Alternative to the Medicare Therapy Caps: Change is Imminent!

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Session Overview

- History of Therapy Caps

- New Medicare guidelines for reporting functional outcomes (effective Jan. 1, 2013)

- Measurement and Outcomes
Financial
• ASHA employee since 1996.

Non financial
• Participate in meetings with CMS, MedPAC
• Represent ASHA on Measures Application Partnership (National Quality Forum)
• Author of chapter in *Outcomes in Speech-Language Pathology*—no royalties or other remuneration
A Brief History

- Medicare program: 1965
  - Title XVIII of the Social Security Act
- SLP benefits added in 1972
- Audiology and SLP definitions added in 1994
- SLP Private Practice authorized in 2008 to begin July 2009
MEDICARE PART A

• Inpatient benefit
  ◆ Hospital
  ◆ Skilled Nursing Facility (SNF)
  ◆ Home Health Agencies
Medicare Part B

- Hospital outpatient
- Skilled nursing facilities (after 30 days)
- Rehabilitation agencies
- Comprehensive outpatient rehab facilities
- Private practice (SLP, Aud, OT, PT)
- Physicians
Beginning of Therapy Caps

• Balanced Budget Act of 1997 (eff. 1999)
  ✷ $1500 cap on SLP and PT services per year
  ✷ $1500 cap on OT
• Moratorium on caps
• Exceptions process 2005--present
Problems

• Escalating costs for Part B across therapies
  ✤ 10.1% increase per year 1998-2008
  ✤ 2.9% increase in Medicare beneficiaries

• Concerns about fraud and abuse, overutilization

• Focus of MedPAC (Medicare Payment Advisory Committee)
Band aids

- 2012 Multiple Procedure Payment Reductions (MPPR)
  - 8 SLP codes
- Beginning Oct. 1, 2012
  - Manual medical review after $3700 threshold for SLP and PT
We Need an Alternative!!

- Mechanism for collecting relevant clinical patient data for risk adjustment and payment
  - CARE tool (Continuity Assessment Record & Evaluation)
  - Developing Outpatient Payment Therapy Alternatives (DOTPA)
  - STATS
CARE Tool

• Mandated by 2005 Deficit Reduction Act
• Standardized assessment to
  “Uniformly measure and compare the health and functional status of Medicare Beneficiaries over time and across health care setting”

  “Provide data to support equitable payment to all provider settings”

  DRA 2005 Section 5008
DOTPA 2008-2013

• “…(CMS) cannot adequately assess the appropriateness of utilization patterns or the impact of changes in payment policy without better information tied to patient need and the effectiveness of outpatient therapy services.”

• Development of CARE-C and CARE-F for therapy functional status
Short Term Options

• STATS project (2008-2010): CSC
  - Update data on utilization of therapy services
  - Develop a method for CMS to update quarterly
  - Identify characteristic of patients who need therapy services
  - Develop specific fee schedule-based payment policy applications that can be implemented in the short term that limits payments to medically necessary services
“Therapies” and CMS

- CMS has been seeking one solution for all rehab disciplines
- 2013 Medicare guidelines are a breakthrough for ASHA and NOMS
- PT and OT approaches
Medicare Changes for 2013: Evolution To Reporting Measures

Lisa Satterfield, MS CCC-A
Director, Health Care Regulatory Advocacy
ASHA
Financial
• ASHA employee since 1/5/2012

Non financial
• Participate in meetings with CMS, MedPAC, and other federal agencies related to health care policies
Medicare Physician Fee Schedule

• Final Medicare rules for 2013
• Regulations and rates for services provided to Medicare Part B beneficiaries
• Key provisions for therapy services are in response to legislative mandates for outcome reporting on the claim form
Therapy Cap Amount

• Calculated increase to $1900
  ✷ Combined SLP and PT services

• Congressional action necessary for:
  ✷ Exceptions process (-KX modifier) for services over $1900
  ✷ Manual medical review
  ✷ Continuation of hospital outpatient department therapy services under the cap
Reporting outcomes on the claim?

• Mandated by Congress in Middle Class Tax Relief and Job Creation Act that CMS implement claims-based data reporting by January 1, 2012
• Intent to assist in the payment reform for outpatient therapy services
CMS adopted 7 of the NOMS FCMs for reporting on the claim form, and one generic code:

- Swallowing
- Motor Speech
- Spoken Language Comprehension
- Spoken Language Expression
- Attention
- Memory
- Voice
- Other SLP Functional Limitation
G-code format

• 3 codes for each condition (FCM)
  1. Represents current status at time of initial therapy treatment/episode outset and reporting intervals (every 10\textsuperscript{th} treatment day)
  2. Projected goal status
  3. Status at discharge or end of reporting
# Severity Modifiers

<table>
<thead>
<tr>
<th>NOMS Level</th>
<th>CMS Description</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>0 percent impaired, limited, or restricted</td>
<td>CH</td>
</tr>
<tr>
<td>6</td>
<td>At least 1 percent but less than 20 percent impaired, limited or restricted</td>
<td>CI</td>
</tr>
<tr>
<td>5</td>
<td>At least 1 percent but less than 20 percent impaired, limited or restricted</td>
<td>CJ</td>
</tr>
<tr>
<td>4</td>
<td>At least 1 percent but less than 20 percent impaired, limited or restricted</td>
<td>CK</td>
</tr>
<tr>
<td>3</td>
<td>At least 1 percent but less than 20 percent impaired, limited or restricted</td>
<td>CL</td>
</tr>
<tr>
<td>2</td>
<td>At least 1 percent but less than 20 percent impaired, limited or restricted</td>
<td>CM</td>
</tr>
<tr>
<td>1</td>
<td>At least 1 percent but less than 20 percent impaired, limited or restricted</td>
<td>CN</td>
</tr>
</tbody>
</table>
How many FCMs do I report?

