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Gauging Your Practice’s Financial Health
August 2018

I’d submit that the gross number of patients seen or evaluated per day or hour provides no indication of the value of care or of the revenue generated. The number of treatment units per hour that are billed for and paid—which has no relationship to the number of people seen—is a much more useful metric. If a therapist sees 8 people in an 8-hour day and provides 4 units of care, billable to the patient or a third-party payer, then the therapist has a 100% productivity rate. At the end of the day, 32 units of 15 minutes were billed for, and there is no more room for any sort of “improvement” in that. There is no more time in the day in which to bill.

At the same time, the therapist who sees 16 people in an 8-hour day sees them for roughly 30 minutes. He’s spent twice as much time washing his hands, walking to the waiting room and back, and documenting his patient care visits. Can he bill 32 units in that 8-hour period, considering the preceding?

It’s a conundrum we’re in, with reimbursement based on procedures and not true value of care. It’s unhelpful to use metrics like the number of visits to describe any factors relevant to “value” without some discussion of the “8-minute rule.”

Leon Richard

Physical Therapy for People With Autism
July 2018

Bravo! And thank you for this article! My daughter is on the spectrum, and I am a third-year PT student. Our experience and the lack of services is exactly why I made a career change and now find myself in grad school at almost 40. My daughter didn’t receive early intervention because her motor delays and my concerns were ignored by many professionals I consulted. She is now 17. I’m dreading and terrified of the transition to adulthood. I’m desperately searching for higher education inclusion programs for her. Thank you! Thank you! Thank you for helping to raise awareness of the needs and concerns of families like ours!

Travis Coombs
In my opinion, working with the aging population and people with life-changing health conditions and helping them stay in their home, regain independence, stay out of the hospital, save money, and improve their quality of life is much more rewarding.

Ronald Drummer

Folks: The fact is, we are not worth the hourly rates we seek, at least based on what insurance is willing to pay. I see lowering our rates as being the only way we can get reasonable productivity requirements. That’s a painful reality. Every time productivity standards are raised we are, in effect, being given a pay cut. It may be time we adjust our income expectations (sadly—we are overeducated for that!) and relax our frenetic work pace.

Either that, or go into private practice, offering cash-based service so that people can receive real therapy. What we are doing now—churning patients in and out and cycling them through—is a disgrace to the profession. So many folks I’ve known have sought physical therapy for pain only to be put on a bike for 15 minutes and given a few home exercises. Shameful! And we know it. But we are just trying to get through the day and pay our bills.

Ginny

This is wonderful! There is so much potential to expand physical therapist delivery of care by innovating and creating group programs and changing the way we practice. An alternative model of physical therapy care can include individual treatment and small-group exercise classes for specialized populations and individuals with complex medical needs.

Group exercise design and the therapeutic use of music could be included in our DPT training. An abundance of research supports the benefits of group exercise from both psychological/social and physical perspectives. As we know, the 2 are interrelated. Our profession needs to expand its reach and innovate with programs like this. I am so excited to see this [Defining Moment] essay, in which students are advancing our profession and transforming society.

Patrice Hazan
Understanding the CPT Process
Here’s what’s involved and why it’s important to know.

CPT® (Current Procedural Terminology) coding is the means by which the vast majority of health care providers receive payment. Although physical therapists (PTs) frequently use CPT codes, they aren’t necessarily familiar with the process by which the codes are developed, approved, adopted, valued, modified, and deleted. Understanding CPT codes, what they represent, and how precisely they do or do not translate into actual payment is an important aspect of physical therapist practice.

PT coding is not simply an administrative task. It represents the level and intensity of care provided by the PT. In their 2006 book *Redefining Health Care*, Michael E. Porter and Elizabeth Olmstead Teisberg defined value as outcomes over cost. With the American health care system moving toward value-based care and payment models, PTs must be able to provide objective information for both the numerator and denominator in Porter and Teisberg’s equation.

If a PT does not understand coding—and thus does not ensure billing of the codes that most specifically and accurately represent the provided care—that PT risks inaccurate reimbursement, denials, recoupment of payments, and even investigation for fraud and abuse.

**Basics**

CPT is the universal language describing medical, surgical, and diagnostic services. The American Medical Association (AMA) holds its copyright. In 2000, the CPT code set became the national coding standard for health care professionals under the Health Insurance Portability and Accountability Act (HIPAA). This means that all HIPAA entities must use CPT coding for billing services and procedures. (Non-HIPAA entities such as workers’ compensation and auto insurance are not mandated to use CPT coding.)

There are 3 categories of CPT codes:

- Category I describes the majority of services
and procedures billed by providers. It includes the 97000 code series often billed by PTs.

Category II tracks performance measurement. For example, code 4400F indicates whether the provider discussed rehabilitative therapy service options at least annually with a patient with Parkinson disease.

