Part B: A - Z

December 7, 2022

NARA Webinar Provided by Lincoln Reimbursement Solutions

Housekeeping Reminders

- All attendees are on mute
- Handouts were provided in the reminder email for this webinar sent 1 hour ago
- **Questions for Speakers:** submit them using the Q&A button on the attendee control panel
- **Technical Questions:** submit them using the Chat button on the attendee control panel
- **Recording:** will be emailed to all registered attendees 48 hours after concluded; posted for NARA Members on the Portal within 24 hours
- **Awarding of CEUs:** During the presentation, there will be 2 key words provided that will be needed to complete the Assessment. The assessment must be completed by January 6, 2023. ASHA members must provide their ASHA number on the assessment to be awarded credit.
Disclaimer

The information shared in today’s presentation is shared in good faith and for general information purposes only. It is accurate as of the date and time of this presentation. Providers should seek further guidance and assistance from CMS and their Medicare Administrative Contractor (MAC), commercial payers, state and national associations, and continue to watch for new developments and information regarding the topics discussed today.
ABOUT the PRESENTERS

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COO Lincoln Reimbursement Solutions

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OBJECTIVE

1. Discuss the impact the 2022 payment cuts
2. Understand the common reasons for denials and non-payments
3. Implement processes to generate a high first pass payment
4. Understanding of payor requirements for authorizing visits
5. Understanding the importance and common mishaps of contracting and credentialing
6. Understand and optimize key performance indicators
CLAIM PROCESSING with ASSISTANT PAYMENT REDUCTION

1. Application of the beneficiary’s deductible
2. Application of the MPPR
3. Application of the beneficiary’s 20% coinsurance

4. Application of the 15% reduction for PTA/OTA services
5. Application of 2% sequestration* 2% effective July 1, 2022

6. Coinsurance / secondary insurance

EXAMPLE 1

Allowed amount on 97012 = $11.56
PT is paid $9.06
PTA paid $7.70

Coinsurance - $2.31

Difference on one unit = $1.36
Difference on four unit = $5.44

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Allowed amount  = $438.53

Total ‘Allowed’ When all rendered by PTA - $365.13

Coinsurance = $87.71

If all were delivered by a PT, difference of +$73.40

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**OTHER Payers and the CQ/CO MODIFIERS**

**Cigna**
- CO/CQ effective 10/15/2022 for all states except CO, KY, OH, TX effective 11/1/22
- Contract through ASH you will not be affected

**Humana**
- CO/CQ effective 1/1/2020
- OTA/PTA service paid at 85% of the contracted rate or base maximum amount payable under the member’s plan effective 1/1/2020

**Tricare**
- CO/CQ effective 4/16/2020
- OTA/PTA service shall be reimbursed at the non-physician class CMAC effective 1/1/2020

**UHC Medicare Advantage Plan**
- CO/CQ effective 1/1/2020
- For dates of service on and after January 1, 2020 reimburse providers with Medicare Fee for Service (FFS) contract agreements at 85% of the otherwise applicable Part B payment amount

**Highmark**
- CO/CQ effective 3/2022
MEDI'CAR E O N V E R S I O N F A C T O R

2022

- .75% Conversion Factor

97110
2020 → 2022
difference of -$1.36

97530
2020 → 2022
difference of -$2.22

97162
2020 → 2022
difference of +$14.43

CEU Key Word 1:
COMMON REASONS for NON PAYMENT & UNDERPAYMENT

- Intake / patient registration
- Verification of benefits / eligibility
- Missing or incorrect authorizations
- Place of Service
- Credentialing denials
- Contracting

Importance of accurate demographic information:
Claim rejections for incorrect spelling, DOB, JR/SR, Eligibility dates, Claims address, Auth requirements?

Verify coverage of patient diagnosis/treatment up front: Place of Service, TMJ, Aquatic, Splints, etc.

COB Denials: example to follow
COB DENIAL EXAMPLES:

- Whole balance gets pushed to the patient
- Did patient give you incorrect information? Or was incorrect payor selected at intake?

AUTHORIZATIONS

When asking for initial or additional visits, important to document medical necessity

Ensure the diagnosis is clear

How many visits are you aiming for them to approve?

Evaluate the patient’s goals and clearly document progress
ASH EXAMPLE 1

The therapist was asking for 19 additional visits to be approved

Payor only approved 6

Problems & Goals

1. Problem: Home exercise program
   Status: Active
   Goal:
   1. Type: Short term
      Description: Patient will increase global strength to at least 4-5 in order to squat
      Target Timeframe: Six weeks
      Status: In Progress
   2. Problem: Decreased strength
      Status: Active
      Goal:
      1. Type: Long term
         Description: Patient will increase global strength to at least 4-5 in order to ride horses
         Target Timeframe: Six weeks
         Status: In Progress
   3. Problem: Pain

Patient Presentation

- Patient had diagnosis of Z47.1: Aftercare following joint replacement surgery
- Patient received 13 authorized visits

ANTHEM/AIM EXAMPLE:

The initial requests for AIM look at the primary diagnosis code, comorbidities, functionalist scores and if the surgery was completed in the last 3 months. Both patients have similar functionality scores and comorbidities, the primary difference is the diagnosis code.

