PPTA Fall 2017
Reimbursement and Regulation Update

Presented by
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PPTA Reimbursement Specialist
• Resource available to all PPTA members and non PTs/PTAs working with a member
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  • 412-266-8717

• If you are not the member, please provide the member’s name in your email
PPTA Website as a Resource

• [www.ppta.org](http://www.ppta.org)
• Log in
• Navigate to Members only section
• Reimbursement
• Please email [csgalletta@gmail.com](mailto:csgalletta@gmail.com) with suggestions for additions to the website
PPTA Reimbursement Blast

• **Member benefit**

• **Email:** tannibali@ppta.org
  • Member name/APTA Member number
  • Your email address(s)
  • Sponsored administrative staff may sign up
  • **Please do not** include email addresses of PTs or PTAs who are not PPTA members
  • Reimbursement Blasts are now archived on the PPTA website!
Since we last met in April
(via webinar) ... 
What’s happened in PA?
Commercial payer trends/denial issues

• ICD-10 related denials
• 2017 Payer Policy review
• Direct Access
• 4-unit limitations
• Utilization management/Utilization review
  • Authorization issues
• Audit trends
• Audience discussion: payment/denial trends
ICD-10 related denials
ICD-10 update
October 1, 2017


• https://www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf
  (Hyperlink Resource file)
ICD-10 related denials

• ICD-10 transition occurred in October 2015, CMS put a “grace period” into effect.
• This allowed ICD-10 codes to pass through as long as the ICD-10 code was in the right “family.”
• The “grace period” ended January 1, 2017, and it appears that many payers are now enforcing more stringent specificity... specifically, the “Excludes 1” guideline (p. 11 ICD-10 Guidelines – Resource File)
Excludes 1

• An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note.
Excludes 1 example:
2017 ICD-10-CM Diagnosis Code R42 Dizziness and giddiness

• Type 1 Excludes
  • vertiginous syndromes (H81.-)
  • vertigo from infrasound (T75.23)

• This “Type 1 Excludes H81. – means you cannot submit R42 and a code from the H81.- series together.

• This is where payer policy may have an impact. For instance, if you are billing for CPT 95992 (canalith repositioning) per Novitas-Solutions Local Coverage Determination L35036, Medicare requires the H81. – series of codes for this CPT code.
Other ICD-10 issues?
2017 Payer Policy review

Audience experience

How many have Provider Reps or Liaisons?
With which payers?

Please forward this information to csgalletta@gmail.com
Aetna
BQ: What are other offices experiencing with Aetna and the billing of evaluations?
Audience experience?
What is a good way to handle Aetna 25th visit reviews?
Audience experience?
• Physical therapy should be provided in accordance with an ongoing, written plan of care. The purpose of the written plan of care is to assist in determining medical necessity and should include the following:

• The written plan of care should be sufficient to determine the medical necessity of treatment, including:
Aetna Policy – Physical Therapy Number: 0325
Appendix (Last reviewed 5/24/17)

I. The diagnosis along with the date of onset or exacerbation of the disorder/diagnosis;
   A. A reasonable estimate of when the goals will be reached;
   B. Long-term and short-term goals that are specific, quantitative and objective;
   C. Physical therapy evaluation;
   D. The frequency and duration of treatment; and
   E. The specific treatment techniques and/or exercises to be used in treatment.
Aetna Policy – Physical Therapy Number: 0325
Appendix (Last reviewed 5/24/17)

II. **Signatures of the patient's attending physician** and physical therapist.

The plan of care should be ongoing, (i.e., updated as the patient's condition changes), and treatment should demonstrate reasonable expectation of improvement (as defined below):

- Physical therapy services are considered medically necessary only if there is a reasonable expectation that physical therapy will achieve *measurable improvement* in the patient's condition in a reasonable and predictable period of time.
The patient should be reevaluated regularly (at least monthly), and there should be documentation of progress made toward the goals of physical therapy.
However, the policy goes on to state...

• “The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by Aetna) for a particular member. The member's benefit plan determines coverage.”
We've had tons of problems with Aetna claims processing this year. Are other providers experiencing the same? Audience experience?