Category III codes are temporary and track data for emerging technologies. For instance, low-frequency, nonthermal ultrasound at one time was assigned a category III code (0183T) to track its use, before it was assigned a category I code (97610).

Although the majority of services and procedures provided by PTs are represented by the 97000 series, PTs are not limited to billing codes in that series. For example, PTs often bill vestibular function tests found in the 92000 series. Any code representing a service or procedure that a PT legally can provide is available to that provider for billing purposes.

Each time a CPT code is included in a claim for payment, the PT is stating that he or she provided or performed the service or procedure described by that code. So, accurate coding is a professional responsibility. It is important to understand that CPT coding and payment policy are 2 different things. The existence of a code does not guarantee payment. Payment policy is set by each individual payer and is determined by the employer benefit package language. Some payers may limit or restrict payment, or may consider certain codes to be bundled. Also, the billing of certain code pairs or combinations may be prohibited or may require use of a modifier to explain why codes should be allowed in a specific situation. These code pairs are addressed within the National Correct Coding Initiative (NCCI), created by the Centers for Medicare and Medicaid Services (CMS) to promote correct coding methodologies. NCCI edits often are adopted and enforced by commercial payers, as well.

Components
The value assigned to a CPT code is based on 3 components:

- The physician or qualified health care professional work, which includes the time, technical skill, and physical effort required to perform the service or procedure, the mental effort and judgment involved, and the amount of stress associated with the level of risk to the patient.
The practice expense, which includes physical therapist assistant and physical therapy aide time, as well as the cost of equipment and supplies associated with the service or procedure.

The professional liability insurance relative value, which is a fixed figure established and updated by CMS.

To determine the professional work and practice expense, societies or associations representing members who perform the service or procedure have the opportunity to survey a representative sample of their members. The survey tool captures the data necessary to determine the professional work and the practice expense. The specialty organization then submits recommendations based on the study to the AMA’s Relative Value Scale Update Committee (RUC) for consideration. The RUC may accept the specialty organization’s recommendation or propose an alternate value, which it in turn submits to CMS. The RUC’s recommendations are considered but not necessarily accepted, as CMS ultimately determines the value of a code for the purpose of the physician fee schedule.

Once CMS assigns a relative value to a code based on the 3 components, that value is multiplied by a conversion factor that takes into account geographical differences in resource costs.

APTA members may remember going through this valuation process twice in the past few years. In 2015, members were surveyed about the 3 new tiered evaluation codes that replaced the single 97001 code to reflect increasing levels of patient complexity. CMS ultimately maintained the same value for all 3 codes but continues to monitor their use; in future years the agency may stratify the values. In 2016, members again were surveyed about a variety of physical therapy-related codes that had appeared on CMS’s “misvalued” list—codes that were subject to review to ensure that their values remained current.

**Editorial Panel**

Before a CPT code is assigned a relative value, it must be reviewed by the CPT Editorial Panel. The panel, authorized by the AMA Board of Trustees, is responsible for maintaining the CPT code set. It has 17 members—15 physicians and 2 representatives from HCPAC.

The CPT Editorial Panel is supported by a larger group of more than 300 CPT advisors, professional society/association staff, and AMA staff. APTA is represented by 2 members acting as the advisor and alternate advisor for HCPAC, and by APTA staff. CPT advisors representing APTA are volunteer members who dedicate a significant amount of time and expertise to this process. Their responsibilities include providing comment to all CPT code change applications, attending and participating in CPT Editorial Panel meetings, and submitting any code change applications that are sponsored or cosponsored by APTA.

The CPT Editorial Panel meets 3 times per year to review applications for new codes or code changes. The majority of applications are submitted by professional societies or associations, although other stakeholders, such as medical device developers or companies, also may submit applications.

The code change application initially is reviewed by AMA staff and CPT advisors. Applicants may be asked to provide clarifying information or to respond to additional questions before the application is considered complete for consideration and placed on the agenda of the next CPT Editorial Panel meeting. Additional information may include clarifying some component of the description of the procedure, or some aspect of the typical patient for whom the service or procedure is indicated.

AMA staff and CPT advisors have the opportunity and responsibility to review and provide comment on code change applications prior to the
meeting. They may ask applicants for clarifying information or, if 2 applications have common elements, suggest that the requests be merged into a single application.

**Change Request Outcomes**

There are 4 possible outcomes for a code change application:

- A new code is approved or an existing code is revised.
- The application is referred to a work group for further study. Ad hoc work groups are formed at the request of the panel to address complex coding issues that require more time than can be afforded during the meeting.
- Consideration of the application is postponed to allow for additional information to be provided.
- The application is rejected.

If a new code or code change is approved, it goes to the RUC to establish its value and pricing and will become available for use in the next published CPT manual.

**Further Information**

For more insights into CPT codes and their relationship to reimbursement, go to APTA’s coding and billing page at www.apta.org/Payment/CodingBilling/. There, you’ll find links to podcasts, courses, issues and interpretations, and more.

