August 6, 2019

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-6082-NC
Room 445-G
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Submitted electronically

RE: Request for Information; Reducing Administrative Burden to Put Patients over Paperwork [CMS-6082-NC]

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments on the Centers for Medicare and Medicaid Services’ (CMS) Request for Information (RFI) on Reducing Administrative Burden to Put Patients over Paperwork. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for health care services. Physical therapists’ roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession’s vision of transforming society by optimizing movement to improve the human experience.

APTA supports CMS’s efforts to reduce administrative burdens on Medicare fee-for-service (FFS) providers. In order to continue to reduce burdens for health care providers and patients, improve the quality of care, decrease costs, and ensure that patients and their providers are making the best health care choices possible, APTA offers the following recommendations for CMS’s consideration.
Administrative Burdens Challenging the Physical Therapy Profession

Background and Purpose
Recognizing that administrative burden is a major problem for the physical therapy profession—and health professions in general—easing it is one of APTA’s strategic priorities. To convey the concerns of the physical therapy community to congressional committees and staff, federal and state regulators, state legislators, employers, payers, third-party administrators (TPAs), and others, APTA recently collected objective, measurable findings. From December 2018 to January 2019, the association surveyed 1,599 members (number of responses included after screening criteria was applied to 1,617 returned surveys) on prior authorization, obtaining treatment approval, patient impact, and effects on the profession. The results allow APTA to be specific in articulating the amount of burden on the profession, the greatest burdens being faced, and the toll these burdens are taking on patient outcomes and on the physical therapists and physical therapist assistants who provide services. Below is a summary of our findings:

1. Prior authorization is a primary source of burden with most front desk staff spending more than 10 minutes for an initial prior authorization and a majority of front desk staff and clinicians spending more than 10 minutes when requesting approval for continued visits for patients in all types of health plans.
2. 72.5% of respondents wait for a prior authorization from a health plan an average of 3 days or more.
3. Nearly 3/4 of respondents indicated that prior authorization requirements delay access to medically necessary care by more than 25%.
4. Most respondents indicated that 25% of clinician and staff time would be saved if Congress constructed legislation that requires standardization of prior authorization forms and processes.
5. 74% of respondents agreed or strongly agreed that prior authorization requirements negatively impact patients’ clinical outcomes.
6. More than 3/4 of respondents say prior authorization burden increases by more than 25% when a TPA is involved in the approval process.
7. 40% of respondents report that even after a payer has said prior authorization is not required, more than 25% of claims are later denied for that reason.
8. 65% percent of respondents say more than 30 minutes of staff time is spent preparing an appeal for 1 claim.
9. More than 50% of appealed claims are overturned.
10. 85.2% of providers agree or strongly agree that administrative burden contributes to burnout.
11. 76.5% of facilities have added nonclinical staff to accommodate administrative burden.
12. Top 5 items identified that would reduce administrative burden are:
   a. Standardization of documentation requirements across all stakeholders (51.5% of respondents)
   b. Standardization of coverage policies across payers (38.1%)
   c. Standardization of prior authorization process (36.0%)
   d. Unrestricted direct access (36.1%)
   e. Elimination of requirement for Medicare plan of care signature and recertification (38.8%)
Medicare FFS Recommendations

Credentialing Delays
Pursuant to CMS Publication 100-08, Medicare Program Integrity Manual, Chapter 15, Section 15.17, and in accordance with 42 CFR 424.520(d), the effective date of billing privileges for physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, anesthesiology assistants, certified nurse midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, physician and nonphysician practitioner organizations (eg, group practices) consisting of any of the categories of individuals identified above, and ambulance suppliers, is the later of:

- The date the supplier filed an enrollment application that was subsequently approved, or
- The date the supplier first began furnishing services at a new practice location.

APTA strongly recommends that CMS modify 42 CFR 424.520(d) and revise the Medicare Program Integrity Manual, Chapter 15, Section 15.17 to include physical therapists within the list of individuals and organizations for whom CMS has established an effective date for billing privileges. Physical therapists in private practice frequently experience significant delays with Medicare credentialing, ranging anywhere from 3 to 12 months. A seemingly endless wait for a new physical therapist to move through the Medicare credentialing process hinders a practice’s ability to quickly onboard the physical therapist. These delays hinder access for Medicare beneficiaries and cause disruptions in care delivery.

