

Understanding The CPT Code Reimbursement System.

This article is designed to assist therapists in understand how the Part B Medicare system has developed, how payment for each CPT code is established and what the forthcoming 2011 changes will mean to your bottom line.

Annual Changes to the Fee Schedule:

As with many things under Medicare, therapists are regulated by the Rules that apply to different systems than therapy alone. For Part B reimbursement, therapist, by default, are regulated by the guidelines that affect physicians and the services that they provide, as well as through other areas such as supervision. The way that currently therapy services are reimbursed follows the guidelines for physician reimbursement through the **Physician Fee Schedule (PFS)** or the CPT coding system.

The **PFS** is priced on three variables known as Relative Values. These 3 RVs are based on the work that is required to perform this code, this includes the complexity and the knowledge required to perform it, the **Work RV**; the malpractice cost that is associated with the performance of this procedure, the **MP RV**; and the practice expense which takes into account the office space required, the staff involved, the cost of equipment, etc. the **PE RV**.

The next variable that is added to the calculation is known as the **Geographic Practice Cost Indices (GPCIs)**. These are indices that are calculated based on the location of where the provider is working. These **GPCIs** take into account such things as cost of real estate, wages, etc. The National Rate is based on the indices of 1, and each area, either the whole state, or portions of the state, including counties and cities have this calculation published. For example, Florida has 3 areas, Miami –Dade, Ft Lauderdale, and the rest of Florida.

The third factor in the calculation is the **Sustainable Growth Rate (SGR)** which produces the dollar conversion factor each year and that, multiplied by the appropriate indices for your location produces the final payment that the provider will receive for each CPT code.

With that information in mind, let's look at what these new changes mean.

The SGR is a calculation meant to keep the overall growth of the Medicare Program at sustainable level. Its composition has been a concern for many years as it is well believed that it is based on incorrect data. Each year, the conversion factor is reduced, as opposed to increased based on growth rate, etc. This decrease has always been negated for each year through Congressional action. All this does is delay the implementation each year, but has never addressed the underlying flawed cause. Thus each year, the negative component is still calculated and, for 2010, this reduction was intended to be approx a negative 23%.

Congress, once again, did its Band-Aid application and in 2 separate bills, delayed its implementation. However, come December 1st, that delay runs out and providers are once again faced with a 23% reduction over the current schedule. The current conversion factor \$36.8729 is being reduced to \$28.3868 on December 1st, and then another reduction to \$25.5217 will occur on January 1st 2011; thus reducing the current reimbursement levels by approx 25.5%.

Several of the A/B Macs have already started publishing the new rates, but have included that these rates are based on current law and could be ultimately changed by Congress. Again, we may be subject to the wait and see, and wait and see again game that has been typical for the last 4 years.

Therapy Caps:

Starting in 1999 as a result of the Balanced Budget Act of 1997, CMS standardized a capitated system for all providers of Part B therapy services. Prior to 1999, only Physical and Occupational therapist in Private

Practice were subject to a capitated system. All institutional providers were reimbursed on a cost basis. The new system established the new caps at \$1500 per beneficiary per year, PT and SLP sharing one cap, OT having the other. This system was developed with an annual adjustment to the cap levels. The only exception to this being Hospital based Outpatient Clinics, From 2000 until 2006, there was a moratorium to the caps while Congress and CMS considered alternative ways to pay for therapy services. In the mid 2000s, an exception process was devised, to enable beneficiaries with Medical Necessity for services beyond the cap, to still retain access to services other than through the Hospital. The first year established a Manual and Automatic Exception Process, and then the automatic exception became the only mode. Each year, Congress has extended the exception process, through the usual stop gap measures.

This year, the financial limit on the cap has been \$1860 and will be increased to *\$1870 for 2011*. Presently, the exception extension expires December 31st 2010.

As CMS so astutely observed, the reduction in reimbursement for therapy services will actually enable the beneficiary to receive more treatment than before!!!!

Multiple Procedure Payment Reduction (MPPR):

This new and controversial policy will come into effect on January 1st 2011. CMS, as identified in the interim rule in July, believes that providers of services under Part B are being paid more than they should due to the methodology of valuing the CPT codes. CMS estimates that the new policy will effectively reduce payments for outpatient physical therapy services by 7-9% in 2011.

The way that this policy will work is that on any claim submitted by a provider or supplier of therapy services, for that date of service, the contractor will pay in full the CPT code with the highest PE RV and then every other CPT code provided that day will have the PE RV reduced by 25%. This policy is provider specific, not discipline or session specific. This means that for institutional providers that provide more than one discipline per day will have all but the highest PE reduced by 25 %.

So, for example, based on the PE RV published in the Final Rule, a Speech hearing treatment and Speech swallowing treatments have PEs of 0.69 and 0.72 and are the highest PE with the exception of treatment codes wound care 97597 and aquatic therapy 97113. Therefore, if speech is provided on the same day as either PT or OT, then ALL of those codes will be paid at the 25% reduced rate.

What is surprising is that attended e-stimulation 97033 has a PE value of 0.64 which is higher than the most commonly used codes of therex 0.45, manual therapy 0.41, therapeutic activities 0.54 and self care ADLs 0.53.

What it could mean for YOU.

As Congress has just reconvened, we may see in December, CMS issuing the same instructions to its contractors as it did at the beginning of this year. That is to withhold payment for 14 days while it was anticipated that Congress would do what Congress appears to be best at on this subject since 2002, of providing Band Aid fixes. If changes will occur to the MPPR is anyone's guess. This is a very unpopular move and many professional organizations are working to get it changed. So once more, it's a wait and see and prepare for the worst.