



SNF Therapists

**Upcoming Changes
Medicare Part A & B**

www.MonteroTherapyServices.com

Presented by
Dolores Montero, PT, DPT, RAC-CT,
RAC-CTA

Montero Therapy & MDS
Compliance Team

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1

Author / Presenter : Dolores Montero, PT, DPT, RAC-CT, RAC-CTA

Dolores Montero, PT, DPT, RAC-CT, RAC-CTA is President of Montero Therapy Services, a geriatric private practice and consulting firm for long-term care therapy professionals and skilled nursing facilities.

As a Doctor of Physical Therapy with over 30 years in the field of geriatrics, Dr. Montero's experience includes rehabilitation management, program development, education and consultation in the public, governmental and private sector throughout the country. Dr. Montero was recognized by the American Board of Physical Therapy Specialties as a Board Certified Geriatric Clinical Specialist from 1999 through 2019, a designation that less than 2,700 physical therapists hold nationally. Dr. Montero achieved Certified Resident Assessment Coordinator (RAC-CT) status in 2012 and continues to be recognized by the American Association of Nurse Assessment Coordinators (AANAC). In May 2019, Dr. Montero achieved the level of RAC-CTA, designating exceptional knowledge in the SNF RAI /MDS process and area of clinical reimbursement in the SNF setting.

Dr. Montero established www.MonteroTherapyServices.com, an online Membership Website to provide training, education and support to therapy professionals working in long term care, including Rehab Managers, physical therapists, occupational therapists, PT/OT assistants, MDS Nurses and administration. Montero Therapy currently supports members in all states and provides education to therapy professionals with a focus on Rehab Manager Training, MDS Training and compliance.

Dr. Montero is a 30+ year member of the American Physical Therapy Association (APTA) and New York State Physical Therapy Association (NYPTA) and has served in various capacities on the Board of Directors at the District and State levels. In addition to consulting, Dr. Montero presents nationally on topics including rehabilitation management, ethics and reimbursement in the skilled nursing facility setting. Dr. Montero has been featured in recent articles from [GoDaddy](#) and the [New York Physical Therapy Association Member Spotlight](#).

For more information, visit our [Management Team page](#).



2

2

Key Topics for Review

1. **Medicare Part A Updates** from the Final Rule for 10/1/21

- PDPM
- Part A Rates / Wage Index
- ICD-10 Mapping/ MDS
- CMS Quality Measures

2. **Medicare Part B Updates** from the Proposed Rule for 1/1/22

- Rates
- Payment Reduction for PTA/OTA – When to use Modifier
- Virtual Services / Direct Supervision

3. **COVID-19 – Rule Changes – Keeping it all straight!**

- PHE End Date / 1135 Waiver
- Updates



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3

3

Today's Objectives



- Learner will differentiate between Medicare Part A and Medicare Part B Rule changes for the SNF setting
- Learner will identify Med A & MDS changes for 10/1/21 and how they will impact therapy for Part A
- Learner will identify where to obtain updated CMS Quality Measure data and identify QM programs
- Learner will identify when CO/CQ Modifier for Medicare Part B Services is required
- Learner will be able to explain the rule changes due to PHE and identify which rules will expire when the PHE ends

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4



A Word About “The Rules”

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5

SNF Medicare Part A Rules

- **Medicare Part A Skilled Nursing Facility Prospective Payment System (SNF PPS) FY2022 Final Rule** taking effect 10/1/21
- Fiscal Year
- Proposed Rule vs Final Rule
- April & July
- Effective 10/1/21-9/30/22
- [LINK TO RULE](#)



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6

6

SNF Medicare Part B Rules

- **Medicare Part B Physician Fee Schedule (PFS) Proposed Rule**, previewing what will kick in 1/1/22
- Calendar Year
- All settings that bill Medicare Part B using Physician Fee Schedule=SNF Part B
- July & November
- [LINK TO RULE](#)



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7

7

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8

8

SNF PPS Final Rule – Medicare Part A Changes



Chapter 8 of the
Medicare Benefit Policy Manual

The SNF PPS Final Rule addresses changes to 2 main components of Medicare Part A:

1. SNF PPS **payment policy** under the SNF Prospective Payment System
 - Includes PDPM, Payment Rates and MDS Changes
2. SNF **Quality Measures**
 - SNF Value-Based Purchasing Program (VBP)
 - SNF Quality Reporting Program (QRP)

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9

PDPM – Happy 2nd Birthday!



Changes based on how its going....

- Time for CMS Feedback & Tweaking
- Rate Changes
- Policy Changes
- Looking at Outliers

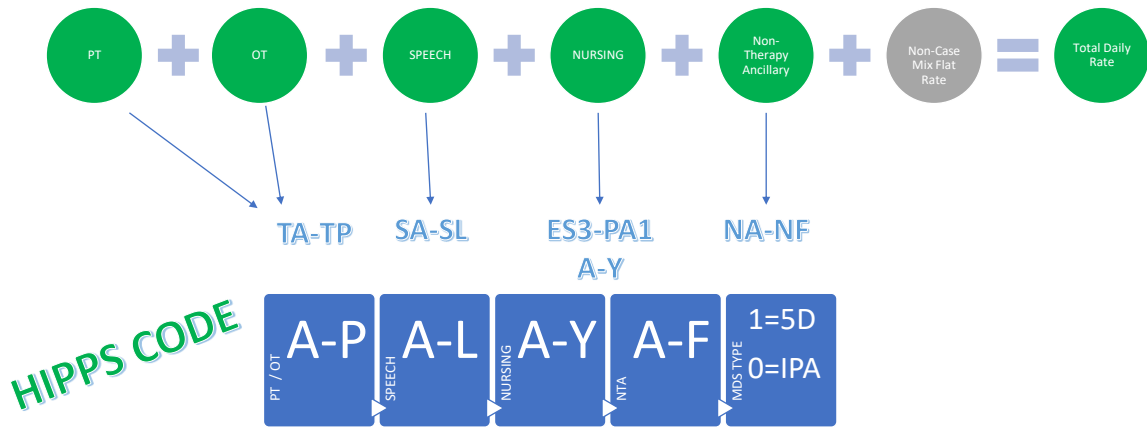
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9

10

How Is PDPM Payment Structured?



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11

11

PDPM – Parity Adjustment 1 Year Delay



- The Proposed Rule included ***“Recalibrating the PDPM Parity Adjustment.”***
 - CMS shared ***therapy data and provider practice patterns*** that knocked PDPM off its’ budget neutral pedestal, by \$1.7 Billion (or 5%), and discussed the necessary “recalibration” {payback} that will be required.
- Proposed Rule identified PT and OT rate decrease average of \$5 per day each, Speech average \$3 decrease per day, and Nursing and NTA \$5-26 and \$3-15 per day decrease per CMG respectively
- **Final Rule: 1 Year Delay**
 - Details in Proposed Rule next Spring

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12

12

PDPM– Why a Parity Adjustment?



TABLE 23: Average Case-Mix Index, Expected and Actual, by Component

| Component | Expected CMI (FY 2019 Estimate) | Actual CMI (FY 2020) | Actual CMI (FY 2020 without DR or COVID) |
|-----------|---------------------------------|----------------------|--|
| | Average CMI | Average CMI | Average CMI |
| PT | 1.53 | 1.50 | 1.52 |
| OT | 1.52 | 1.51 | 1.52 |
| SLP | 1.39 | 1.71 | 1.67 |
| Nursing | 1.43 | 1.67 | 1.62 |
| NTA | 1.14 | 1.20 | 1.21 |

22.6% increase in Speech Case Mix Group scores
 16.8% increase in Nursing Case Mix Group scores
 5.6% increase in NTA Case Mix Group scores

\$1.7 Billion Over Budget

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PDPM – What Did CMS Find?