Given the lack of clarity surrounding the effective date of Medicare billing privileges for physical therapists, APTA has spoken with various Medicare Administrative Contractors (MACs) regarding the delay in credentialing and its impact on newly enrolled physical therapists, or physical therapists who have switched practices, and when such physical therapists may start treating patients and billing Medicare. MACs have advised APTA that if a physical therapist were to see Medicare patients prior to having their enrollment application approved, they would be doing so at their own risk. While a physical therapist may begin seeing Medicare patients after the effective date requested on the application, if the application is denied or held up, then there is no guarantee the physical therapist will be reimbursed for those services, placing the provider in an untenable position.

Given the inability to bill for services, the cost associated with credentialing physical therapists is substantial. Moreover, the increased need for Medicare-credentialed physical therapists, particularly in light of the opioid epidemic, is critical. To improve access to physical therapy, particularly in rural and medically underserved areas, it is imperative that CMS improve upon the credentialing process to the greatest extent possible. Therefore, to reduce credentialing delays—better ensuring beneficiary access to medically necessary physical therapist services—APTA strongly recommends that CMS remedy many of our members’ concerns by including physical therapists within the list of practitioners for whom CMS has established an effective date of Medicare billing privileges.

Direct Access to Physical Therapists in Critical Access Hospitals (CAHs)
Physical therapists can provide evaluation and treatment services within their respective disciplines without the need for an order or referral from any other health care professional in
accordance with state law (or where allowed by state law). Moreover, since 2005, Medicare has stated that a physician order or referral is not a requirement for coverage of outpatient physical therapy services delivered to Medicare beneficiaries. However, our members have indicated that due to the practitioner order requirement in CAHs, Medicare beneficiaries who require rehabilitation frequently are admitted to a CAH but then must “sit and wait” until a practitioner can sign an order. This not only decreases efficiency but also lowers patient satisfaction and may negatively impact outcomes. Therefore, to promote beneficiary access and improve continuity of care, APTA recommends that CMS modify the Interpretive Guidelines for CAHs and eliminate the requirement that rehabilitation services be initiated only upon the order of a practitioner responsible for the patient per the Interpretive Guideline for 42 CFR 485.63(e).¹

Physical Therapists Prescribe Physical Therapy in Accordance With State Law

Direct access to a physical therapist means the removal of the physician or other health care professional referral or order mandated by state law to access physical therapists’ services for evaluation and treatment. Every state, the District of Columbia, and the US Virgin Islands (USVI) have recognized the safety and benefits of direct access to physical therapy by removing from their statutes all or some of the referral requirements or order provisions for evaluation and treatment by physical therapists. In all of these states, physical therapists are “self-referring” or “ordering” and are furnishing services to their patients with limited or no restrictions. Specifically, in 20 states, laws are silent on the need for an order or referral, indicating there are no restrictions or limitations on accessing physical therapist services; in 27 states, the District of Columbia, and the USVI, individuals have access to a physical therapist’s evaluation and treatment with varying limitations, such as a time or visit limit, or a referral requirement for a specific treatment intervention; and in 3 states, patients have more limited access to physical therapist services—for instance, physical therapist services may be restricted to patients with a previous medical diagnosis or who are subjects of a previous physician referral.

Direct Access to Physical Therapists in the US Military

For more than 50 years, “US Army physical therapists have had the advantage of being able to care for soldiers and other beneficiaries by means of direct access. Physical therapists in the US Air Force, and to a limited extent in the US Navy, have served their beneficiary populations in a similar role over the past few decades. The impact of physical therapists on improving the health and military readiness of service members has garnered the support of the military's medical leadership to such a degree that they are regularly credentialled by local military hospitals and health care facilities with clinical privileges to: safely examine patients with and without physician referral; order diagnostic imaging; prescribe medications; order laboratory tests; refer

¹ The Interpretive Guideline for 42 CFR 485.63(e) states: Rehabilitation services are optional CAH services. If a CAH provides any rehabilitative services to its patients, either directly or under arrangement or agreement, either inpatient or outpatient, the services must be provided by staff qualified under State law, and consistent with the requirements for therapy services in §409.17. Rehabilitation services can be initiated only upon the order of a practitioner responsible for the care of the patient… CAHs must have policies and procedures consistent with State law. Rehabilitation services must be provided according to national standards of practice as established by professional organizations such as, but not limited to, the American Physical Therapy Association, the American Occupational Therapy Association, and the American Speech-Language-Hearing Association.
patients to other practitioners; initiate duty limitations; and perform electromyographic and nerve conduction studies.”