Specific trends/issues that can be addressed?
BQ: Which payers apply the NCCI edits?

• Could you please review which insurance companies use the same CCI edits as Medicare...

• Aetna, Highmark, Humana, PA Workers’ Comp... the list goes on!

• Audience Experience? ... Are there any payers that don’t apply the NCCI edits?
Humana
Influx of calls to APTA re: Humana issues

• Duplicate application of MPPR
• In network providers’ contracted rate being further discounted with the application of MPPR
• Inconsistency in application of modifier 59 and denials even though the 59 modifier was visible on the claim
• Difficulty accessing a supervisor in order to get more detail around audits, denials, and/or recoupments
• Lack of provider notification when policies or processes change.
Humana Medical Review Dispute Policy

• Post-payment recoupment: If the initial findings letter describes an overpayment made to your facility, and you wish to avoid recoupment and dispute the initial findings, you must submit a formal, written Level One dispute letter along with all relevant documents within 75 calendar days from the date of the findings letter.
Humana Medical Review Dispute Policy

• If recoupment has not been initiated by the time we receive your dispute, the overpayment is placed on hold so that monies are not recouped or offset from future payments until the dispute process is completed.

• [https://www.humana.com/provider/support/claims/disputepolicy](https://www.humana.com/provider/support/claims/disputepolicy)  
Hyperlink Resource file
Humana
Claims Coding Processing Edits

• Humana periodically updates its policies and claims payment systems to be aligned with correct-coding initiatives, as well as national benchmarks and industry standards (CMS; CPT; HCPCS; ICD-10)

• Updates are posted the first Friday of each month. Each item notified will indicate the item’s implementation date.

• [https://www.humana.com/provider/support/claims/processing-edits](https://www.humana.com/provider/support/claims/processing-edits)

Hyperlink resource file
Contact APTA!

• Contact adovacacy@apta.org with new and/or ongoing issues with Humana.
• Provide actual examples to demonstrate the issues you identify.
• Attach redacted documentation when reporting concerns.
• Copy the PPTA Payment Specialist
Highmark BS
Highmark Claims Correction change
Effective 1/1/18

• Effective January 1, 2018, Highmark will no longer accept requests for claim corrections via telephone or NaviNet investigation. Providers instead must submit corrected (replacement) claims electronically.

• Because electronic replacement claims normally process in the same time frame as an original claim, your adjustments will likely process faster than those changes requested via phone or NaviNet investigation.

• Highmark Provider News Issue 4, 2017
Highmark’s systems recognize claim submission types based on the claim frequency code submitted on professional (837P) electronic claims.

• There are three valid Frequency Type claims:
  • Frequency Type 1 is the original claim.
  • Frequency Type 7 is a replacement claim. It corrects data that was incorrect on the original claim.
  • Frequency Type 8 is a void or cancellation of a prior claim that was submitted in error.
The original claim number assigned by Highmark is required for all Frequency Type adjustment claims.

• **Providers must work with their practice management system vendor** to ensure the Highmark-assigned claim number is reported in the 837P, Loop 2300, REF – Payer Claim Control Number Segment.

• This requirement also applies to claims already adjusted that now require a second (or subsequent) adjustment.

• Please note: *Electronic corrected claims will replace the previously processed claims.* When submitting a correction, send the claim with all changes exactly as the claim should be processed.
Highmark/OPPS/FLR-G codes – recent communications
Facility providers only!

• **8/16/17**: Navinet notice requiring FLR G codes on all claims (Commercial and Advantage plans) retroactive to July 1, 2013.

• **9/8/17 Clarification**: Requirement for resubmission of denied claims to include FLR G codes was retroactive to July 28, 2017.

• APTA and PPTA communicated with Highmark
Highmark notice
9/27/17 Revision:
• Highmark will remove FLR G code Requirement on OPPS claims on 9/29/17.

• Determined FLR G code not required for commercial and MC Advantage

• System Update will remove all changes related to therapy billing implemented 7/28/17
Loose ends” ...

