Medicare 101

Presented by:

State Advocate for Medicare Policy

Objectives

Upon completion of this session, participants will be able to:

- Name their state representative and know how to contact this person
- Explain the role of the ASHA StAMP
- Outline the structure of the Medicare system and its processes
- Differentiate Medicare inpatient benefits from Medicare outpatient benefits
- Provide general information regarding Medicare documentation requirements
- Provide basic information regarding impending changes to the Medicare program

Arizona StAMP

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What is StAMP?

- State-appointed representative assigned to:
  - Participate in monthly conference calls with ASHA for Medicare updates
  - Serve as a conduit for information and strategy regarding Medicare policy
  - Be a resource to fellow audiologists and speech-language pathologists regarding Medicare policy
  - Be a catalyst to mobilize state membership for effective advocacy
  - Serve state members with up-to-date information to enhance service provision and ensure appropriate reimbursement

State Advocacy Networks StAMPs

Medicare Basics

Defining the Medicare beneficiary

Medicare

- Health insurance program run by U.S. Government
- Provides medical coverage to citizens or permanent residents of the U.S. who worked at least 10 years in Medicare covered employment
- Funded by automatic payroll deductions

50 MEDICARE 1965-2015 MEDICAID ANNIVERSARY

Medicare Benefits

- Medicare Part A Hospital Insurance
  - Automatic benefit
  - No monthly premium (if minimum Medicare employment is met)
- Medicare Part B Supplemental for outpatient services
  - Optional benefit
  - Monthly premium
  - 20% co-pay for services
- Medicare Part C Medicare Advantage
  - Medicare benefits managed by private insurance company
  - Requires enrollment
  - Plans vary by company
- Medicare Part D Prescription Drug benefit

Management and Enrollment

Centers for Medicare & Medicaid Services (CMS)

Social Security Administration

Medicare Administrative Contractors

- Based on geographic location
- Medicare benefits managed at local/regional levels
- Process claims
- Define the Medicare benefit in Local Coverage Determinations
- Conduct medical reviews
- Audit cost reports for skilled nursing facilities

Medicare Eligibility

- Contributed through payroll deduction through
  - Employer
  - Railroad Retirement
  - State Teacher's Retirement System
- Must be age 65
  - Can qualify on spouse's employment if spouse is at least 62 years old
- OR entitled to Social Security disability benefits for at least 24 months
- OR have ALS or permanent kidney failure

Medicare Enrollment

Enroll at local Social Security office or online:
www.socialsecurity.gov/medicare/apply.html

Medicare Inpatient

Post-Acute Care: IRF, SNF, HHA, LTCH

Medicare Inpatient - Part A

- Covers inpatient care in:
  - Acute care hospitals
  - Inpatient rehabilitation facilities
  - Skilled nursing facilities
  - Home health
  - Hospice
- Coverage is tied to an episode of care that starts with an acute inpatient admission
  - Observation status and emergency room visits do not count
  - 3-day hospital admission qualifies for post-acute care services. Less than 3 days does not qualify.
  - Post-acute care may occur up to 30 days from the inpatient discharge
  - A new episode is not counted until 60 days of wellness has passed

Prospective Payment Systems

- Pay on a set daily rate
- Adjustments made on severity of patient condition or intensity of services
- Requires data collection in resident assessment instruments
- Typically do not use procedure codes, though medical record documentation may require for verification of the services provided.

Post-Acute Care Settings

Inpatient Rehabilitation Facilities

- Intensive therapy – 3 hours per day, 5 days per week (any of the 7 days)
- Management by a rehabilitation physician
- Specific diagnoses required (known as the “60% rule”

Skilled Nursing Facilities

- Covers up to 100 days when skilled care is necessary
- Days 1-20 covered in full
- Days 21-100 include patient co-payment
- Must have stayed in approved inpatient admission for 3 days

Post-Acute Care

Home Health

- All services managed by the home health agency
- Physician must certify patient meets "homebound" definition
- May transition from SNF or inpatient stay
- Episodes of 60-days with plan of care managed by the physician

