

An Alternative Payment System for Physical Therapy Services

Developmental Draft for APTA Members
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American Physical Therapy Association

BACKGROUND & DESCRIPTION OF ALTERNATIVE PAYMENT SYSTEM PROPOSED MODEL

Policymakers are seeking ways to reform payment systems to achieve greater reporting accuracy, promote quality care, and reduce fraud and abuse. In the Balanced Budget Act of 1997, Congress charged the Centers for Medicare and Medicaid Services (CMS) to develop an alternative to the Medicare therapy cap—an arbitrary limit that restricts patient access to clinically appropriate services.

The American Physical Therapy Association's (APTA) goal is to reform payment for outpatient physical therapy services to improve quality of care, recognize and promote the clinical judgment of the physical therapist, and provide policymakers and payers with an accurate payment system that ensures the integrity of medically necessary services.

APTA proposes to reform payment for outpatient physical therapy services by transitioning from the current fee-for-service, procedural-based payment system to a per session payment system. APTA believes that a system that categorizes patients based on the severity of their condition and intensity of the interventions required better reflects the professional clinical reasoning/judgment and decision making by the physical therapist, improves provider compliance, reduces administrative burdens surrounding current payment models, and is consistent with and enhances payer recognition of the value of physical therapist-directed care. To achieve this reformed payment system for outpatient physical therapist services, changes to the existing Current Procedural Terminology (CPT) coding system, which describes services based on 15-minute time-based units and direct one on one contact, would be necessary. Following these coding changes, the new codes will be valued through the AMA Relative Value Update (RUC) process and implemented in federal, commercial, and state-based payment systems.

Establishing new codes that physical therapists report for their services would be a significant change that would

require therapists to learn the new codes and update billing systems. However, with elimination of many of the existing codes that therapists report and the many associated edits, administrative burden would be reduced. This bundled approach to the codes could result in more appropriate valuation of therapy services that better reflects the patient's condition and the clinical judgment of the therapist.

The alternative payment system (APS) would consist of 3 evaluation codes and 9 examination and intervention codes for a total of 12 codes. A physical therapist could conduct an evaluation and an examination and intervention service in the same day; otherwise a single examination and intervention code would be reported for the services that were delivered. Evaluation codes would be differentiated based on the level of complexity of the evaluation to the physical therapist—limited complexity, moderate complexity, and significant complexity (refer to Table 1). Intervention codes would be differentiated into levels based on the severity of the patient's condition at the time of the visit and the intensity of services provided for the patient during that visit. The patient's severity would be determined to be either limited, moderate, or significant and the intensity of the therapy for that visit would be designated as limited, moderate and significant (refer to Table 2). Appendix A includes factors that could be used as a reference by the physical therapist to determine the patient's severity. The descriptors for each CPT code are included below. For each code, an illustration of a patient visit that would be reported using the code is included. These illustrations include a description of the patient's condition and characteristics and the intensity of the intervention provided by the physical therapist.

TABLE 1: EVALUATION BASED ON CLINICAL COMPLEXITY OF THE EVALUATION

Clinical Considerations and Complexity of the Examination Evaluation	Level of Evaluation
Limited/Problem-focused	1
Moderate/Detailed	2
Significant/Comprehensive	3

Problem-focused: A limited examination of the affected body area or system.

Detailed (moderate decision making): An extended examination of the affected body area(s) and other symptomatic or related system.

Comprehensive (high intensity/complexity): A general multisystem examination or a complete examination of a single system.

Table 2: The Visit/Session Based Examination (Patient Severity) and Intervention (Intensity of Visit)

Intensity of the Visit	Patient Severity at the Time of the Visit		
	Limited	Moderate	Significant
Limited	4	5	6
Moderate	7	8	9
Significant	10	11	12

The actual numbers in the boxes (1 through 12) are placeholders for possible future CPT codes.