- CMS has conducted comprehensive data monitoring and analysis to identify trends and changes in provider behavior and payments
- Pre and Post PDPM
- Pre COVID-19 and with COVID-19
- Identified a number of changes that reflect the impacts of implementing PDPM, as well as clear impacts of the COVID-19 PHE.

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14

13

14

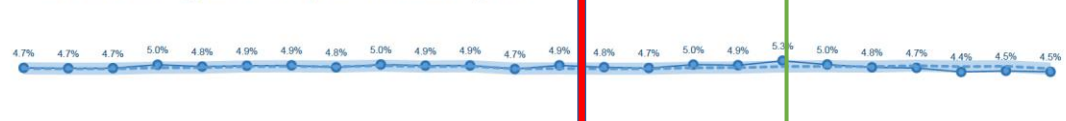
PDPM & PHE – Little Impact

*Source: CMS Presentation by John Kane 4/22/21

– Percentage of stays with Oxygen Therapy



– Percentage of stays with Dialysis



PDPM

PHE

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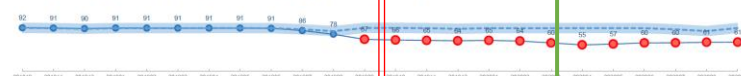
PDPM & PHE – Immediate PDPM Impact

*Source: CMS Presentation by John Kane 4/22/21

– Percentage of Stays with Depression



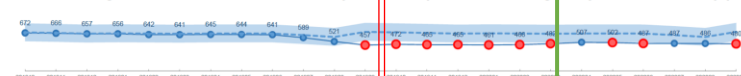
– Average Number of Therapy Minutes Per Day



– Percentage of Stays with Swallowing Disorder



– Average SLP Minutes Per Day for Stays Receiving Any SLP Therapy



PDPM

PHE

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16

15

16

PDPM & PHE – Changes Related to PHE

*Source: CMS Presentation by John Kane 4/22/21

– Percentage of Stays with Infection Isolation



– Percentage of LTC Nursing Home Stays in SNF



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17

17

Immediate PDPM Impact, Then PHE Correction

*Source: CMS Presentation by John Kane 4/22/21

– Percentage of Stays Receiving Any Concurrent Therapy



– Percentage of Stays Receiving Any Group Therapy



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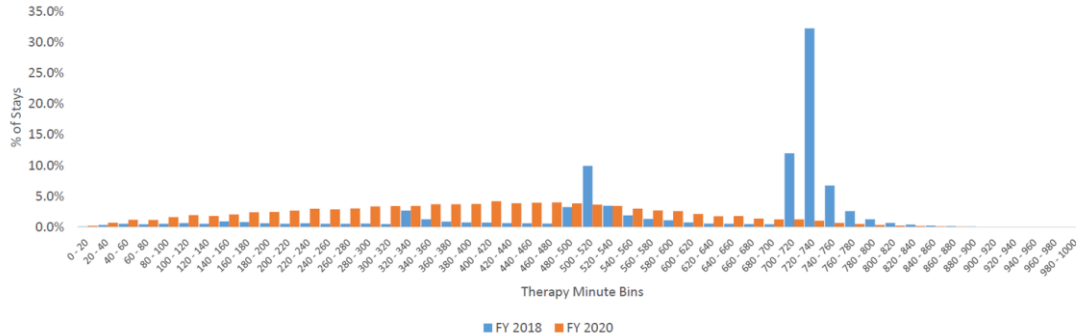
18

18

Change in Therapy Provision Pre-Post PDPM

*Source: CMS Presentation by John Kane 4/22/21

To learn more about the therapy data CMS shared, as well as the PDPM recalibration options from the Proposed Rule, [CLICK HERE](#) to read more.



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19

SNF PPS Payment Rate Update for FY2022

- SNF "raise" 1.2%
- \$410 million more in SNF payments vs 2021 (divided by 15,000.....)
- Was 2.7%, then corrected by -1.5%, .7% adjustments + 1.2 million reduction / shift from A to B for Consolidated Billing change

TABLE 4: FY 2022 Unadjusted Federal Rate Per Diem—URBAN

| Rate Component | PT | OT | SLP | Nursing | NTA | Non-Case-Mix |
|-----------------|---------|---------|---------|----------|---------|--------------|
| Per Diem Amount | \$62.82 | \$58.48 | \$23.45 | \$109.51 | \$82.62 | \$98.07 |

TABLE 5: FY 2022 Unadjusted Federal Rate Per Diem—RURAL

| Rate Component | PT | OT | SLP | Nursing | NTA | Non-Case-Mix |
|-----------------|---------|---------|---------|----------|---------|--------------|
| Per Diem Amount | \$71.61 | \$65.77 | \$29.55 | \$104.63 | \$78.93 | \$99.88 |

Unadjusted for Case Mix

Not yet multiplied by CMI value

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20

20

Federal Rates for FY2022 – Urban and Rural

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TABLE 5: FY 2022 Unadjusted Federal Rate Per Diem—RURAL

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| Per Diem Amount | \$71.61 | \$65.77 | \$29.55 | \$104.63 | \$78.93 | \$99.88 |



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21

21

Wage Index

- Urban vs Rural
- Need to know in order to find rates
- <https://www.monrotherapyservices.com/urban-or-rural-find-your-snf-wage-index>



PDPM Tools and Resources

New Rates October 1st, 2021



PDPM Daily Rate Calculator - FY2022

PDPM CMS ICD-10 Code Mapping Tool - FY2022

PDPM Wage Index Look-Up Tool

PDPM FAQs

PDPM Fact Sheets & Additional Resources

* Indicates Individual & Facility Member Access

* PDPM Daily Rate Calculator for YOUR SNF - FY2022

* PDPM Rates: Case-Mix Adjusted - FY2022

* Function Score Calculator - Therapy and Nursing

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22

22

Nursing Component

Daily Rate ranges from:
\$72.28 to \$444.61 per day
ES3-PA1

\$1.35 per day increase from last year

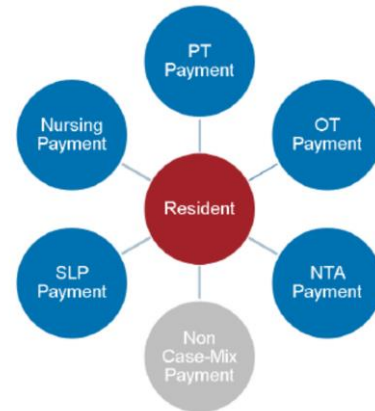


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23

23

Non-Therapy Ancillary Component

\$1.02/day increase
from last year



Points system from 0-12+

Pre-determined list of
diagnosis available
(ie: DM, Obesity, COPD,
Asthma, Skin Issues, etc.)