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New technologies constantly are emerging in attempts to make health care more responsive to patient needs while, ideally, containing costs. Many feature articles and other items in this magazine have spotlighted physical therapy’s expansion into such areas as virtual reality, genomics, and regenerative medicine.

What is the ethically appropriate response, however, when a physical therapist (PT) questions his or her ability to fully deliver on the promise of a technology-aided clinical tool? Consider the following scenario.

Robotics Reservations

John is employed at Rising Sun, a small outpatient rehabilitation facility located in a rural area. He’s been there for 3 years, after a brief stint at a private practice after graduation. He loves his work, which primarily is with patients who have neurologic impairments. His goal is to become a board-certified clinical specialist in neurologic physical therapy.

One of John’s patients, Mary, is 66 and recovering from a stroke she sustained 3 weeks ago. She already has regained enough function in her affected right leg to ambulate with a cane. Progress has been slower, however, in her right arm and hand. She’s encouraged that some movement has returned, but she’s frustrated by the pace of improvement, given that her right hand is her dominant one, and that she’s eager to return to crafts in which she’s been avidly engaged since her retirement last year. Mary also notes that Max, her Bernese mountain dog, is looking awfully shaggy. She can’t very well manage the grooming tools with just her nondominant left hand.

Then there’s the matter of Chet, Mary’s husband, a self-employed plumber who’s been the couple’s sole breadwinner since Mary’s retirement. Driving her to Rising Sun 3 times a week for the past couple of weeks has cut into his business, as public transportation options don’t exist in their county.

“The human hand contains complex circuitry,” John advises Mary. “You’ll get there. It’s just going to take a little bit of time.”
“I understand,” she replies. “I know that you’re doing everything you can. I sincerely appreciate it. I just wish there was a way we could nudge the healing process along a little bit—for Chet’s sake as much as for mine.”

The very next day, Mary gets a call from her physician that seems to answer her plea. “I just attended a lecture at the university on ‘Electromechanical and Robot-Assisted Arm Training Poststroke,’” he says. “It’s an area that shows promise. The thinking is that by efficiently activating new neural pathways with this technology, functional recovery may be more complete—and perhaps faster—than it would be using traditional rehabilitation methods. I think you’re a good candidate for it. There’s an ongoing study. Were you to be accepted into it, you’d get a device to use at home. You’d work with John. You’d just have to go in once a week for him to train you on different ways to use the device.”

This sounds perfect to Mary. She excitedly discusses it with John on her next visit. “What do you think?” she asks him.

He pauses before responding. John is vaguely familiar with the technology in question, as it had been conceptually discussed in one of his classes when he was in school. But he has never even seen a hands-on demonstration of it. He supposes he could read up on it, and presumably there are demonstration videos that he could watch. He probably could learn enough to instruct Mary and Chet in safe and effective home use of the device. He’s always been a quick study, John reasons. He didn’t finish school near the top of his class for nothing. Also, this

resources

At www.apta.org/EthicsProfessionalism/

▶ Core ethics documents (including the Code of Ethics for the Physical Therapist and Standards of Ethical Conduct for the Physical Therapist Assistant)

▶ Ethical decision-making tools (past Ethics in Practice columns, categorized by ethical principle or standard; the Realm-Individual Process-Situation [RIPS] Model of Ethical Decision-Making; and opinions of APTA’s Ethics and Judicial Committee)

At www.apta.org/PTinMotion/2006/2/EthicsinAction/

▶ “Ethical Decision Making: Terminology and Context”

Also

Considerations and Ethical Decision-Making

As John internally debates what is in Mary’s best interest, he must consider his ability to effectively use the technology. Might any lack of proficiency compromise her care—and the value of any data collected from the study?

**Realm.** The realm is *individual.* Were John to participate in a research study resulting in the dissemination of data, the realm would be societal, as well.

**Individual process.** *Moral judgment* is required of John, as he must consider the ethical principles of autonomy (Mary’s), beneficence, nonmaleficence, and justice.

**Ethical situation.** This is an *ethical temptation* for John. He senses what he should do based on his own competence, but he’s hopeful about what the device could do for his patient, and what it could mean for his own professional development.