Physical therapists are well-qualified, through both formal education and clinical training, to evaluate a patient’s condition, assess his or her physical therapy needs, and, if appropriate, safely and effectively treat the patient. Physical therapists also are well-qualified to recognize when patients demonstrate conditions, signs, and symptoms that should be evaluated by other health care professionals. Therefore, APTA recommends that CMS modify the Interpretive Guidelines for CAHs and eliminate the requirement that rehabilitation services be initiated only upon the order of a practitioner responsible for the patient.

Direct Supervision of Outpatient Therapy Services in Hospitals and CAHs
APTA appreciates that CMS has proposed in the CY 2020 Hospital Outpatient Prospective Payment System (OPPS) rule to eliminate the direct supervision requirement for outpatient therapy services furnished in hospitals and critical access hospitals. We urge CMS to finalize the policy as proposed.

National Correct Coding Initiative
Each calendar year, APTA reviews and provides feedback on proposed changes to the National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) programs. We commend CMS for recognizing the far-reaching impact of these edits and for soliciting input from the organizations whose members may be impacted by their adoption. APTA respectfully requests that CMS work with Capitol Bridge LLC and reconsider an existing edit for the following code pairs:

- 97530 97116
- 97530 97113
- 97140 97530

CPT code 97530 (therapeutic activities) is not inclusive of CPT code 97116 (gait training), CPT code 97113 (aquatic exercise), or CPT 97140 (manual therapy). Each of these procedures are separate and distinct. When delivering therapeutic activities, a therapist does not, and cannot, simultaneously perform gait training, aquatic therapy, or manual therapy. Additionally, the combination of these procedures during the same treatment session constitutes usual care for the vast majority of patients. Moreover, while it is common for physical therapists to address movement and mobility issues through the use of manual therapy technique (97140) during a treatment session, these services are not delivered at the same time as therapeutic activities, which address functional performance issues.

These edits lead to inappropriate denials, an unnecessary decline in reimbursement, and increased frustration and confusion among physical therapists who code and bill for therapeutic activities and gait training, aquatic therapy, or manual therapy on the same date. To limit the administrative and financial burden on physical therapists and on their patients, better support the effective and efficient treatment of a patient’s condition, avoid delay of a

---

meaningful intervention, and prevent the need for an otherwise unnecessary follow-up visit, we encourage CMS to discontinue the edit for these 3 code pairs.

Plan of Care Certification Requirements
As discussed below, APTA strongly recommends that CMS modify the therapy plan of care certification requirement.

Pursuant to the Medicare Benefit Policy Manual (MBPM) Chapter 15 Section 220, a plan of care must contain diagnoses, long-term treatment goals, and type, amount, duration, and frequency of therapy services. CMS requires physicians/nonphysician practitioners to certify a patient’s therapy plan of care, meaning a dated signature on the plan of care or some other document that indicates approval of the plan of care. CMS states in the MBPM that it is not appropriate for a physician/NPP to certify a plan of care if the patient was not under the care of some physician/NPP at the time of the treatment or if the patient did not need the treatment. In certifying an outpatient plan of care for therapy, a physician/NPP is certifying that: Services are or were required because the individual needed therapy; a plan for furnishing therapy has been established by a physician/NPP or by the therapist providing such services and is periodically reviewed by a physician; and services are or were furnished while the individual was under the care of a physician. The MBPM Chapter 15 further states that there is no Medicare requirement for an order, however, “when documented in the medical record, an order provides evidence that the patient both needs therapy services and is under the care of a physician.” The MBPM also states that if the signed order includes a plan of care, no further certification of the plan is required (emphasis added).

Compliance with the physician signature requirement is a logistical and administrative burden on therapy providers and physicians, taking valuable time and resources away from delivering patient care. Although an unintended consequence, care frequently is delayed while awaiting a physician signature—often after multiple requests—placing the beneficiary’s health at risk due to the delay. Although the physical therapist may have performed due diligence in requesting a physician signature, the financial burden falls on the physical therapist if a signature is not obtained. Moreover, in instances of delayed certifications, the therapist must identify and compile evidence that is necessary to justify the delay, further increasing his or her administrative burden. This is compounded by the frequent lack of physician response, which leaves the therapist with an inadequate paper trail of the interaction.

