Message from the Practice Committee

Dear Members,

The Academy of Neurologic Physical Therapy Practice Committee is pleased to announce our first "**Message from the Practice Committee**". Our goal is to deliver focused information to members on relevant practice issues such as payment, reimbursement, coding, etc.

We are open to your feedback and suggestions.
Please feel free to contact Anna de Joya at adejoya@sbcglobal.net.

Thank you!
The Practice Committee
Katie Flores, PT, DPT, NCS
Heather Knight, PT, DPT, NCS
Aimee Perron, PT, DPT, NCS, CEEAA
Eileen Tseng-Stultz, PT, DPT, NCS
Leslie Wolf, PT, DPT, NCS
Anna de Joya, PT, DSc, NCS

Jimmo v Sibelius: Did you know?

The landmark 2013 settlement in the class-action lawsuit Jimmo v Sebelius, shattered the longstanding assumption that skilled therapy services could only be provided to Medicare beneficiaries if patient's condition improved. This assumption is often called the "Improvement Standard." This settlement clarified that skilled therapy services may be covered by Centers for Medicare and Medicaid Services (CMS) if (1) the therapy is "medically necessary." This means that the ordered therapy is considered a specific and effective treatment for the patient's condition under accepted standards of medical practice; (2) the therapy required can be safely and effectively performed only by, or under the supervision of, a qualified therapist because of the complexity of the therapy or medical condition of the patient; (3) the therapy performed by a skilled professional is necessary to prevent further deterioration or to preserve current capabilities.
The impact of this ruling affects therapists in every practice setting that may be working with Medicare beneficiaries. The APTA has extensive educational resources to learn more about how this ruling impacts your practice.

Check out the following web links for more information:

- APTA Statement:
  - http://www.apta.org/PTinMotion/NewsNow/2013/2/8/APTAStatement/
- Self Help Packet:

- http://www.medicareadvocacy.org/self-help-packet-for-outpatient-therapy-denials/
- Skilled Maintenance Webpage:
  - http://www.apta.org/Payment/Medicare/CoverageIssues/SkilledMaintenance/

CMS Sets Rule on Overpayment

CMS established expectation on the "60 day rule." The requirements of the rule have been established to ensure compliance with applicate statutes, to promote the delivery of high quality care, and to protect the Medicare Trust Funds against fraud and improper payments. CMS specified that once a provider identifies an overpayment through the exercise of 'reasonable diligence,' the provider has 60 days to report and return overpayment. If appropriate action is not taken, the healthcare provider will be subject to federal False Claims Act (FCA) liability. Providers are expected to look back for 6 years. According to CMS, this 6 year look back rule begins on March 14, 2016 and will not be retroactive. The take home point: Do not ignore payments that seem too high!

Check out the following web links for more information:

- DHHS Rule and Regulations:
  - https://www.gpo.gov/fdsys/pkg/FR-2016-02-12/pdf/2016-02789.pdf
- CMS Fact Sheet on Overpayment:
  - https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-11.html