**Ethical principles.** The following principles of the Code of Ethics for the Physical Therapist can provide guidance to John:

- **Principle 2A.** Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients/clients over the interests of the physical therapist.
- **Principle 3B.** Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient/client values.
- **Principle 4A.** Physical therapists shall provide truthful, accurate, and relevant information and shall not make misleading representations.
- **Principle 5C.** Physical therapists involved in research shall abide by accepted standard governing protection of research participants.
- **Principle 6B.** Physical therapists shall take responsibility for their professional development based on critical self-assessment and reflection on changes in physical therapist practice, education, health care delivery, and technology.

is very intriguing technology. There’s a part of John that’s quite interested in gaining experience with it. Still, he feels uncomfortable. John knows that he must sign off as a participant in order for Mary to be added to the study, but he’s hesitant even to send her and Chet off to the university’s research center—an inconvenient hour’s drive away—to be evaluated. John is not yet board-certified in neurologic physical therapy, and he isn’t sure he’s the PT to help Mary maximize any benefits this technology may offer. John is certain, on the other hand, that, as she’s told her, she’ll “get there” with the traditional physical therapy that he is well-qualified to provide. It just may take a bit longer—certainly not so long that Chet’s plumbing business will be significantly impaired. And Mary’s crafts still will be there as enjoyable retirement activities once her hand function has been restored.

“Is there a problem?” Mary asks. “Don’t you think this sounds like a great idea?”

“Maybe,” John responds uncertainly, while weighing what to say next.

**For Reflection**

PTs have an ethical obligation to demonstrate
professional judgment that’s in the patient’s best interest. John has an opportunity to use a therapeutic procedure that may yield better and quicker results for Mary than would traditional physical therapy. He’s not sure, however, that he can quickly and successfully gain the knowledge he’ll need to help his patient optimize the technology. What action, therefore, is in Mary’s best interest?

**For Followup**

If you are reading the print version of this column, go online to www.apta.org/PTinMotion/2018/11/EthicsinPractice/ for a selection of reader responses to the scenario, as well as my views on how the situation might be handled. If you are reading this column online, simply scroll down to the heading “Author Afternote.”

Be aware, however, that it generally takes a few weeks after initial publication for feedback to achieve sufficient volume to generate this online-only feature.

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CMS has proposed changes to the 2019 physician fee schedule that would require eligible PTs to participate in Medicare’s Quality Payment Program next year. To prepare, PTs must understand what’s behind these efforts, what they need to do, and what may lie ahead.

BY CHRISTINE LEHMANN, MA, NTP
In January, Medicare payment for outpatient services is expected to move dramatically toward value-based payment. Physical therapists (PTs) and other providers likely will be added to the provider types that must participate in Medicare’s Quality Payment Program (QPP). The impact on physical therapy? An estimated 55,200 physical therapists (as of 2016) in noninstitutional settings who bill Medicare Part B for outpatient services will be eligible to participate in QPP.

The plan, included in the Centers for Medicare and Medicaid Services’s (CMS) proposed Medicare physician fee schedule rule for 2019, would require certain PTs, occupational therapists, social workers, and clinical psychologists to participate in QPP after having been excluded for the first 2 years of the program.

The goals of QPP, CMS says, are to improve beneficiary outcomes, reduce burden on clinicians, increase adoption of and maximize participation in Advanced Alternative Payment Models (Advanced APMs), improve data and information sharing, ensure operational excellence in implementing programs, and deliver technology capabilities that meet users’ needs.

“This is a landmark event for PTs” says Craig Johnson, PT, MBA, chief operating officer of Therapy Partners Inc in Oakdale, Minnesota, “because it creates an opportunity to participate in value-based care and payment, and commercial health plans may take notice.” Johnson, a board member of APTA’s Private Practice Section, adds, “It’s been hard to move forward with value-based care models at the local level because payers are uncertain about how to approach it. PT providers could do well in value-based models, because we have shown ourselves to be effective providers who can lower episodic costs.”

Rick Rausch, PT, DPT, president of Sovereign Rehabilitation in Chicago and a member of APTA’s Public Policy Advisory Committee, agrees: “Having PTs included in the QPP program is a win for the profession. We might not like the extra work, but it acknowledges that CMS sees us as a vital part of the health care team and part of the solution for escalating costs.”

How Did We Get Here?

PTs have engaged in quality reporting under Medicare Part B since CMS created the Physician Quality Reporting System (PQRS) in 2007. Eligible professionals using the claims-based PQRS program received bonus payments or were subject to penalties based on their level of compliance with the program’s reporting requirements for covered services provided to Medicare Part B fee-for-service beneficiaries.

The vast majority of PTs billing Medicare Part B participated in PQRS. Of the 56,387 eligible clinicians in 2016, 82% reported—10% higher than the national average participation rate of 72% that year, according to CMS 2016 data.2

Meanwhile, the Medicare Access and Children’s Health Insurance Program Reauthorization Act of 2015 created QPP, establishing 2 tracks for participation: the Merit-based Incentive Payment System (MIPS) and Advanced APMs. Clinicians who successfully participate in an Advanced APM are exempt from MIPS reporting. PTs are eligible to participate in Advanced APMs; however, to date only physicians, physician assistants, and nurses have been eligible to participate in MIPS for the potential payment incentive or penalty.

