Navigating the Complex World of Health Care Integration
Helene M. Fearon, PT

- Graduate of Marquette University’s Physical Therapy program
- Owner of Fearon Physical Therapy
- Partner in Fearon & Levine Consulting
- APTA’s representative to the American Medical Association’s CPT HealthCare Professionals Advisory Committee (HCPAC) and has completed 8 years of service on the AMA’s CPT Editorial Panel
William Huff, MD

- Graduated from UCSF School of Medicine in 1986
- Family Practice Residency at Group Health in 1993
- Board certified in family practice and has worked as a physician in large HMO (Group Health) for 20 years, as well as private practice
- Trained with certification in medical acupuncture, has additional training and experience in craniosacral therapy, visceral manipulation, and Jin Shin Do.
- Currently practices at Group Health in the Activity, Sports and Exercise Medicine clinic and is medical director for alternative services there
Susan Rosen

• Massage therapist for 32 years

• Instructor in professional massage training programs and advanced courses at colleges & private massage schools since 1980.

• Owner of a group practice in a multidisciplinary health care clinic, specializing in restorative massage treatment.

• Leader in the integration of clinical and medical massage into mainstream healthcare.

• AMTA’s representative on the AMA CPT Health Care Professionals Advisory Committee (HCPAC).
Expectations for the Session

Define Healthcare Integration
• The Panelist’s and other profession’s perspectives of working within the healthcare system
• Healthcare Integration: Examples of different models

Fundamentals of Reimbursement
• How to make a living, how to get paid
• CPT Code Overview
Defining Healthcare Integration

• What does “Healthcare Integration” mean?

• Each panelist will share a brief description of their integrated healthcare setting
Integration Care Algorithm

1. Direct Care/Treatment
2. Consultation
3. Co-Management
4. Referral
Audience Poll

What kind of practice are you a part of?

- Clinic/Medical Office
- Home Based/Home Visit
- Spa
- Health club
- Hospital
Audience Poll

How do you get paid?

- Cash
- Third party payer/Insurance
Evolution of Integration Into Healthcare

• Naturopathic Physicians

• Physical Therapy
Evolution of Integration into Healthcare

- Naturopathic Physicians
  - Evolution of “integration”
  - What can the massage therapy profession learn as we move forward in the current landscape?
Reframing Professional Self Image

1. Take What’s Yours

2. Emerging to a Developing Profession

3. Client → Patient
   Stress Reduction → Clinical

4. Primary Contact
Evolution of Integration into Healthcare

• Physical Therapists (PT’s)
  – Evolution of “integration”
  – What can the massage profession learn from the PT’s?
  – Retrospective of PT Profession: leadership/participation in the development of Physical Medicine/Rehab codes
  – Opportunities for the Massage Therapy Profession
Patient Protection and Affordable Care Act

Opportunities:

• **Non discrimination**: include, provide access to authorized scope, payment. ERISA - Employment Retirement Income Security Act - Level playing field.

• **Workforce**: inclusion of/codes for licensed CAM and IHC providers, residencies, loan forgiveness. Improve reimbursement for team care codes. (Impact of inclusion of emerging non licensed health professions?)
Examples of Different Integrated Models

• Private Clinics
  – On-site Integrated Practices - Multidisciplinary. 2-12 practitioners.
  – Group Massage or PT Clinic integrated by referrals and reimbursement (virtual network). Single discipline, director/owner.
Examples of Different Integrated Models

• Partial Integration: Non-Physician-Group Clinic
  – Multi-disciplinary, nonhierarchical
  – Salaried Practitioners, hierarchical
    (i.e. PT’s, MT’s, DC’s)

• Integrated Large Group Practice—HMO model
  – Physician run
  – CAM Network contracted- offsite
Examples of Different Integrated Models

• Large Onsite Integrated Facility (more than 15 practitioners)

• Hospital Based Integrated Care
  – Pre/Post Surgery
  – Pain Control
  – Cancer Care-Oncology
  – Hospice
  – Pediatrics
  – Geriatrics
  – Women Care
Elements of Clinical Success

• Accessible
• Affordable
• Effective
Clinical Use of Massage Therapy in Integrated Managed Practice

Bill Huff MD
Medical Director--Alternative Services
Physician--Activity, Sports and Exercise Medicine
Group Health Cooperative
Goals of managed care include cost effective, patient centered, evidence-based care and guidelines using medical home model for optimal outcomes.
Clinical Massage Therapy in Managed Care

• The majority of us feel better with massage.
  – We all want to feel our best. The lines between wellness, personal responsibility for feeling our best and treatment/rehab for medical conditions can be very blurry and present a dilemma for patients and providers where insurance coverage is considered.
    • Passion and compassion vs. evidence-based medicine, treatment goals and functional outcomes.
    • Research and best practice guidelines needed to guide coverage and care.