- **9/8/17 Clarification stated** “Highmark will not pursue any retroactive adjustments on claims that processed prior to July 28, 2017, and will not be reprocessing the denied claims. If you need to reprocess or adjust a claim that was paid prior to that date, **Highmark will deny the claim if all the billing requirements aren’t met.”**
The “Revision” published 9/27 and effective 9/29/17 makes no mention of how to deal with denied claims.

• PPTA correspondence included concerns about requiring therapists to retroactively apply FLR G codes and severity modifiers, which violates Medicare billing rules.
• Highmark has not responded to APTA/PPTA

• Audience experience with resubmitting claims that were denied?
FLR – G codes with other payers...

• Received word from a provider that Tricare, Tricare West, and all Veteran’s Plans will now require FLR codes... I have not seen confirmation of this in written policy.

• Audience experience?

• I will update via Reimbursement Blast
Highmark Timed Therapy Code policy
January 2016 Medical Policy Update

• “Highmark Blue Cross Blue Shield will adopt Medicare’s method on counting minutes for timed therapy codes. Please reference claims processing publication 100-04 from CMS for complete details. When more than one service represented by 15-minute timed codes is performed in a single day, the total number of minutes of service (as noted in the chart below) determines the number of timed units billed.”


• Highmark Blue Shield Office Manual Chapter 5.2, May 2016 and April 2017 identifies April 1, 2016 as effective date.
Navinet issues... audience experience?

• Provider concern “Since Navinet has changed the information that you are able to receive for Highmark patients, we are not able to receive patient’s benefit period, deductible amount used nor visits used, and we are supposed to call in to get that information, but are on hold forever.”
IBC timed code policy

Policy # 10.03.01g  Effective date: 1/1/17

• Consistent with Chapter 5, titled Part B Outpatient Rehabilitation and CORF/OPT Services, of the Centers for Medicare & Medicaid Services (CMS) Medicare Claims Processing Manual revised, March 16, 2015, the total number of reported units is constrained by the total treatment time of all "timed" procedures provided on a given day. *Utilize the "8 Minute Rule" chart* below to determine the total number of units to apply.

For any single CPT code, bill a single 15-minute unit as follows:
1 unit = greater than 8 minutes and less than 23 minutes
2 units = greater than 23 minutes and less than 38 minutes
3 units = greater than 38 minutes and less than 53 minutes
4 units = greater than 53 minutes and less than 68 minutes
BQ: How do we address temporary PTs in the workplace with regards to credentialing?

Most credentialing applications require a license number.
Payers may or may not accept a temporary license number.
A license number is required to get an NPI

*Audience Experience?*
Direct Access
FAQ: Who is paying for direct access?

• Coverage via direct access is *payer specific*
• The list on the next slide is the information as of (9/2017) on payment for Direct Access in Pennsylvania.
• It is based on PPTA member reports of billing experience and updated through member input.
• There may be variations based on specific plans.
• Please provide information to csgalletta@gmail.com
Providers reporting payment for Direct Access ADDITIONS OR CORRECTIONS?

• Anthem Blue Cross/Blue Shield
• CIGNA PPO**
• Comp Services (an Independence Blue Cross WC product)
• Capital Blue Cross – follow pre-auth requirements
• Erie Insurance (requests copy of DA Authorization)

**Cigna requires PT in our area to go through American Health Specialty and they require RX.
Providers reporting payment for Direct Access ADDITIONS OR CORRECTIONS?

