MEETING MINUTES

Meeting topic: Meeting with the Michigan Physical Therapy Association

Date	May 11, 2018
Time	2:30 PM
Location	Lyon Meadows; Conference Center; Teal - Conf Room K
Facilitator(s)	William Wagner
Physician Lead	Dr Duane DiFranco
Attendees	BCBSM: Rozanne Fleszar, Elain Foster, Dale Domas, and Debra Marvay MPTA: Michael Shoemaker, Peter Van Well, David Gilboe, Barb Herzog, Janis Kemper, Elise Latawiec, and Scott MacDonald
Meeting Objective	To discuss concerns and solutions with the Michigan Physical Therapy Association (MPTA)

Minutes:

Meeting started with introductions.

PROVIDER AUDIT

Blue Cross Blue Shield of Michigan (BCBSM) introduced the new audit process. The audit process has been contracted out to HMS and SCIO. Audits could be on site but likely medical charts will be requested. BCBSM stated that the vendor is reimbursed by contingency fee. All the vendors are national and Medicare approved. The appeal process has changed to a two-step process which will be done by an external vendor.

There are physical therapists on staff at HMS and SCIO. The reason for the change in process is that this expands our capabilities. Site inspections will not likely happen unless we have a reason to do so. The MPTA asked if there could be an increase in audits. BCBSM said that is possible. Things that can cause an audit are quantity, typos, inconsistent billing, etc. BCBSM will provide the audit criteria which is also in the provider manual.

Audits are done for all provider types, not looking for specific providers. We are required by our groups to do these audits and we have a responsibility to make sure that claims are being billed correctly.

The first level appeal is with the vendor while the second level appeal goes to an independent review entity. BCBSM still manages the vendor and ensures compliance with our policies and procedures, as well as maintaining a relationship with our providers. BCBSM is still managing the audit process so providers can contact BCBSM if they have an issue with the process.

EviCore PROGRAM ALTERNATIVES

The MPTA wants to address the problem of practice variation. The MPTA recommends developing clinical pathways, creating standards of best practices, and using the right provider at the right time. The MPTA recommends managing outliers but not doing so in a way that punishes everyone. The MPTA feels that the recommendation of the chiropractors is the correct way to go. The MPTA stated we are not yet at the point to base decisions off clinical data analysis. The MPTA wants to develop the collaboration needed to create a program that works for both groups. Other methods have succeeded in reducing cost. Also, physical therapy serves as a first line for spine care which has reduced cost.

MPTA stated the companies recommended by the chiropractors were Secure Care, AMI, and Spine Care Partners. These companies are acceptable to both the provider and the payor side. Spine Care partners is the furthest along in developing collaborative programs. BCBSM stated that it appreciated the clinical pathways but BCBSM must ensure they are actual pathways. BCBSM does not want pathways that are vague and do not prescribe much of anything. BCBSM wants guidelines that are as specific, objective, and clear as possible.

EviCore will continue to be working with BCBSM. BCBSM can discuss goals and what they should be. However, BCBSM would require project funding and resources to do any large changes. BCBSM does not believe that these meetings are the context to have these discussions. It would have to involve the dedication of a set workgroup. BCBSM does not have the resources available now to be able to do this. BCBSM stated, what we can do at this meeting is establishing realistic criteria for tiering without a curve that keep

some providers out of the top tier or constantly changing the benchmarks to keep providers out of the top tier. If everyone can be an A provider then they can be an A provider. Both sides would have to work on outcomes because you have efficiency and quality and they are sometimes inversely related.

The MPTA wants to tackle the larger problem. BCBSM feels there is a lot to be gained from pre-work for the eventuality of changing our program if that becomes a possibility. BCBSM does not want this to be a discussion that will not get us where we want to go and that it is a discussion that is going to create something concrete. It is a preliminary discussion that if we ever get to the point of changing anything, this discussion will provide value. BCBSM stated that these conversations regarding discovery may or may not lead to any changes.

Physical Therapy cannot have a general overall pathway, including standards and quality. However, each condition that is treated with physical therapy can have its own pathway. BCBSM stated that when you have a problem, you need to explore many different solutions to develop the best one.

BCBSM wants to not curve the category As but move us towards an absolute benchmark. The reward is the elimination of the burden of the program.