Daily Rate ranges from:
\$59.49 to \$267.69 per day
NA-NF

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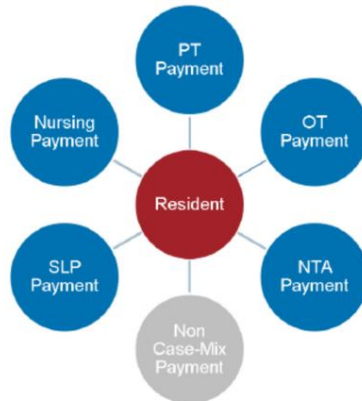
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24

Speech Component

Daily Rate range from
\$15.95 to \$98.72 per day
SA-SL



Dependent on 5 Items:

- 1- ICD-10 Code chosen by SNF to represent the primary reason for skilled care activating Medicare Part A coverage
- 2- Cognition
- 3- "Other" Speech-related comorbidities
- 4- Swallowing Disorder
- 5- Mechanically Altered Diet

TABLE 4: FY 2022 Unadjusted Federal Rate Per Diem—URBAN

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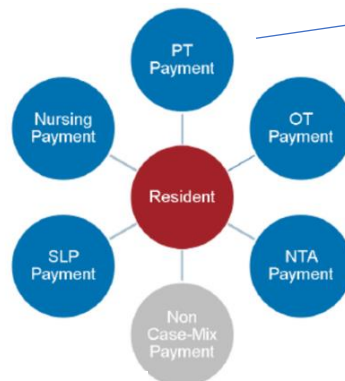
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25

PT and OT Component

Dependent on 2 Items:

- 1- ICD-10 Code chosen by SNF to represent the primary reason for skilled care activating Medicare Part A coverage
- 2- The Therapy Function Score



Daily Rate ranges
from
\$67.85 to \$120.61
per day
TA-TP

\$0.73 - \$0.78/day increase
from last year

Daily Rate ranges
from
\$63.74 to \$98.83
per day
TA-TP

TABLE 4: FY 2022 Unadjusted Federal Rate Per Diem—URBAN

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26

26

PT and OT Component – ICD-10 Mapping Changes

| PDPM Clinical Categories | PT & OT Clinical Categories |
|---|---|
| Major Joint Replacement or Spinal Surgery | Major Joint Replacement or Spinal Surgery |
| Acute Neurologic | Non-Orthopedic Surgery & Acute Neurologic |
| Non-Orthopedic Surgery | |
| Non-Surgical Orthopedic/Musculoskeletal | Other Orthopedic |
| Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery) | |
| Medical Management | Medical Management |
| Cancer | |
| Pulmonary | |
| Cardiovascular & Coagulations | |
| Acute Infections | |

Section I Active Diagnoses

I0020. Indicate the resident's primary medical condition category
Complete only if A0310B = 01 or 02

Enter Code:

Indicate the resident's primary medical condition category that best describes the primary reason for admission

- 01. Stroke
- 02. Non-Traumatic Brain Dysfunction
- 03. Traumatic Brain Dysfunction
- 04. Non-Traumatic Spinal Cord Dysfunction
- 05. Traumatic Spinal Cord Dysfunction
- 06. Progressive Neurological Conditions
- 07. Other Neurological Conditions
- 08. Amputation
- 09. Hip and Knee Replacement
- 10. Fractures and Other Multiple Trauma
- 11. Other Orthopedic Conditions
- 12. Debility Cardiorespiratory Conditions
- 13. Medical Complex Conditions

I0020B. ICD Code

Code entered here will determine Clinical Category for PT / OT, and possibly impact Speech. Must be a code that represents the primary reason for SNF Medicare Part A stay

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27

27

Primary ICD-10 Mapping Changes for 10/1/21

| PDPM Clinical Categories | PT & OT Clinical Categories |
|---|---|
| Major Joint Replacement or Spinal Surgery | Major Joint Replacement or Spinal Surgery |
| Acute Neurologic | Non-Orthopedic Surgery & Acute Neurologic |
| Non-Orthopedic Surgery | |
| Non-Surgical Orthopedic/Musculoskeletal | Other Orthopedic |
| Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery) | |
| Medical Management | Medical Management |
| Cancer | |
| Pulmonary | |
| Cardiovascular & Coagulations | |
| Acute Infections | |

New to Acute Neuro (from RTP):

G93.1 Anoxic Brain Damage
P91.821, 822, 823 Neonatal cerebral infarction

New to Medical Management (from RTP):

K20.81 Other esophagitis with bleeding...
K20.91 Esophagitis unspecified w/bleed...
K21.01 Gastro-esophageal reflux disease w/esophagitis w/bleeding...
U07.0 Vaping related disorder

New to Medical Management (from Other Ortho):

M35.81 Multisystem inflammatory syndrome

All codes that DON'T MAP to 1 of these pillars are "Return to Provider"

New to Return to Provider (was Med Mgt):
D57.42 Sickle-cell thalassemia beta zero...
D57.44 Sickle-cell thalassemia beta plus...

•FY 2022 PDPM ICD-10 Mappings (ZIP)

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28

28

Non-Case Mix Payment – 6th Component

Flat rate per day will be assigned to all residents to cover costs including: Overhead, room, board, laundry, dietary, capital
Daily Rate:
\$98.07
 Increase of \$1.22 per day from last year

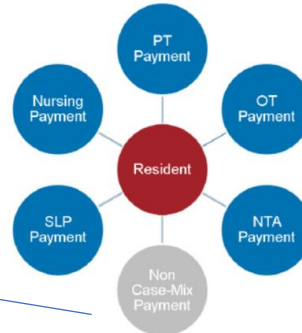


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29

29

Medicare Part A Reimbursement With PDPM

Updated With FY2022 Rates (Urban)

