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Eli's Rehab Report

Regulations: Final Rule Roundup

Get a breakdown of the key provisions in the final rules that will impact your practice or facility in 2017.

2017 Medicare Physician Fee Schedule

It's official: In 2017, physical therapists and occupational therapists will each have three new CPT® codes to choose from when evaluating patients.

The new codes first appeared in the Proposed Medicare Physician Fee Schedule earlier this year and became official in the final MPFS rule. The new PT codes are:

- 97161, Physical Therapy Evaluation-Low
- 97162, Physical Therapy Evaluation-Moderate
- 97163, Physical Therapy Evaluation-High

Rather than getting paid by the number of minutes they spend with patients or the procedures they perform on patients, PTs will get reimbursement based on complexity and patient progress.

What does this mean for PTs exactly? The good ones who do thorough work with their patients fare well under this rule. Therapists who are just delivering volume care will struggle.

PTs will get a grace period while they learn the new three-tiered coding system, during which reviewers cannot penalize providers on the medical necessity for the new evaluation requirements. CMS wants providers to use this time to get educated and learn how to code under the new system accurately.

"We're very excited about the three-tiered codes. We look forward to being able to show the difference in complexity that PTs treat," says **Roshunda Drummond-Dye** of the **American Physical Therapy Association (APTA).** "We're very encouraged that Medicare is allowing professional societies and associations to have the time to educate members on how to use these codes appropriately."

Cool tool: For tips on using and documenting the new PT codes, go to: www.apta.org/uploadedFiles/APTAorg/Payment/Reform/NewEvalCodesQuickGuide.pdf.

The 10 misvalued codes that were identified in the 2016 physician fee schedule will be revalued and come into play in the 2018 fee schedule. "We'll be working with CMS on that list. We look forward to making sure we work through the AMA process and with CMS directly to give them the best data possible to value those codes," says Drummond-Dye. "It's important to get the basis of payment right so that we'll be ready for new payment models when they arrive."

The Medicare therapy cap has increased from $1960 in 2016 to $1980 in 2017. Finally, the 2017 Medicare conversion factor is $35.88, a $0.05 increase from 2016.

OT's Get New Codes Too

Beginning January 1, 2017, occupational therapists will no longer use CPT® code 97003. Instead, they'll use the following codes:

- 97165, Occupational Therapy Evaluation-Low
- 97166, Occupational Therapy Evaluation-Moderate
- 97167, Occupational Therapy Evaluation-High

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Cool tool: For tips on using and documenting the new OT codes, go to the AOTA at: http://www.aota.org/~/media/Corporate/Files/Advocacy/Federal/Evaluation-Codes-Overview-2016.pdf.

2017 Final Home Health PPS Rule

Released on October 31, the provisions in the final rule for the 2017 Home Health Prospective Payment System (HHPPS) do not differ drastically from the proposed rule published earlier this year.

APTA reports that one of the biggest changes we'll see in 2017 is the $130 million reduction (0.7 percent) cut »»» in Medicare reimbursement to home health, which takes effect in 2017. This cut is less than the $180 million reduction in the proposed rule. The overall cut includes a mix of increases and decreases, such as an increase in payment rate by 2.5 percent, which is being paid for by an $81 reduction in a 60-day episode payment.

Why the cut? To make up for the high overpayments made to home health services dating back to 2000, the Affordable Care Act mandated this reduction. And according to the **Centers for Medicare & Medicaid Services,** the rule helps "move our healthcare system to one that values quality over quantity and focuses on ... achieving better health outcomes, preventing disease, helping patients return home, helping manage and improve chronic diseases ..."

The final rule also states that payments for non-typical services, or "outlier payments," will move from a cost-per-visit system to a cost-per-unit one, where 15 minutes equals one unit. The fix-dollar loss ratio, which is used to calculate outlier payments, will rise to 0.55 to "better reflect the cost of an outlier episode of care," says CMS.

When it comes to quality reporting, CMS has replaced six quality measures with four new ones, eliminating ones that aren't helpful in distinguishing between providers in reporting.

What does all of this mean for rehab therapists? That now more than ever, you need to demonstrate how you are helping to achieve patient outcomes, including keeping patients out of hospitals and skilled nursing facilities, says **Cindy Krafft, PT, MS, HCS-O,** and President of **Kornettie & Krafft Health Care Solutions.** No longer can therapists afford to stay in the "safe zone" of improving patients' functioning. Therapists must step forward and demonstrate how they add value, reduce hospitalizations/SNFs, and preserve patients' independence.

To read the final rule, go to: www.federalregister.gov/documents/2016/11/03/2016-26290/medicare-and-medicaid-programs-cy-2017-home-health-prospective-payment-system-rate-update-home.

Final OPPS Rule for 2017

CMS released the final rule for the Hospital Outpatient Prospective Payment System (OPPS) on November 1, stating that there will be a 1.7 percent increase in OPPS payments. The rule finalizes a provision under Section 603 that off-campus provider-based hospital outpatient departments (HOPDs) that provided services to patients on or after November 2, 2015 will be reimbursed based on the new rates for the Medicare Physician Fee Schedule (MPFS), not the Hospital OPPS. The reimbursement rate for those services will be about 50 percent of the OPPS rate.

Emergency departments, locations where hospital inpatient services are provided, and locations within 250 yards of a remote location of a hospital are exempted from this provision and can still be billed under OPPS.

Another big deal in the final rule is focus on addressing physicians' concerns regarding the use of opioids to manage pain. The rule eliminates patient survey questions about pain management from the CMS patient satisfaction survey.

Providers are currently reimbursed based on how well they demonstrate the value they give to patients, for example, helping them get out of pain. But that can also incentivize physicians to overprescribe medications. Removing these questions is an attempt to discourage physicians from overprescribing.

CMS is accepting comments on this rule through December 31.

To read the final rule, go to: www.federalregister.gov/documents/2016/07/14/2016-16098/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment.

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