Physical, Occupational and Speech Therapy Payment Reform and Coding

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Course Details

This session will explore billing and reimbursement processes and upcoming changes affecting physical, occupational and speech language pathologists. Coding review will include: Physical Medicine and Reimbursement codes; ICD10; and 2014 Speech Pathology Evaluation codes. Reimbursement review will include clarification regarding Medicare reimbursement for graduate clinicians; individual, group, concurrent and co-treatment. Additionally, information will be provided regarding bundled payment initiatives and alternative payment models.

Objectives

1. Evaluation codes for PT, OT and ST
2. Describe appropriate procedures for billing individual, group, concurrent and co-treatment services for Medicare beneficiaries
3. Discuss trends in bundled payments and alternative payment models

Who are the “Players”

• Medicare Part A
• Medicare Part B
• Medicare Replacement
• Managed Care
• Medicaid
• Commercial Insurance

Medicare ABCD

Medicare is for 65+ population and for certain severe disabilities

A: Everyone 65+ who paid taxes into Medicare has Part A
○ Hospital inpatient services, Inpatient Psych, Inpatient Rehab Facilities, Skilled Nursing Facilities, Home Health, Hospice
B: Not everyone has Part B
○ Outpatient services, durable medical equipment, ambulance service, mental health, clinical research
C: Medicare Replacement Plans
○ Medicare Advantage Plan may have different rules, but the plan must give beneficiary at least the same coverage as Original Medicare
D: Drug coverage

Medicare Part A PPS

Prospective Payment System (PPS)

• The prospective payment system was instituted in July 1998 as a result of the Balanced Budget Act passed by Congress in 1997.

• PPS provides reimbursement for skilled nursing facility (SNF) inpatient stays covered under Medicare A. It provides an all-inclusive per-diem payment based on level of complexity of services provided and resources utilized in caring for Part A patients.
What is a RUG?

- RUG = Resource Utilization Group

- Each patient in the SNF/Part A stay is classified into one of 66 classifications (RUG levels) based on the responses to questions on the Minimum Data Set (MDS).

- The MDS 3.0 data is submitted and the data is utilized to assign an appropriate RUG based on that data.

Admission Requirements

- Must have been an inpatient of a hospital for a medically necessary stay of at least 3 consecutive days
- Must admit to the SNF within 30 days of discharge from the hospital
- Must require SNF care for a condition that was treated during the qualifying hospital stay, or for a condition that arose while in the SNF for treatment of a condition for which the beneficiary was previously treated in the hospital.

SNF Level of Care

- All four factors must be met:
  - The patient requires skilled nursing services or skilled rehab services; are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in the SNF for a condition for which he received inpatient hospital services
  - The patient requires these skilled services on a daily basis
  - As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF
  - The services delivered are reasonable and necessary for the treatment of a patient’s illness or injury. The services must also be reasonable in terms of duration and quantity

Medicare Part B Billing

- Part B therapy is paid under the physician fee schedule
- Non-billable services include:
  - Documentation time
  - Case management type activities without the patient present and participating
  - Timed code delivered less than 8 minutes for a 15 minute based code if it is the only timed service delivered
- Services are reported on the claim with CPT codes
  - Timed codes
  - Untimed codes = one unit and one unit only
- Must document minutes on the treatment encounter note to support the billing on the claim
  - Total treatment time in minutes (timed minutes + untimed minutes)
  - Total timed treatment time in minutes
  - Provider can choose to report minutes per CPT code but it is not required

Medicaid - Basics

- Enacted in 1965 as part of Title XIX of the Social Security Act
- Partnership program funded jointly between the States and Federal Government with more than half funded by the Feds.
- Mandatory service example is EPSDT.
- Optional service example is Rehab and other therapies.

MEDICAID

- The Affordable Care Act expanded coverage for the poorest Americans by creating an opportunity for states to provide Medicaid eligibility, effective January 1, 2014, for individuals under 65 years of age with incomes up to 133% of federal poverty level
- Federal law requires states that participate in Medicaid to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups (optional eligibility groups).
  - In all states, Medicaid provides free or low-cost care for some low-income people, families and children, pregnant women, the elderly, and people with disabilities.
  - States set individual eligibility criteria within federal minimum standards.
    - www.medicaid.gov/AffordableCareAct/Provisions/Eligibility.html
Medicaid or Medicare

- Both are Government sponsored healthcare programs in the US that differ in the way they are governed and funded.
- Medicaid is an assistance program that covers low and no income families and individuals.
- Medicare is an insurance program that primarily covers seniors ages 65 and older and disabled individuals who qualify for Social Security.
- Some may be eligible for both depending on their circumstances.

CODING 101
CPT, ICD-10, G-Codes

- Medicaid uses the same ICD and CPT healthcare coding systems as Medicare and other payers, but payment policies and rates vary widely from state-to-state.
- Check with your State Medicaid agency for a fee schedule and provider manuals.
- ASHA Tool Kit: www.asha.org/Practice/reimbursement/medicaid/Medicaid-Toolkit/

Coding- Keeping Control

International Classification of Diseases, 10th Revision

1. What is ICD-10?
2. What are the principles of ICD-10?
3. What is I code incorrectly?
4. Where do I find appropriate codes for KY?
ICD-10

International Classification of Diseases, 10th Revision, Clinical Modification (aka ICD-10 codes)
- Diagnostic codes that describe the reason we are evaluating or treating the client/patient
- ICD 10 STARTED OCTOBER 2015

ICD-10-CM

Began October 1, 2015
- ICD-10 includes approx 160,000
  - ICD-10-CM diagnosis codes for all settings
  - > 68,000 codes in Clinical Modification
  - ICD-10-PCS procedure codes for hospital inpatients
- Chapters based on body systems (e.g. nervous, circulatory, respiratory, digestive)
- Owned by the World Health Organization (WHO)
- Required for everyone covered by the Health Insurance Portability Accountability Act (HIPPA)
- ICD-11 scheduled to be released in 2017

Highest Level of Specificity

- Highest degree of medical certainty or specificity
- Carry out to the 4th or 5th digit when possible
- For example – General
  - R41.8 Other symptoms and signs involving cognitive functions and awareness
- More specific
  - R41.841 Cognitive communication deficit
  - R41.844 Frontal lobe and executive function deficit

CGS LCD- Provider Responsibility

- It is the responsibility of the provider to code to the highest level specified in the ICD-10-CM.
- The correct use of an ICD-10-CM code does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

AVOID Unspecified Codes

- Avoid Not Otherwise Specified (NOS) and Not Elsewhere Classified (NEC) codes

Coding Normal?