• Federal Blue Cross/Blue Shield
• Health America/Health Assurance
• Highmark Blue Shield
• Keystone Healthplan Central
• State Farm Auto
• UPMC
BQ: When we ask Aetna about direct access w/o MD script, we are told it's not required but I'm not sure if the customer service grasp the difference between script and referral. Can you clarify whether Aetna accepts direct access or not.
Aetna Medical Policy requires referral

• Aetna considers physical therapy medically necessary *when this care is prescribed* by a chiropractor, DO, MD, nurse practitioner, podiatrist or other health professional qualified to prescribe physical therapy according to State law in order to significantly improve, develop or restore physical functions lost or impaired as a result of a disease, injury or surgical procedure.
No longer on the DA list... IBC
Independence Blue Cross (PC, KHPE, IA, AA)

• IBC Medical Policy
• The service is prescribed by a physician or other qualified professional provider.
  • For reimbursement, the Company requires that a physician or other qualified professional provider prescribe the service, even though Direct Access is available to licensed practitioners in designated states.

http://medpolicy.ibx.com/policies/mpi.nsf/6eeddf656d983ec98525695e0068df68/85256aa800623d7a85258199006601a9!OpenDocument&Highlight=0,physical,therapy,medical,necessity
(Hyperlink Resource file)
The DA payer list is informational... *it is the provider’s responsibility at all times to verify each patient’s member contract* for benefits and limitations including a payer’s recognition of payment for physical therapy treatment without a physician referral.

“Referral” ... be sure you’re speaking the same language!
Commercial Payer 4-unit limitations

Monitor unit restriction denials from all payers closely and contact me when they occur so we can investigate the policy behind the restrictions
Utilization management/
Utilization review

Authorization issues
Capital Blue Cross

• Navinet information different than “Clear Coverage”
• Different authorization number on approval sheet
• Requiring phone calls to Capital to confirm info

• Audience experience?
Highmark / Healthways

• Multiple authorization issues... have they been resolved?
Utilization Management Toolkit:

http://www.apta.org/UMToolkit/ChapterStrategies/ (Hyperlink Resource File)
Recourse for Delayed Payment (> 45 days)
PA Prompt Payment Act
*** Excludes Auto and Workers Comp ... both of which have 30 day payment requirements (+ 6 days mailing)

Filing a claim
Filing a Prompt Payment/Clean claim complaint:

• See Resource File: Clean Claim Act

• IMPORTANT !!! *Identify the impact on the patient and be clear it is NOT a contract issue because a* frequent PA Insurance Department response is:

You have expressed dissatisfaction with the medical claim allowance or a demand for the repayment of a claim.

Please understand that these types of matters are contractual and fall outside the jurisdiction of the Pennsylvania Insurance department.
Complaints to the Department regarding the prompt payment of claims shall contain the following information:

(1) The provider’s name, identification number, address and daytime telephone number and the claim number.

(2) The name and address of the licensed insurer or managed care plan.

(3) The name of the patient and employer (if known).

(4) The dates of service and the dates the claims were submitted to the licensed insurer or managed care plan.
Info for prompt payment claims (cont’d)

(5) Relevant correspondence between the provider and the licensed insurer or managed care plan, including requests for additional information from the licensed insurer or managed care plan.  

(6) Additional information which the provider believes would be of assistance in the Department’s review.  

(7) Any additional information pertinent to the complaint as requested by the Commissioner.
Audit trends

Audience experience with commercial payer audits?
Additional discussion Payment/denial trends?

Please forward any policies and guidelines for major payers that you think may be of interest to the Payment Specialist.

csgalletta@gmail.com
PA Workers’ Compensation
Workers’ Compensation

• Status of PPTA petition regarding 2017 fee schedule amounts
• Evolving Network issues
  • “Supervising PT” signatures requirement (One Call)
  • Contract language versus PA WC regulations
• Fee Reviews/Utilization Reviews
• Audience discussion: payment/denial trends
PA Workers’ Comp Fee Schedule: Four geographic regions

• The PA WC fee schedule divides fees into four geographic regions.

• Use the zip code list as a reference in determining if your payment amount is correct.
  • [http://www.portal.state.pa.us/portal/server.pt/community/charge_classes_by_zip_code/10428](http://www.portal.state.pa.us/portal/server.pt/community/charge_classes_by_zip_code/10428)
  • Also available at [www.ppta.org](http://www.ppta.org) Reimbursement News (members only)
National Correct Coding Edits apply to workers’ comp billing

• CCI edits Updated Quarterly
• Complete list of NCCI edits

2017 Workers’ Comp Fee Schedule

• Based on Medicare Physician Fee Schedule amounts in effect on December 31, 1994.
• Updated annually since then by the percentage change in the PA Statewide average weekly wage.