\$ Amount per day
 Potential Daily Range from
 ~\$377.38 to \$1,128.53

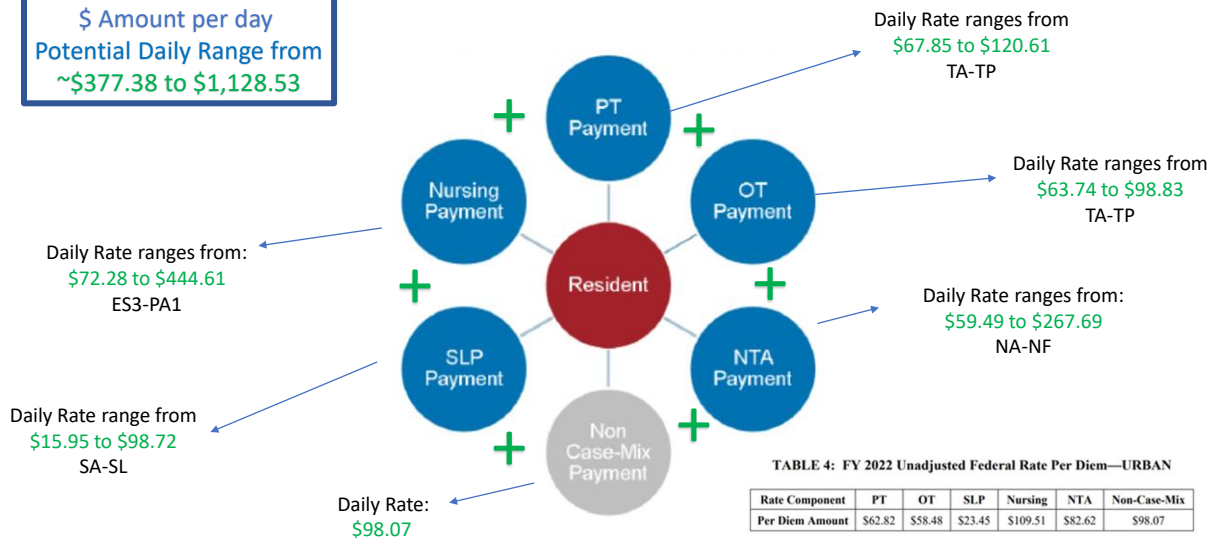


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30

30

Daily Rate for Each Component Based on CMG

TABLE 6: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—URBAN

| PDPM Group | PT CMI | PT Rate | OT CMI | OT Rate | SLP CMI | SLP Rate | Nursing CMG | Nursing CMI | Nursing Rate | NTA CMI | NTA Rate |
|------------|--------|----------|--------|---------|---------|----------|-------------|-------------|--------------|---------|----------|
| A | 1.53 | \$96.11 | 1.49 | \$87.14 | 0.68 | \$15.95 | ES3 | 4.06 | \$444.61 | 3.24 | \$267.69 |
| B | 1.70 | \$106.79 | 1.63 | \$95.32 | 1.82 | \$42.68 | ES2 | 3.07 | \$336.20 | 2.53 | \$209.03 |
| C | 1.88 | \$118.10 | 1.69 | \$98.83 | 2.67 | \$62.61 | ES1 | 2.93 | \$320.86 | 1.84 | \$152.02 |
| D | 1.92 | \$120.61 | 1.53 | \$89.47 | 1.46 | \$34.24 | HDE2 | 2.40 | \$262.82 | 1.33 | \$109.88 |
| E | 1.42 | \$89.20 | 1.41 | \$82.46 | 2.34 | \$54.87 | HDE1 | 1.99 | \$217.92 | 0.96 | \$79.32 |
| F | 1.61 | \$101.14 | 1.60 | \$93.57 | 2.98 | \$69.88 | HBC2 | 2.24 | \$245.30 | 0.72 | \$59.49 |
| G | 1.67 | \$104.91 | 1.64 | \$95.91 | 2.04 | \$47.84 | HBC1 | 1.86 | \$203.69 | - | - |
| H | 1.16 | \$72.87 | 1.15 | \$67.25 | 2.86 | \$67.07 | LDE2 | 2.08 | \$227.78 | - | - |
| I | 1.13 | \$70.99 | 1.18 | \$69.01 | 3.53 | \$82.78 | LDE1 | 1.73 | \$189.45 | - | - |
| J | 1.42 | \$89.20 | 1.45 | \$84.80 | 2.99 | \$70.12 | LBC2 | 1.72 | \$188.36 | - | - |
| K | 1.52 | \$95.49 | 1.54 | \$90.06 | 3.7 | \$86.77 | LBC1 | 1.43 | \$156.60 | - | - |
| L | 1.09 | \$68.47 | 1.11 | \$64.91 | 4.21 | \$98.72 | CDE2 | 1.87 | \$204.78 | - | - |
| M | 1.27 | \$79.78 | 1.30 | \$76.02 | - | - | CDE1 | 1.62 | \$177.41 | - | - |
| N | 1.48 | \$92.97 | 1.50 | \$87.72 | - | - | CBC2 | 1.55 | \$169.74 | - | - |
| O | 1.55 | \$97.37 | 1.55 | \$90.64 | - | - | CA2 | 1.09 | \$119.37 | - | - |
| P | 1.08 | \$67.85 | 1.09 | \$63.74 | - | - | CBC1 | 1.34 | \$146.74 | - | - |
| Q | - | - | - | - | - | - | CA1 | 0.94 | \$102.94 | - | - |
| R | - | - | - | - | - | - | BAB2 | 1.04 | \$113.89 | - | - |
| S | - | - | - | - | - | - | BAB1 | 0.99 | \$108.41 | - | - |
| T | - | - | - | - | - | - | PDE2 | 1.57 | \$171.93 | - | - |
| U | - | - | - | - | - | - | PDE1 | 1.47 | \$160.98 | - | - |
| V | - | - | - | - | - | - | PBC2 | 1.22 | \$133.60 | - | - |
| W | - | - | - | - | - | - | PA2 | 0.71 | \$77.75 | - | - |
| X | - | - | - | - | - | - | PBC1 | 1.13 | \$123.75 | - | - |
| Y | - | - | - | - | - | - | PA1 | 0.66 | \$72.28 | - | - |

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31

31

Daily Rate for Each Component Based on CMG

TABLE 7: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—RURAL

| PDPM Group | PT CMI | PT Rate | OT CMI | OT Rate | SLP CMI | SLP Rate | Nursing CMG | Nursing CMI | Nursing Rate | NTA CMI | NTA Rate |
|------------|--------|----------|--------|----------|---------|----------|-------------|-------------|--------------|---------|----------|
| A | 1.53 | \$109.56 | 1.49 | \$98.00 | 0.68 | \$20.09 | ES3 | 4.06 | \$424.80 | 3.24 | \$255.73 |
| B | 1.70 | \$121.74 | 1.63 | \$107.21 | 1.82 | \$53.78 | ES2 | 3.07 | \$321.21 | 2.53 | \$199.69 |
| C | 1.88 | \$134.63 | 1.69 | \$111.15 | 2.67 | \$78.90 | ES1 | 2.93 | \$306.57 | 1.84 | \$145.23 |
| D | 1.92 | \$137.49 | 1.53 | \$100.63 | 1.46 | \$43.14 | HDE2 | 2.40 | \$251.11 | 1.33 | \$104.98 |
| E | 1.42 | \$101.69 | 1.41 | \$92.74 | 2.34 | \$69.15 | HDE1 | 1.99 | \$208.21 | 0.96 | \$75.77 |
| F | 1.61 | \$115.29 | 1.60 | \$105.23 | 2.98 | \$88.06 | HBC2 | 2.24 | \$234.37 | 0.72 | \$56.83 |
| G | 1.67 | \$119.59 | 1.64 | \$107.86 | 2.04 | \$60.28 | HBC1 | 1.86 | \$194.61 | - | - |
| H | 1.16 | \$83.07 | 1.15 | \$75.64 | 2.86 | \$84.51 | LDE2 | 2.08 | \$217.63 | - | - |
| I | 1.13 | \$80.92 | 1.18 | \$77.61 | 3.53 | \$104.31 | LDE1 | 1.73 | \$181.01 | - | - |
| J | 1.42 | \$101.69 | 1.45 | \$95.37 | 2.99 | \$88.35 | LBC2 | 1.72 | \$179.96 | - | - |
| K | 1.52 | \$108.85 | 1.54 | \$101.29 | 3.7 | \$109.34 | LBC1 | 1.43 | \$149.62 | - | - |
| L | 1.09 | \$78.05 | 1.11 | \$73.00 | 4.21 | \$124.41 | CDE2 | 1.87 | \$195.66 | - | - |
| M | 1.27 | \$90.94 | 1.30 | \$85.50 | - | - | CDE1 | 1.62 | \$169.50 | - | - |
| N | 1.48 | \$105.98 | 1.50 | \$98.66 | - | - | CBC2 | 1.55 | \$162.18 | - | - |
| O | 1.55 | \$111.00 | 1.55 | \$101.94 | - | - | CA2 | 1.09 | \$114.05 | - | - |
| P | 1.08 | \$77.34 | 1.09 | \$71.69 | - | - | CBC1 | 1.34 | \$140.20 | - | - |
| Q | - | - | - | - | - | - | CA1 | 0.94 | \$98.35 | - | - |
| R | - | - | - | - | - | - | BAB2 | 1.04 | \$108.82 | - | - |
| S | - | - | - | - | - | - | BAB1 | 0.99 | \$103.58 | - | - |
| T | - | - | - | - | - | - | PDE2 | 1.57 | \$164.27 | - | - |
| U | - | - | - | - | - | - | PDE1 | 1.47 | \$153.81 | - | - |
| V | - | - | - | - | - | - | PBC2 | 1.22 | \$127.65 | - | - |
| W | - | - | - | - | - | - | PA2 | 0.71 | \$74.29 | - | - |
| X | - | - | - | - | - | - | PBC1 | 1.13 | \$118.23 | - | - |
| Y | - | - | - | - | - | - | PA1 | 0.66 | \$69.06 | - | - |

