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Outpatient Therapy Faces Payment Cuts in 2021, Audits Are Underway

By Nina Youngstrom

In a double whammy, outpatient therapy providers are facing a 10% payment cut next year and audits by Medicare administrative contractors (MACs) have resumed even though Targeted Probe and Educate (TPE) is on hold because of the COVID-19 public health emergency (PHE). But there's good news on the telehealth front for physical therapists (PTs), occupational therapists (OTs) and speech language pathologists (SLPs), at least in the short term.

The 2021 Medicare Physician Fee Schedule (MPFS) rule[1] revalued evaluation and management (E/M) and other codes. The net effect is a payment increase for some physicians and other qualified health practitioners, mainly in primary care. At the same time, about 30 specialties took a hit, along with PTs, OTs and SLPs. "To maintain budget neutrality, there had to be winners and losers," said Nancy Beckley, president of Nancy Beckley & Associates, at a Dec. 10 webinar[2] sponsored by RACmonitor.com.

For example, payment for the most frequently used code in physical therapy, CPT 97110 (therapeutic exercise), will be cut 10.2%, she said. The same goes for number two—CPT 97140 (manual therapy). Occupational therapy faces the same reduction for its top code, CPT 97530 (therapeutic activities). The percentages are based on geographic adjustments that vary by location, she noted.

The MPFS rule also added numerous PT, OT and SLP codes to the list of covered Medicare telehealth services. For the time being, therapists can provide them. But the codes are in category three, which means coverage isn't permanent. At the end of the year in which the PHE ends, presumably 2021, the codes will live on, but PTs, OTs and SLPs will be cut off from them "because they're not eligible providers under the statute to bill for telehealth," Beckley said. "It's a weird conundrum."

Following the end of the PHE, only therapy providers billing incident to a physician will be able to use the telehealth codes. The new codes are 97161-97168, 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521, 92522, 92523, 92524 and 92507.

CMS has also announced the 2021 Medicare therapy threshold. The per-beneficiary threshold for OT is $2,110, and for PT and SLP combined, it's $2,110, an increase of $30. When beneficiaries reach the therapy threshold, they may receive additional services, with strings attached. Therapists have to put modifier KX on claims, which is an attestation that the above-threshold therapy is medically necessary and documented in the medical record, Beckley said.

When therapy services exceed $3,000 for a beneficiary, they may be selected for targeted medical reviews. Beckley said the factors used to identify therapy providers for targeted medical review include if the provider is newly enrolled, a high denial percentage, or a billing pattern that is aberrant compared to peers.

Postpayment Therapy Audits Are Back

CMS audits were paused between March and August because of the pandemic, but they have resumed, although TPE is still in hibernation. Instead, MACs are doing postpayment reviews. Beckley said several MACs, including First Coast Service Options, Noridian Medicare and National Government Services, are reviewing outpatient therapy providers. They're looking at claims submitted mostly in 2019, focusing either on CPT code 97110 or 97164 (re-evaluation of physical therapy established plan of care).

Beckley listed TPE denial reasons from various MACs before it was paused. Here are some of them:

- Insufficient documentation (e.g., to support number of therapy minutes/units billed).
- Incorrect rendering provider.
- Documentation lacked objective measurements and progress toward goals on the daily note and evaluation/re-evaluation.
- No PT or MD signature on evaluation/plan of care.
- Recommended protocol was not ordered and/or followed.
- No physician certification/recertification.
- No documentation of medical necessity.
- No valid plan of care.
- Units billed more than ordered.

In another MPFS provision with implications for therapists, CMS clarified its new relaxed documentation standard, which is designed to reduce provider burden. The rule states that "any individual who is authorized under Medicare law to furnish and bill for their professional services, whether or not they are acting in a teaching role, may review and verify (sign and date) the medical record for the services they bill, rather than re-document, notes in the medical record made by physicians, residents, nurses, and students (including students in therapy or other clinical disciplines) or other members of the medical team."

In other words, physicians don't have to document services again if they review, sign and date the notes, and this time around, CMS explicitly included therapists and the students on their team. But Beckley has a warning: Most therapy codes require direct one-to-one time with the therapist, and the therapist is either guiding the student or the student is jointly providing therapy that will be billed by the therapist. "I recommend documenting in the notes who did the therapy," she said. "I have a strong bias about a student signing documentation, because although they're trying to get practice, it should be identified in the electronic medical records when the student is signing documentation that the therapist was there one on one." Otherwise, the provider may be looking at a denial if the record is reviewed or faced with a potential payback or self-disclosure.

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1 CMS and HHS, "Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories;

Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE) Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency (PHE) for COVID-19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID-19," unpublished final rule, December 1, 2020, https://go.cms.gov/3qicQuK.

2 Nancy Beckley, "Outpatient Therapy: 2021 Strategies for Survival," webinar, December 10, 2020, RACmonitor.com, https://bit.ly/3758r6U.