Medicare 2021

Therapy Threshold * COVID-19*NCCI* MIPS *Direct Access

2021 Medicare Quick Look

Medicare Deductible:	$203
Therapy Threshold:	$2,110 add KX to continue treatment
Targeted Medical Review	when patient exceeds $3,000, some but not all claims are subject to Review
MIPS:	Required for 2021 – Check to determine if you are required to Participate

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2021 Therapy Thresholds

The new law, through section 50202 of the BBA of 2018, preserves the former therapy cap amounts as thresholds above which claims must include the KX modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record. Just as with the incurred expenses for the therapy cap amounts, there is one amount for PT and SLP services combined and a separate amount for OT services.

For CY 2021 this KX modifier threshold amount is:

- **$2,110 for PT and SLP services combined, and**
- **$2,110 for OT services**.

Along with this KX modifier threshold, the new law retains the **targeted** medical review (MR) process, but at a lower threshold amount of $3,000. This threshold amount is now termed the Medical Record (MR) threshold amount – one MR threshold amount for PT and SLP services combined and another for OT services – remains at $3,000 until CY 2028 at which time it will be updated

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2021 Fee Schedule

2021 Changes to Fee Schedule Payments

For services provided on or after Jan. 1, 2021, per the fee schedule final rule there was a projected 9% cut for PT/OT services.

However, the recently passed omnibus and COVID-19 relief package reduces the planned cut to physical therapy payment under Medicare. The bill includes provisions that reduce the extent of the cut from a projected 9% to something closer to 3.6%. That means CMS will need to calculate a new conversion factor. Watch for updates to this page once the new conversion factor is released.

CMS also significantly increased the values of the evaluation and reevaluation codes (97161-97164) in the final rule.

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Sequestration

Medicare FFS Claims: 2% Payment Adjustment (Sequestration) Suspended Through March

The Coronavirus Aid, Relief, and Economic Security (CARES) Act suspended the payment adjustment percentage of 2% applied to all Medicare Fee-For-Service (FFS) claims from May 1 through December 31. The Consolidated Appropriations Act, 2021, signed into law on December 27, extends the suspension period to March 31, 2021.

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Teletherapy

Telehealth and Communication Technology-Based Services

During the COVID-19 public health emergency, Medicare covers telehealth services including two-way, real-time interactive communications, e-visits, virtual check-ins, remote assessment of visual recordings, and telephone assessment and management services when furnished by PTs in private practice and by facility-based physical therapy providers.

The 2021 Physician Fee Schedule made coverage of the following communication technology-based services permanent as of Jan. 1, 2021.

- E-visits (98970, 98971, 98972)
- Remote assessment of recorded video or image (G2250)
- Virtual check-in (G2251)

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Teletherapy

Two-Way, Real-Time Interactive Communication

This form of telehealth entails real-time two-way interaction between the provider and patient or caregiver using audio and video communication technology. Eligible services are reported using the same CPT codes that describe in-person services.

In the 2021 Physician Fee Schedule, CMS created a third temporary category of criteria for adding services to the Medicare telehealth services list— a category that includes services for which there is likely to be clinical benefit when furnished via telehealth, but for which there is not yet enough evidence to permanently add the services to the Medicare covered telehealth services list.

Any service added under Category 3 will remain on the Medicare telehealth services list through the calendar year in which the public health emergency ends.

The final rule includes the following codes: 97161-97164, 97110, 97112, 97116, 97535, 97750, 97755, 97760, and 97761.

However, barring congressional action — and even with these codes added to this list on a temporary basis — during the time between the end of the PHE and the remainder of the calendar year in which the PHE ends, the above codes can only be furnished via telehealth by a PT if billed incident to the professional services of a physician or practitioner who is authorized to furnish and bill for telehealth services, provided that the “incident to” requirements are met.

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2021 COVID-19 Provisions

Supervision of PTAs

To help limit COVID–19 exposure, CMS now allows PTs to provide direct supervision to PTAs using real-time, interactive audio and video technology through the calendar year in which the COVID-19 PHE ends (in accordance with state law). The patient's medical record should reflect why virtual supervision was necessary.

NCCI Edits

Common Physical Therapy Code Pairs With PTP Edits

(As of January 2021)

These are the most common code pairs used in physical therapy, not a complete list — for the full list of code pairs, see the CMS website.

(See next page for table)

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NCCI Edits

PT Evaluation and Reevaluation		
Column One	Column Two	Modifier Indicator
97161	97164, 97750, 97755, 97763	Not Allowed
97162	97164, 97750, 97755, 97763	Allowed
97163	97161, 97162, 97164, 97750, 97755, 97763	Not Allowed
97164	97750, 97753, 97763	Not Allowed
Modalities		
97012	97140, 97164	Allowed
97016	97018, 97026, 97164	Allowed
97018	97022, 97164	Allowed
97022	97164	Allowed
97024	97018, 97026, 97164	Allowed
97026	97018, 97022, 97164	Allowed
97028	97018, 97022, 97026, 97164	Allowed
97032, 97034, 97036, 97403	97164	Allowed
G0283	97164	Allowed
Therapeutic Procedures		
97112	97022, 97036, 97164	Allowed
97113	97036	Not Allowed
97113	97022, 97110	Allowed
97124, 97127, 97129, 97130, 97139	97164	Allowed
97140	97124	Not Allowed
97140	97018, 97750	Allowed
97150	97110, 97112, 97113, 97116, 97124, 97140, , 97539, 97533, 97535, 97537, 97542, 97760, 97761, 97763	Allowed