While the medical record may illustrate the medical necessity of therapy services, CMS contractors will deny payment or seek recoupment if the plan of care is missing a signature, if the signature was not obtained within the required timeframe, or if the signature is of marginal or questionable legibility.

The administrative burden of this regulation is untenable. Physical therapists and other therapy providers should not be held responsible and possibly subject to medical review due to a physician’s inaction. Moreover, the plan of care signature requirement is not consistent with contemporary physical therapist practice. As discussed above, every state, DC, and the USVI have all recognized the safety and benefits of direct access to physical therapy by removing from their statutes all or some of the referral requirements or order provisions for physical therapist
evaluation and treatment. Yet, despite all states having adopted direct access, in the majority of instances, a Medicare beneficiary obtains an order from a physician/NPP before visiting a physical therapist.\(^3\) Accordingly, we recommend that CMS modify the plan of care certification requirement. CMS should accept either an order signed by a physician/NPP or have a plan of care certified by a physician/NPP within 30 days of the initial therapy treatment.

When there is an order for therapy in the record, the order demonstrates that the patient is under the care of a physician/NPP and the patient needs therapy. Forcing physical therapists, after developing the plan of care, to send it to the physician for signature (which can take weeks to obtain and often requires multiple follow-up calls and emails), even in the presence of an order, is both burdensome and unnecessary. That said, when a physician/NPP order is present, the therapist would continue to share the plan of care with the physician/NPP, the difference being there would be no requirement for the physician to sign the plan of care and return it to the therapist to indicate approval. In instances where a patient does not have an order, the physical therapy provider would be required to comply with the current plan of care signature requirements. To reduce significant burden on outpatient therapy providers, APTA strongly encourages CMS to modify the therapy plan of care certification requirement in future rulemaking.

Recertification requirements may continue to remain as currently outlined in MBPM Chapter 15; if there is a need to significantly modify the plan or at least every 90 days after initiation of treatment under that plan, recertification of the plan by the physician/NPP is required.

**Quality Reporting**

While APTA supports CMS’s efforts to harmonize reporting requirements across federally funded programs requiring the same or similar electronic health record (EHR) data from health care providers, we recommend that CMS modify quality reporting requirements for all provider types and settings (including physicians and hospitals) to include metrics regarding the collection and communication of information required at transitions, as well as timeliness and completeness metrics, therefore ensuring that we are not adding to providers’ burden in complying. We also encourage CMS to base future quality and regulatory reporting on elements in the standardized data set to maintain alignment between clinical needs, reporting requirements, and semantic standardization.

**Skilled Nursing Facility (SNF) 3-Day Stay Inpatient Requirement**

APTA strongly recommends that CMS modify its policy to allow days spent in observation to satisfy the 3-day inpatient hospital stay requirement for Medicare Part A coverage of SNF care. Congress also has expressed support for such a policy change, as members in both the House and Senate have introduced the Improving Access to Medicare Coverage Act of 2019 (S. 753/H.R. 1682). The legislation expands the definition of inpatient for purposes of the 3-day inpatient stay requirement, and it allows time spent in observation to count toward satisfying the requirement.

---

\(^3\) Physical therapists have shared anecdotally that it would be extremely rare for an order to include a plan of care, as it is typically always the therapist who develops the plan of care and then sends to the physician for review/signature.
Medicare Advantage (MA) Recommendations

Utilization Management
As discussed in detail below, many utilization management (UM) programs are pervasively flawed, fraught with problems, and fail to put the patients’ needs at the forefront of care. For example, our members report the rollouts across numerous states of various Medicaid and Medicare Managed Care UM programs have been extremely disorganized and haphazard due to lack of notification, training, and preparation. Ultimately, implementation of these programs has led to widespread confusion and delays in obtaining authorization, inhibiting the delivery of seamless medically necessary care to enrollees. Moreover, implementing UM programs for outpatient therapy services only exacerbates the already overwhelming financial and administrative burdens facing these providers and further disrupts medically necessary care. The technical and programmatic issues experienced by therapy providers upon implementation of UM programs for outpatient physical therapy services include:

- **Lack of timely notification and education**: Therapy providers report they do not receive the contractually required advance notification of the program change. Therapy providers also report receiving no education or training prior to implementation.

- **Eligibility determination**: Providers report widespread issues with eligibility determination. Information on eligibility determination is vague, and the system is unreliable. Additionally, information that clarifies when the need exists to submit a request for prior authorization is vague.