- When results of diagnostic testing are NORMAL, code signs or symptoms to report the reason for test/procedure and explain normal result in report
Procedure Matching ICD-10

Examples:
- ICD R13.12 Dysphagia, oropharyngeal phase
- CPT 92610 Clinical Swallow Evaluation
- ICD R47.01 Aphasia
- CPT 92523 Eval of Production and Language

ASHA/ APTA/ AOTA Tools for ICD-10-CM

- AOTA
- APTA
  - [http://www.apta.org/ICD10/?navID=1073743327](http://www.apta.org/ICD10/?navID=1073743327)
- ASHA
  - [www.asha.org/uploadedFiles/ICD-10-Codes-Audiology.pdf](www.asha.org/uploadedFiles/ICD-10-Codes-Audiology.pdf)
  - [www.asha.org/uploadedFiles/ICD-10-Codes-SLPpdf](www.asha.org/uploadedFiles/ICD-10-Codes-SLPpdf)
  - [www.asha.org/icdmapping.aspx](www.asha.org/icdmapping.aspx)

KNOW your LCDs

- LCDs are Local Coverage Determines specific to your Medicare Contractor.
- Kentucky- CGS Administrators
  - Local Coverage Determination (LCD): Outpatient Physical and Occupational Therapy Services (L34049)
  - Local Coverage Determination (LCD): Speech-Language Pathology (L34046)

Current Procedural Terminology

1. What is a CPT?
2. How are CPTs created?
3. What are the new CPT Eval Codes for ST?
4. Will PT and OT be creating new eval codes?

Current Procedural Terminology

- Developed, maintained, and copyrighted by the American Medical Association (AMA)
- Every medical, surgical, and diagnostic procedure assigned a 5-digit code
- CPT codes are used to
  - Simplify the reporting of services
  - Ensure uniformity of communication
  - Approximately 8,000 codes

Who Maintains CPT?

CPT is maintained by the CPT Editorial Panel, which meets three times a year to discuss issues associated with new and emerging technologies as well as difficulties encountered with procedures and services and their relation to CPT codes
AMA Criteria for CPT Codes

- **Unique** procedure that is not covered by other established codes
- Procedure widely used within U.S.
- Not investigational
- Supported by substantial peer reviewed literature in published in US journals

Relative Value Unit (RVU)

- Every CPT procedure or service has a resource-based relative value
- Payments for services are determined by the **resource costs** needed to provide them
- Each code has a "relative value" based on 3 components:
  - Professional work
  - Practice expense
  - Professional liability insurance
- All procedures are ranked on this same scale
- Standardized physician payment schedule

Current Procedural Terminology
CPT

92610
Evaluation of Oral & Pharyngeal Swallowing Function

Medicare Benefit Policy Manual (MBPM), Dysphagia Defined:

Dysphagia, or difficulty in swallowing, can cause food to enter the airway resulting in coughing, choking, pneumonia problems, aspiration or laryngospasm and hypoxia which results in weight loss, failure to thrive, pneumonia and death. It is most often due to complex neurological or structural impairments including head and neck trauma, cerebrovascular accident, neurodegenerative diseases, head and neck cancer, dementia, and myopathies. For these reasons, it is important that only qualified professionals with specific training and experience in this disorder provide evaluation and treatment (1).

MBPM, Swallowing Assessment Inclusions:

- Swallowing assessment and rehabilitation are highly specialized services. The professional rendering care must have education, experience and demonstrated competencies. Competencies include but are not limited to:
  - Identifying abnormal upper aerodigestive tract structure and function
  - Conducting an oral, pharyngeal, laryngeal and respiratory function examination as it relates to the functional assessment of swallowing
  - Recommending methods of oral intake and risk precautions
  - Developing a treatment plan employing appropriate compensations and therapy techniques (2).

New Evaluation Codes 2014

**Background**

Effective January 1, 2014, Current Procedural Terminology (CPT, ©American Medical Association) for code 92506 (Evaluation of speech, language, voice, communication, and/or auditory processing) will be deleted and replaced with four new, more specific evaluation codes related to language, speech sound production, voice and resonance, and fluency disorders.

When should I start using the new codes?

- You should have started using the new codes for billing patients on or after January 1, 2014.
Why did four new codes replace CPT 92506?

- The four new evaluation codes were developed by ASHA’s Health Care Economics Committee (HCEC) in collaboration with experts in the field from ASHA’s Special Interest Groups.

- The HCEC has been working with the American Medical Association (AMA) to change most speech-language pathology codes since 2009, when a new law took effect that allows private practice SLPs to bill Medicare directly for their services. Because of that change, the AMA’s Relative Value Update Committee re-evaluated speech-language pathology codes to include “professional work” value (one of three components of a code’s value that reflects the amount of time, technical skill, physical effort, stress, and judgment required to provide the service). Prior to 2009, SLPs were considered “technical support” and their work was included in the “practice expense” component of the code’s reimbursement formula. During this process, the RUC recognized that CPT 92506 reflected more than one procedure; this recognition gave ASHA an opportunity to develop specific evaluation procedure codes to replace 92506 and more accurately and appropriately value the professional work performed.