Long-Term Care Hospitals

- Certified acute hospitals
- Patient requires stay of 25 days
- Patents transfer from ICU or CCU
- Often have more than one serious condition

SNF: Minimum Data Set

Skilled Nursing Facilities - The MDS 3.0 (Minimum Data Set)

MDS Assessment	Determines Payment For
5 Day MDS	Day 1 – Day 14 of stay
14 Day MDS	Day 15 – Day 30 of stay
30 Day MDS	Day 31 – Day 60 of stay
60 Day MDS	Day 61 – Day 90 of stay
90 Day MDS	Day 91 – Day 100 of stay

Resource Utilization Groups

Category	Minutes	Disciplines
Ultra high	720 minutes/week	1 discipline for 5 days 1 discipline for 3 days
Very high	500 minutes/week	1 discipline for 5 days
High	325 minutes/week	1 discipline for 5 days
Medium	150 minutes/week	5 distinct days across disciplines
Low	45 minutes/week	3 days combined 2 restorative programs

SNF OMRA & ADL

Other Medicare Required Assessments

- Start of therapy assessment (SOT)
- Change of therapy assessment (COT)
- End of therapy with resumption (EOT-R)
- End of therapy assessment (EOT)

Activities of Daily Living

- Bed mobility
- Transfers
- Ambulation
- Dressing
- Eating
- Toilet use
- Personal hygiene
- Bathing

Medicare Outpatient

Private practice, group practice, university clinics, outpatient services in hospitals and facility settings

Medicare Part B

- Must be selected by patient as supplement to Part A
- Covers diagnostic and therapy services that meet definitions of medical necessity and skilled care
  - Medical necessity for diagnostics (e.g., audiology)
    - Physician orders the test
    - The reason for the test is to determine a diagnosis or treatment of a condition
  - Skilled care
    - Is a level of complexity that requires the professional skills of a licensed provider for safe and effective provision of the service

Part B Billing

Audiology

Medicare Physician Fee Schedule is used for stand-alone practices

- Private practice
- Group practice
- University clinic
- Clinics not associated with hospitals

Outpatient Prospective Payment System (OPPS) is the method for hospitals to bill hospital services

- Bundles several codes into one payment
- Codes are still reported on the claim

Speech-Language Pathology

Services across settings are billed under the Medicare Physician Fee Schedule

- including 90% of hospital services
- there are FEES/radiology codes that are not billed under the fee schedule, but fall within the OPPS

SNF requires Consolidated Billing (billed through SNF Provider Number)

Medicare Physician Fee Schedule

- Annual rules and rates published in November
- Uses Current Procedural Terminology (CPT) codes and pays per-service
  - Criticism: providers are rewarded for the number of services they provide, rather than outcomes or efficiency
- Fee schedule includes
  - Therapy caps
  - Quality and outcome reporting
- Resources

Medicare Benefit Policy Manual, Chapter 15
www.asha.org/Practice/reimbursement/medicare/feeschedule/

Part B Therapy Cap & Exceptions Process

- Set arbitrary limits on therapy services
  - Physical therapy and SLP services are combined
- Congress created "exceptions process" for services above the cap
  - Add –KX modifier to the claim attesting there are medically justified reasons for going over the therapy cap
- Congress later added a mandatory review at $3,700 (PT + SLP)
  - Contractors notify providers with an Additional Documentation Request
  - Reviews are supposed to be targeted
- Amounts are based on 100% of the Medicare Physician Fee Schedule
- All outpatient services regardless of setting

Part B Outcomes and Quality

Functional Reporting – SLPs only

- Requires functional reporting on Part B claims for therapy services
- G-codes and severity modifiers
- Every evaluation
- Every 10th treatment – in line with progress note

www.asha.org/Practice/reimbursement/medicare/Claims-Based-Outcomes-Reporting-for-Medicare-Part-B/