• 2017 1.7%
• 2016 2.9%
• 2015 2%
• 2014 1.6%

§ 127.152. Medical fee updates on and after January 1, 1995
Status of PPTA petition regarding 2017 fee schedule amounts

• ISSUE: The 2017 CPT codes (97161, 97162, and 97163) replace 97001, and the documentation requirements are more detailed to describe complexity, however, the procedure described (PT evaluation) is not a new procedure and shouldn’t be valued as such.
PPTA has petitioned that § 127.153. (b) should apply

• (b) On and after January 1, 1995, adjustments and modifications by HCFA relating to a change in description or renumbering of any HCPCS code will be incorporated into the basis for determining the amount of payment as frozen in subsection (a) for services rendered under the act.
Bureau contends § 127.153 (c) should apply:

• (c) On and after January 1, 1995, payment rates under the act for *new HCPCS codes* will be based on the rates allowed in the Medicare fee schedule on the effective date of the new codes. These payment rates shall be frozen immediately, and thereafter updated annually by the percentage change in the Statewide average weekly wage.
What’s the difference?

• If the 2016 PA WC Fee schedule value for CPT 97001 was multiplied by the 2016 increase in average weekly wage (1.7%) the 2017 fee schedule amount for CPT codes 97161, 97162, and 97163 would have been: $121.24 (area 1) and $109.60 (areas 2,3,4).

• Using the PA Bureau of Worker’s Comp interpretation (Medicare x 113%) the 2017 amounts for payment are: $98.06 (area 1) and $89.85 (areas 2,3,4).
If you have additional questions regarding the PPTA’s challenge to the PA Bureau of WC, or need information about how to file a Fee Review, please be in touch.
Medical Fee Review notifications

• As of September 22, 2017, notifications for all Medical Fee Review correspondence will be available via email and through your WCAIS* Dashboard.

• *Workers' Compensation Automation and Integration System
§ 127.404. Prospective, concurrent and retrospective review

• The request for UR shall be filed within 30 days of the receipt of the bill and medical report for the treatment at issue.
Evolving network issues
Disclaimer

• The decision to participate or not participate in Workers’ Compensation networks is an internal business decision based on a variety of factors. Today’s presentation will provide information that participants can use in making their own internal business decisions and developing policies related to managing Workers’ Compensation claims. Information in today’s presentation should not be considered legal or practice management advice.
HOMELINK Therapy Network (HTN)
Another new kid on the block?

• HOMELINK Therapy Network (HTN) is a network designed to help partner quality therapy providers with workers’ compensation payers.

• Audience Experience?
Align Network (One Call)

• iPTCA, the Independent Physical Therapists of California, is engaged in against Align Networks, now known as One Call, fighting unfair competition for physical therapists caring for workers’ compensation patients.

• The lawsuit alleges that Align Networks has engaged in illegal payment negotiation tactics, illegal billing practices, and unlawful utilization review and claims administration. The lawsuit asks for declaratory and injunctive relief, which would force One Call to cease any or all of the behaviors found to be illegal during trial.
BQ: Anyone else being asked to include the “supervising PT” signature on One Call claims?

Other issues with One Call?

Audience Experience?
Contract language v.
PA WC language
Network “creep”

• “Whereas, (the network) has entered or will enter into agreements with employers, insurance companies and medical service companies, hereinafter referred to as “Payors” to arrange for the delivery of efficient and cost effective health care services to the Covered Individuals…”

• Know how many entities your contract allow you to be pulled into!
Fee Reviews

**Timeliness of payment** (30 + 6 days mailing)

§ 127.208. Time for payment of medical bills

**Amount of Payment** (WC Fee schedule amount)

What is considered “timeliness” of payment in your network contracts and what recourse do you have?
PPO Networks and PA WC Laws...

“Please be advised neither the Workers’ Compensation Act nor the Department regulations address PPOs. The Fee Review Section cannot address either parties’ obligation under such agreement.”