New Codes Defined

- 92521 Evaluation of speech fluency (e.g., stuttering, clauding)

- 92522 Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)

- 92523 Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)

- 92524 Behavioral and qualitative analysis of voice and resonance

Can new codes be billed together same day?

- The CPT Handbook does not include language to restrict an SLP’s ability to bill these codes together because there are circumstances when it is appropriate for a patient to be evaluated for multiple disorders on the same day.

- Note: In those cases, documentation should clearly reflect a complete and distinct evaluation for each disorder.

92521 - Evaluation of Speech Fluency

- Inclusions: Evaluation of Stuttering and Clustering

- The following disorders are typically non-covered for the geriatric Medicare beneficiary:
  - Fluency disorder
  - Dysprosody
  - Stuttering and clarding (except neurogenic stuttering caused by acquired brain damage)

92522

- Evaluation of Speech Sound Production

- Inclusions: Articulation, Phonological Process, Apraxia, Dysarthria

92523

- Eval of Speech Sound Production with Eval of Language Comprehension and Expression

- Inclusions: Articulation, Phonological Processes, Apraxia, Dysarthria; Receptive and Expressive Language
92523 is combined speech sound production and language? What if I only evaluate language?

- If two or more procedures are billed together at least 51% of the time, it is standard to develop a bundled CPT code for that set of services.
- ASHA surveyed practices and clinics and confirmed that evaluations for language are accompanied by evaluations for speech sound production 80% of the time. However, the reverse is not true. It is common for speech sound production abilities to be evaluated independent of a language evaluation, which is why there is a stand-alone code for speech sound production evaluation.
- If a patient is evaluated only for language, SLPs should bill 92523 with the -52 modifier, which is used when the services provided are reduced in comparison with the full description of the service.

Can I bill 92522 and 92523 same day?

- No, you may only bill one or the other. A speech sound production evaluation (CPT 92522) is already included as a part of CPT 92523 (speech sound production evaluation with language evaluation).

92524

- Behavioral & Qualitative Analysis of Voice & Resonance

Q: Does CPT 92524 (behavioral and qualitative analysis of voice and resonance) include instrumental assessments?

A: No. There are separate codes for instrumental assessments, such as CPT 92520 for laryngeal function studies.

One Hour Time Based Eval Codes

- 92626- Evaluation of Auditory Rehabilitation Status, First Hour
- 92627- Evaluation of Auditory Rehabilitation Status, Each additional 30 minutes
- 96125- Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report. Per Hour.
- 96105- Assessment of Aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling and/or writing ex. by BDAE) with interpretation and report- Per Hour
- 92607 Evaluation for prescription for speech-generating AAC device face to face with the patient- First Hour.
- 92608 Evaluation for prescription for speech-generating AAC device face to face with the patient- Each additional 30 minutes.

92626- Evaluation of Auditory Rehab Status

- Inclusions: Evaluation and treatment for disorders of the auditory system may be covered and medically necessary, for example, when it has been determined by a speech-language pathologist in collaboration with an audiologist that the hearing impaired beneficiary’s current amplification options (hearing aid, other amplification device or cochlear implant) will not sufficiently meet the patient’s functional communication needs. Audiologists and speech-language pathologists both evaluate beneficiaries for disorders of the auditory system using different skills and techniques, but only speech-language pathologists may provide treatment.
- Rec 31 mins minimum

96125- Standardized Cognitive Performance Testing

- Inclusions- Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional’s time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report. Per Hour
- Includes criterion referenced measures which combine standardized measures
96105- Assessment of Aphasia

- Inclusions: Assessment of Aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling and/or writing ex. by BDAE) with interpretation and report Per Hour

Billing Time Based Codes

- Codes are timed and based on ONE HOUR increments.

- The number of units billed are based on time:
  - 0 units = 0-30 minutes
  - 1 unit = 31-90 minutes and
  - 2 units = 91-150 minutes and so on.

- Billing below 31 minutes is not recommended.

Time Based: Med A versus Med B

- Medicare Part A
  - MDS Section O: Rules for Recording Treatment Minutes
    - (RAI Manual, Chapter 3, Section O: directly quoted text is in italics)
    - The therapist’s time spent on documentation or on initial evaluation is not included (Page O 17)
    - The therapist’s time spent on subsequent reevaluations, conducted as part of the treatment process, should be counted (Page O 17)
    - http://www.asha.org/Practice/reimbursement/medicare/Medicare-Guidance-for-SLP-Services-in-Skilled-Nursing-Facilities/

- Medicare Part B
  - 96105 and 96125 billing for Medicare Part B beneficiaries follows the definition of codes set forth per LCD definitions therefore allowing ST to account for interpretation time in assessment.

96105/96125 “Interpretation Time” Med B

- 96105/96125 definitions include language which allows therapist to count interpretation for review of data obtained during evaluation.
- 96125 allows for use of norm-referenced (results are interpreted based on established norms and compare test-takers to each other) and/or criterion-referenced (results are interpreted based on the person’s performance/ability to complete tasks or demonstrate knowledge of a specific topic).
- 96105 allows for norm-referenced measures from standardized assessment of Aphasia (e.g. BDAE)

92607

- 92607- Evaluation for prescription for speech generating AAC Device

- Inclusions: Evaluation for prescription for speech generating AAC device face to face with the patient- First Hour. Rec 31 mins minimum
  - 92608 Evaluation for prescription for speech generating AAC device face to face with the patient- Each additional 30 minutes.