- **Limited visit approval**: Providers routinely receive only 1-2 initial visit approvals for all patients, regardless of case complexity or post-operative status. For example, providers treating post-operative anterior cruciate ligament repair, a pediatric neurological case, and traumatic brain injury may all receive the same limited approvals.

- **Approval turnaround time**: There are extensive delays in approval turn-around time.

- **Other technical and programmatic issues**:
  - Systems freeze, and when they continue, all previous information is lost, requiring the provider to start over.
  - Systems do not permit saving and continuing at a later time.
  - Referring physicians fail to show up in the system, resulting in authorization denials.
  - Clinics show up as out-of-network, but individual providers show up as in-network.
  - Providers are unable to enter an authorization request into the portal until all visits from the previous authorization are used. This is problematic for busy clinics and patients who need to be scheduled in advance, as they lose their space on the schedule while pending additional authorization. While providers are instructed to “hold the time,” that is not an equitable alternative for practices. If the visits are not approved, the practice will have lost the opportunity to fill the space with another patient.
  - Only one diagnosis may be allowed per authorization. This limits the ability to document comorbidities and complexity of the patient.
  - UM vendors conduct arbitrary visit authorizations without use of relevant clinical data.
Application of a long date range for approved visits relative to the number of visits approved and the therapist’s plan of care (which is not considered)—ie, approval of 3 visits for a 6-week period despite a plan of care strongly documenting the need for a frequency of 1-2 visits per week for 6 weeks.

Complete lack of consideration of clinical documentation, outcome measures, functional status, etc.

While APTA supports appropriate UM to promote the delivery of value-based care, we contend that many programs fall short and exponentially increase administrative burden, while adversely impacting patient access to medically necessary care and creating a systematic focus on volume of services.

Prior Authorization
In accordance with the Triple Aim, APTA understands and supports reasonable efforts to ensure appropriate utilization of physical therapy services that recognize the physical therapist's ability to render patient-centered care using evidence-based guidelines, clinical judgment and decision-making, full scope of licensure, timely patient access to medically necessary services, and streamlined administrative processes. However, current managed care prior authorization programs are not consistent with these objectives. Prior authorization runs contrary to a value-based model and does not facilitate professional judgment or clinical decision-making based on patient presentation. Further, each plan’s instructions for obtaining prior approval for current and ongoing patients are highly variable and often unclear. To better align with CMS’s Patients over Paperwork initiative APTA strongly encourages CMS to examine how it may eliminate overburdensome prior authorization processes within managed care programs, thereby improving access to physical therapy. We urge CMS to take action toward a goal of reducing unnecessary burden, increasing efficiencies, and improving the customer experience by controlling how MA plans may utilize prior authorization or, at a minimum, penalizing MA plans that fail to furnish authorizations within the timeframe listed in the policy.

Prior authorization substantially increases administrative burden and the possibility of inadvertent error; moreover, it is in direct conflict with contemporary clinical practice. Currently, managed care (both MA and Medicaid) enrollees must undergo a prolonged, burdensome process to obtain treatment authorizations. A delay in authorization may severely hinder a patient’s recovery, requiring physical therapists and other providers to decide between furnishing an uncovered service at their own expense, abiding their ethical obligations, or risk the patient’s health and well-being by waiting for a plan to authorize medically necessary care. Additionally, the care authorized by the health plan or TPA often disagrees with the health care professional’s recommendations. Protecting MA enrollees from arbitrary care denials and restrictions would help to better ensure patient access to timely, high-quality care that is appropriate for the patient’s condition, avoid preventable adverse events, and saves plans, providers, and patients from expending resources on unnecessary services.

To reduce clinician burden and promote standardized data collection within the MA program, we recommend that CMS incorporate standard language within its contracts that requires MA plans to:

- Use the same standardized request form for prior authorization, developed by CMS, that follows the information collection comment request process,
• **Accept requests through the same submission mechanism, such as through a provider portal, and**
• **Adopt a required response period for prior authorization and repeat authorization requests.**

Requiring MA plans to adopt a prior authorization process wherein all prior authorizations—whether submitted directly to the MA insurer or to a subcontractor—are submitted through an electronic portal (consistent portal framework) would allow the payer to use algorithms—to be reviewed by stakeholders including professional associations—to identify the most blatant instances of abuse, and would allow for proper, timely care to patients. Under such a process, a MA insurer or subcontractor would be required to “deny” an authorization within a set timeframe, such as 24 or 48 hours, allowing 72 hours for the provider to appeal, again through a similar electronic portal. If the insurer or subcontractor fails to reply within the timeframe, the authorization would be granted and claims for the services paid. This type of process

Further, to ensure that patients continue to receive high-quality care and avoid stinting on medically necessary services, APTA suggests that CMS consider exempting from prior authorization patient populations with certain conditions and clinicians who participate in standardized data collection system and willing to share outcomes; requiring the use of specific performance-based outcome measures; and/or requiring the collection of patient-reported outcome measures that have clinical utility and importance that are meaningful to a diverse set of provider types.