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32

32

Consolidated Billing Changes

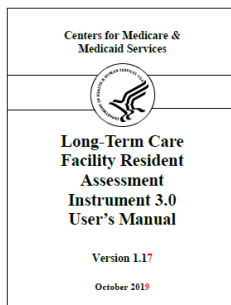
- The Final Rule **established an additional category of excluded codes from consolidated billing** requirements, specific to certain blood clotting factors and services for the treatment of hemophilia and other bleeding disorders.
- The specific items and services are those identified by HCPCS codes J7170, J7175, J7177–J7183, J7185–J7190, J7192–J7195, J7198–J7203, J7205, and J7207–J7211. Based on input received after the Proposed Rule, the Final Rule also added codes J7204, J7212 for blood disorders, and Q5123 for the chemotherapy drug, Riabni.
- These exclusions impact the Part A rates as previously mentioned by shifting the \$1.2 million from Part A to Part B, and as such, adjustments to the Part A rates from the NTA and Nursing Components of PDPM are included.
- The latest list of excluded codes can be found on the SNF Consolidated Billing website at <https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling>

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33

33

MDS Changes



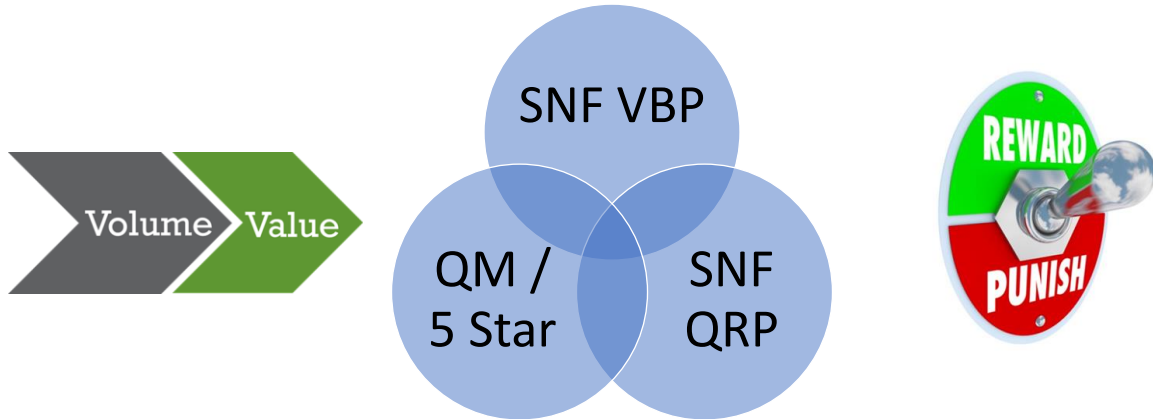
- CMS ODF clarification: No RAI updates 2021-22, no item set changes
- MDS Content Changes
 - Major changes planned for 10/1/20 were postponed (Eliminate G / Add GG to OBRA assessments)
- [MDS-3.0-RAI-Manual-v1.17.1 October 2019](#)
- [Link for item sets - Toolbox](#)

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34

34

CMS Quality Measure Programs



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35

35

“The” Quality Measures

- QM – **Most** are part of 5-Star Quality Rating System and linked to survey
- Nursing Home Compare = Public

1. Health Inspections / Survey
2. Staffing
3. Quality Measures



Important Resources:

<https://www.medicare.gov/care-compare/>

Technical Users Guide (Jan 2021): <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/usersguide.pdf>

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36

36

Value Based Purchasing (SNF VBP) Program

Part A

- Payment incentives based on points and score for Readmissions
- All SNF's will have a 2% reduction in PPS \$ for FY for funding; Incentive...to get as much back as possible
- "SNF 30-Day All-Cause Re-admission Measure (SNFRM) NQF#2510 / "Skilled Nursing Facility Potentially Preventable Re-admissions after Hospital Discharge"



Unplanned Readmissions to Hosp
of Med A Admits/Readmits to SNF

DC From
Hosp and
Admitted
to SNF

30 Day Risk Window

XXXXXX

Day 31 In
The SNF –
In The
Clear

Day 31 At Home If DC
From SNF Prior to
Day 31 – In The Clear

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37

37

Value Based Purchasing (SNF VBP) Program

Part A

- For FY2022 *suppressing the use of SNF readmission measure data* for purposes of *scoring and payment* adjustments in the SNF VBP Program.
- All SNFs participating in the FY 2022 SNF VBP program **will be assigned** a performance score of zero, resulting in identical performance scores and identical incentive payment multipliers.
- The 2% reduction will apply, followed by a 60% return of the 2% (a 1.2% payback).
 - *The other 40% stays with Medicare.*
 - Exception for SNFs with less than 25 eligible stays, allowing these SNFs the full 100% payback.
- CMS will use the following 12 months for reporting FY2022: 4/1/19 to 12/31/19, and 7/1/20 to 9/30/20. (excludes 2Q of PHE)
- Performance scores **will be publicly reported** for the FY 2022 Program year
- Program ranks, achievement scores, and improvement scores **will not be publicly reported.**
- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/SNF-VBP-Page>



Unplanned Readmissions to Hosp
of Med A Admits/Readmits to SNF

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38

38

SNF Quality Reporting Program (SNF QRP)

Part A

- Improving Medicare Post-Acute Care Transformation Act
- This is a **"pay for reporting program,"** and data collection for the multiple measures will continue.
- Facilities will continue to be subject to a **2% Part A payment penalty for "not reporting,"** by submission of Part A MDS's with missing data in select items.... AKA "dashes."
- Multiple sections, including Section GG of PPS MDS, on at least 80% of MDS's submitted to avoid 2% penalty
- Will now be new measure subject to 2%



of MDS w/100% Items Completed



MDS Submitted

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39

39

SNF QRP for FY2021-2022

Part A

TABLE 26: Quality Measures Currently Adopted for the FY 2022 SNF QRP

| Short Name | Measure Name & Data Source |
|---|---|
| Resident Assessment Instrument Minimum Data Set (Assessment-Based) | |
| Pressure Ulcer/Injury | Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury |
| Application of Falls | Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674) |
| Application of Functional Assessment/Care Plan | Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631) |
| Change in Mobility Score | Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) |
| Discharge Mobility Score | Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636) |
| Change in Self-Care Score | Application of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2635) |
| Discharge Self-Care Score | Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635) |
| DRR | Drug Regimen Review Conducted With Follow-Up for Identified Issues-Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) |
| TOH-Provider* | Transfer of Health Information to the Provider Post-Acute Care (PAC) |
| TOH-Patient* | Transfer of Health Information to the Patient Post-Acute Care (PAC) |
| Claims-Based | |
| MSPB SNF | Medicare Spending Per Beneficiary (MSPB)-Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) |
| DTC | Discharge to Community (DTC)-Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) (NQF #3481) |
| PPR | Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) |

*In response to the public health emergency (PHE) for the Coronavirus Disease 2019 (COVID-19), CMS released an Interim Final Rule (85 FR 27595 through 27597) which delayed the compliance date for collection and reporting of the Transfer of Health Information measures for at least two full fiscal years after the end of the PHE.