Case Studies

- Mr. Smith is admitted to SNF following acute onset of RCVA requiring standardized measure of language and cognitive functions
  - 96105- Assessment of Aphasia AND/OR
  - 96125- Standardized Cognitive Performance Testing
  - After 6 weeks of intensive treatment you determine he will require speech generating AAC device to meet communicative needs. Use 92607- Evaluation for prescription for speech generating AAC Device

- Ms. Jones requires evaluation of expressive/receptive language; motor speech and voice secondary to progression of Parkinson’s disease.
  - 92523 Eval of Speech Sound Production with Eval of Language Comprehension and Expression AND
  - 92524 Behavioral & qualitative analysis of Voice & Resonance
Case Studies

Mr. Smith is referred for evaluation due to stuttering. He presents with Advanced Dementia.
- Remember – Dysfluency services are not covered by Medicare, nor would interventions aimed at fluency be supported by Evidenced Based Practice Patterns.
- Use 92523 Eval of Speech Sound Production with Eval of Language Comprehension and Expression AND/OR
- 96105 – Assessment of Aphasia if patterns follow diagnostic criteria for Primary Progressive Aphasia associated with Dementia OR
- 96125 – Standardized Cognitive Performance Testing inclusive of Dementia Staging Tools when disease process follows AD type Dementia.

CPT- Treatment Codes

92526
92507
97532

92526 – Dysphagia Therapy

- Patient/caregiver training in feeding/swallowing techniques
- Proper head and body positioning
- Amount of intake per swallow
- Appropriate diet (determining) texture and viscosity
- Means of facilitating the swallow
- Feeding techniques and need for self help eating/feeding devices
- Facilitation of more normal tone or oral facilitation techniques
- Laryngeal elevation training
- Compensatory Swallow techniques
- Oral sensitivity training
- Techniques to reduce shortness of breath of fatigue during duration of meal.

Dysphagia per Medicare Manual

- Dysphagia, or difficulty in swallowing, can cause food to enter the airway, resulting in coughing, choking, pulmonary problems, aspiration or inadequate nutrition and hydration with resultant weight loss, failure to thrive, pneumonia and death.
- Most often due to complex neurological and/or structural impairments including head and neck trauma, cerebrovascular accident, neuromuscular degenerative diseases, head and neck cancer, dementias, and encephalopathies. For these reasons, it is important that only qualified professionals with specific training and experience in this disorder provide evaluation and treatment. (MBPM, 2014)

Specialized Dysphagia Care

Per the Medicare Benefit Policy Manual definition of SLP Scope: Swallowing assessment and rehabilitation are highly specialized services. The professional rendering care must have education, experience and demonstrated competencies. Competencies include but are not limited to: identifying abnormal upper aerodigestive tract structure and function; conducting an oral, pharyngeal, laryngeal and respiratory function examination as it relates to the functional assessment of swallowing; recommending methods of oral intake and risk precautions; and developing a treatment plan employing appropriate compensations and therapy techniques (MBPM, 2014).

Think... What makes my services UNIQUE?

- How do you educate Patient/caregiver training in feeding/swallowing techniques?
- What changes are made to head & body positioning
- Amount of intake per swallow (specific)
- Appropriate diet (determining) texture and viscosity
- Means of facilitating the swallow
- Feeding techniques and need for self help eating/feeding devices
- Facilitation of more normal tone or oral facilitation techniques
- Laryngeal elevation training
- Compensatory Swallow techniques
- Oral sensitivity training
- Techniques to reduce shortness of breath of fatigue during duration of meal

SPECIFIC- tsp; tbs; # of trials; goals related to PD diet/therapeutic portion

Relation to Instrumental

MEASURES: BOGS, Pulse Ox, amount of time prior to, upper suffer
Now... How am I Documenting this?

Daily Note Sample 1:
Patient seen with noon meal for skilled ST likes mechanical meats, nursing fed 100% of the time, verbal cue to sit up straight

Daily Note Sample 2:
Patient received therapeutic PO trials of mechanical soft meats at noon meal, noted increased bolus formation when presented in 1 tsp size bolus as evidenced by reduced oral stasis throughout oral cavity s/p swallow, education provided to CNA staff with noted verbal understanding and return demonstration of technique on 7/10 trials

Esophageal Phase: Medicare Regulations

- Dysphagia most often reflects problems involving the oral cavity, pharynx, esophagus, gastroesophageal junction, or proximal stomach.
- While dysphagia can affect any age group, it most often appears among the elderly. Speech-language pathology services are covered under Medicare for the treatment of dysphagia, regardless of the presence of a communication disability.

92507
Treatment of Speech, Language, Voice, Communication, Auditory Processing

Skilled interventions aimed at:
- Increasing expressive language skills including ability to communicate wants and needs and treatments to address appropriate syntax and morphology.
- Increase receptive language skills for comprehension of spoken and written language impacting ability to respond to questions, follow directions, and comprehend structured and spontaneous interactions with others.
- Increasing speech intelligibility skills including interventions aimed at improving articulatory patterns and addressing motor speech impairments such as apraxia of speech and dysarthria.
- Improving pragmatic language skills related to social aspects of communication including adequate knowledge and use of rules for conversation and story-telling and appropriate adaptations of language based on setting and conversational partner.
- Increase vocal function related to respiration, phonation, resonance, and pitch.
- Aural rehabilitation including provision of speech reading.
- Training and use of non-speech generating augmentative and alternative communication (AAC).
- Training and modification in the use of a voice prosthetic.

97532- Development of Cognitive Skills

97532 is a time based code used for development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes

97532- Considerations for Use

- Providers should bill CPT 97532 only when cognitive treatment is truly a distinct, separate activity. When appropriate diagnostic assessment is conducted, should correspond with new onset for justification of decline.
- Differs from services provided for 92507- Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual.
- Can be used in conjunction with 92526, however should not be used simply due to the fact dysphagia services are being provided to an individual with cognitive impairment.
- Can only be used when appropriate differential diagnosis is completed to rule out the following as root cause:
  - AMS associated with period of delirium including those associated with infection (UTI)
  - Underlying language and/or auditory impairment as primary cause of communication breakdown.
**92507 and 97532**

Correct Coding Initiative (CCI) Edits
- 92507 and 97532 CANNOT be billed same day.

Determining appropriate coding use:
- Differential diagnosis into root cause of functional impairments begins at SOC.