Physician Quality Reporting System – Audiologists and SLPs

- Reporting quality "measures" to avoid future deductions in payment on all Part B claims
- Only practice based, not facilities
- Measures include
  - Did you document medication?
  - Did you assess for pain?
- PQRS is changing in 2017 to Merit-Based Incentive Payment System (MIPS)

www.asha.org/practice/Health-Care-Reform/Physician-Quality-Reporting-System/

Documentation

Orders, Reports, Plans of Care, Skilled Therapy

Skilled Level of Care

- Of a level of complexity that requires a qualified technical or professional health personnel
- Cannot be provided by other caregivers
- Include professional decision making and assessment throughout the evaluation and/or treatment
- Must be documented in the evaluation report, plan of care, and progress notes

Medicare Documentation

Evaluations

- Physician order
- The reason for the test
- Qualified provider
- Justification for each procedure code billed
- Quality/Outcomes reporting

Treatment

- Plan of Care
- Progress Report
- Discharge/Discontinuation Report
- Daily Treatment Notes

Physician Order

- Required for diagnostic services, which includes all audiology services
- Must be obtained before the testing
- Can be received:
  - hand-delivered (e.g., from patient)
  - mail
  - fax
  - electronic mail
  - telephone call
    - If the order is communicated via telephone, both the treating physician/practitioner or his/her office and the testing facility must document the telephone call in their respective copies of the beneficiary's medical record

Plan of Care

- Minimum requirements
  - Diagnoses
  - Long-term treatment goals
  - Type of therapy (discipline)
  - Amount (number of times a day)
  - Frequency (number of days per week)
  - Duration (number of total sessions or weeks)
- Best practice
  - Short-term goals
  - Comprehensive reason for referral
  - Prognosis
  - Specific treatment/therapy
  - History of previous conditions/speech intervention

Plan of Care Certification

- Required for the plan of care to be recognized by Medicare
- May be:
  - Dated signature on plan of care
  - Dated signature on separate document specifying approval of plan of care
  - Verbal order in medical record, with dated signature following within 14 calendar days of verbal order
- Certification by:
  - Physician
  - Clinical Nurse Specialist
  - Physician Assistant
  - Nurse Practitioner
  - Certified Nurse Midwife
- Must be signed within 30 days of first treatment session

Plan of Care Recertification

- Must occur minimally every 90 days from first treatment session
  - States may have every 30 day requirement in state practice acts
- Must be recertified if:
  - Changes in long-term goals
  - New condition develops
  - Permanent change in the frequency, amount or duration of treatment
- Same signature requirements as plan of care

Progress Report

- Required minimally every 10th treatment day and must include:
  - Person performing treatment
  - Assessment of progress
  - Discussion of continued treatment and/or treatment plan revisions
  - Changes in long and/or short term goals
  - Distinction between rehabilitation and maintenance program
  - Part B requires functional outcome/limitation reporting (G-codes)
- Discharge report can serve as the last progress report for the episode of care
  - Content for progress report is required in discharge report
- Progress and discharge reports will be used in medical reviews to determine skilled services were provided and/or necessary

Treatment/Daily Notes

- Date of service
- The procedure(s) performed
- The length each procedure was performed
- The signature and professional identification of the provider of the procedure(s)

Our Medicare

Arizona

Medicare Administrative Contractors

Arizona MAC Information

- Noridian Healthcare Solutions LLC
- https://med.noridianmedicare.com/
- https://med.noridianmedicare.com/web/jfa/provider-types/irf
- https://med.noridianmedicare.com/web/jfa/provider-types/outpatient-therapy
- https://med.noridianmedicare.com/web/jfa/provider-types/snf
- Enter contractors name, contact numbers, webpages

Local Coverage Determinations

- Define the Medicare benefit at the regional level
- Use Current Procedural Terminology (CPT) codes
  - 92507
  - 92557
- Use International Classification of Diseases Codes
  - ICD-9-CM
  - ICD-10-CM
- List of LCDs

Near Future

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)