*Numbers correspond to the code descriptor number

CODE DESCRIPTORS

Evaluation Code #1– Therapy Evaluation: Limited Complexity (Problem-focused Evaluation)

- Clinical presentation with stable characteristics of patient’s condition, complaints, cognitive status, and with minimal to absent safety concerns,
- A problem focused history, limited examination, straightforward clinical decision making with no personal factors or comorbidities that impact the condition being evaluated,
- Limited use of standardized tests and measures is required to establish or update a plan of care addressing 1 or more similar impairments, activity limitations and/or participation restrictions,
- Initiation of or updates to the plan of care, including goals and the selection of interventions is documented by a physical therapist, and
- Plan of care requires minor or no referral or coordination, consultation or communication with other health care professionals.

Illustration of Typical Patient for Evaluation Code #1

A 66-year-old female reports pain during walking after sustaining a left ankle sprain 1 week ago after twisting her ankle walking on an uneven terrain. Patient’s history is insignificant except for a family history of Alzheimer disease, high blood pressure controlled with medication, and arthritis in left knee. Examination by history and observation reveals no ankle edema or discoloration, mild ankle tenderness by patient report, and is not currently using an assistive device by patient report. Standardized functional assessment instrument reveals pain, difficulty walking with full weight bearing, and fear of falling among the top 3 problems from patient’s perspective. Plan of care requires intervention with minor or no referral, coordination, consultation, or communication with other health care professionals.

CODE DESCRIPTORS (CONTINUED)

Evaluation Code #2– Therapy Evaluation: Moderate Complexity (Detailed Evaluation)

- Clinical presentation with evolving or changing characteristics of patient's condition, complaints, cognitive status, and with moderate safety concerns, and potential for functional decline or delayed progress,
- A detailed history and examination, and consideration of impact of other health conditions or impairments on functional recovery with documentation of 2 or less personal factors and/or comorbidities that impact the condition(s) being evaluated,
- Use of standardized tests and measures, the complex consideration of the interaction of multiple health conditions or impairments on functioning and, the establishment of a detailed plan of care or update of an established plan of care addressing impairments, activity limitations and/or participation restrictions as identified by standardized functional assessment instrument(s),
- Initiation of or updates to the plan of care, including goals and the selection of interventions is documented by a physical therapist, and
- Initiation of or updates to the plan of care, requiring some referral to, coordination, consultation and/or communication with other providers.

Illustration of Typical Patient for Evaluation Code #2

A 55-year-old female reports right knee pain for the past 2 weeks. The problem began after gardening and has not abated since the initial onset. A patient history was completed and she has mild asthma that worsens in the spring due to tree pollen and a history of diabetes, osteopenia, and controlled hypertension. She reports having fallen twice during the past 6 months with no significant injuries and is not active due to knee pain but still works as a receptionist. Examination reveals pain in right knee when ascending and descending stairs, pain and stiffness when walking more than 30 minutes and after 1 hour of sitting, and pain and limited range of motion in both shoulders. There is no ligamentous laxity in the knees and range of motion is normal. Radiographs show degenerative changes including joint space narrowing. Standardized functional assessment instruments indicate objective functional deficits related to use of both the lower and upper extremities. Plan of care includes physical therapy interventions and consultation and communication with primary care physician for potential referral to rheumatologist, and referral to the local Stepping On falls program at the YMCA once balance has improved and patient could safely participate in this program.

CODE DESCRIPTORS (CONTINUED)

Evaluation Code #3– Therapy Evaluation: Significant Complexity (Comprehensive Evaluation)

- Clinical presentation with unstable and unpredictable characteristics of patient's condition, complaints, cognitive status, and with substantial risk for diminished safety,
- Detailed history and examination using standardized tests and measures (including performance based tests and measures), and complex consideration of the interaction of multiple health conditions or impairments on functioning, with documentation of 3 or more personal factors and/or comorbidities that impact the condition(s) being evaluated,
- Establishment of a comprehensive plan of care or the update of an established plan of care addressing impairments, activity limitations and/or participation restrictions as identified by functional assessment instrument(s),
- Initiation of or updates to the plan of care, including goals and the selection of interventions is documented by a physical therapist, and
- Initiation of or updates to the plan of care, requiring referral to, coordination, consultation and/or communication with other providers.

