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Eli's Rehab Report

Outpatient Outlook: Ride the Waves of the Medicare's Latest Physician Fee Schedule Changes

Good news: Functional status reporting requirements improved from proposed rule.

It's that time of year again: CMS has released its Final 2013 Physician Fee Schedule Rule. As to be expected, the therapy cap exceptions process expires at the end of 2012, along with a 26.5 percent cut to the Medicare sustainable growth rate -- without Congressional action.

Ray of hope: The therapy cap amount for physical therapy and speech combined and the therapy cap for occupational therapy will each increase from $1,880 to $1,900 in 2013. Also, if Congress overrides the SGR cut, "physical therapy services will see an aggregate increase in Medicare payments of 4 percent," reports **Gayle Lee, JD,** senior director of health finance and quality for the American Physical Therapy Association.

Prepare to Report Functional Status

The Middle Class Tax Relief Job Creations Act of 2012 mandated the collection of functional status data for outpatient therapy patients. According to the Final Rule, CMS must collect patients' functional status information via G-codes and modifiers starting Jan 1, 2013.

This is "the biggest issue for rehab in the fee schedule Final Rule for calendar year 2013," says **Jennifer Hitchon, JD, MHA**, counsel and director of regulatory affairs for the American Occupational Therapy Association. You will select a G-code to identify the primary issue therapy is addressing, and one of seven severity modifiers to indicate the complexity of the patient, she explains. (See the Clip 'n' Save for a list of the G-codes and modifiers.)

CMS requires you to report the G-codes and modifiers on the claim form at the initial evaluation, every 10 treatment days, and at discharge. Your patient's functional limitations will not affect the level of your reimbursement; the G-codes and modifiers are for data collection only.

Don't miss: CMS asks providers to begin reporting your patient's functional status and goals starting Jan. 1, 2013, and you have six months to get your duck in a row. After July 1, 2013, Medicare will begin denying payments on these claims.

Proposed Rule Has Come a Long Way, Baby

"A lot of therapists won't be happy about this new reporting burden, but it's definitely much improved from what was proposed," Lee points out. "CMS gave our comments serious consideration and made a lot of positive changes."

Example: In the proposed rule, the frequency of reporting was much higher -- in fact, CMS originally wanted G-codes for every therapy visit, Lee recalls. But the Final Rule trimmed the reporting requirements down to admission, discharge, and every 10 treatment days.

Another change: In the proposed rule, CMS said therapists would choose one assessment tool to determine the patient's severity level and then would have to translate that into a G-code modifier on a 12-point severity scale. "A lot of therapists had problems with that because, often they use more than one tool, in addition to history and other findings -- so using one tool would be very limiting," Lee says. In the Final Rule, therapists are no longer limited to using one tool to determine severity and are also allowed to use other objective findings.

Plus: CMS created specific categories of functional limitations to help organize the G-codes. For example, "one category is walking and moving and another is self-care," Lee explains. "The therapists will pick the predominant category they're

working on, and score the functional limitations in it."

Finally, APTA had suggested that CMS create a G-code category titled "other" in case the patient's functional limitation didn't fit into an existing category. "CMS took that suggestion, too," Lee reports. Wound care would be an example of a functional limitation that doesn't fit into existing G-code categories, where you would use the "other" category, she says.

Speech Gets Special Attention

The speech-language community was concerned with the Proposed Rule because its coding system "didn't really represent the different conditions of speech-language pathology," says **Lisa Satterfield,** director of Health Care Regulatory Advocacy for the American Speech-Language Hearing Association. "ASHA also expressed concern about CMS' originally proposed 12-point severity scale, which doesn't correspond with any scales currently used by SLPs, especially the NOMS system."

Victory: In the Final Rule, CMS included seven of ASHA's functional communication measures to represent speech-language pathology, Satterfield reports. "CMS also adopted a seven-point severity scale, which is also used with the National Outcomes Measurement System (NOMS)."

Physical and occupational therapy advocates also were happy to see the 12-point severity scale be reduced to only seven modifiers, making the scaling process simpler.

Additional benefit: NOMS is also used for speech PQRS reporting, and many SLPs use it for their own outcomes tracking, Satterfield points out. "So CMS adapting their version [of functional status reporting] so that we can continue to use NOMS is going to help our providers significantly."

Meanwhile, ASHA is in the process of reconfiguring NOMS to better correspond with CMS' progress note requirement and to include CMS' new G-codes, Satterfield reports.

Challenges: Reporting projected goals is one requirement that still remains in the Final Rule, even though ASHA was not in favor of this."SLPs often work on several issues at once, and CMS has indicated they only want one issue reported at a time and then the primary goal," Satterfield says. "And at times it is difficult for an SLP to determine what is primary: Is it language comprehension? Cognition? Etc."

This projected goal requirement may also prove confusing for therapy providers other than SLPs, Satterfield says.