Examples:
- Resident presents with decreased ability to follow commands. Root cause could be: Decreased immediate memory for directives (cog); decreased attention to task (cog); decreased auditory comprehension of directives (language); decrease auditory acuity (AR - 92507 per Medicare Regulations)

**97532 and 92526**

- SLPs should not bill cognitive treatment when they provide only swallowing or language treatment to a patient who also has cognitive disorders.
- However, it may be appropriate to bill 97532 on the same day if there are distinct plans of care and specific goals and treatment activities for cognitive impairment and for swallowing.
- Take Home Point - Cognitive impairment alone does not necessitate use of 97532.

**Case Studies: 97532;92526**

- Ms. Smith presents with a severe oropharyngeal dysphagia following TBI with resulting increased oral processing of bolus, anterior spillage, pocketing/ stasis after the swallow, delayed initiation of pharyngeal swallow and overt s/s aspiration with intake. Deficits are compounded by cognitive impairments including impulsivity with intake.
- Anticipated intervention coding:
  - 92526 for Swallowing Therapy
  - 97532 for Cognitive interventions r/t impulsivity and decreased attention to task.

**Case Studies: 92526;92507**

- Mr. Jones presents with progression of dementia with resulting decreased oral coordination, anterior loss, increased processing and decreased ability to follow basic commands at meals in order to increase ability to follow swallow strategies.
- Anticipated intervention coding:
  - 92526 for increasing swallow functions
  - 92507 for increasing success with ability to follow commands. Note language POC may be maintenance based in nature in that interventions will be short term in order to establish/train caregiver regarding techniques.

**What About PT and OT Codes?**

**AOTA- AMA Proposal**

- A Brief Overview of AOTA’s Proposed Physical Medicine and Rehabilitation Coding Changes
  - The following describes the framework for AOTA’s proposed changes to the Common Procedural Terminology (CPT) coding structure and how codes would be reported on a claim form. The total number of codes to be used for occupational therapy has been reduced by approximately half, a goal that has been referenced by several policy makers.

AOTA–AMA Proposal

- Evaluation, Assessment, and Review Section (E&R)
  Coding for each and every visit will include a code for evaluation, assessment, and review to reflect that these elements are always part of the clinical reasoning in any session.
- The occupational therapy evaluation code has been expanded into 3 levels of evaluation. The definitions and descriptive information determine the level, whether low, moderate, or high work intensity that would be reported by an occupational therapist. Differences in levels are based on the complexity of the evaluation, considering client condition, comorbidities, performance strengths and weaknesses, and therapist’s clinical decision-making.
- The occupational therapy re-evaluation code has been reworded, with clarifying information.
- A new code has been added to describe a simple review of patient status that would be done at the start of each regular treatment session, assuming no other evaluation or assessment is needed or billed on the same day.
- The wheelchair management and assistive technology assessment codes have been changed to reflect the total service provided in a session (i.e., 15-minute unit designations have been deleted). These can be billed as stand-alone codes or with other interventions, but they cannot be billed with other E&R codes.

APTA–AMA Proposal

- Will documentation requirements change with these new CPT codes?
  - Yes, most likely. Physical therapists will need to make sure their documentation supports the services they are performing and billing, as described by the code. Therapists also must document their clinical reasoning and be able to support the code they selected, based on the severity of the patient’s condition and the intensity of services performed.

APTA–AMA Proposal

- Is APTA engaging in discussions with CMS regarding the new coding system?
  - Yes. CMS has a seat on the American Medical Association’s (AMA) Current Procedural Terminology (CPT) Editorial Panel, as well as the Relative Value Update Scale Committee Health Care Professionals Advisory Committee Review Board (RUC HCPAC), and is aware of proposed changes to the physical medicine and rehabilitation codes. APTA has met with CMS on several occasions to update the agency on the progress of the new coding system and incorporate CMS feedback.

G-CODES

Claims Based Data Collection

- Required by the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA)
- Beginning January 1, 2013, required CMS to begin a claims based data collection strategy for PT, OT and SLP services
- This strategy shall provide for collection of data function during the course of therapy services in order to better understand patient condition(s) and outcomes

WHY?

- CMS is trying to have a better understanding of how therapy affects patient outcomes
- This is a tracking mechanism for them to develop an alternative payment system
WHO?
- Applies to all outpatient therapy claims: PT, OT and SLP services
- SNF Part B patients are included

WHEN?
- Effective date: January 2013
- Mandatory Implementation: For dates of service beginning July 1, 2013
  - Claims returned/rejected without applicable G-codes and modifiers beginning July 1.

Non-Payable G-Codes and Modifiers
- CMS will use G-codes to collect data on the patient's functional limitation
- This is required:
  - At the outset of therapy episode (THERAPY EVAL)
  - Every 10 visits from the start of care
  - At discharge
  - When an eval or re-eval is billed.
  - To end reporting of one functional limitation
  - To begin reporting of a different functional limitation

Overview
- Only one primary G-code will be reported at a time per discipline
- The clinician will report the beneficiary's primary functional limitation defined as the most clinically relevant functional limitation at the time of initial therapy onset (evaluation) and the establishment of the plan of care

PT and OT categorical functional limitations:
- 4 sets
  - Mobility: Walking and Moving Around
  - Changing and Maintaining Body Position
  - Carrying, Moving, and Handling Objects
  - Self Care
- 2 sets are for “Other” (General G-code)
  - Other PT/OT Primary
  - Other PT/OT Subsequent

8 SLP categorical functional limitations:
- Swallowing
- Motor Speech
- Spoken Language Comprehension
- Spoken Language Expression
- Attention
- Memory
- Voice
- Set for “Other”
Functional Modifiers

- In additional to the G-Code selected, the clinician must use a modifier to report the severity/complexity for that functional limitation

Percent impaired, limited, or restricted:
- CH: 0 percent impaired
- CI: At least 1 percent but less than 20 percent
- CJ: At least 20 percent but less than 40 percent
- CK: At least 40 percent but less than 60 percent
- CL: At least 60 percent but less than 80 percent
- CM: At least 80 percent but less than 100 percent
- CN: 100 percent impaired