- Defines post-acute care (PAC) providers
  - SNF
  - IRF
  - LTCH
  - HHA
- Requires PAC providers to report:
  - standardized patient assessment data
  - standardized quality measures
  - resource use measures
- Requires Medicare to
  - modify PAC assessment instruments (not create new ones)
  - allow for comparison across all PAC providers

IMPACT Act Timeline

Table 1: Timeline for New Quality Domains*

Quality Domains	HHAs	SNFs	IRFs	LTCHs
Functional Status	1/1/2019	10/1/2016	10/1/2016	10/1/2018
Skin Integrity	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Medication Reconciliation	1/1/2017	10/1/2018	10/1/2018	10/1/2018
Major Falls	1/1/2019	10/1/2016	10/1/2016	10/1/2016
Patient Preference	1/1/2019	10/1/2018	10/1/2018	10/1/2018

*Displayed dates are deadlines for measure specification and data collection. Confidential feedback reporting and public reporting is required one and two years, respectively, after the dates displayed above.

Merit-Based Incentive Payment Program

- Established into law in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (enacted April, 2015).
- Reimburses providers of Medicare services based on scores for
  - performance on quality measures
  - resource use
  - clinical practice improvement activities
  - use of electronic health records
- Composite scores are compared to providers in the same category/discipline, and ranked on a linear scale to determine increase or decrease in payment
- Providers who participate in Alternative Payment Models receive highest composite scores

When does it apply to us?

- 2017 • Measures/ Registry approved by CMS
- 2019 • Participation required
- 2021 • Payment scale in place +/- 7%

MIPS Quality Measures

Must fall into one of the mandated "Quality Domains"

- Clinical Care
- Safety
- **Care coordination**
- **Patient and caregiver experience**
- Population health and prevention

Measures currently for a discipline must encompass at least 3 of the domains, including resource use.

Measures must include minimally two patient outcome measures.

Requirements for patient-reported/patient experience measures are anticipated in future Medicare rules.

Clinical Practice Improvement Activities

- Defined as activities that will likely result in "improved outcomes"
- Must include
  - Expanded practice access
  - Population health/Participation in QCDR
  - **Care Coordination**
    - **Care team participation**
  - **Beneficiary engagement**
    - **Establishment of Care Plan**
  - Patient safety and practice assessment
  - Participation in Alternative Payment Model

Resource Use

- Utilization numbers
  - How many services were performed per beneficiary?
- Risk adjustment for chronic conditions
- Lower resource use = higher performance score

Electronic Health Records – required in the near future?

