



April Marks Sequestration Implementation and MPPR Increase

by Susan Feeney, Senior Director of Communications and Policy

As we reported in the last edition of The Monitor, April 1, 2013 will bring with it the application of the 2% Medicare Sequester and the increase of the Multiple Payment Procedure Reduction (MPPR) percentage to 50% on the Practice Expense (PE) component of subsequent CPT codes for outpatient therapies.

But what does it all mean?

2% Medicare Sequester

As sequestration applies to all Medicare Fee for Service providers, it will impact reimbursement for Medicare Parts A and B covered therapy services. All Medicare claims with dates of service on or after April 1, 2013 will have a 2% payment reduction applied to the Medicare reimbursed portion of the claim. For sites of service paid according to discharge as opposed to per diem rates, will see the 2% reduction applied to discharges on or after April 1. The reduction occurs after any copays, deductibles and any other contractual adjustments are made.

While the sequester will reduce Medicare reimbursements through the end of this fiscal year – September 31, 2013 – it will not reduce rates. This means that any updates to Medicare reimbursement rates for next year will be based on current rates.

50% MPPR on Outpatient Therapies

As we reported previously, the *American Taxpayer Relief Act of 2012* increased the MPPR reduction of the Practice Expense component to 50% for all outpatient therapy regardless of setting. This provision will go into effect on April 1, 2013.

While the sequester and the changes to the MPPR are a concern to Medicare providers and therapists, at RehabCare our goal is to guarantee patients' access to medically necessary therapy services so that we may deliver on our goal of hope, healing and recovery. By closely following the regulatory and legislative updates, we are able to navigate the changes and ensure a smooth transition to the new policies for our patients and customers alike.



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New CMS Guidance on Medical Manual Review (MMR) for Therapy Claims Above \$3,700

On March 21, CMS issued new guidance regarding the Medical Manual Review process for outpatient therapy claims above the \$3,700 cap established in 2012.

Beginning on April 1, 2013, the review process will change with a prepayment review "demonstration" in 11 states and claims in all other states subject to an immediate post-payment review conducted by Recovery Auditors. The 11 states in the Recovery Audit Prepayment Review Demonstration are Florida, California, Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina and Missouri. Previously all claims meeting the \$3,700 threshold had been subject to the prepayment review.

Under the new guidance, in both the prepayment and post-payment

reviews, the Medicare Audit Contractors (MACs) will send the additional document requests (ADRs) to the provider and ask that the necessary information be sent to the Recovery Auditors, who will conduct the review and notify the MAC of the payment decision. In a change of policy, **only the prepayment reviews must be conducted within 10-days of receiving the additional documentation.**

We believe that CMS' revised guidance is a result of significant commentary and feedback from the therapy community – including RehabCare. While the new guidance is not perfect, it is a step in the right direction and an indication that CMS is receptive to input from the provider community.

MedPAC Delivers Annual Report To Congress

In Mid-March, the Medicare Payment Advisory Commission (MedPAC) delivered its annual report to Congress on Medicare Payment Policy, and provided testimony before the House Ways and Means

Health subcommittee. The report includes recommendations for FY 2014 payment updates and reforms to the reimbursement systems for Medicare providers including inpatient hospitals, inpatient



MedPAC Delivers Annual Report To Congress *(continued)*



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rehabilitation facilities (IRF), skilled nursing facilities (SNF) and home health agencies among others.

The Commission is statutorily required to make the annual report to Congress, and its recommendations are considered as Congress legislates changes to the Medicare system, however MedPAC has no authority to make any changes to Medicare.

In regard to therapy, three subject areas are of particular interest to RehabCare: SNFs, IRFs, and "moving forward from the sustainable growth rate (SGR) system"

Skilled Nursing Facilities

Once again, MedPAC recommended no payment update factor for SNF 2014 Medicare payment rates. The Commission also reiterated last year's recommendations to revise the Prospective Payment System (PPS) to base payments for rehabilitative therapy services on patient care needs (not service provision), more accurately pay for nontherapy ancillary (NTA) services, and to rebase the entire system beginning with a 4% reduction in Medicare payments in 2014 "and subsequent reductions over an appropriate transition until Medicare's payments are better aligned with providers' costs." The Commission did comment that any of these changes would require Congressional action.

Of note within the report was that in recognizing providers' ability to

navigate the changes in therapy policy made over the course of the past several years. MedPAC specifically recognized RehabCare's improved efficiency of therapists through the use of hand held devices.

Inpatient Rehabilitation Facilities

As with many of the other Medicare providers, MedPAC recommended no payment update for IRFs in 2014. It based this recommendation on the facts that beneficiary access to IRF care remains stable, quality of care across the industry remained relatively stable, providers retain good access to capital and that "in 2011, Medicare payments per case to IRFs grew faster than costs per case." The report also recognized that the IRF industry – both freestanding and hospital based units – continued to maintain compliance with the 60% threshold in 2012.

Moving forward from the sustainable growth rate (SGR) system

In the Appendix to the MedPAC report, they reproduced their October 2011 letter to Congress which details the recommendation to repeal the sustainable growth rate system. The flaws in the SGR – the formulaic payment method for physicians and other health professionals including therapists – have led to the annual need for Congress to legislate a 'doc fix'. The Commission

MedPAC Delivers Annual Report To Congress (continued)

highlights the Congressional Budget Office's (CBO) recent reduction in the estimated cost to permanently fix the SGR as the rationale for Congress to take action now.

We expect that the June MedPAC report to Congress that addresses Medicare and the Health Care Delivery System will include the congressionally-mandated report on

reforming Part B Outpatient Therapy Services.

Proposals to Eliminate the Sustainable Growth Rate (SGR) Formula

As we indicate above, recently the Congressional Budget Office revised the cost to eliminate the troublesome SGR system and create a permanent 'doc fix' – down to \$138 billion over ten years (down from \$245 billion). Members of Congress have responded favorably to this change in scoring with the introduction of bipartisan legislation by Representatives Allyson Schwartz (D-PA) and Joe Heck (R-NV) entitled the *Medicare Physician Payment Innovation Act of 2013*. Additionally, the two House Committees of jurisdiction –

House Ways & Means and Energy & Commerce Committees – have announced that they, too, are working on a framework for a permanent repeal of SGR.

Efforts to repeal the SGR are of importance to therapy for two critical reasons; first because Medicare Part B reimbursement rates for therapists are determined by the Physician Fee Schedule, and second because any efforts to repeal the SGR would likely be funding – all or in part – by reductions in payments to other providers. In the past such

proposals have included increasing the IRF threshold to 75%, reducing Medicare rates for skilled nursing and rehabilitative care, as well as other Medicare cuts.

The RehabCare government relations team will use the opportunity to continue to advocate to protect critical Medicare funding, preserve the 60 percent rule, and promote common sense measures that preserve appropriate access to rehabilitative care across the continuum.

About RehabCare

RehabCare is the leading provider of rehabilitation services, including physical, occupational and speech-language therapies, to over 2,000 hospitals and long-term care facilities in 46 states. We are the premier provider of rehab throughout the full continuum of care, including long-

term acute care hospitals, nursing and rehabilitation centers, inpatient acute rehab units, independent rehabilitation facilities and hospice and home care locations.

Because RehabCare therapists treat patients throughout acute and post-acute settings, they are able to facilitate effective care coordination, management of patient episodes,

as well as understand and comply with myriad regulations targeting rehabilitative care and services. Our vast network enables you to access best practices and geographic market knowledge that will take your care center to the next level.



Have **Questions?**
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