**Additional ideas for the agency’s consideration:**

• Adopt a standard list of self-reporting, objective, and commonly accepted outcome tools by body region, ability to participate in activities, and general health reporting.
• Limit prior authorizations to a specified number of visits and not units of service. Authorization of the number of billed units is not appropriate and should be left to the discretion of the provider, based on medical necessity. The duration of each intervention should not be arbitrarily specified by the TPA or payer by limiting the number of authorized time units.
• Gold card (remove the utilization management requirement for) clinicians who agree to share standardized outcomes data.
• Implement outlier management so only providers with egregious practice patterns are subject to review—thereby reducing the burden on the vast majority who are compliant.
• Institute a standard under which a provider can obtain delegated credentialing based on adherence to specific criteria, such as that of the Council for Affordable Quality Healthcare. Credentialing requirements by many payers far exceeds requirements for participation in Medicare Part B and impedes access to qualified providers.
• Have TPAs defer to the MA plan for appeals of denied or reduced care during the prior authorization process. The TPA makes the decision to reduce or deny care based on its evaluation of medical necessity but defers to the plan for the provider to defend its rationale. There should be one entity making the decision and handling the appeal of that decision.
• Create a standard for initial authorization of care that is applied across MA plans. This could be a specified number of visits for nonsurgical care and a different number for postsurgical care.
• Adopt standardized template reporting for submission of prior authorization clinical data.
• Mandate that TPAs or UM companies maintain current eligibility information on their enrollees. Authorization approvals that are obtained through these entities must be honored as valid for the purpose of payment by the payer. Frequently, data between the payer and TPA/UM company databases do not match, placing the validity of the prior authorization in question.

Inconsistent Documentation Requirements
A significant burden for providers who treat MA enrollees is that each MA plan has its own documentation requirements and determining what each plan requires is nearly impossible. For example, plans may have differing requirements for referrals/orders, initial evaluations, progress reports and treatment notes, etc. Moreover, trying to sort out these requirements takes time away from direct patient care, as plans’ requirements often are hidden within policy manuals, plan websites, and/or provider handbooks. APTA recommends that all MA plans be required to adopt a single standardized set of documentation requirements.

Inconsistency Between CMS and MA Plans’ Requirements for Medical Review
Additionally, there is significant inconsistency between CMS and MA plans’ requirements when conducting medical review. For example, when submitting documentation in response to an Additional Documentation Request (ADR), providers must use one process for Original Medicare; a different process for MA insurer #1, yet another process for MA insurer #2, and so forth. If the CMS contractor or MA insurer uses a website for electronic submission, the provider must log into a different portal for each payer. Making the process even more complex is the burden on the provider to locate the data submission location page for each MA insurer and CMS contractor. Even then, when on the submission page, the process is not consistent from one insurer to the next. In fact, we are aware of at least one MA insurer that refuses to allow electronic submission, requiring providers to fax the ADR.

To decrease burden and substantially increase compliance and interoperability, APTA recommends CMS recognize the value of standardizing the submission of data to all Medicare contractors, as well as to MA insurers. This feature alone would increase interoperability, allowing for data to be standardized, pulled, and submitted directly from the EHR, while also decreasing provider burden. At a minimum, there should be a ceiling on the number of varying data submission processes.

Inconsistent Application of Definition of Medical Necessity
APTA recommends that CMS standardize the Medicare coverage, coding, and billing guidelines that an MA plan may adopt. MA plans state that they follow Medicare guidelines, but then have confusing interpretations of these guidelines with regard to the use of Correct Coding Initiative edits, the multiple procedure payment reduction, the 8-minute billing rule, etc. The lack of standardized guidelines between original Medicare and MA creates confusion among providers, leading to potential loss of documentation integrity, resulting in limited care coordination and collaboration among health care providers, and significantly increasing provider burden without improving the quality of care. APTA also recommends that to reduce
burden on providers participating in original Medicare, CMS requires that MA plans use the same definition of medical necessity that exists under Medicare Part B. MA plans commonly use language from the payer’s commercial products and not the Medicare definition, creating even more confusion and misunderstanding, resulting in inappropriate claim denials and delays in patient access.