BUNDLED PAYMENT INITIATIVE

The bundled payment initiative is the second attempt at creating a bundled payment. BCBSM has 65 providers set up and the bundle is a retrospective bundle. All services rendered will come in as fee for service, as they do today, with no changes to authorization or referral requirements. There is a backend reconciliation with the surgeon for the bundle. Physical therapy will get paid fee for service and will be paid regardless of what happens with regards to the bundle payment. The surgeon will be monitoring the physical therapy very closely. If the services for physical therapy are under the number of services allowed in the bundled payment the surgeon gets to keep the extra funds. If they are more than what is expected then the surgeon loses the extra funds to pay the physical therapist. This could create a pattern of referral in the affected areas. It could also decrease the amount of services the surgeon prescribes for physical therapy. The surgeons will select the physical therapy outfit that the patient goes to, possibly based on outcomes of that physical therapy location. It could increase demand for pre-hab services, which are included in the bundle.

MPTA stated this is more like an Accountable Care Organization (ACO) model. The provider assumes the risk by being responsible for the total amount of patient care. If the patient has a 30, 60, or 90-day benefit, the prehab is considered the start of care and could use up a significant number of patient's allotted time. Is BCBSM going to do anything regarding this so the patient can have the appropriate amount of time in rehab? The MPTA is also concerned about self-referral or referral to friends. The MPTA understands that the bundle payment is ok for surgery but not sure about other rehab conditions. They are concerned that providers will sign up with a company that acts as a medical director that is also a surgeon and the surgeon refers the patient to the therapy group for which they are the medical director.

Bundled payments for hips and knees are high cost per procedure and they are not easy to build an episode around. Setting this up took two years and several iterations to be able to do it and it is currently in trials. Typically, the health care plan focuses on the efficiency and the provider focuses on the quality. In a bundled payment model that role switches to the plan being worried about quality and the provider being worried about efficiency.

BCBSM has moved away from the physician group incentive program (PGIP) model of incentivizing the infrastructure. BCBSM is moving towards building reimbursement around incentivizing a quality outcome and leaving the provider to find the infrastructure they need. This could be in the form of a bundled payment. This does include the risk of providers cherry picking cases to guarantee outcomes. There are other ways to deal with risk that could eliminate utilization management.

PHYSICIAN PRESCRIPTION REQUIREMENT

BCBSM stated that we want to understand more about the data regarding direct access to physical therapy. The MPTA stated that many times a patient will get a script for physical therapy for 6 visits but the physical therapist states they only need three visits so the patient feels more is better and finds another physical therapist. This can lead to the physical therapist fulfilling the script for the full amount if the patient is willing to come. Direct access to physical therapy avoids this and using direct outcomes and incentivizing performance would control utilization. MPTA is interested in outcomes to track the performance of providers, so they get their information from Web Outcomes.

BCBSM stated that the IT issues on our side are very frustrating. It takes a long time to do something and it costs a significant amount of money. Also, the IT system is limited in what data it can provide. MPTA stated that they are using Photo or other methods to collect data. The MPTA wants to use our payment policy to drive positive behaviors amongst physical therapists.

MEETING MINUTES

PATIENT UTILIZATION COUNTER

The MPTA wants BCBSM to put a counter on WebDenis to tell the provider how many days, how many services a patient and how much money the patient has remaining. Patients are unreliable when remembering how many services they have had or how much money has been spent towards care. It can take 30 to 45 minutes to get through to Provider Servicing on the phone. The provider can only present 3 cases and then must hang up and call back to present more. This must be costing BCBSM significant resources as well as costing the providers significant resources. Other payors do have the capability to do this online. This issue affects BCBSM Medicare only.

KX MODIFIER THRESHHOLD REPORTING

The MPTA stated that under the Medicare guidelines the patient has a $2010 spending limit. After $3000 providers must bill with the KX modifier to show that the service is medically necessary and reasonable. Under Medicare Plus Blue you need to get an authorization if the dollar amount is exceeded. However, if the patient changes providers or the provider is unaware regarding where they are with the patient's limit then the claim could be rejected for not having an authorization.

BCBSM stated that this will be taken back to determine if a solution can be made in our systems. BCBSM asked if some payors just let you go over the $2010 limit and do an audit. The MPTA said yes some do. Congress passed a bill to remove the physical therapy cap. Medicare changed the cap to a threshold and after the threshold they must use a KX modifier. It is still a requirement that the KX modifier needs to be billed.

Next meeting:

Date	
Time	
Location	