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NCCI Edit Deletions

The original 2020 version of the edits list included prohibitions on several code pairings commonly used in physical therapy; CMS responded to advocacy by APTA and its members and reversed that decision in early February. Then, in April, CMS responded to additional APTA advocacy and lifted more edits, only to reinstate them on Oct. 1. The latest announcement paves the way for a more settled coding environment in 2021.

The code pairing restrictions deleted in both office and facility-based settings include:

97110 with 97164
97112 with 97164
97113 with 97164
97116 with 97164
97140 with 97164
97150 with 97164
97530 with 97116
97530 with 97164
99281-99285 with 97161-97168
97161-97163 with 97140
97127 with 97164
97140 with 97530
97530 with 97113

In its announcement, CMS says that some of the positive changes are retroactive to Oct. 1, 2020, with others retroactive to Dec. 31, 2019. APTA has reached out to CMS and its NCCI contractor to get more answers on the deletion dates and provisions that could allow reprocessing of previously denied claims. The association also will update the code pairing chart available on its Medicare National Correct Coding Initiative webpage.

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PTA/OTA Modifiers

Section 53107 of the BBA of 2018, mandates the use of a new modifier to identify the PT and OT services provided by a therapy assistant.

If a PTA or OTA provides more than 10% of a therapy service, the new payment modifiers must be applied

The modifier is required on claims beginning January 1, 2020 continues.

- **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
  - ❖ *This is in addition to the GP or GO modifier*

Beginning in 2022, claims containing one of the new, assistant-dependent payment modifiers, will be reimbursed at 85% of the cost of the provided service.

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2021 Medicare Physician Fee Schedule (MPFS) Final Rule Provisions

Medical Record Documentation

In the CY 2020 MPFS final rule, we finalized broad modifications to the medical record documentation requirements for the physician and certain NPPs. The 2021 finalized rule clarifies that: MLN Matters: MM12071 Related CR 12071 Page 3 of 9 • Physicians and NPPs, including therapists, can review and verify documentation entered into the medical record by members of the medical team for their own services that are paid under the MPFS • Therapy students, and students of other disciplines, working under a physician or practitioner who furnishes and bills directly for their professional services to the Medicare program, may document in the record so long as it is reviewed and verified (signed and dated) by the billing physician, practitioner, or therapist.

Therapy Assistants Furnishing Maintenance Therapy

We are finalizing the part B policy for maintenance therapy services that was adopted on an interim basis for the PHE for COVID-19 in the May 1st COVID-19 Interim Final Rule with Comment Period (IFC). This finalized policy allows: • Physical Therapists (PT) and Occupational Therapists (OT) to delegate the furnishing of maintenance therapy services, as clinically appropriate, to a Physical Therapy Assistant (PTA) or an Occupational Therapy Assistant (OTA) • PTs/OTs to use the same discretion to delegate maintenance therapy services to PTAs/OTAs that they use for rehabilitative services

MIPS and PT/OT/SLP

Physical, occupational therapists, and qualified Speech-language pathologists, may be required to participate in MIPS

In order to be MIPS eligible, a clinician must:

- Be identified as a MIPS eligible clinician type on Medicare Part B claims,
- Have enrolled in Medicare before 2020
- Exceed the low-volume threshold as an individual

❖ ***Clinicians who don't meet these requirements are exempt from MIPS.***

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MIPS Participation Status

Your eligibility will be reviewed twice during Performance Year 2020. Reviews will analyze CMS Medicare Part B Claims data and PECOS data from two 12-month time periods:

Data from the first segment is released as preliminary eligibility. Data from the second segment is reconciled with the first segment and released as the final eligibility determination.

Data from these dates to will be used to determine eligibility (including whether you exceed the low-volume threshold)

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MIPS Participation Status

Use the QPP online Participation Status tool to determine if you are required to Participate

https://qpp.cms.gov/participation-lookup

- *Please note that the QPP Participation Status Tool is only a technical resource and is not dispositive of any eligible clinician's, group's, or organization's status under QPP. For more information, please refer to the Quality Payment Program regulations at 42 C.F.R. part 414 subpart O.*

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MIPS Participation Status

Low-Volume Threshold

The low-volume threshold includes 3 aspects of covered professional services:

- Allowed charges
- Number of beneficiaries who receive services
- Number of services provided

Clinicians and groups fall under the low-volume threshold and are exempt from MIPS if they:

- Bill $90,000 or less in Medicare Part B allowed charges for covered professional services payable under the Physician Fee Schedule (PFS), or
- Provide covered professional services for 200 or fewer Part B-enrolled individuals, or
- Provide 200 or fewer covered professional services to Part B-enrolled individuals

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MIPS Participation Options

If you're exempt from MIPS for Performance Year 2020, you have the following options:

- Do nothing. You are not required to participate.
- Opt-in to MIPS - if you are an eligible clinician or group who exceeds 1 or 2 (but not all 3) of the low-volume threshold criteria during either review period. If you are an eligible clinician or group who opts-in to MIPS, you will receive a MIPS final score and a payment adjustment in 2022.
- Voluntarily report - you will receive a MIPS final score but no payment adjustment.