**Accrued Amount of Therapy Services for MA Enrollees**

Through Section 50202 of the Balanced Budget Act of 2018, Congress essentially made permanent the exceptions process for outpatient therapy services. In Medicare FFS, outpatient therapy providers generally can access the accrued amount of therapy services from ELGA (Part A eligibility) screen inquiries (now the Medicare Health Insurance Portability and Accountability Act Eligibility Transaction System, or HETS) in the Common Working File, through the interactive voice response system, through the provider portal, etc. Suppliers lacking access to those modes could call the contractor to obtain the accrued amount.

APTA has concerns that MA payers requiring therapy providers to affix the KX modifier for services above the outpatient therapy threshold to indicate medical necessity do not furnish providers with information related to each MA enrollee’s utilization based on the outpatient therapy threshold. MA enrollees can receive outpatient therapy services from the offices of privately practicing therapists, physician offices, outpatient hospital departments, CAH outpatient departments, rehabilitation agencies, comprehensive outpatient rehabilitation facilities, skilled nursing facilities, and/or from home health providers. Frequently, however, MA plans do not update the accrued amount of therapy services, which requires therapy providers who furnish care to MA enrollees to internally track total claim amounts for enrollees and apply the KX modifier to claims exceeding the threshold ($2,040 for physical therapy and speech-language pathology combined in 2019) when appropriate.

By refusing to update the accrued amount of outpatient therapy services, MA plans render it extremely difficult, if not impossible, for outpatient therapy providers to determine when to affix the KX modifier to the claim to indicate that services over the threshold are medically necessary. Not providing such information creates simply one more administrative and financial burden on outpatient therapy providers, which not only results in a loss of reimbursement for outpatient therapy providers, but also forces providers to direct time, effort, and resources away from patient care in order to call MA plans and inquire as to beneficiary eligibility, as well as submit appeals. Moreover, such practices are contrary to CMS’s goals to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience.

To continue to reduce burdens for therapy providers, improve the quality of care, decrease costs, and ensure that MA enrollees and their therapy providers are making the best health care choices possible, we strongly request that CMS direct MA plans to make data on enrollee utilization of therapy services readily available to providers. The ability to know when to affix the KX modifier to claims requires therapy providers to have access to real-time MA enrollee utilization data.
Health Information Technology Recommendations

Certified Electronic Health Records Technology
Physicians and hospitals were afforded EHR incentive funding and multiple stages to adopt EHRs and learn how to successfully exchange patient information using certified electronic health record technology (CEHRT) whereas physical therapists in private practice, other nonphysician health care professionals, and long-term and postacute care facilities were ineligible to participate in the Meaningful Use EHR Incentive Program (now the Promoting Interoperability category within the Merit-based Incentive Payment System, or MIPS) and have received little to no direction, as well as time and resources, to adopt and implement comprehensive, interoperable EHR systems that promote care coordination and improve patient outcomes. The Office of the National Coordinator for Health Information Technology (ONC) certification process has established standards and other criteria for structured data that EHRs must use. However, vendors that develop and offer EHRs for physical therapists and other nonphysician providers are unclear as to how to satisfy the 2015 Edition Health IT Certification criteria, given that several of the criteria are inapplicable to these health care professionals. Due to the lack of guidance for these vendors and physical therapists, only a limited number of EHRs have been certified by ONC and encompass the necessary components for the documentation and transmission of information regarding physical therapy services.

APTA supports rehabilitation providers being able to fully participate in the Quality Payment Program (QPP) – both MIPS and Advanced Alternative Payment Models (APMs). However, CEHRT requirements are designed for prescribing professionals and do not capture tasks performed by nonphysician professionals using different types of EHRs (or electronic medical records (EMRs)). Moreover, the Medicare Access and CHIP Reauthorization Act of 2015 mandates that APM Entities participating in Advanced APMs require eligible clinicians to use CEHRT. In 2019, to participate in a Medicare Advanced APM, each APM entity must require at least 75% of eligible clinicians to use CEHRT to document and communicate clinical care with patients and other health care professionals. In 2020, this threshold will increase to 100%. As of January 1, 2020, CMS requires that to qualify as an Other Payer Advanced APM, 75% of eligible clinicians participating in the other payer arrangement must use CEHRT. This threshold will increase to 100% in future years.