Example of G-Code Set

- Mobility: Walking & Moving Around
  - G8978 Mobility Current Status
  - G8979 Mobility Goal Status
  - G8980 Mobility D/C status

- Eval G-Code example:
  - G8978CK Mobility Current Status
  - G8979CH Mobility Goal status

Progress Example

- G8978CK Mobility Current Status
  - Upon evaluation, gait may be impaired at 50%
- G8980CH Mobility D/C status
  - Upon discharge, patient is Independent with gait with 0% impairment

- Pt improved from 50% impairment (CK) to 0% impairment (CH)

Billing example

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>Goal</th>
<th>D/C</th>
<th>Units</th>
<th>Charge</th>
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<tr>
<td>Physical Therapy</td>
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</tr>
</tbody>
</table>

MPPR

MULTIPLE PROCEDURE PAYMENT REDUCTION
Multiple Procedure Payment Reduction (MPPR)

- Applies a 50% reduction to multiple codes to outpatient therapy services effective April 1, 2013.
  - Section 633 of the American Taxpayer Relief Act of 2012
  - Formula for CPT codes: Work + PE + Malpractice
  - The code with the highest practice expense will be paid at the full physician fee schedule amount. For the second and each subsequent code billed that day (regardless of discipline), the practice expense value of the physician fee schedule amount will be reduced by 50%

MPPR Impact on Payment: Multiple Evaluations Same Day

<table>
<thead>
<tr>
<th>CPT Code Billed</th>
<th>Full Payment</th>
<th>PE</th>
<th>MPPR Payment</th>
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</thead>
<tbody>
<tr>
<td>97003 (OT Eval)</td>
<td>82.26</td>
<td>1.24</td>
<td>82.26</td>
</tr>
<tr>
<td>97001 (PT Eval)</td>
<td>72.46</td>
<td>.95</td>
<td>57.11</td>
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<tr>
<td>Total Payment</td>
<td>154.72</td>
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<td>139.37</td>
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</table>

Impact = $15.35 Reduction in Payment

MPPR Impact on Payment: Three Unit Example

<table>
<thead>
<tr>
<th>CPT Code Billed</th>
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<td>Total payment</td>
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</table>

Impact = $16.99 Reduction in Payment

Individual Therapy

- Individual Therapy
  - Therapy provided on an individual basis
  - "One on one"

Individual Therapy Example

- Mr. Weary is receiving SLP services for dysphagia. He received one on one treatment time of 30 minutes.
  - MDS Record:
    - Individual Therapy= 30 minutes
    - All 30 minutes are counted toward MDS
**Concurrent Therapy**

- Concurrent Therapy
  - Treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payor source, both of whom must be in line-of-sight of the treating therapist for Part A.
  - When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident, regardless of the payor source of the second resident.

**Concurrent Therapy Example**

- Tammy Therapist is treating two Part A patients. She assists Mr. A with Therapeutic Exercises in order to improve Lower Extremity strength due to knee buckling during gait. She also performs interventions with Ms. B for balance activities. She goes back and forth between the two patients. Total treatment time is 20 minutes.
  - MDS Record:
    - Concurrent for each patient is 20 minutes.
    - 10 minutes is counted toward RUG.

**Group Therapy**

- For Part A as the treatment of 4 residents, regardless of payor source, who are performing the same or similar activities.
- For Part B: treatment of two patients or more, regardless of payor source, at the same time.

**Group Therapy Example**

- Ollie, OT, is performing a Group activity with 4 patients for cooking. While in the activity, the patients work on fine motor skills for chopping and measuring, balance activities by reaching in cabinets and cognition by ability to follow directions. The treatment for all 4 patients lasts one hour.
  - MDS Record:
    - Group Therapy: 60 minutes for all four patients
    - 15 minutes are counted toward RUG score

**Co-Treatment**

- For Part A:
  - When two clinicians, each from a different discipline, treat one resident at the same time with different treatments, both disciplines may code the treatment session in full.

**Co-Treatment**

- For Part B:
  - Therapists, or therapy assistants, working together as a "team" to treat one or more patients.
  - Cannot bill separately for the same or different service provided at the same time to the same patient.
Co Treatment Example: ST/OT

- Speech and Occupational Therapy may provide co-treatment to an individual during meal time in order to yield greater meal time functional outcomes for an individual with dysphagia in addition to self-feeding deficits.

Co Treatment Example PT/ST

- Physical and Speech Therapy may provide co-treatment for an individual who presents with gait disturbance in addition to cognitive impairments affecting their abilities to negotiate obstacles in facility in order to yield greater functional outcomes for ability to ambulate throughout environment.

Conversion Factor

- A conversion factor (CF) is used to calculate the MPFS reimbursement rates.

- The conversion factor for 2016 is $35.8279. This represents a slight decrease from the July-December 2015 conversion factor of $35.9335 and reflects the elimination of the sustainable growth rate (SGR).

Conversion Factor Background

Since January 1, 1992, Medicare has paid for physicians’ services under section 1848 of the Act, “Payment for Physicians’ Services.” The system relies on national relative values that are established for work, PE, and MP, which are adjusted for geographic cost variations. These values are multiplied by a conversion factor (CF) to convert the RVUs into payment rates. The concepts and methodology underlying the PPS were enacted as part of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-239, enacted on December 19, 1989) (OBRA ’90), and the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508, enacted on November 5, 1990) (OBRA ’90).

The final rule published on November 25, 1991 (56 FR 59502) set forth the first fee schedule used for payment for physicians’ services.

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How is the Conversion Factor Calculated?

To calculate the conversion factor for the year, we multiply the product of the current year conversion factor and the update adjustment factor by the budget neutrality adjustment, and then adjust that figure by the target recapture amount, if applicable.