Illustration of Typical Patient for Evaluation Code #3

The patient is a 75-year-old female who reports constant pain, instability, and edema in the right knee of 4 months duration. She is unable to bear weight on the right lower extremity and is using the arm of her daughter to assist her in ambulating into the clinic. She had a fall this morning when getting out of bed and has a contusion on her right shoulder and over her right eye. Her medical history includes rheumatoid arthritis for 20 years, advanced osteoporosis secondary to prolonged steroid use, and breast cancer with mastectomy 15 years ago. She had a right total hip replacement 10 years ago. The prosthesis is loose and needs a revision. She has deformities and pain in both wrists and hands secondary to the rheumatoid arthritis. Standardized functional assessment instruments identified multiple objective limitations. Tests and measures included the Timed Up and Go, Four Square for falls, and gait speed and confirmed substantial neuromusculoskeletal impairments and major home safety issues. Plan of care includes physical therapy interventions, referral to orthopedics for assessment of right total hip prosthesis, consultation with a rheumatological nurse practitioner, and extensive communication with an occupational therapist related to home safety supports.

CODE DESCRIPTORS (CONTINUED)

Examination and Intervention Code #4 – Limited Patient Severity, Therapy Intervention Limited

- Based on examination, clinical presentation is stable with minimal safety issues due to health and/or cognitive status,
- Patient receives limited interventions (typically 30 minutes or less), a portion of which involves individualized interaction between the qualified health care professional and the patient, and
- Patient response to intervention is monitored and adjusted based on clinical information/data gathered.

Illustration of Typical Patient for Examination and Intervention Code #4

Patient is an 83-year-old woman who slipped and fell on the ice 2 weeks ago while shoveling snow on steps outside her home. The nondisplaced fracture was treated conservatively and placed in a sling. Goal is full return to previous level of function. This is the second home visit focusing on active assistive range of motion (ROM) and functional training in bed mobility using unaffected side.

Examination and Intervention Code #5– Moderate Patient Severity, Therapy Intervention Limited

- Based on examination, clinical presentation demonstrates evolving or changing characteristics of patient condition, complaints, cognitive status, with moderate safety concerns,
- Patient receives limited interventions (typically 30 minutes or less), a portion of which involves individualized interaction between the qualified health care professional and the patient, and
- Clinical problem solving or decision making occurs throughout the intervention based on changes in the patient's status, response to treatment, and whether the planned procedure or service should be modified.

Illustration of Typical Patient for Examination and Intervention Code #5

A 75-year-old patient had a closed, comminuted fracture of the proximal humerus 1 week ago. The fracture was treated with closed reduction and the arm was immobilized in a sling. Current problems include difficulty sleeping and finding a comfortable position. Relevant medical history includes osteoarthritis in both knees and mild dementia. This is his third physical therapy visit following evaluation. Treatment consists of therapeutic exercise, instruction in positioning, and instructions for home cryotherapy.

CODE DESCRIPTORS (CONTINUED)

Examination and Intervention Code #6 – Significant Patient Severity, Therapy Intervention Limited

- Based on examination clinical presentation demonstrates unstable and unpredictable characteristics of patient condition, complaints, and/or cognitive status affecting safety requiring evaluation by a physical therapist during session,
- Patient receives limited interventions (typically 30 minutes or less), a portion of which involves individualized interaction between the qualified health care professional and the patient, and
- Clinical problem solving or decision making occurs throughout the intervention based on changes in the patient's status, response to treatment, and whether the planned procedure or service should be modified.

Illustration of Typical Patient for Examination and Intervention Code #6

A 26-year-old female with rheumatoid arthritis was referred for evaluation and treatment following a motor vehicle accident when the car was struck from behind. Radiograph is equivocal for fracture of odontoid process. Patient is unable to work due to pain. Patient is also obese with increased thoracic kyphosis. She was seen today for her second visit consisting of active and active assistive exercise for the neck and upper quadrant, palliative modalities for pain, and instructed in positioning for sleeping.

