs Non-Participating Provider
The Payment Difference – Example #2

	Participating	Non-Participating Assigned Claim	Non-Participating Unassigned Claim
Medicare Visit – Allowed amount is $120.00	Allowed amount is $120.00	Allowed amount is 95% of $120 which is $114.00	Allowed amount is 95% of $120 which is $114.00
Medicare pays 80%	Medicare pays $96.00 to clinic	Medicare pays $91.20 to the clinic	Patient pays $91.20 to the clinic and CMS pays $91.20 to patient
Secondary or patient pays 20%	Secondary or Patient pays $24.00 to clinic	Secondary or Patient pays $22.80 to clinic	Patient pays $22.80 to clinic and insurance pays $22.80 to patient
Limiting amount of 115% of the Medicare allowed amount	Not Applicable	Not Applicable	115% multiplied by the Medicare allowed amount of $114 equals $131.10. Take the $131.10 and subtract the $114.00 that was paid and that leaves a balance of $17.10 that the non-participating provider can collect from the patient
Total Payment	$120.00	$114.00	$131.10 is paid by patient at time of visit to clinic

68

68

Qualified Medicare Beneficiary Program

- Qualified Medicare Beneficiary (QMB) program was established to "assist low-income beneficiaries with Medicare premiums and cost-sharing
- These beneficiaries have Medicare primary and Medicaid secondary
- Medicare and Medicare Advantage providers are prohibited by federal law from billing individuals enrolled in QMB for Medicare cost sharing, including deductibles, coinsurance, or copayments for Medicare Part A or Part B services, but state Medicaid programs may pay for those costs
- Nonparticipating providers **must accept assignment** for each QMB patient and must accept the Medicare payment in full

GAWENDA SEMINARS & CONSULTING

69

69

Qualified Medicare Beneficiary Program

- Providers and suppliers may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States can limit Medicare cost-sharing payments, under certain circumstances
- Medicare beneficiaries in the QMB program have no legal obligation to pay Medicare providers for Medicare Part A or Part B cost-sharing
- Individuals enrolled in the QMB program keep their protection from billing when they cross State lines to receive care. Providers and suppliers cannot charge individuals enrolled in QMB even if their QMB benefit is from a different State than the State where they get care.
- Individuals enrolled in QMB **cannot** elect to pay Medicare deductibles, coinsurance, and copays, but may have a small Medicaid copay

GAWENDA SEMINARS & CONSULTING

70

70

Qualified Medicare Beneficiary Program

- Providers and suppliers can use Medicare eligibility data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third-party vendors) by CMS' HIPPA Eligibility Transaction System (HETS) to verify a patient's QMB status and exemption from cost-sharing charges
- Medicare Advantage providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members
- Providers and suppliers may also verify a patient's QMB status through State online Medicaid eligibility systems or other documentation, including Medicaid identification cards, Medicare Summary Notices and documents issued by the State proving the patient is enrolled in the QMB program

GAWENDA SEMINARS & CONSULTING

71

71

Qualified Medicare Beneficiary Program

Beginning October 2, 2017, messages will appear on the provider's remittance advice to reflect a beneficiary's QMB status with one of the following remittance advice remark codes (RARCs):

- N781 - No **deductible** may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
- N782 - No **coinsurance** may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
- N783 - No **co-payment** may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.

GAWENDA SEMINARS & CONSULTING

72

72

Break Even Point for Non-Participating Provider

Percent of Medicare Claims Assigned	Percent of Unassigned Claims Which Must Be Collected to Break Even
0%	91.5%
20%	92.7%
40%	94.6%
50%	96.1%
60%	98.4%
64.9%	100%
70%	102.2%
80%	109.8%

73

73

Medicare Advantage Plans

- **Scenario**: Provider **is not enrolled** with the Medicare Advantage (MA) plan. The MA plan **does** have out-of-network (OON) benefits.
- **Question:** Must I submit a claim to the MA carrier and are there limitations in how much I can charge the patient?
- **Answer:** The provider must accept as payment in full the amount the plan pays the non-contracting provider which is the summation of what the plan pays, and the patients cost sharing responsibility and cannot charge anything further. You cannot balance bill.

  Regarding the submission of the claim, you would need to contact the MA plan

GAWENDA SEMINARS & CONSULTING

74

74

Medicare Advantage Plans

- **Scenario**: Provider **is not enrolled** with the Medicare Advantage (MA) plan. The MA plan **does not** have out-of-network (OON) benefits.
- **Question**: Must I submit a claim to the MA carrier and are there limitations in how much I can charge the patient?
- **Answer:** Since the MA plan has no OON benefits and PT is not contracted with the MA plan, the MA patient must compensate the provider in full for the therapy services they received.

  There would be no claim submission to the insurance carrier

GAWENDA SEMINARS & CONSULTING

75

Hospice and Outpatient Therapy: Medicare

- If therapy needs are related to your terminal illness, your hospice benefit should cover everything you need related to your terminal illness. Your hospice benefit will cover these services even if you remain in a Medicare Advantage Plan or other Medicare health plan.
- After your hospice benefit starts, you can still get covered services for conditions not related to your terminal illness. Original Medicare will pay for covered services for any health problems that aren't part of your terminal illness and related conditions
- Medicare beneficiary would be responsible for any deductible and coinsurance amounts for all Medicare-covered services you get to treat health problems that aren't part of your terminal illness and related conditions

GAWENDA SEMINARS & CONSULTING

76

Hospice and Outpatient Therapy Medicare

- If you were in a Medicare Advantage Plan before starting hospice care, and you decide to stay in that plan:

  1. You can get covered services for any health problems that aren't part of your terminal illness and related conditions

  2. You can choose to get services not related to your terminal illness from either your plan or Original Medicare

GAWENDA SEMINARS & CONSULTING

77

Hospice and Outpatient Therapy Medicare

- If you start hospice care on or after October 1, 2020, you can ask your hospice provider for a list of items, services, and drugs that they've determined aren't related to your terminal illness and related conditions

- This list must include why they made that determination

- Your hospice provider is also required to give this list to your non-hospice providers or Medicare if requested

GAWENDA SEMINARS & CONSULTING

78

Hospice and Outpatient Therapy: Medicare

- Modifier GW: Service not related to the hospice patient's terminal condition
- Unsure if all, if any, Medicare Administrative Contractors recognize this modifier when appended to CPT codes on a claim form that described outpatient therapy services
- My recommendation is to try this modifier as a last result before having to begin an appeals process
- Best option is to have the hospice provider enter into a contract for your services and pay you directly

GAWENDA SEMINARS & CONSULTING

79

End of this Presentation

GAWENDA SEMINARS & CONSULTING

80

However, You Still Have One More Session to Go!

81

References and Resources
RBRVS

- American Medical Association, RBRVS Overview

  https://www.ama-assn.org/about/rvs-update-committee-ruc/rbrvs-overview

- American Medical Association, Medicare Physician Payment Schedules

  https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-physician-payment-schedules

82

References and Resources
Internet-Only Manuals

- http://www.cms.gov/Manuals/
- Click on Internet-Only Manuals
- Click on Pub 100-2 Medicare Benefit Policy Manual
- **Chapter 15 – Covered Medical and Other Health Services, Section 220 – 230.6**

83

MPPR References

- CMS Pub 100-04, Chapter 5, Section 10.7

  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf

- Always or Sometimes Therapy Codes

  https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html

84

Resources and References

- CQ/CO Modifiers and Therapy Threshold

  https://www.cms.gov/medicare/billing/therapyservices

- Qualified Medicare Beneficiary Program

  https://go.cms.gov/3ui5JDC

- Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners, Section 20.4.1

  https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12

GAWENDA SEMINARS & CONSULTING

85

Resources and References

- Hospice Care

  https://bit.ly/3ynsoBo

- ABN Form and Instructions
  http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html

- CMS Pub 100-04, Chapter 30, Financial Liability Protections
  http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf

- CMS ABN FAQ's
  http://www.cms.gov/Medicare/Billing/TherapyServices/Downloads/ABN-Noncoverage-FAQ.pdf

GAWENDA SEMINARS & CONSULTING

86

Medicare Advantage Resources and References

- Centers for Medicare and Medicaid Services, Medicare Advantage Resources

  https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/MA_Resources

- CMS Medicare Managed Care Manual

  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326

GAWENDA SEMINARS & CONSULTING

87

87

Upcoming Webinars

- **November 16, 2022**

  Establishing Your Budget and Metrics for 2023

- **December 8, 2022**

  2023 Outpatient Therapy Regulatory and Payment Updates

- **December 15, 2022**

  2023 MIPS for Physical, Occupational and Speech Therapy Services

GAWENDA SEMINARS & CONSULTING

88

88

Upcoming Webinars

- **January 5, 2023**

  NCCI Edits and Modifier 59: Version 29.0

- **January 12, 2023**

  Remote Therapeutic Monitoring for Physical & Occupational Therapy in 2023

- **January 26, 2023**

  Complying with The Good Faith Estimate Requirement in 2023

GAWENDA SEMINARS & CONSULTING

89

Upcoming Webinars

- **February 16, 2023**

  Outpatient Therapy Compliance Programs: Key Elements You MUST Have

- **March 8, 2023**

  2023 Documentation for Evaluations and Reevaluations for PT, OT & SLP

- **April 19, 2023**

  2023 Documentation for Everything After the Initial Evaluation for PT, OT & SLP

GAWENDA SEMINARS & CONSULTING

90

Gawenda Website Subscription

Subscription Benefits
Current News – Full access with all links
Gawenda NCCI Edit Reference "Cheat Sheet"
Total Access to Questions & Answers in FAQ Section
Access to Your Medicare Contractors Therapy Policies
Access to Major Private Insurance Therapy Policies and News Bulletins & Newsletters
Access to State Practice Acts & Administrative Rules
Electronic Monthly Newsletter
Real-Time Email Blasts with Breaking News
And Much More!!!!!!!!!!!!!
Cost is $200 per year
Sign Up At: https://gawendaseminars.com/subscription

91

91

Gawenda Seminars New Membership Levels

Platinum Membership - $350 per year

Includes all Gold Membership benefits plus our annual December Outpatient Therapy Payment and Regulatory Update Webinar for the following year as well as our annual January NCCI Edits and Modifier 59 webinar and the playback link for each webinar. This is a savings of over $125 per membership year.

Diamond Membership - $1200 per year

Includes all Platinum Membership benefits plus all webinars Gawenda Seminars & Consulting provides **during your membership year**. In addition, you will receive the playback link for each webinar. This is a savings of over $900 per membership year.

GAWENDA
SEMINARS & CONSULTING

92

92

Contact Information

- rick@gawendaseminars.com
- **www.gawendaseminars.com**
- Phone: (734) 531.7718
- Like Gawenda Seminars & Consulting at:
  http://www.facebook.com/gawendaseminars
- Follow me on Twitter at: https://twitter.com/gawendaseminars

  @gawendaseminars

GAWENDA
SEMINARS & CONSULTING

93

93