PA WC Medical Fee Schedule Update (9/15/17)
If the payer refers the claim for UR, does that lengthen the 30 day payment deadline?
Yes, but only for the dates of treatment under dispute
§ 127.208. Time for payment of medical bills

What are your network contract provisions for utilization review?
Prior Authorization to treat?

PA WC law *does not require pre-authorization*

What additional administrative burden does your network require?

PA is a “NO AUTH” state for WC ... check your contracts and challenge the administrative burden of the pre-auth process.
Negotiated rates for volume?

• “Nothing contained herein shall be interpreted to require (the Network) to refer any Covered Individuals to Participating Provider for Covered Services”

• **Under what circumstances will the network direct patients to me? Am I really seeing patients that wouldn’t have otherwise walked through my door?**
Network trends/issues?
Please share your experiences with the PPTA Payment Specialist
PA Motor vehicle

- Peer review/reconsideration... timelines and requirements
- Audit trends
- Audience discussion: payment/denial trends
Are providers still experiencing denial of auto based on review of the physician referral?
What to do if your patient’s auto injury treatment is referred to a PRO for **review of the physician referral... challenge it!**

Initial determination
Peer Review
§ 69.51. Authority

• (b) An insurer shall make a referral to a PRO within 90 days of the insurer’s receipt of sufficient documentation supporting the bill.

• An insurer shall pay bills for care that are not referred to a PRO within 30 days after the insurer receives sufficient documentation supporting the bill.

• If an insurer makes its referral after the 30th day and on or before the 90th day, the provider’s bill for care shall be paid.
Initial Determination... Peer Review?

• “An initial determination shall be effected by a licensed practitioner of like specialty or a licensed practitioner with experience providing and prescribing the care subject to the review.”
Communicating with claims managers
Auto Peer Review

• Civil action suit in the court of Common Pleas in Lebanon County re: Peer Review of physician’s referral

• Cite the legal precedent to the insurance company - Potena PT v. State Farm Auto

• If they ask for the precedent, instruct them to contact Edward McVey at the PID, emcvey@pa.gov
Filing complaints with the Pennsylvania Insurance Department (PID)

• [http://www.insurance.pa.gov/Consumers/File%20a%20Complaint/Pages/default.aspx#.VvMqYivD9ag](http://www.insurance.pa.gov/Consumers/File%20a%20Complaint/Pages/default.aspx#.VvMqYivD9ag)

• Or download a complaint form and mail to:
  Pennsylvania Insurance Department
  1209 Strawberry Square
  Harrisburg, PA 17120
  Toll-free: 1-877-881-6388
  Fax: (717) 787-8585
  TTY/TDD: (717) 783-3898
Not certain how to handle an initial determination that denies your treatment?

Contact the PPTA Payment Specialist
Auto claim "pended" as "under investigation". How long can they do this?
PA Medicaid and Managed Medicaid Programs

• 2017 evaluation/re-evaluation code issue
• Dual eligible QMB
• CHIP provider enrollment requirements
• Audience discussion: payment/denial trends
PA DHS (Department of Human Services) delayed publication of 2017 eval codes

• The PA DHS (Department of Human Services) posted the fee schedule amounts (effective date of 8/7/17) for the 2017 PT evaluation/re-evaluation codes.

• PT Evaluation 97161/97162/97163: $63.61
  • 97001 paid $45.11 1/1/17 through 8/6/17

• PT Re-evaluation 97164: $43.12
  • 97002 paid $17.18 1/1/17 through 8/6/17
Medical Assistance Bulletin 8/7/17
See Resources

• PT and OT **evaluation codes** must be used in combination with the **U8** pricing modifier **if the service is provided to a MA beneficiary who is not in the Early Intervention Program**.

  • 97161 (U8)
  • 97162 (U8)
  • 97163 (U8)
  • 97165 (U8)
  • 97166 (U8)
  • 97167 (U8)
PA Medicaid managed care

• PA DHS statement:

• Exhibit A of the HealthChoices Agreement allows Managed Care Organizations (MCO) to follow their own payment methodology provided it is not more restrictive than the fee-for-service delivery system; it does not exempt the MCO from the HIPAA requirement to bill using the 2017 CPT codes effective January 1, 2017.
•Pursuant to 45 CFR 162.1000, when conducting a transaction, a covered entity must use the applicable medical data code set and nonmedical data code sets.
§162.1000 General requirements.