MDS based-measures:

Jan 2022 Refresh: will see July-Dec 2020, Jan-March 2021
April 2022 Refresh: will see July – Dec 2020, Jan – June 2021

TOH Measures on hold – delayed due to COVID-19 (2 years post PHE)

Change to TOH Info to Patient QM: Excluding residents who dc home with home health or hospice from calculation

Claims-based measures:

Jan 2022 refresh: 6Q of data
Will return to 8Q of data in 2023

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40

40

SNF QRP – 2 New Measures for FY2023

1. SNF Healthcare-Associated Infections Requiring Hospitalization (SNF HAI)

- Outcome measure using *hospital claims* data, principal diagnosis
- This measure would estimate the risk-standardized rate of HAIs that are acquired during SNF care that result in hospitalization (> 4 days in SNF, < 3 days after DC)
- The measure would include multiple infection types (sepsis, UTI, pneumonia) and compare SNFs to their peers.
- Includes risk adjustments and exclusions
- **Publicly reported April 2022: Data from FY2019 claims**
- LINK with all dx codes
 - <https://www.cms.gov/files/document/development-skilled-nursing-facility-snf-healthcare-associated-infections-hais-requiring.pdf>

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41

41

SNF QRP – 2 New Measures for FY2023

2. COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)

- Process measure developed with the Centers for Disease Control and Prevention (CDC) to track % of HCP who receive complete COVID-19 vaccination coverage among healthcare staff in the SNF setting.
- SNFs are required to submit COVID-19 data through the CDC's NHSN National Healthcare Safety Network Long-term Care Facility COVID-19 Module (weekly)
- CMS will use data from 1 week in Oct, Nov and Dec 2021 to represent the reporting next year....QRP Measure requires date for 1 week each month during the quarter...if > 1 week, last week of the month data is used.
- Going forward will use most recent Q of data instead of 4Q for reporting
- Due date of May 16, 2022 *Penalty if not in compliance with data reporting (2% Annual payment update APU) *CMS Clarification pending for calculation criteria
- Public with October 2022 refresh (Q4 2021)
- LINK <https://www.cdc.gov/nhsn/pdfs/nqf/covid-vax-hcpcoverage-508.pdf>

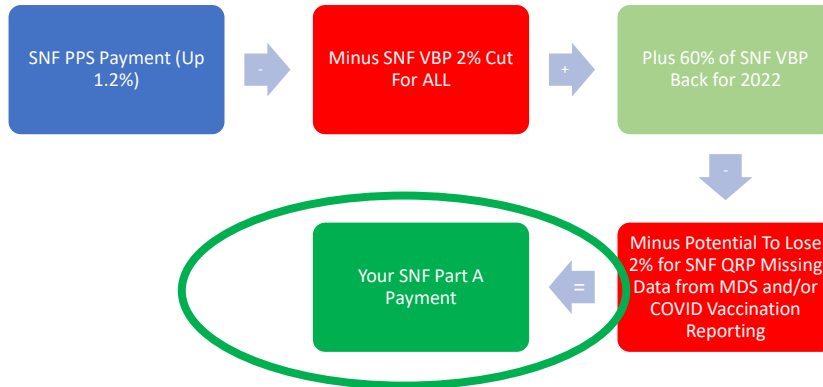
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42

42

SNF Medicare A Payment Maze



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43

43

Key Topics for Review

1. **Medicare Part A Updates** from the Final Rule for 10/1/21

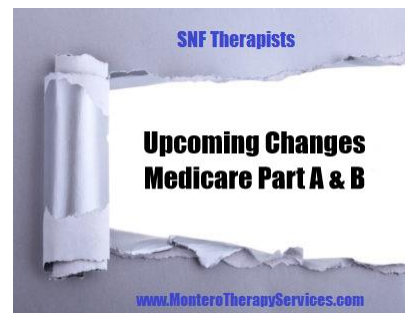
- PDPM
- Part A Rates / Wage Index
- ICD-10 Mapping/ MDS
- CMS Quality Measures

2. **Medicare Part B Updates** from the Proposed Rule for 1/1/22

- Rates
- Payment Reduction for PTA/OTA – When to use Modifier
- Virtual Services Status
- Direct Supervision Rules

3. **COVID-19 – Rule Changes – Keeping it all straight!**

- PHE End Date / 1135 Waiver
- Updates



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44

44

SNF Medicare Part B



- **SNF Physician Fee Schedule (PFS) Proposed Rule: Medicare Part B Changes**
- Medicare Part B Physician Fee Schedule(PFS) proposed changes preview what will kick in 1/1/22, unless changes are made in the Final Rule

[Chapter 15 Medicare Benefit Policy Manual](#)

[Proposed Rule PDF Document](#)

[Physician Fee Schedule CY2022 Files](#)

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45

45

SNF Medicare Part B – CUTS!



- Last year.... Expected 9% cuts due to the **re-valuation** of multiple Current Procedural Terminology (CPT) Codes
- The value of E/M CPT codes increased
 - Balance by reducing **other CPT codes**
- Cuts were decreased from 9% to 3.5% **when Congress intervened** with \$3 billion on December 27, 2020, the Consolidated Appropriations Act modified the CY 2021's Conversion Factor settled to \$34.89
- **CY2022:** Continued cuts [3.75%],....and no word of a monetary intervention from Congress is in sight!

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46

46

SNF Medicare Part B – CF Trend

2020 \$36.09
2021 \$34.89
2022 \$33.58

- The Conversion Factor (CF) is a **value** that CMS modifies yearly. **Part of the formula** that **determines \$ for each CPT code** by converting Relative Value Units (RVU), and impacts all CPT Codes across the board.
- When the CF decreases, the overall payment rate for the CPT codes decrease**, unless the RVU for a specific CPT code is increased significantly.
- In the Proposed Rule**, the OT Evaluation CPT codes 97165-97167 are proposed to have a **technical error correction** which would normally increase reimbursement for these codes slightly

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47

47

2021 Rates: National (Facility)

Visit the Website
Toolbox for all PT, OT,
SLP codes

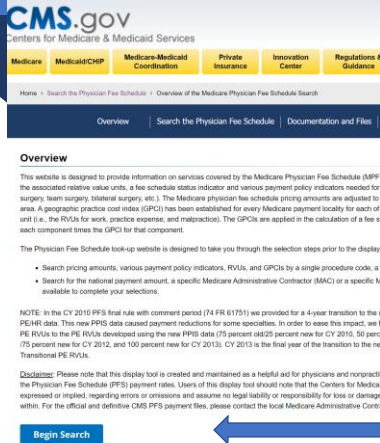
| | | REIMBURSEMENT RATE (NATIONAL) | | | |
|-------------|-------------------------------------|-------------------------------|----------|-------|------|
| CPT CODE | DESCRIPTION | 2020 | 2021 | | 2022 |
| 97161-97163 | PT Evaluation | \$87.70 | \$101.89 | 16.0% | ? |
| 97164 | PT Re-evaluation | \$60.27 | \$69.79 | 15.8% | ? |
| 97165-97167 | OT Evaluation | \$92.75 | \$98.75 | 6.5% | ? |
| 97168 | OT Re-Evaluation | \$64.24 | \$66.65 | 3.8% | ? |
| 97110 | Therapeutic Exercises ▲ | \$31.40 | \$30.36 | -3.3% | ? |
| 97116 | Gait Training ▲ | \$31.04 | \$30.36 | -2.2% | ? |
| 97140 | Manual Therapy ▲ | \$28.87 | \$27.91 | -3.3% | ? |
| 97530 | Therapeutic Activities ▲ | \$40.42 | \$39.43 | -2.5% | ? |
| 97535 | Self Care Management / Trng ▲ | \$35.01 | \$33.85 | -3.3% | ? |
| 97112 | Neuromuscular Reeducation ▲ | \$36.09 | \$35.24 | -2.4% | ? |
| 97150 | Group Therapy | \$18.77 | \$18.14 | -3.4% | ? |
| 97542 | WC Management ▲ | \$33.92 | \$32.80 | -3.3% | ? |
| 97763 | Orth/Pros Management (subsequent) ▲ | \$54.13 | \$55.13 | 2.0% | ? |
| 92610 | Swallow Evaluation | \$74.71 | \$86.54 | 16.0% | ? |
| 92526 | Oral Function Therapy | \$89.50 | \$86.54 | -3.3% | ? |
| 92521 | SPEECH EVALUATION - FLUENCY | \$115.85 | \$136.78 | 18.0% | ? |