• Objective--
  – to better equip all clinical providers with understanding and tools when considering the role of clinical massage
  – reduce clinically inappropriate utilization.
Clinical Massage Therapy at Group Health

- Is part of the rehabilitation benefit
  - must meet medical necessity criteria and be part of a rehab plan of care
- Is not a self referral benefit
  - requires a physician Rx or order though requests are often patient driven
- Coordinated care is crucial
  - Care is tied to determination of functional outcome
- Massage therapy provided through a contracted network
- LMP-C certification
The Massage Benefit at GH

- Massage therapy, when covered, is part of the outpatient rehabilitation benefit which allows up to X combined visits per year for ST, PT, OT and MT
  - Maximum visits not guaranteed. Must meet health plan and clinical review criteria for medical necessity.

- Benefit Language
  - Rehabilitation services including massage therapy are covered. Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness or surgery. Such services are provided only when significant, measurable improvement to the condition can be expected within a sixty (60) day period (or reasonable period of time) as a result of the therapy.
  - It must be part of a rehab plan of care.
Evaluating a Patient for Massage

- Clinical massage can be useful in the treatment of responsive primary and secondary musculoskeletal conditions
  - Massage may be indicated for treatment of acute or subacute musculoskeletal injuries (e.g. neck and back pain, strains, sprains, tendinopathies, bursitis...) with mechanical, muscular or myofascial dysfunction.
  - Chronic musculoskeletal conditions such as chronic back pain and fibromyalgia may also respond. However, massage is not covered for ongoing supportive or “maintenance” therapy, even though it may feel good, help improve function and reduce pain if used on a regular basis. Judicious consideration of an occasional short course for a severe and persistent acute flare that is not responsive to self care or other treatments in a timely manner may be reasonable to help return to baseline function.
    - But not for regular “tune-ups”
    - Time between flares should be considerable
  - It may also be part of end of life care when it may provide comfort and reduce need for pain medications that reduce mental awareness.
  - It is not covered for relaxation, stress reduction, prevention.
The Massage Prescription

- **Evaluation**
  - Documentation of clinical indication

- **History**
  - Including the specific functional limitations and barriers hindering resolution

- **Exam**
  - Documentation of any structural and functional limitations

- **Assessment**

- **Plan for Rehab**
  - Set functional goals of treatment, #visits and frequency, follow up

- **Counsel**
  - Expectations of care
Evaluating Functional Outcomes

• Why measure functional outcomes?
  – All providers types increasingly accountable

• Documentation and measures - Group Health currently uses:
  – Functional Rating Index (FRI)
  – Visual Analog Scale
  – Treatment summary

• Other outcome measures/rating scales available
  – Care Connections for PT applied to MT?
Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the number which most closely describes your condition right now.

<table>
<thead>
<tr>
<th>1. Pain Intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>No pain</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Sleeping</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>Perfect sleep</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Personal Care (washing, dressing, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>No pain; do no restrictions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Travel (driving, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>No pain on long trips</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>Can do usual work; unlimited extra work</td>
</tr>
</tbody>
</table>

6. Recreation

<table>
<thead>
<tr>
<th>0-1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can do all activities</td>
<td>Can do most activities</td>
<td>Can do some activities</td>
<td>Cannot do any activities</td>
</tr>
</tbody>
</table>

7. Frequency of pain

| 0 | 1 | 2 | 3 | 4 |
|-----------------|----------------|----------------|----------------|
| No pain | Occasional pain; 25% of the day | Intermittent pain; 50% of the day | Frequent pain; 75% of the day | Constant pain; 100% of the day |

8. Lifting

| 0 | 1 | 2 | 3 | 4 |
|-----------------|----------------|----------------|----------------|
| No pain with heavy weight | Increased pain with heavy weight | Increased pain with moderate weight | Increased pain with light weight | Increased pain with any weight |

9. Walking

| 0 | 1 | 2 | 3 | 4 |
|-----------------|----------------|----------------|----------------|
| No pain; any distance | Increased pain after 1 mile | Increased pain after 1/2 mile | Increased pain after 1/4 mile | Increased pain with all walking |

10. Standing

| 0 | 1 | 2 | 3 | 4 |
|-----------------|----------------|----------------|----------------|
| No pain after several hours | Increased pain after several hours | Increased pain after 1 hour | Increased pain after 1/2 hour | Increased pain with any standing |

Name _____________________________  ID/#SS# _____________________________  Plan ID _______  Total Score _______

Signature ___________________________  Date _____________________________

© 1999-2001 Institute of Evidence-Based Chiropractic
Partnering in Care

- Communication and co-ordination of care between providers
- Evidence-based research on indications and outcomes for massage therapy
- Best practice guidelines
- Clinical education (a two way street)
Question and Answer Session

1. Hand in Questions
2. Break (10 mins)
3. Q&A Session
Fundamentals of Reimbursement

*How to make a living, how to get paid!*

- Reimbursement – Insurance, cash, combination.