  - ❖ *If you would like more detailed information about the MIPS program please contact CPM*

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Direct Access and Medicare

Medicare beneficiaries are able to go directly to physical therapists (PT) without a referral or visit to a physician. This policy became effective in 2005 through revisions to the Medicare Benefit Policy Manual (Publication 100-02). The 2005 revisions eliminated the physician visit requirement. However, a patient must be "under the care of a physician," which is indicated by the physician certification of the plan of care.

- **What the Rules Say**
- PTs must comply with the laws in their state related to the need for a referral for physical therapy.
- The plan of care developed by the PT must be certified by a physician or nonphysician practitioner (NPP) within 30 days of the initial therapy visit.
- The plan of care must include, at a minimum, (1) diagnoses; (2) long-term treatment goals; and (3) type, amount, and duration of therapy services.
- Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care. Stamped signatures are not acceptable. If the order to certify is verbal, it must be followed within 14 days by a signature.
- Medicare does not require that the patient visit the physician/NPP. However, a physician/NPP may require the visit.

What This Means for PTs

- ***To be paid by Medicare for their services, PT practices should have procedures in place to ensure that the plan of care is certified.*** Medicare does not require certification of the plan of care before treatment is initiated. However, if the PT does not have a relationship with the physician or is not confident that the physician will sign the plan of care, it may be prudent for the PT to contact the physician for verbal authorization before initiating treatment.

To File Medicare Claims Under Direct Access

- Providers must report the name and NPI number of the certifying physician/NPP on the claim for therapy services.

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California Direct Access

California is one of 28 states that allow direct patient access to PT with some provisions

- The physical therapist shall not continue treating the patient beyond **45 calendar days or 12 visits**, whichever occurs first, without receiving, a dated signature on the physical therapist's plan of care from the patient's physician or surgeon indicating approval of the physical therapist's plan of care. Approval of the physical therapist's plan of care shall include an in-person patient examination and evaluation of the patient's condition and, if indicated, testing by the physician or surgeon, except when providing wellness physical therapy services, or providing physical therapy services pursuant to a family service plan or individualized education plan (IEP) and the individual does not have a medical diagnosis. (Effective 1/1/2019)
- PT must refer the patient to their physician if, at any time, the patient has signs or symptoms of a condition that requires treatment beyond the scope of practice of a physical therapist or the patient is not progressing toward documented treatment goals
- PT shall disclose to the patient any financial interest he or she has in treating the patient and, if working in a physical therapy corporation, shall comply with Chapter1, Article 6, commencing with Section 650.
- With the patient's written authorization, the physical therapist shall notify the patient's physician and surgeon, if any, that the physical therapist is treating the patient.
- Must provide notice to the patient, orally and in writing, in at least 14-point type and signed by the patient indicating they are receiving direct physical therapy treatment services and may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

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Other Important Stuff

For All Payors:

- Ask patients if their Insurance has changed – many people have insurance or policy changes at this time of year
- Check Eligibility, Benefits and Auth Requirements (see below), even if insurance stayed the same, benefits may change.
- **Collect Deductibles, Co-Insurance and Co-Pays**

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Eligibility, Benefits & Authorization They are NOT the same thing

Understanding the components of Eligibility, Benefits and Authorization is key to making sure you get reimbursement for services rendered.

- **Eligibility** – Check that the patient has an Active policy in effect on the date of service.
- **Benefits** – If the patient has an Active Policy then Benefits need to be checked to determine if PT,OT,SLP or Chiro is a covered Benefit of the policy
- **Authorization** – If it is a covered Benefit then determine if Authorization or Per-Certification or a Referral is required. If so then in must be obtained.
- **Medical Necessity Review (MNR)** – Additionally some insurances may require that a MNR form be filed within so many visits.

It is important to understand that each of these needs to be verified in order to insure proper reimbursement.

*****Having authorization does not mean the patient has benefits.**

Also, re-check often as things do change.***

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ABN – Advanced Beneficiary Notice

- The ABN is a written notice you must issue to a Fee-For-Service beneficiary before furnishing items or services that are usually covered by Medicare but are not expected to be paid in a specific instance for certain reasons, such as lack of medical necessity.
- If the beneficiary does not get written notice when it is required, he or she may not be held financially liable if Medicare denies payment
- Common reasons for Medicare to deny an item or service as not medically reasonable and necessary include care that is:
  - Experimental and investigational or considered “research only”;
  - Not indicated for diagnosis and/or treatment in this case;
  - Not considered safe and effective; or
  - More than the number of services Medicare allows in a specific period for the corresponding diagnosis.
- See https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ABN_Booklet_ICN006266.pdf for complete details

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