We estimate the CY 2016PFS conversion factor to be $35.8279, which reflects the budget neutrality adjustment, the 0.5 percent update adjustment factor specified under the MACRA, and the 0.77 percent target recapture amount required under Section 1840(c)(2)(O)(iv) of the Act.

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Outpatient Therapy Caps

M. Therapy Caps
1. Outpatient Therapy Caps for CY 2016

Section 1833(g) of the Act requires application of annual per beneficiary limitations on the amount of expenses that can be considered as incurred expenses for outpatient therapy services under Medicare Part B, commonly referred to as “therapy caps.” There is one therapy cap for outpatient occupational therapy (OT) services and another separate therapy cap for physical therapy (PT) and speech-language pathology (SLP) services combined.

The therapy caps apply to outpatient therapy services furnished in all settings, including the previously exempted hospital setting (effective October 1, 2012) and critical access hospitals (CAHs) (effective January 1, 2014).

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Outpatient Therapy Caps

The therapy cap amounts under section 1833(g) of the Act are updated each year based on the Medicare Economic Index (MEI).

Specifically, the annual caps are calculated by updating the previous year's cap by the MEI for the upcoming calendar year and rounding to the nearest $10.00.

Increasing the CY 2015 therapy cap of $1,940 by the CY 2016 MEI of 1.1 percent and rounding to the nearest $10.00 results in a CY 2016 therapy cap amount of $1,960.

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Exemptions Process

An exceptions process for the therapy caps has been in effect since January 1, 2006.

Originally required by section 5107 of the Deficit Reduction Act of 2005 (DRA), which amended section 1833(g)(5) of the Act, the exceptions process for the therapy caps has been extended multiple times through subsequent legislation as described in the CY 2015 PFS final rule with comment period (79 FR 67730) and most recently extended by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10).

The Agency's current authority to provide an exceptions process for therapy caps expires on December 31, 2017.

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KX Modifier

After expenses incurred for the beneficiary’s outpatient therapy services for the year have exceeded one or both of the therapy caps, therapy suppliers and providers use the KX modifier on claims for subsequent services to request an exception to the therapy caps.

Use of the KX modifier, the therapist is attesting that the services above the therapy caps are reasonable and necessary and that there is documentation of medical necessity for the services in the beneficiary's medical record.

Claims for outpatient therapy services over the caps without the KX modifier are denied.

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Manual Medical Review

Since October 1, 2012, under section 1833(g)(5)(C) of the Act, we have been required to apply a manual medical review process to therapy claims when a beneficiary’s incurred expenses for outpatient therapy services exceed a threshold amount of $3,700.

There are two separate thresholds of $3,700, just as there are two separate therapy caps, one for OT services and one for PT and SLP services combined; and incurred expenses are counted towards the thresholds in the same manner as the caps.

Now, under section 1833(g)(5) of the Act as amended by section 202(b) of the MACRA, claims exceeding the therapy thresholds are no longer automatically subject to a manual medical review process as they were before.

Rather, CMS is permitted to do a more targeted medical review on these claims using factors specified in section 202(b) of the MACRA.

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Manual Medical Review

The reviews will occur over five cycles:

- The first additional documentation request (ADR) sent to each provider will only request the documentation for one claim.
  - The second ADR sent to a provider can request up to 10% of the total number of eligible claims.
  - The third ADR sent to a provider can request up to 25% of the remaining eligible claims.
  - The fourth ADR sent to a provider can request up to 50% of the remaining eligible claims.
  - The fifth ADR sent to a provider can request up to 100% of the remaining eligible claims.
The statutorily-required manual medical review process required under section 1833(g)(5)(C) of the Act expires at the same time as the exceptions process for therapy caps on December 31, 2017.

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**MMR- Targeted Review**

Targeting those therapy providers with a high claims denial rate for therapy services or with aberrant billing practices compared to their peers.

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**ICD-10 FAQs**

Q1. What if I run into a problem with the transition to ICD-10 on or after October 1st 2015?

• A1. CMS understands that moving to ICD-10 is bringing significant changes to the provider community. CMS will set up a communication and collaboration center for monitoring the implementation of ICD-10.

• This center will quickly identify and initiate resolution of issues that arise as a result of the transition to ICD-10. As part of the center, CMS will have an ICD-10 Ombudsman to help receive and triage physician and provider issues. The Ombudsman will work closely with representatives in CMS’s regional offices to address physicians’ concerns. As we get closer to the October 1, 2015, compliance date, CMS will issue guidance about how to submit issues to the Ombudsman.

---

**ICD-10**

Q2. What happens if I use the wrong ICD-10 code, will my claim be denied?

A1. While diagnosis coding to the correct level of specificity is the goal for all claims, for 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule for ICD-10 code inputs related to factors such as the correct family of codes. Furthermore, an EP will not be subjected to a penalty if CMS experiences difficulty calculating the quality scores for PQRS, VBM, or HEDIS due to the transition to ICD-10 codes. CMS will not deny any informal review request based on 2015 quality measures if it is found that the EP submitted the requisite number/type of measures and appropriate domains on the specified number/percentage of patients, and the EP’s only error(s) is/are related to the specificity of the ICD-10 diagnosis code (as long as the physician/EP used a code from the correct family of codes).

However, a valid ICD-10 code will be required on all claims starting on October 1, 2015. It is possible a claim could be chosen for review for reasons other than the specificity of the ICD-10 code and the claim would continue to be reviewed for these reasons. This policy will be adopted by the Medicare Administrative Contractors, the Recovery Audit Contractors, the Zone Program Integrity Contractors, and the Supplemental Medical Review Contractor.