- Insurance reimbursement - Pros and cons
Payment Methodologies

Fee For Service Models

- Cash/Patient Self Pay
- Per Visit
- 3rd Party Provider/Preferred Provider Organization
  - Credential
  - Reimburse
Every Category of Provider Law

• Washington State Legislative Mandate
  – Requires insurance coverage for every category of licensed provider and includes licensed massage therapists
  – Set stage for insurance coverage of massage therapy in Washington state
Fundamentals of Reimbursement

- Affordable Care Act and Ramifications for the Future

- Opting into the system without being “co-opted” and compromising our principles
  
  - AMTA survey results show many MT’s are split down the middle when it comes to the concept of accepting insurance reimbursement

  - The importance of MT’s participating in healthcare integration as contracted providers (benefits, limits, challenges). It can prove to be a mutually beneficial relationship
Basic CPT Coding Structure

What are they, who uses them, and why?

- Brief history of CPT coding
- What is the AMA CPT Editorial Panel & HCPAC
- How AMTA is involved
Basic CPT Coding Structure

- CPT as a reporting model
- CPT as a reimbursement model
Common Theme: Need to Prove Value

• Value-based health aims to **improve quality, lower cost, and drive toward value** in healthcare delivery.
• The demand for value requires greater accountability on the part of all stakeholders within healthcare.

**Identification of training and best practices**
**Provider adherence to best practices**
**Measurement of provider performance**
**Benefit design**
**Cost-effectiveness**

VALUE
How Professional Services are Described

AMA’s
CPT and RUC Process
What are CPT codes?

Current Procedural Terminology

• 5 digits coupled with nomenclature describing a clinical service organized in manual by medical specialty or similarity of services for physician and non-physician health care providers

• Used in third party pay system to reimburse providers for healthcare services, as described under their benefits

• The most common system to describe services for third party reimbursement despite the methodology of payment
CPT and HCPAC

Current Procedural Terminology (CPT) and Health Care Professions Advisory Committee (HCPAC)

• Who runs it

• How it works
  - E/M & procedural codes
  - Provider type blind

• Why it matters

• Limitations
How it Works - Why it Matters

CPT  RUC  Payers
(CMS:MCAC/Private)

Code  Valuation  Coverage Decisions

Provider Reimbursement for service to patient
Who Are We?

Your Licensed CAM and Integrative Health Care Advisors on CPT/HCPAC

- Craig S. Little DC: ACA
- Susan B Rosen LMP: AMTA
- W. Bruce Milliman ND: AANP
Who Are We?

Other Health Care Professions

• Physical therapists
• Physician Assistants
• Respiratory Therapists
• Dieticians
• Nurses
• Occupational Therapists
• Optometrists
• Podiatrists
• Speech and Hearing Therapists
• Athletic Trainers
• Psychologists
• Social Workers
• Genetic Counselors
• Pharmacists
CPT Code Process and Structure

• AMA CPT Editorial Panel representing physician and non-physician practice and health care services, make final recommendations for codes to be published and valued

• CPT Advisors represent physician and non-physician organizations and are provided ability to propose and/or comment on all proposed CPT codes (new/revised/deletions)

• CPT Health Care Professionals Advisory Committee (HCPAC) represents 19 non-physician organizations and elect two panel seats
Role of CPT/HCPAC Advisors

- Advise re: deletion of obsolete codes
- Advise re: editing existing codes
- Advise re: introduction/new codes
- Facilitate introduction of proposed new codes for health professions
- Participate in workgroups re: CPT language and policy
“Qualified Health Care Professional”

“The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians in differing specialties. E/M services may also be reported by other qualified health professionals who are authorized to perform such services within the scope of their practice.”

p 4 CPT Manual 2010
Access to Payment for Service

- Is it codeable? *CPT*
- Is code valued? *RUC*
- Do payers recognize it? *MCAC/ Coverage Committees*
- Is it in provider’s scope? *State Non discrimination & workforce legislation*
- Is service “medically necessary”? *Big discussion*
- Is service charted appropriately? *CPT/payer Hot topic*
- Is service coded to documented level? *Provider/payer*
- How do you decide which code to pick?
CPT Quick Facts

- American Medical Association - Copyrighted
- Over 8500 CPT codes published annually
- Editorial process allows for annual additions, revisions and deletions
- Purpose is to provide for accurate descriptive terms for purpose of reporting medical services
- 3 categories of CPT codes are used to report services
- Provides uniform language used by most payers
- Allows for reliable nationwide communication
Physical Medicine and Rehabilitation: 97000 series

New introductory language published applies to all services included in code set

“The work of the qualified healthcare professional consists of face to face time with the patient (caregiver, if applicable) delivering skilled services. For the purpose of determining the total time of the service, incremental intervals of treatment at the same visit may be accumulated”

AMA CPT 2011, Pg 509, Professional Edition
How Is CPT Used?