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48

48

CMS CPT Code Look-up



- Look up any code:

<https://www.cms.gov/medicare/physician-fee-schedule/search/overview>

- Click Begin Search, then click “Agree” on the CPT Code Copyright Screen

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49

49

The Time Has Come.... Payment Reduction for Assistant Services

- **2 years in the making**
- **Services on or after 1/1/22 provided “in whole or in part” by an Assistant will have a *payment reduction of 15% applied – Payment Modifier CQ or CO***
- Now: Medicare pays at 80% of the “allowed charge” (actual charge or fee schedule \$ - lesser). Remaining 20% is resident copayment.
- 1/1/22: Still 80/20 split....Payment @ 85% of 80%. 20% resident copayment.



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50

Modifier Details – Many Changes

- 2 Years of practice and feedback. CMS accepted input from APTA/AOTA/ASHA
 - Documentation, when modifier needed, calculations, etc
 - “Final Unit” “2 Remaining Units” “Midpoint Rule” “Tie-breaker Rule”
- Awaiting Final Rule in November – **CMS Website examples not updated since 3/3/21 – “incorrect” billing examples....don’t use for training!**
- Change in **therapy scheduling of treatments for timed and untimed codes (group)**
- Change in **documentation...will need to allow reviewer** to determine if modifier is necessary.... Assistant time vs Therapist time... for each CPT

Full Course with Modifier Scenarios

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51

51

How Does CMS Define When Modifiers Are Needed?

“In whole” as provision of the full service by an assistant

- ie: The assistant provided the full treatment for the day. No part of the treatment was split with the therapist.

“In part” as provision of **more than 10% of a “therapy service”** by an assistant [*de minimis*]

- ie: The assistant shared the treatment day with the therapist, assistant provided >10% of a “service”



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52

52

More Than 10% of a “Therapy Service?”

“Therapy service” does not mean “the day”

Understand how therapy is billed on the SNF claim

Each “procedure” is identified line by line to include CPT codes, units and modifiers.

“Therapy service”
procedure identified by a HCPCS code {CPT Code}

The new modifiers would be added specifically to the procedure line item to show an assistant provided treatment that met the de minimis standard.

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53

53

How We Currently “Code”

- First:** Determine Total Treatment Time
- (Timed vs Untimed codes)
- Second:** Determine How Many Units Can Be Billed
- Determine How to allocate the units to be billed in CPT's
- 8-22 minutes = 1 unit
23-37 = 2 units
38-52 = 3 units
53-67 = 4 units
Flat Rate = Always 1 unit

- Third:** Document to support coding

45 Minute Group Treatment
Flat Rate / Untimed = 1 Unit

Tx consisted of:

45 minutes of 97150 for each resident in group
15 minutes provided by Assistant
30 minutes provided by Therapist

46 Minute Individual Treatment – Direct Contact Time
Timed Codes = 3 Units

Tx consisted of:

12 minutes of 97110 (Therapist)
14 minutes of 97110 (Assistant)
20 minutes of 97116 (Therapist)

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54

54

How Billing for Untimed Codes Will Change

First: Determine Total Treatment Time
• (Timed vs Untimed codes)

Second: Determine How Many Units Can Be Billed

- Determine How to allocate the units to be billed in CPT's

8-22 minutes = 1 unit

23-37 = 2 units

38-52 = 3 units

53-67 = 4 units

Flat Rate = 1 unit

45 Minute Group Treatment

Flat Rate / Untimed = 1 Unit

Tx consisted of:

45 minutes of 97150 for each resident in group

15 minutes provided by Assistant

30 minutes provided by Therapist



Modifier needed when Assistant > 10% of service

Assistant + Therapist divided by 10, round up, add 1 = # of minutes
(15+30) / 10 = 4.5 rounded to 5 +1 = 6 minutes or more for modifier

Or

Assistant divided by Therapist + Assistant x 100 = %

15 / (30 + 15) = .33 x 100 = 33% Greater than 10% need modifier

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55

55

How Billing for Timed Codes Will Change

de minimis standard applied to each 15 minute unit or "service" (vs total)

46 minute treatment – direct contact time

Allows for 3 units

Tx consisted of:

12 minutes of 97110 (Therapist)

14 minutes of 97110 (Assistant)

20 minutes of 97116 (Therapist)

If Therapist performed full tx = no changes = no modifier

If Assistant performed full tx = Need Modifier on all codes

**If Therapist and Assistant split the tx= Need to determine which codes need modifier
Based on rule set provided by CMS**

Modifier when Assistant > 10% of service

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56

56

Modifier Example – Based on July Proposed Rule

46 minute treatment – direct contact time

Allows for 3 units

Tx consisted of:

12 minutes of 97110 (Therapist)

1 unit 97110 – NO modifier

14 minutes of 97110 (Assistant)

1 unit 97110 – YES modifier

20 minutes of 97116 (Therapist)

1 unit 97116 – NO modifier

First, look for 15+ minutes and assign unit (determine if any excess of 15) = NOT 8+

Next, look at remaining codes/minutes & leftover minutes to distribute units. How many units left to bill?

*Did Therapist/Assistant **split time** with any codes?

Rules when Therapist/Assistant separately provides minutes of **same code**

If 1 unit left to bill, therapist > 8 = no modifier; If therapist and assistant < 8 = modifier

If 2 units left to bill (23-28 minutes) and each 9-14 minutes, bill 1 with and 1 without modifier

Rules when Therapist/Assistant provide minutes to **different codes (for remaining minutes)**

If remaining assistant min > therapist = modifier

If Therapist and Assistant minutes are the same, “tie-breaker” – You decide

“Midpoint Rule” If 1 unit left to bill, therapist > 8 minutes for any code, no modifier, even if assistant > 8

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57

57

Therapy Threshold, KX Modifier and Manual Reviews

- No Therapy Cap: Rule retained the cap amounts as thresholds
 - CY 2021 \$2110 for PT/SLP combined; \$2110 for OT
 - CY 2022 will be in final rule (~\$30)
- KX Modifier: Required on claims when services exceed threshold amount. Next to each line item of service.
 - KX Meaning: “Attestation that services are medically necessary, and that supportive justification is documented in the record” this means extra documentation!
- Manual Medical Reviews:
 - \$3000 through 2028 for PT/SLP and OT
 - “Targeted” review process