Examination and Intervention Code #7 – Limited Patient Severity, Therapy Intervention Moderate

- Based on examination clinical presentation is stable with minimal safety issues due to health and/or cognitive status,
- Patient receives moderate interventions (typically 31-45 minutes), a portion of which involves individualized interaction between the qualified health care professional and the patient, and
- Patient response to intervention is monitored and adjusted based on clinical information/data gathered.

Illustration of Typical Patient for Examination and Intervention Code #7

The patient is a 74-year-old male with lateral epicondylitis, who plays tennis doubles several times a week. He began physical therapy 1 week ago and has been compliant with his home program of daily exercise. Today's treatment included manual therapy, therapeutic exercise, neuromuscular reeducation, and an updating of the home program.

CODE DESCRIPTORS (CONTINUED)

Examination and Intervention Code #8 – Moderate Patient Severity, Therapy Intervention Moderate

- Based on examination clinical presentation demonstrates evolving or changing characteristics to patient condition, complaints, cognitive status, with moderate safety concerns,
- Patient receives moderate interventions (typically 31-45 minutes), a portion of which involves individualized interaction between the qualified health care professional and the patient, and
- Clinical problem solving or decision making occurs throughout the intervention based on changes in the patient's status, response to treatment, and whether the planned procedure or service should be modified.

Illustration of Typical Patient for Examination and Intervention Code #8

A 57-year-old woman is attending her seventh treatment session for chronic pain due to fibromyalgia for the past 5 years. This recent exacerbation includes decreased range of motion and pain in her right elbow and left knee. Although she is independent in all basic activities of daily living (ADL), her husband has needed to hire help to take care of the family even though the patient stopped working as a librarian 3 years ago. Today's treatments comprised manual therapy for soft tissues, relaxation training using guided imagery, aerobic conditioning on a stationary bicycle, and modalities for palliative care.

Examination and Intervention Code #9– Significant Patient Severity, Therapy Intervention Moderate

- Based on examination clinical presentation demonstrates unstable and unpredictable characteristics to patient condition, complaints, and/or cognitive status affecting safety requiring evaluation by a physical therapist during session,
- Patient receives moderate interventions (typically 31-45 minutes of 1:1 interventions involving active patient participation exclusive of modality interventions), and
- Clinical decision making occurs throughout the intervention based on changes in the patient's status, response to treatment, and whether the planned procedure or service should be modified.

Illustration of Typical Patient for Examination and Intervention Code #9

The patient is a 48-year-old female with generalized weakness of unknown etiology that began 3 months ago. Patient was formerly independent with gait and all ADLs with no assistive devices. She is now wheelchair dependent and dependent for all transfers, rolling, and ADLs. She is not able to stand. She can sit for brief periods without support, but is unable to recover when balance is lost in sitting. Today's treatment focuses on strengthening, transfer training, neuromuscular reeducation, and caregiver instruction.

CODE DESCRIPTORS (CONTINUED)

Examination and Intervention Code #10 – Limited Patient Severity, Therapy Intervention Significant

- Based on examination, clinical presentation is stable with minimal safety issues due to health and/or cognitive status,
- Patient receives significant interventions (typically more than 45 minutes), a portion of which involves individualized interaction between the qualified health care professional and the patient, and
- Clinical problem solving or decision making occurs throughout the intervention based on changes in the patient's status, response to treatment, and whether the planned procedure or service should be modified.

Illustration of Typical Patient for Examination and Intervention Code #10

A 54-year-old woman has been seen 12 times over 6 weeks to remediate a frozen shoulder that evolved 6 months ago. This is the first week that she has been able to achieve nearly full ROM without pain and reports that her pain level this week has been 2-3 out of 10. Treatment today consists of grade IV mobilization, strengthening exercises, neuro-muscular reeducation for scapulohumeral rhythm, postural education, update of home program, and palliative modalities as the conclusion of the session.