With the onset of MIPS, PQRS expired at the end of 2016. Since then, PTs have been allowed to voluntarily report to MIPS without any assessment or impact on payment. But despite encouragement from APTA for PTs to continue reporting as they did under PQRS, participation understandably dropped off significantly once PQRS expired and MIPS reporting remained voluntary. However,
Goodbye, Burdensome Medicare Rules

In addition to adding PTs to QPP, the proposed 2019 physician fee schedule would end functional limitation reporting (FLR), which has long been criticized by APTA as an undue administrative burden with little value. CMS estimates that PTs in private practice would have saved between 130,000 and 190,000 hours of administrative work in 2017 had FLR not been in place.

Mark Besch, PT, comments, “This is a big win. The FLR design was flawed from its inception due to lack of specificity of the information obtained. The categories were too broad and we had to collect a lot of data that was not meaningful. Although CMS eliminated those FLR G-codes, we still need other mechanisms focused on outcomes.”

Rick Rausch, PT, DPT, offers a different perspective. “I am glad to see some reduction in paperwork requirements as we move into the MIPS system, but I really felt that functional reporting was a step in the right direction. We are all about function as PTs. Not all therapists use assessment tools in their evaluations and treatment, and the FLR system was an attempt to have all PTs use function, and change in function, in their plan of care.”

Beyond eliminating the FLR requirement, Besch suggests that some of the patient assessment requirements with physical therapy-specific components—such as the Minimum Data Set in skilled nursing facilities (SNFs) or the Outcome and Assessment Information Set in the home health environment—could be simplified by eliminating some categories. A good example of CMS simplifying burdensome assessments is the proposed Patient-Driven Payment Model in SNFs, which would reduce frequent patient assessments to an assessment at the 5-day mark of a SNF stay and another at discharge.

How MIPS Works

MIPS combines aspects of various expired programs, including the defunct PQRS. Providers participating in MIPS must collect data throughout the year and submit it for an annual score, similar to the PQRS process. The reported data is used to measure clinicians’ performance in 4 areas: Quality (which succeeded PQRS), Promoting Interoperability (renamed from Advancing Care Information and successor to the defunct meaningful-use program to encourage use of electronic health information), Clinical Practice Improvement Activities, and Cost.

“A big problem in health care is the variation in treatment with little outcomes data,” Rausch observes. “CMS is trying to guide providers down a certain path so that we include specific reporting requirements in our evaluations and interventions.”

Based on their performance in the 4 categories, providers are awarded points that make up their total score. That score determines whether providers earn a payment incentive, incur a penalty, or neither. Similar to PQRS, payment incentives and penalties under MIPS will kick in 2 years after the data-collection year. For example, for 2019, when mandatory reporting is expected to start for PTs, MIPS data will determine incentives and penalties in the 2021 payment year.

Payment incentives and penalties are much higher for MIPS than they were for PQRS: 4% plus or minus in 2019, 5% in 2020, 7% in 2021, and 9% in 2022 and beyond.

Here is what PTs need to know about how MIPS would be applied to them according to the 2019 proposed physician fee schedule. (The final rule is expected sometime this month. APTA will provide an update as soon as the rule is released.)

1. Initially, PTs would be assessed on only 2 of the 4 MIPS categories.

   Unlike physicians, who must report on all 4 categories, PTs in 2019 would be assessed only on quality and clinical improvement activities. Their quality score would count for the majority of their overall performance score.

2. PTs would need to meet 3 criteria to qualify for mandatory participation.

   CMS determines MIPS participation based on meeting or exceeding a “low-volume threshold.” Medicare providers must meet these 3 criteria: have $90,000 or more in Medicare Part B allowed charges, treat 200 or
**MIPS OR NOT?**

Do you have to participate in MIPS in 2019? Can you participate voluntarily? Or do you sit out participation for now? Use this decision tree to help you determine your status and your options.

### Are you a physical therapist in private practice who treats Medicare Part B patients?

**NO**  
You will not be eligible to participate in MIPS in 2019.

**YES**

### Are you in a group practice that typically during a single year:

- has over $90,000 in allowed Medicare charges
- sees over 200 unique Medicare patients
- provides over 200 professional services a year?

**NO**

You will not be eligible to opt in to MIPS in 2019, but you still can report voluntarily without any payment adjustment.

**YES**

### Are you a solo practitioner or in a group practice?

**GROUP**

You likely will be required to participate in MIPS in 2019.

**SOLO**

### Are you a solo practitioner who typically during a single year:

- has over $90,000 in allowed Medicare charges
- sees over 200 unique Medicare patients
- provides over 200 professional services a year?

**NO**

You likely will be eligible as a group to opt in to MIPS in 2019.

**YES**

### Does your group meet at least 1 of the above 3 annual eligibility criteria?

**NO**

You will likely be eligible as a group to opt in to MIPS in 2019.

**YES**

You likely will be eligible to opt in to MIPS in 2019.