• When conducting a transaction covered by this part, a covered entity must meet the following requirements:

• (a) Medical data code sets. Use the applicable medical data code sets described in §162.1002 as specified in the implementation specification adopted under this part that are valid at the time the health care is furnished.
Aetna Better Health
Aetna Better Health Kids (6/21/17 notice)

• Updated rates for evaluation codes will be applied retroactively to January 1, 2017.

• “We will go back and reprocess claims that paid at the old default rate.

• Questions? Aetna Provider Relations 1- 866-638-1232

• See 6/21/17 Aetna notice in Resources
BQ: What is known about a new requirement for getting paid for CHIP patients only if you are participating with Medicaid?
CHIP enrollment
• Effective January 1, 2018
  • Department of Human Services (Department) is implementing the Affordable Care Act (ACA) Provider Screening and Enrollment provisions which require all providers who render services to CHIP enrollees to be enrolled with the Department of Human Services.

• This application is for **enrolling in only in the Children's Health Insurance Program (CHIP)**
CHIP enrollment

• Applications for Individuals and Facility/agency (See Resources and Hyperlink file)

• Submit all documentation 60 days in advance of 12/31/17.

• For questions, please call Provider Enrollment at 1-855-537-8862 and select option 3, then option 1, option 1 and option 4.
Providers who:
• Have already enrolled in the PA Medical Assistance program do not need to enroll again.
• Are part of another state’s Medicaid or CHIP program, or who are enrolled in Medicare, must still enroll with the Department.
• Receive this letter from multiple CHIP managed care organizations are only required to enroll once.
• Practice at multiple locations must enroll each location.
Prohibition on Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program

• QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing.

• Medicare providers may not bill people in the QMB program for Medicare deductibles, coinsurance, or copays.

MLN Matters® Number: MM9911

Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System

• Related Change Request (CR) #: CR 9911
• Related CR Release Date: June 28, 2017
• Effective Date: *for claims processed on or after October 2, 2017*
QMB indicator added

• CR 9911 *adds an indicator of QMB status* to Medicare’s claims processing systems.

• This will trigger notifications to providers (through the Provider Remittance Advice) and to beneficiaries (through the Medicare Summary Notice) to reflect that the beneficiary is enrolled in the QMB program and has no Medicare cost-sharing liability.
QMB indicators that reflect the beneficiary’s QMB status:

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

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

• N783 – No co-payment may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
QMB
Claim Adjustment Reason Code 209

• MACs will include a Claim Adjustment Reason Code of 209 (“Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA (Other Adjustment)).
QMB

• State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, states can limit provider payment for Medicare cost-sharing, under certain circumstances.

• Audience experience?
Passed/Pending/Proposed state and federal legislation

- Provider Credentialing
- Locum Tenens
- Retrospective Denial
- Telehealth
- Physical Therapy Licensure Compact
Reminder!
Act 146: Limitation on payback requests (24 months)

http://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2016&sessInd=0&act=146
Approved November 4, 2016
Took effect 60 days later
PA HB 125
Health Care Practitioner Credentialing Act.

An Act providing for the use of certain credentialing applications, for credentialing requirements for health insurers and for protections for enrollees of health insurers; imposing penalties; and conferring powers and imposing duties on the Insurance Department and Department of Health.
HOUSE BILL 345 - PN 334

An Act amending Title 40 (Insurance) of the Pennsylvania Consolidated Statutes, in special provisions related to particular classes of insurers, providing for nondiscrimination by payers in health care benefit plans.
HB 345
02/03/17 Referred to Insurance

• Re-introduced HB 294 of 2015. This legislation will insure that private practitioners and facilities remain “in network” if they are qualified and willing to accept the terms and conditions of the contract. Pennsylvania currently does not have “Any Willing Provider” (AWP) legislation despite multiple attempts.