Patient A
- The patient had diagnosis of Z47.1: Aftercare following joint replacement surgery
- Patient received 13 authorized visits

Patient B
- The patient had diagnosis code of M17.12: Unilateral Primary Osteoarthritis
- Patient received 6 authorized visits
**IMPORTANCE of DIAGNOSIS in VERIFICATIONS/AUTHORIZATIONS**

Authorizations will not be approved without thorough documentation and explanation in notes of condition and diagnosis.

Need a strong diagnosis code to support the story for why more visits are needed.

- Diabetic
- TMJ
- Post OP
- Speech Therapy

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**The Stars Align:**
Contracting and Credentialing
CONTRACTING
Negotiating and renegotiating the best rates for your practice

1. Review your contract
   - Know your current rates
   - Compare most frequently billed codes to the Medicare fee schedule

2. Set the stage
   - Which payers have the lowest reimbursement rate?
   - Which payers account for the largest portions on your payer mix?

3. Make your case
   Include the following:
   - Date contract was executed or last negotiated
   - Current fee schedule and Proposed reimbursement rate
   - Cost to deliver care
   - Outcome measures and Patient satisfaction scores
   - Certifications, technology, specialty programs
   - Volume of patients

4. Write your letter (of intent)
   - Make a connection
   - Draft a formal letter of intent

5. Follow up
   - Don’t be forgotten
   - Declined request - reconsideration!
   - Escalate if needed

6. REPEAT!
   - Review every 2 years
   - Consider going OON
   - Fight for the reimbursement you deserve!

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CREDENTIALALING for NEW HIRES

1. Create and utilize comprehensive new hire credentialing documents (include specific payor materials, CAQH information, education)

2. Submit credentialing payor applications to payor

3. Have a clear process for keeping track of payor applications, submission ids, reference numbers, etc.

4. Set follow up guidelines for each payor. Ask the payor for expectations.

5. Clear guidelines for your cosignature process or claim hold process. All team members need to be aligned on this, scheduling, intake, verifications, therapist, billers, etc.

6. Process for communication with billing team as approvals come in

7. Process to recredential and reattest CAQH profiles
CONTRACTING and CREDENTIALING DENIALS

Look for and analyze trends with providers or payors

Provider Denials
• Did you attach your provider to your TIN / locations?
• Do you need a provider # on your claims?
• Is your CAQH updated and attested?
• Did your provider have a name change?
• Be aware of credentialing denials disguised as auth denials.

Payor Denials
• Are you OON and you were misquoted during benefits?
• Did a 3rd party contract term?
• Did you miss a recredentialing window?

Location Denials
• Did you forget to add a location to your contract?
• Determine if all locations are denying or just one.

Top 5 denial reasons:
• Work backwards
• These are your holes
  How can you improve processes here?

Top 5 used CPT codes:
• Reimbursement per payor on these codes
• Have a general idea of what each pay
  Is there an adjustment issue?

KPI’s to STAY ON TOP OF

Control the controllables!

Total write off amount per month
• What are the trends?
  How can you fix this?

Revenue per payor
• Revenue per visit per payor
  Is it time to evaluate your contacts?
  Is it time to go out of network?
In 2023, the Part B deductible will be $226.00. This is a $7.00 decrease from 2022.

PHE scheduled to end on January 11, 2023

The Centers for Medicare and Medicaid Services (CMS) has confirmed that CMS will reimburse for outpatient physical, occupational and speech therapy services for 151 days after the public health emergency (PHE) due to COVID-19 has ended. On the 152nd day after the PHE has ended, physical therapists, occupational therapists and speech-language pathologists will not be able to be reimbursed for outpatient therapy services delivered via telehealth under Medicare Part B.

In the calendar year 2021 Final Rule for services reimbursed under the Medicare Physician Fee Schedule, the Centers for Medicare and Medicaid Services finalized their proposal to have the following CPT codes remain temporarily on the Medicare telehealth list through the end of the year in which the PHE for COVID-19 ends (category 3 services):

- 92521- 92524, 92507, 97161 – 97168, 97110, 97112, 97116, 97535, 97750, 97755, 97760, and 97761.

CMS states "Direct supervision requires that the supervising private practice therapist be present in the office suite at the time the service is performed. These direct supervision requirements apply only in the private practice setting and only for therapists and their assistants".

During the PHE, CMS is revising the definition of direct supervision to include a virtual presence through the use of interactive telecommunications technology for services paid under the Medicare Physician Fee Schedule (MPFS).

- State practice act trumps CMS rulings

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Thank You!

- **CEU Requirements:**
  - Complete the assessment by January 6, 2022
- **NARA Spring Conference 2023**
  - May 2 – 5, 2023 in Washington DC
- **Next Webinar: Re-Engaging Treatment Tactics for Diversification** – January 25, 2023