---

*a* Indicates a solo practitioner

*b* Indicates a group practice

*c* Indicates a voluntary report

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a. How do I know if I meet the thresholds?

To help you estimate whether you or your practice would meet MIPS low-threshold requirements, you can view 2016 data from the CMS “Medicare Physical and Other Supplier National Provider Identifier (NPI) Aggregate Report.” On the webpage (https://data.cms.gov/Medicare-Physician-Supplier/Medicare-Physician-and-Other-Supplier-National-Pro/85jw-maq9/data), enter your NPI, then find the columns for “Number of Services,” “Number of Medicare Beneficiaries,” and “Total Medicare Allowed Amount.” Keep in mind this is only an estimate—review the page for further details. CMS will publish 2019 eligibility data in the first quarter of 2019 on the CMS website at https://qpp.cms.gov/.

b. If I am not required to, why would I voluntarily participate in MIPS?

There are 2 good reasons: First, MIPS allows PTs and physical therapy practices to earn incentive payments and prepare for participation in alternative payment models through the collection of data. Because eligible PTs will report on only 2 MIPS categories in 2019—Quality and Improvement Activities—scoring will be weighted solely on these 2 categories. The Quality category is based on the former Physician Quality Reporting System (PQRS), and PTs who successfully reported under PQRS also potentially would score well in the MIPS Quality category. Second, voluntarily reporting now prepares PTs for the future, when mandatory MIPS participation could extend to wider groups of participants.

c. Should I participate as an individual or as a group?

Many PTs in group practices may find it easier to participate in MIPS as a group, as this will allow the group to work together in reporting the same quality measures to achieve the highest possible point total for all providers in the group.
More Physical Therapy-Related Provisions in the Proposed Rule

Several other provisions in the proposed fee schedule would have an impact on physical therapist practice. The rule would:

- Officially establish the physical therapy assistant (PTA) payment differential. The rule establishes 2 new therapy modifiers that would be used beginning January 1, 2020, to identify outpatient services provided in whole or in part by PTAs. Beginning in 2022, these services would be paid at 85% of the fee schedule, per federal budget legislation in 2018 that put an end to the hard Medicare therapy cap. CMS anticipates that a voluntary reporting system for the new modifiers will be created beginning in 2019. APTA opposes CMS’s proposed definition of “in part” and will be advocating for changes before the 2022 implementation date. Mark Besch, PT, DPT, echoes APTA’s opposition, saying the focus should be on clinical outcomes when evaluating services for payment. “Our outcomes data show that appropriately supervised PTAs produce similar treatment results to those of PTs.” Rick Rausch, PT, DPT, comments, meanwhile, “I would hope future rules will clarify how this new requirement will work. Otherwise, it will cause considerable confusion. The scary thing with this rule is that it could very possibly open the flood gates of private payers paying at the 85% rate for work done by the PTA. If that happens, there will be serious implications for reimbursement for smaller clinics as well as the job demands for the PTA.”

- Increase payment slightly. After applying adjustment factors mandated by the Bipartisan Budget Act of 2018, the proposed fee schedule conversion factor would increase slightly, from $35.9996 to $36.0463.

- Keep KX modifier requirements. The permanent fix to the Medicare therapy cap enacted in 2018 included requirements to continue using the KX modifiers for claims that exceed a threshold, which in 2018 is $2,010 for physical therapy and speech-language pathology services combined. CMS also references the targeted medical review process, noting the threshold amount of $3,000. That system would continue, but the proposed rule emphasizes that not all claims exceeding the threshold would be subject to review.

- Indicate that CMS is considering broader use of technology. CMS is proposing that activities such as virtual check-ins, interprofessional internet consultation, and remote evaluation of prerecorded patient information could qualify for some form of payment. While CMS implies these services would be performed by physicians, APTA is advocating that CMS include PTs in the types of qualified health care professionals eligible to furnish and bill for these services.

Implementation Challenges

Although PTs use electronic health records, many EHR systems do not have CEHRT status—which is not required in 2019 for PTs but may be in future years.

“Cost is the biggest barrier for PTs, especially those in small private practices, to move to EHR platforms,” Craig Johnson says. “Although grant money was available to physicians willing to adopt EHRs 3 to 4 years ago, that program has expired.” Now that CMS requires PTs to use CEHRT to participate in APMs, Johnson hopes that funding would be made available to offset the costs of adoption.

PTs who do not already use EHRs will have a bigger hurdle in transitioning to MIPS than those who do, notes Rausch. “They will have to scramble to be ready to participate by January 1 or face payment reductions. In contrast, PTs who used EHRs for PQRS reporting should have a fairly easy transition.”