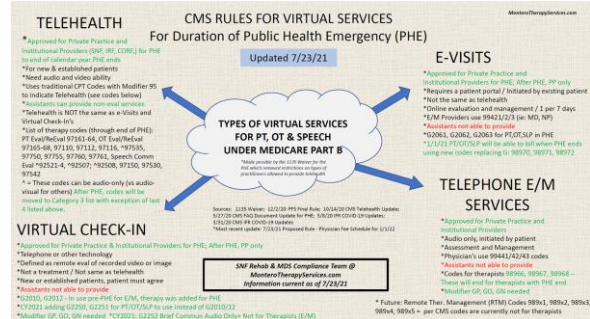
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58

58

Virtual Services: Telehealth, E-Visits, Virtual Check In, Telephone Services

- **Therapists were not able to provide telehealth services** prior to the PHE. Only able to provide now **through waiver authority**.
- **When the PHE ends, all temporary rules, including allowing therapy professionals to provide telehealth, will end.**
- Some “therapy” codes that remain in effect through the end of 2023, therapists can’t provide and bill Medicare for these services
- There is current legislation, the **Expanded Telehealth Access Act [H.R. 2168]**, in the works now to try to make PT/OT/SLP approved providers of telehealth by permanently adopting the policy that is temporarily in place due to the Public Health Emergency (PHE).
 - Likely apply to private practice, not SNF or institutional providers



Print from Toolbox

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59

List of Acceptable Telehealth CPT Codes

- CMS provided the **updated list of Telehealth CPT Codes for the PHE duration on 7/19/21**. You can download the list here:
- [List of Acceptable Telehealth CPT Codes for PHE Duration](#)
- The Proposed Rule also discusses CPT code G2252 (introduced in 2021 for non-therapy providers), and a new set of Remote Therapy Management (RTM) codes (989x1, 989x2, 989x3, 989x4, 989x5) that **at this point, will not be for therapists to utilize**.
- CMS is seeking feedback on these RTM codes for possible classification that would allow therapy providers to use them in the future.
- SNF vs Private Practice

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60

Direct Supervision by Interactive Telecommunications Technology

- **PHE temporary rule:** Medicare rule around supervision has been modified to include **providing direct supervision** via audio-visual technology through 12/31/2021. The Proposed Rule discussed the possibility of making this permanent policy, thus removing the need for direct supervision for Medicare reimbursement.
- **Does not impact the SNF setting** as Medicare Part A and Part B in the SNF currently require **“general supervision,”** meaning a therapist does not need to be in the room or on site in order for an assistant to provide services. Medicare Part B supervision rules for Private Practice only
- **Do not confuse this rule with your State Practice Act** requirements for supervision. This is only a **Medicare payment regulation** based on **Medicare’s definition of Direct Supervision**. Therapy professionals must abide by their discipline State Practice Act which may require on-site supervision and would supersede the Medicare rule.

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61

61

Key Topics for Review

1. **Medicare Part A Updates** from the Final Rule for 10/1/21
 - PDPM
 - Part A Rates / Wage Index
 - ICD-10 Mapping/ MDS
 - CMS Quality Measures
2. **Medicare Part B Updates** from the Proposed Rule for 1/1/22
 - Rates
 - Payment Reduction for PTA/OTA – When to use Modifier
 - Virtual Services / Direct Supervision
3. **COVID-19 – Rule Changes – Keeping it all straight!**
 - PHE End Date / 1135 Waiver
 - Updates



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62

62

COVID-19 Rule Status

- PHE extended on July 19th for 90 more days
- 60-day notice to states
- 1135 Waiver: Has been added to since start of PHE and some portions have ended
- Most recent CMS update to Waiver 9/8/21, focusing on QHS and BPW

Document History

| Date of Change | Description |
|-------------------|---|
| September 8, 2021 | We revised this Article to add more information about the SNF waivers. You'll find substantive content updates in dark red font on page 13. All other information remains the same. |

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63

1135 Waiver – 2 Pieces to SNF Part A

1. **Qualifying Hospital Stay** – waiver of the 3 midnight stay for “all” affected by emergency
 - “When disruptions arising from a PHE affect coverage under the SNF benefit and prevent a patient from having the 3-day inpatient QHS...”
 - DR on claim
2. **Benefit Period Waiver** – waiver of ability to get 60 days of wellness to gain new benefit period
 - Not “all” affected; Specific criteria; Requires DOCUMENTATION to SUPPORT
 - “PHE disrupts the process of ending the patient’s current benefit period and renewing their benefits”
 - Need DR, COVID100 and Manually reviewed

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64

1135 Waiver – 2 Pieces to SNF Part A

- <https://www.cms.gov/files/document/se20011.pdf> Updates 9/8/21 in red
- The emergency SNF QHS and benefit period requirements under Section 1812(f) of the Social Security Act help restore SNF coverage that patients affected by the emergency would be entitled to under normal circumstances. **By contrast, these emergency measures don't waive or change any other existing requirements for SNF coverage under Part A such as the SNF level of care criteria, which remain in effect under the emergency.**
- Using the authority under Section 1812(f) of the Social Security Act, CMS doesn't require a 3- day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services (including SNF-level swing-bed services in rural hospitals and CAHs) without a QHS, for those people who experience dislocations, or are otherwise affected by COVID-19. **At the same time, we're monitoring for any SNF admissions under Section 1812(f) that don't meet the SNF level of care criteria (which, as noted above, remain in effect during the emergency), and we'll take appropriate administrative action in any instances that we find. See SNF Billing Reference for more information on SNF eligibility and coverage requirements.**
- Also, for certain patients who recently exhausted their SNF benefits, the waiver authorizes a **one-time renewal** of benefits for an added 100 days of Part A SNF coverage without first having to start a new benefit period (this waiver will apply only for those patients who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).

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65

65

COVID-19 Rule Status

| Rule Category | Rule in place for PHE | Rule will end when PHE expires | Rule will remain after PHE expires |
|--|---|---|---|
| 1135 Waiver Qualifying Stay (3 night) Waived | Yes | Yes | No |
| 1135 Waiver 60 Day Benefit Period Waived | Yes *Document to justify* | Yes | No |
| Virtual Services FOR PT, OT and SPEECH | Yes | Partial | Partial |
| 1- Part B Telehealth for Therapy: (Audio-Visual; Modifier 95; Cannot be provided by Assistants; Can only use certain CPT codes: PT/OT Eval/Reeval, 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, Speech Com Evals, 92507, 92508, 97150 97530, 97542) | Yes for PP and Institutional Providers. | Yes. Will end for all therapists in all settings. | No. Would need congress to approve therapists as providers |
| 2- Part B Virtual Check-Ins and E-Visits for Therapy: (Remote eval of recorded video or image, not a treatment; Assistants unable to provide; G2250, G2251 for PT/OT/SLP with modifier GP,GO,GN; Evisits – through patient portal) | Yes for PP and Institutional Providers | Yes for Institutional Providers. Will remain for PP | Will remain for PP only. |
| 3- Telephone E/M Visits for Therapy: (Audio only; Assistants unable to provide; Therapist codes 98966, 98967, 98968) | Yes for PP and Institutional Providers | Yes for Institutional Providers. Will remain for PP | Will remain for PP only. |
| Direct Supervision of Assistants/Students via A-V Technology | Yes | *Pending | *Potential for removing direct supervision for Medicare reimbursement |

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66

66

Questions? Comments?

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67

67

Thank You for All You Do!!



This information for this presentation was current at the time it was presented. Source documents are provided. Due to the frequent change in Medicare policy, participants should verify policy change at the time of material application.



This presentation was prepared to provide general information on the subject material. Participants are encouraged to further review the specific statutes, regulations and other materials for a full understanding of how to utilize this information in practice.




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68

68



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69