• Under an AWP law, a health insurer may not refuse to accept as a participating provider any provider in its geographic area who is willing to meet its conditions of participation. The definition of “insurer” includes companies; health maintenance organizations, or HMOs; PPO’s, dental service corporations; and other entities.
HOUSE BILL 1293 - PN 1611

An Act providing for preauthorizations conducted by utilization review entities relating to health care services.
HOUSE BILL 1617 - PN 2139

Diabetes education – professionals
HOUSE BILL 1648 - PN 2207

An Act providing for telemedicine, for insurance coverage of telemedicine services and for Medicaid program reimbursement.
Physical Therapy Licensure Compact

• Qualified PTs and PTAs would be able to choose any or all participating compact states to gain practice privileges, but would only need to maintain licensure in their "home" state. This compact privilege turns on 2 very important points:

• (1) the PT or PTA must comply with each state's practice act when practicing in that state, and

• (2) "practice" is considered to take place wherever the patient or client is located at the time of the encounter—not where the PT or PTA is.
Key elements of the PTLC

1. You must comply with each state's laws.
2. Practice takes place where the patient is.
3. Discipline in any compact state = loss of compact privileges in all non-home states.
4. Nothing can happen until 10 states join the system. UPDATE... we have 10 states!
5. Boards and chapters need to be on the same page, and no editing the legislation.
BQ: Will the changes for the locum tenens policy impact PT’s?
Changes to the Payment Policies for Reciprocal Billing Arrangements and Fee-For-Time Compensation Arrangements (formerly referred to as Locum Tenens Arrangements)


Effective date 6/13/17
Change Request (CR) 10090

- Implements the 21st Century Cures Act (Section 16006).
- **Outpatient** physical therapy services furnished by physical therapists in a Health Professional Shortage Area (HPSA), a Medically Underserved Area (MUA), or in a rural area can be billed under reciprocal billing and fee-for-time compensation arrangements in the same manner as physicians bill effective June 13, 2017.
- HPSA and MUA (Hyperlink Resource File)
Change Request (CR) 10090

• Informal and reciprocal, or
• Involves per diem or other fee-for-time compensation for such services.
• The regular physician generally pays the substitute physician on a per diem or other fee-for-time compensation basis with the substitute physician having the status of an independent contractor, rather than of an employee, of the regular physician.
Requirements applicable to Physician Medical Group or Physical Therapy Group Claims Under Fee-For-Time Compensation Arrangements

Pub 100-04 Claims Processing Manual
Chapter 1 Section 30.2.11 C
Fee for time compensation

• The services **must not be provided by the second physician over a continuous period of more than 60 days** unless the regular physician is called or ordered to active duty as a member of a reserve component of the Armed Forces.
“continuous period of covered visit services”

- A “continuous period of covered visit services” begins with the first day on which the substitute physician or physical therapist provides covered visit services to Medicare Part B patients of the regular physician or physical therapist, and ends with the last day the substitute physician or physical therapist provides services to such patients before the regular physician or physical therapist returns to work.
Fee for time compensation
Q6 Modifier

• MACs will accept claims from Physical Therapists, Provider Specialty 65 –Physical Therapist in Private Practice, for fee-for-time compensation arrangements, when submitted with the Q6 modifier.

• In addition, the physical therapist on whose behalf the services were furnished by a substitute must be identified by his/her NPI in block 24J of the appropriate line item.

• The physical therapy group must enter in item 24d of Form CMS-1500 the HCPCS code modifier Q6 after the procedure code.
Fee for time compensation

• A record of each service provided by the substitute physician or physical therapist must be kept on file along with the substitute physician’s or physical therapist’s NPI.

• This record must be made available to the A/B MACs Part B upon request.
Telehealth

APTA recommendations Re: Proposed Rule

• APTA recommends that CMS establish a pilot or demonstration program to evaluate the clinical benefits of physical therapists, occupational therapists, and speech-language pathologists delivering telehealth services to Medicare beneficiaries.