Mark Besch, PT, chief clinical officer for Aegis Therapies in Frisco, Texas, says, “We fit into the category of having no experience with MIPS. As a result, I expect a steep learning curve.” MIPS reporting would affect the 70 outpatient clinics Aegis operates in multiple settings, including retail locations, senior living communities and health clubs.
Aegis uses an EHR system for documentation and billing, but Besch says it has limited interoperability with other electronic medical records systems. “Meeting Medicare’s requirements for interoperability poses a greater challenge in terms of timing and expenditures for postacute providers than it does for acute providers such as hospitals,” Besch notes. He is a member of APTA’s Post-Acute Payment Work Group and belongs to 2 APTA sections—the Academy of Geriatric Physical Therapy and the Section on Health Policy and Administration (HPA the Catalyst).

**MIPS Alternatives**

PTs also can participate in QPP through Advanced APMs or an option that involves a Medicare Advantage demonstration.

“APMs have experienced remarkable growth in the past 3 to 5 years,” Besch says. “The type of APMs PTs can participate in will depend on their employment settings. A hospital-based APM will look very different from an APM that is open to independent clinics and private practices,” he observes.

Advanced APMs are a subset of APMs that qualify under QPP to offer participating clinicians incentive payments for improving quality and reducing care costs. Advanced APMs address a specific clinical condition, episode of care, or patient population. Participants can earn higher incentive payments when they take on risks based on Medicare spending and patient outcomes. And, as noted earlier, clinicians and practices that participate successfully in Advanced APMs need not report to MIPS.

Craig Johnson, who is a member of APTA’s Payment Policy Advisory Committee, believes practices that otherwise would be required to participate in MIPS next year may want to look at Advanced APMs sooner rather than later. “Right now, they will need to collaborate with health systems and other medical providers to meet the APM criteria,” he says. “We know coordinated and collaborative care with other providers benefits patients.”

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**Let APTA Help You Get Ready For MIPS and Advanced APMs**

- Consider APTA’s Physical Therapy Outcomes Registry your MIPS solution (a CMS-Qualified Clinical Data Registry) to earn points for quality and clinical improvement activity standards—2 required categories for MIPS reporting in 2019. [www.ptoutcomes.com](http://www.ptoutcomes.com)
- Make sure you report the 6 CMS-approved quality measures to MIPS, and ensure that your vendor can transmit the required data to CMS in 2019. APTA will update its MIPS webpage once the rule is finalized. [www.apta.org/MIPS](http://www.apta.org/MIPS)
- Get detailed information on MIPS and Advanced APMs from APTA’s value-based care podcast series. [www.apta.org/VBC/Podcasts](http://www.apta.org/VBC/Podcasts)
- Assess your readiness for QPP with APTA’s self-assessment quiz. [www.apta.org/PaymentReform/StatusQuiz](http://www.apta.org/PaymentReform/StatusQuiz) (login required)
To be eligible for the Advanced APM incentive payment, in 2018, clinicians must either receive at least 25% of their Medicare Part B payments or provide care to at least 20% of their Medicare Part B patients through the Advanced APM. This threshold increases annually.

Physical therapy facilities can propose their own Advanced APM to CMS or can participate in an existing one. (The models that have been approved by the Centers for Medicare and Medicaid Innovation are listed on their website at innovation.cms.gov.)

For 2019, 3 criteria must be met to qualify as a Medicare Advanced APM, according to the proposed fee schedule:

› The model must require at least 75% of all eligible clinicians to use CEHRT.

› The model must use quality measures that are comparable to those used in MIPS.

› The model must bear financial risk for under-achieving. CMS is proposing that the risk would need to be equal to 8% of the average estimated total Medicare parts A and B revenues of providers and suppliers in the Advanced APM, or 3% of the expected expenditures for which an APM entity is responsible.

Not all PTs are comfortable with assuming risk, Johnson notes. “I think it’s the right direction for us to be heading,” he says, “and PTs can successfully manage risk. Still, it’s still an area where most PTs lack knowledge and experience.”

Two Types of Advanced APMs

The proposed fee schedule describes 2 Advanced APM options available for PT participation: the Medicare Option and the All-Payer Combination Option.

The Medicare Option already exists and allows eligible clinicians to become Qualifying APM Participants (QPs) by participating in Medicare Advanced APMs, including CMS-created models such as the Comprehensive Care for Joint Replacement Model (only the CEHRT track qualifies as an Advanced APM), Bundled Payments for Care Improvement Advanced Model, Next Generation Accountable Care Organization (ACO) Model, Medicare ACO Track 1+, and others.

The proposed All-Payer Combination Option, which would begin in 2019 for payment year 2021, would allow eligible clinicians to become QPs by participating in both Medicare Advanced APMs and alternative payment arrangements that meet certain criteria within Medicaid, Medicare Advantage, and commercial payers. These other payer models are referred to as Other Payer Advanced APMs. Under this option, CMS would assess clinicians through their participation in both types of Advanced APMs.
APTA’s Physical Therapy Outcomes Registry: Ready to Report Data for MIPS and More

PTs in private practice who bill Medicare for outpatient services may be eligible—and some even may be required—to participate in the Merit-based Incentive Payment System (MIPS) next year. MIPS is 1 of 2 tracks eligible professionals can choose for participating in Medicare’s Quality Payment Program (QPP).