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**Want more info on MMR?**

For information on the manual medical review process, go to

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/TherapyCap.html
**Prepare for IMPACT**

**Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014**

Bipartisan bill passed on September 18, 2014 and signed into law by President Obama on October 6, 2014 Requires Standardized Patient Assessment Data that will enable:

- Quality care and improved outcomes
- Comparison of quality and data across post-acute care (PAC) settings
- Improved discharge planning
- Exchangeability of data
- Coordinated care

**Purpose of IMPACT**

**Purposes Include:**

- Improvement of Medicare beneficiary outcomes
- Provider access to longitudinal information to facilitate coordinated care
- Enable comparable data and quality across PAC settings
- Research

Why the attention on Post-Acute Care:

- Escalating costs associated with PAC
- Lack of data standards/interoperability across PAC settings
- Goal of establishing payment rates according to the individual characteristics of the patient, not the care setting

**Quality Measure Domains**

- Functional status, cognitive function, changes in function, and changes in cognitive function
- Skin integrity and changes in skin integrity
- Medication reconciliation
- Incidence of major falls
- Communicating the existence of and providing for the transfer of health information and care preferences

**Measure Domains & Measures Under Consideration**

- Functional status, cognitive function, and changes in function and cognitive function
  - Percent of patients/residents with an admission and discharge functional assessment and a care plan that addresses function
- Skin integrity and changes in skin integrity
  - NQF #0678 Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678)
- Incidence of major falls
  - Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674)

- Measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates
  - IRF Setting (NQF #2502): All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities
  - SNF Setting (NQF #2510): Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)
  - For LTCH Setting (NQF #2512): All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs)
  - HH Services (NQF #2380): Rehospitalization During the First 30 Days of Home Health
Standardized Patient Assessment Data

- Requirements for reporting assessment data:
  - Providers must submit standardized assessment data through PAC assessment instruments under applicable reporting provisions
  - SNF: October 1, 2018
  - IRF: October 1, 2018
  - LTCH: October 1, 2018
  - HHA: January 1, 2019

- Data categories:
  - Functional status
  - Cognitive function and mental status
  - Special services, treatments, and interventions
  - Medical conditions and co-morbidities
  - Impairments
  - Other categories

---

**Incidence of major falls**
- SNF: October 1, 2016
- IRF: October 1, 2016
- LTCH: October 1, 2016
- HHA: January 1, 2019

**Functional status, cognitive function, and changes in functional and cognitive function**
- SNF: October 1, 2016
- IRF: October 1, 2016
- LTCH: October 1, 2016
- HHA: January 1, 2017

**Skin integrity and changes in skin integrity**
- SNF: October 1, 2016
- IRF: October 1, 2016
- LTCH: October 1, 2016
- HHA: January 1, 2017

**Medication Reconciliation**
- SNF: October 1, 2017
- IRF: October 1, 2018
- LTCH: October 1, 2018
- HHA: January 1, 2017

---

**Standardized Data**

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<tr>
<th>Item</th>
<th>Item Description</th>
<th>Impaired Reimbursement Facility Patient Assessment Instrument (REF-PA) v1.2</th>
<th>Minimum Date for MDS (MDD)</th>
<th>Long-Term Care Hospital CARE Data Set v3.0</th>
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<td>SELF-CARE GG0130</td>
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</tr>
<tr>
<td>A Eating</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>B Oral hygiene</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>C Toileting hygiene</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>D Wash upper body</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>E Shower/bathe self</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>F Upper body dressing</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G Lower body dressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H Putting on/off footwear</td>
<td></td>
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</tr>
</tbody>
</table>

---

**MDS Section GG0130: Self Care**

- Effective August 2016. Effective in all care settings.
- Only applicable to inpatient hospital and long-term care settings.
- Only applicable to residents who are expected to be in the facility for at least 7 days or are at risk for dependency.

**MDS Section GG0170: Mobility**

- Only applicable to inpatient hospital and long-term care settings.
- Only applicable to residents who are expected to be in the facility for at least 7 days or are at risk for dependency.

---

**Resource use and other measures**
- SNF: October 1, 2016
- IRF: October 1, 2016
- LTCH: October 1, 2018
- HHA: January 1, 2017

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**Communicating the evidence of and providing the transfer of health information and care preferences**
- SNF: October 1, 2016
- IRF: October 1, 2016
- LTCH: October 1, 2016
- HHA: January 1, 2017

---

**Standardized Data**

**Usage Details**

- CMS MLN Connect October 2015

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**Informational**

- SNF: October 1, 2018
- IRF: October 1, 2018
- LTCH: October 1, 2018
- HHA: January 1, 2019

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**Functional status**

- SNF: October 1, 2016
- IRF: October 1, 2016
- LTCH: October 1, 2016
- HHA: January 1, 2019
Bundled Payments in KENTUCKY

- Bundled Payment Care Initiative, Kentucky One Health:
  - KentuckyOne Health facilities have applied to begin participating in a Centers for Medicare and Medicaid (CMS) Bundled Payment Care Initiative (BPCI) on July 1. This is a collaboration between KentuckyOne Health and KentuckyOne Health Partners, a clinically integrated network. This particular episode program will focus on major joint replacements of the lower extremities (hips and knees).
  - Before elective surgery occurs, Medicare patients will be expected to participate in Joint Academy, a half-day session that includes education about what they can expect before and after surgery, as well as pre-operative lab work.
  - Beginning July 1, any episode patient discharged from a participating KentuckyOne Health facility who has had a hip or knee replacement will be managed for 90 days by a health coach from KentuckyOne Health Partners. This care coordination will include identifying and removing any barriers to care.


Breaking NEWS Hope for ALJ Backlog

The Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act (AFIRM Act) of 2015 would cost $1.7 billion over the next ten years if it is passed in 2016, the Congressional Budget Office estimated in its report.

The bill was formally introduced in December by Finance Committee Chairman Orrin Hatch (R-UT) and ranking member Ron Wyden (D-OR).

ALJ Backlog Facts

- Last week, a court ordered a review of the Medicare appeals backlog to decide whether the situation is dire enough to require the Department of Health and Human Services to adhere to a 90-day deadline for ALJ appeals. The average wait time for ALJ appeals was 572 days at this time last year.

Questions??