Reporting Massage Therapist Services

- **97124** Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion), one or more areas, each 15 minutes

- **97140** Manual therapy techniques, (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes

- **97110** Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

- **97112** Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
How Is CPT Used?

Reporting Massage Therapist Services

- **97535** Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology/adaptive equipment), direct one on one contact by provider, each 15 minutes

- Medical Team Conference, direct contact with patient and/or family, including physician, **99366**
  - or without direct (face to face) contact, **99367**
How Services Are Valued

• Resource Based Relative Value Scale (RBRVS)

• Principle: Payment for services vary with resources and costs needed to provide them

• Payments vary across services and across geographic areas
How Services Are Valued

• RBRVS = Resource Based Relative Value System

• RVU = Relative Value Unit

• RUC = RVU Update Committee
The RUC Process

CPT Editorial Panel Adopts Coding Changes

Specialty Society Advisors Review New and Revised CPT Codes

- Codes Do Not Require New Values
- No Comment
- Comment on Other Societies' Proposals
- Survey Physicians; Recommend Values

RVS Update Committee

Specialty Society RVS Committee

Centers for Medicare and Medicaid Services

Medicare Payment Schedule
Historical Relative Value System

Payment for Services =

Established Relative Value
X Monetary Conversion Factor
Components of Relative Value

- Practice Expense: 44%
- Liability Costs: 4%
- (Provider) Work: 52%
Provider Work and Practice Expense

Provider Work
• Time to perform the service
• Technical Skill & Physical Effort
• Mental Effort & Judgment
• Stress associated with concern of risk to the patient

Practice Expense
• Medical equipment and supplies
• Administrative supplies
• Salaries (non-PT)
• Electricity, water, rent etc..
Geographic Practice Cost Indices (GPCI)

- GPCI’s are relative costs of delivering medical services specific to geographic locations
- Updated every three years
CPT as a Reporting Model

- Track CPT codes reported by therapist with certain diagnosis codes, then compare to outcome measures (LOS, charges/visits, functional change)

- Describe protocols with CPT codes (acute LBP; treated with 97140,97110 and modalities PRN)

- Facilitate budgeting process (reports indicating reporting of codes and payer class/fee schedules)

- Track productivity per therapist/per clinic/facility location
Past and Current Landscape

Re: Insurance Reimbursement

• Is the landscape broken?

• What could a new system look like?

• How can we reinvent it?
Pressing Need for Reform

APTA Developing an Reformed Payment System

• Based on Clinical Judgment of the PT
• Visit/Session Based System
• Factors Patient Severity and Intensity of PT Expertise
Embracing the Future of Integrative Healthcare

Handout in back of room:

“Embracing the Future of Integrative Healthcare”

featured in Massage Today and written by Whitney Lowe, LMT
Embracing the Future of Integrative Healthcare

ACCAHC: Academic Consortium for Complementary and Alternative Healthcare

The Academic Consortium for Complementary and Alternative Health Care (ACCAHC) is a vehicle for shifting medicine toward a system which focuses on health. We envision:

“a healthcare system that is multidisciplinary and enhances competence, mutual respect, and collaboration across all complementary, alternative, and conventional healthcare disciplines. This system will deliver effective care that is patient centered, focused on health creation and healing, and readily accessible to all populations.”
TRIARQ is a community of Physicians, Patients, Physical Therapists, and other healthcare professionals working together to create new standards in clinical and service excellence through continuing education, research, and cross discipline collaboration.
AMTA’s Role in Healthcare Integration

- AMTA’s “Working in a Healthcare Environment” career series
  (*handout in back of room*)

- Health Care career track at this 2011 Convention

- AMTA Post Convention Opportunity: Integrative Medicine of Providence Medical Center Tour - Sunday, October 23, 8:30 - 11:30 a.m.
Session Q & A

Please use a note card to write your question down during the presentation. An assistant will collect your note card and distribute to the panel.

There is a limit of 1 question, the question must be brief and must be addressed to a specific panel member.

Thank you!
Resources

• Kaiser Family Foundation
  – www.kff.org

• Massage Therapy Body of Knowledge
  – www.mtbok.org

• Colleen Leeders – AMTA Industry Relations Program Manager
  – ckleeders@amtamassage.org