Alternative Payment Models

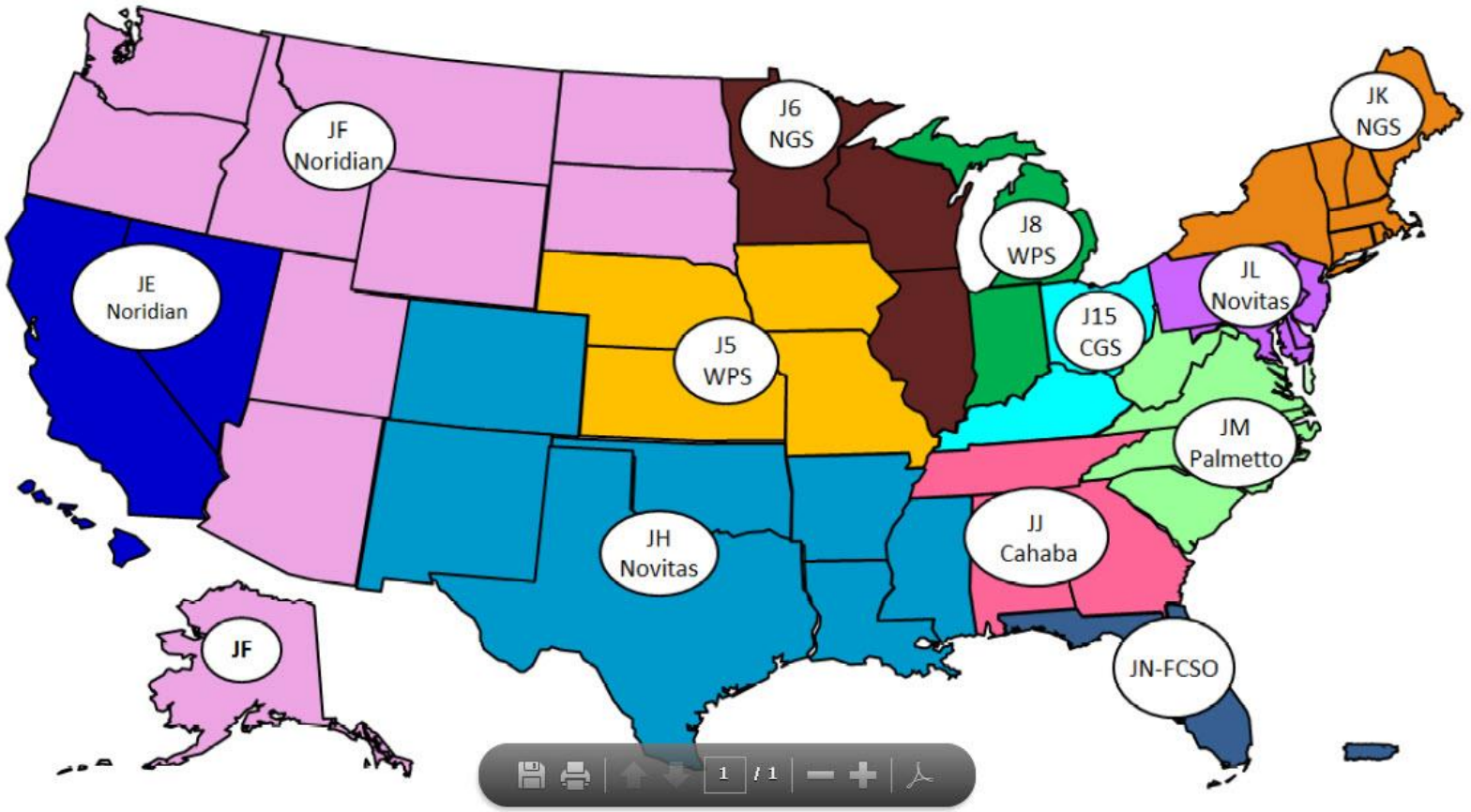
- Accountable Care Organizations (ACOs)
- Patient-Centered Medical Homes (PCMH)
- Episodes of Care
- Bundled Payments

Center for Medicare & Medicaid INNOVATION

What do I need to do?

- Get your NPI
- Enroll in Medicare
- Figure out who your contractor is
- Learn the Medicare rules that apply to your setting
- Seek assistance from ASHA and your StAMP!


PUT YOUR STAMP ON IT!
www.asha.org/Practice/reimbursement/medicare/StAMP/
State Advocacy Networks
Questions?
Contact me!



Interactive State Map to lookup Medicare Contractors and contact information
www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/

Medicare Administrative Contractors (MAC) Jurisdictions for information on state jurisdiction assignments, maps, and tables
www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MACJurisdictions.html

Medicare Basics

StAMP – State Advocate for Medicare Policy

My StAMP is:

Part A:

Part B:

Part C:

Part D:

MAC – Medicare Administrative Contractor

My MAC is:

Medicare Part A

IRF – Inpatient Rehabilitation Facility

SNF – Skilled Nursing Facility

HHA – Home Health Agency

LTCH – Long-Term Care Facility

Medicare Outpatient

MPFS – Medicare Physician Fee Schedule

Therapy Cap Exceptions Process

Outcomes Reporting

Quality Reporting

Documentation

Must show a skilled level of complexity that requires professionals for safe and effective evaluations and/or treatment

Evaluation requirements

Treatment requirements

State Medicare Information

Local Coverage Determinations

Near Future Medicare

IMPACT Act

MIPS – Merit-Based Incentive Payment Program

Alternative Payment Models