• Reporting **on the claim** is limited to **one** functional limitation at a time
  - This does not mean that an SLP cannot **treat** more than one limitation at a time
  - This does not mean that an SLP should only document one limitation in the medical record
  - If the condition that is reported resolves and treatment continues, another condition is reported

• Reporting **in NOMS** should include **all** relevant FCMs in the treatment plan
When do I report?

• Reporting on the claim occurs
  ✷ At admission
  ✷ At discharge
  ✷ At least once every 10\textsuperscript{th} treatment day
  ✷ When evaluations are billed

• This is consistent with the timing requirements for progress reports
  ✷ Medicare is modifying the policy to delete progress note requirements every 30\textsuperscript{th} calendar day
What about reporting goals?

• The primary long-term treatment goal should be reported on the claim
  ❖ At admission of the plan of care
  ❖ At discharge of the plan of care

• This is consistent with requirements in the Benefit Policy Manual
How do I document this requirement?

- The G-code and the related modifiers must be documented in the medical record.
- NOMS is being reconfigured to include the G-codes and the severity modifiers.
  - When you enter your patient data, NOMS will determine the appropriate G-code and modifier to be added to the medical record and given to the biller.
What if a patient does not complete treatment?

- Discharge reporting is required
- The final visit the patient is seen should be considered the discharge visit
- If the SLP does not have enough information to determine the status at the final visit, and the beneficiary discontinued therapy prior to the planned discharge visit, reporting is not required
What is needed for the claim?

• The –GN modifier is still required for SLP services
• The G-codes must accompany a furnished, payable service
• A charge is necessary for each line:
  ❖ 0.01 is added to institutional claims
  ❖ 0.0 is added to private practice claims
• Codes are reported in Box 24.D.
Case scenario

• Patient was referred because of some choking incidents. Patient is able to tolerate soft foods and thick liquids.

• **Functional limitation:** Swallowing, NOMS Level 4 (severity modifier CK)

• **Projected Goal:** NOMS Level 7 (severity modifier CH)
## G-codes for Swallowing

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G8996</td>
<td>Swallowing functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals</td>
</tr>
<tr>
<td>G8997</td>
<td>Swallowing functional limitation, projected goal status, at initial therapy treatment/outset and at discharge from therapy</td>
</tr>
<tr>
<td>G8998</td>
<td>Swallowing functional limitation, discharge status, at discharge from therapy/end of reporting on limitation</td>
</tr>
</tbody>
</table>
Initial Claim

- Line 1:
  - CPT/HCPCS: 92610 (swallowing evaluation)
  - Modifier: GN (SLP services)

- Line 2:
  - CPT/HCPCS: G8996 (swallowing status)
  - Modifier: CK (NOMS level 4)

- Line 3:
  - CPT/HCPCS: G8997 (swallowing projected goal)
  - Modifier: CH (NOMS level 7)
Subsequent Claims

• For visits 2-9, outcome reporting not required if the patient is not discharged from care
• Line 1:
  • CPT/HCPCS: 92526 (swallowing treatment)
  • Modifier: GN (SLP services)
Claim for Visit #10

• Reporting now required for status update

• Line 1:
  - CPT/HCPCS: 92526 (swallowing treatment)
  - Modifier: GN (SLP services)

• Line 2:
  - CPT/HCPCS: G8996 (swallowing status)
  - Modifier: CI (NOMS level 6)
Claim for discharge

- Line 1:
  - CPT/HCPCS: 92526 (Swallowing treatment)
  - Modifier: GN (SLP services)
- Line 2:
  - CPT/HCPCS: G8998 (Swallowing discharge)
  - Modifier: CH (NOMS level 7)
- Line 3:
  - CPT/HCPCS: G8997 (Swallowing goal)
  - Modifier: CH (NOMS level 7)
Where can I get more information on G-code reporting?

- ASHA’s Billing and Reimbursement Website
  - Download PDF of *2103 Medicare Fee Schedule for Speech-Language Pathologists*
MedPAC

• Medicare Payment Advisory Commission (MedPAC)—
  ✤ An independent Congressional agency mandated to advise Congress on Medicare
  • Reimbursement
  • Access to care
  • Quality of care
MedPAC Therapy Cap Short Term Recommendations

• Reduce the therapy cap $1,270 (national average)
• Include a permanent manual medical review for any service beyond the $1,270.
• Reimbursement cuts of approximately 7% for multiple therapy procedures billed in a day (MPPR)
• Require plans of care certification every 45 days, (current 90 days)
• Require a standard diagnosis code on therapy claim forms (no “V” codes)
• Permanently include hospital outpatient therapy services in the therapy cap.
• Increase beneficiary cost-sharing for long episodes of care
• Develop national guidelines and payment edits (target fraud, waste, and abuse)
• The collection of standardized outcome measures that will inform the development of an episodic payment system
And Congress will likely…

• Extend therapy cap exception for one more year (2013)
• Include hospitals permanently in therapy cap
• Continue manual medical review ($ level unknown)
• Recommend payment reduction for multiple services on the same day (MPPR)
• Require CMS to continue outcome reporting and/or require standardized tool for reporting
Questions?

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