Examination and Intervention Code #11 – Moderate Patient Severity, Therapy Intervention Significant

- Based on examination, clinical presentation demonstrates evolving or changing characteristics to patient condition, complaints, cognitive status, with moderate safety concerns,
- Patient receives significant interventions (typically more than 45 minutes of 1:1 interventions involving active patient participation exclusive of modality interventions), and
- The clinical decision making occurs throughout the intervention to identify changes in the patient's status, response to treatment, and whether the planned procedure or service should be modified.

Illustration of Typical Patient for Examination and Intervention Code #11

A 52-year-old woman is currently experiencing intermittent swelling of her left arm that varies with activity. She had breast cancer 4 years ago that was treated with left modified radical mastectomy and axillary lymph node dissection. She has been in remission since her treatment. Left shoulder range of motion is limited for flexion/abduction/external rotation. Weakness noted in her pectoral muscles and posterior scapular/thoracic musculature. Circumferential measurements reveal a 2- to 3-centimeter increase in the affected arm. Treatment focus for today included manual therapy, lymphatic drainage, ROM and active exercise, and wrapping to reduce swelling.

CODE DESCRIPTORS (CONTINUED)

Examination and Intervention Code #12 – Significant Patient Severity, Therapy Intervention Significant

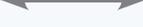
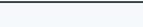
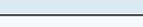
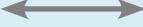
- Based on examination, clinical presentation demonstrates unstable and unpredictable characteristics to patient condition, complaints, and/or cognitive status affecting safety and requiring evaluation or reevaluation during the session,
- Patient receives significant interventions (typically more than 45 minutes of 1:1 interventions involving active patient participation, or modality interventions), and
- Clinical decision making occurs throughout the intervention based on changes in the patient's status, response to treatment, and whether the planned procedure or service should be modified.

Illustration of Typical Patient for Examination and Intervention Code #12

A 50-year-old engineer experienced multiple traumatic injuries following a motor vehicle accident. He underwent surgery for a right hip fracture and is allowed to be weight-bearing as tolerated with axillary crutches. He uses an AFO on the left due to dorsiflexion weakness from an injury to his peroneal nerve. There is an open wound on his left thigh which is covered with a dressing. Prior to the accident he was working full time and had no activity limitations. His family brings him in a wheelchair to his second outpatient physical therapy appointment today with hopes to return to his previous level of activity. Treatment focus is wound management, neuromuscular reeducation, gait training, functional training, and therapeutic activities.

APPENDIX

Appendix A - Criteria to Determine Severity of a Condition as These Criteria Affect Duration and Cost of an Episode of Care

Criteria	Lower Severity		Higher Severity
Patient Safety	Safe/adequate safety to meet patient's needs		not safe/no insight/not safe to meet patient's needs
Age	no concerns related to age/irrelevant to condition		age likely to impact outcome/highly relevant
Time since onset	Intervention well timed to need		timing likely to impact care
Clinical presentation	Straightforward/well circumscribed		clinical presentation evolving
Mechanism of injury/illness	Well defined		uncertain
Current condition	stable		unstable/fluctuating/recurrent
Premorbid functional level	high/stable/sufficient to patient's needs		low/significant change to current/mismatched to patient's needs
Current functional level	high/stable/sufficient to patient's needs		low/ significant change to premorbid/mismatched to patient's needs
Comorbidity impact on function	low impact on function		high impact on function
Cognition	intact/no impact/sufficient to patient's needs		impaired/significant impact/insufficient to patient's needs
Physical environment	no concerns/appropriately matched to current and future needs		Uncertain/significant barrier
Psychosocial support	no concerns/ appropriately matched to current and future needs		Uncertain/significant concerns needs
Goals	directly related to therapist control		outside of therapist control
Goal agreement	high agreement between patient/PT		low agreement between patient/PT
Time to achieve goals	certain/short		uncertain/long/highly variable
Prognosis	good/certain		uncertain/highly variable
Patient mood/motivation	unrelated to goal achievement/motivated		essential to goal/not motivated
Intervention	known/effective		uncertain/questionable
Risk of procedure	low		high
Progression	fast/consistent/predictable		slow/variable/unpredictable
Probable outcome	certain/predictable		uncertain/variable