Barring any regulatory or policy changes to address the numerous technical and financial barriers associated with adopting and using CEHRT, including how physical therapy EHR vendors may certify their rehabilitation-specific products, physical therapists will be unable to fully participate in MIPS and will be excluded from participation in Advanced APMs due to the Advanced APM minimum CEHRT use threshold in the QPP. Therefore, we encourage CMS to acknowledge that appropriate resources and support, including implementation assistance and/or consultant support, must be afforded to physical therapists and other nonphysicians as they adopt and optimize certified EHRs to better enable these providers to participate in new models of care.

Moreover, while large provider groups/health systems may be on a compatible EHR system, most independent practices use EHRs that are not standardized, making it that much more imperative that these providers, and their specific needs, are front and center in the
discussions. In fact, many of these providers use and rely upon an EMR, as opposed to an EHR, which has significant differences in capability.

The repercussions associated with excluding physical therapists from Meaningful Use, leaving them without guidance (or funding) to adopt CEHRT, are mounting. For example, even though physical therapists now are included in MIPS, physicians are less inclined to refer patients to them because they lack CEHRT. Under MIPS, physicians are being scored on the Promoting Interoperability category transition measure, which requires that the referring provider use CEHRT to create a summary-of-care record and electronically transmit it to a receiving health care provider. However, physical therapy EHRs are not equipped to receive such information—requiring physicians to fax the referral, which they prefer not to do, as such practice detracts from their scoring under the Promoting Interoperability category. Physicians and other MIPS-eligible providers expect other eligible providers to have CEHRT and be participating in all 4 categories; however, newly eligible MIPS providers, including physical therapists, do not currently have the capability to participate in the Promoting Interoperability category.

We appreciate that CMS has acknowledged that most nonphysician providers do not have CEHRT and reweighted the Promoting Interoperability category for physical therapists and other newly eligible MIPS providers in 2019 and have again proposed to do so for 2020. However, as CMS stated in the 2019 Medicare Physician Fee Schedule final rule, its “intention is not to continue the proposed policy in perpetuity.” CMS further stated it believes “that for increased interoperability and health information exchange it is important for all types of MIPS eligible clinicians to use CEHRT.”

To move to a more standardized and interoperable environment, promote increased interoperability and care coordination across the continuum, and facilitate nonphysicians’ participation in MIPS and Advanced APMs in the future, we urge CMS to recognize the urgent need to issue guidance and provide financial and administrative support to nonphysicians, including physical therapists, and their EHR vendors, in order to adopt and implement CEHRT.

We also recommend that CMS direct those providers that were afforded federal health IT incentive funding to share patient information with the next care setting in a timely manner (i.e., before the patient arrives at the next care setting rather than closer to 30 days after discharge). To ensure the future health care system is one that is patient-centric and dedicated to improving care quality and increasing patients’ access to their information, all relevant parties across the continuum need, and deserve, financial and administrative support to help them implement CEHRT and adopt measures that give patients the ability to manage their health information. It is critical that patient information can flow between various sectors of the care continuum, including physicians, hospitals, physical therapists in private practice, postacute care and long-term care providers, and other health care providers.

Finally, for the CEHRT adoption process to be equitable and fair for all parties, we recommend that CMS and other federal agencies be cognizant of health IT development cycles. Incorporating newly adopted standards or revised specifications into the development cycle takes time – time

---

to incorporate, test, and verify that the new standard or specification is operating as expected. It also takes time to roll out updates and new products to clients, who will need time to train staff and implement policy changes. **To that end, we request that CMS allow EHR vendors and health care providers a transition period of 3-5 years to develop, adopt, and integrate certified products. We also recommend that CMS educate providers on the certification process in a manner that clearly conveys what providers need to know, what they need to do now and in future years, and the anticipated costs associated with adopting and implementing certified technology.**

**Conclusion**

APTA thanks CMS for the opportunity to comment on the RFI on Reducing Administrative Burden. Should you have any questions regarding our comments, please contact Kara Gainer, Director of Regulatory Affairs, at karagainer@apta.org or 703/706-8547. Thank you for your consideration.

Sincerely,

Sharon L. Dunn, PT, PhD
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy
President

SLD: krg