Beginning in 2019, PTs in the MIPS program will have to report quality measures and clinical practice improvement activities—2 of the 4 MIPS categories that CMS uses to evaluate clinical performance and determine whether participants will receive a positive, negative, or neutral payment adjustment. The adjustment is based on a clinician’s total annual performance score.

PTs who participate in MIPS may use APTA’s Physical Therapy Outcomes Registry (Registry) to submit data in the required structured format. “The Registry is the conduit by which a practice can submit data to CMS. Most EHR [electronic health record] systems are not designed for that reporting mechanism,” says James Irrgang, PT, PhD, FAPTA, professor and chair of the Department of Physical Therapy at the University of Pittsburgh School of Health & Rehabilitation Sciences, and director of the Registry’s Scientific Advisory Panel.

The Registry also can give clinicians valuable real-time feedback on their performance throughout the reporting year, using visually friendly dashboards to identify performance issues and enable clinicians to see how they measure up against established national benchmarks.

APTA has partnered with FIGmd Inc, a health IT company that specializes in EHR-integrated registries, to develop the Registry. FIGmd has developed and maintained numerous registries, including one in collaboration with the American College of Cardiology. It has completed integration projects for more than 80 major EHR vendors. Integration enables seamless EHR data transfer to the Registry database.

APTA’s Board of Directors approved the Registry in 2015 and then officially launched it in February 2017. The Registry has been a CMS Qualified Clinical Data Registry (QCDR) since 2017, when it began sending data to CMS from users who participated in MIPS voluntarily. No other physical therapy software vendor has as much experience with MIPS data submission.

The QCDR designation by CMS allows APTA and other specialty groups to develop and submit new outcomes-based quality measures for MIPS that are beyond the 6 process measures CMS had developed for the previous Physician Quality Reporting System—which was folded into MIPS as the “quality” category.

The Registry’s Scientific Advisory Panel has reviewed and adopted 12 new outcomes measures for inclusion in the Registry. “The new measures reflect the key domains we want to measure in the Registry: physical function, pain, and quality of life,” Irrgang says. “As the Registry matures, PTs will be able to evaluate whether they provided the best evidence-based care for their patients and how their performance compares with other PTs nationally.”

Irrgang acknowledges that some APTA members are nervous about having payment decisions be based on outcomes-based quality measures. “Ultimately, the measures have to be meaningful to patients and clinicians, and truly reflect the quality of the outcome for the treatment provided,” he says, adding, “That’s another benefit of participating in the registry—we’re collecting information on patients that could be used to explain a clinician’s results or adjust the risk based on the results.”

Visit APTA’s Physical Therapy Outcomes Registry website to learn more about the benefits of enrolling (www.ptoutcomes.com).
For both types, PTs who meet or exceed the payment or patient count thresholds would be exempted from MIPS and would be eligible for a 5% Medicare bonus beginning in 2021 for the 2019 performance year, in addition to any other payment adjustments applicable to that model.

To be considered a QP for payment year 2021, PTs must meet certain patient and payment thresholds in 2019, depending on the type of Advanced APM they pursue:

- Under the Medicare Option, PTs must have either provided services through Medicare Advanced APMs for at least 35% of their Medicare Part B patients or received at least 50% of all Medicare Part B payments through the Advanced APMs.

- Under the All-Payer Combination Option, PTs must have either received at least 25% of Medicare Part B payments through the Medicare Advanced APMs and at least 50% of all payments through Advanced APMs or provided services to at least 20% of Medicare Part B patients and at least 35% of all patients served by the Advanced APMs.

PTs who do not meet these thresholds can participate through a “partial QP threshold” option, with lower payment and patient thresholds. Partial QP participants are not subject to MIPS requirements and payment adjustments, but they can choose to report to MIPS although do not qualify for the 5% bonus.

**Medicare Advantage**

PTs also may be able to participate in QPP through the Medicare Advantage Qualifying Payment Arrangement Demonstration (MAQI). Providers who meet the qualifying criteria to participate in a Medicare Advantage Organization (MAO) could be exempted from MIPS reporting and payment adjustments. Providers also would not be required to meet the QP thresholds associated with the Advanced APM options, but they would need to apply for the demonstration project in advance.

The demonstration will test whether:

- There is an increase in clinician participation in payment arrangements with MAOs that meet the criteria of Qualifying Payment Arrangements;
Participating in Qualifying Payment Arrangements and Advanced APMs incentivizes providers to transform their care delivery (to be assessed by interviews with participating clinicians); and

Utilization patterns change among participants in the demonstration and, if so, how those changes affect Medicare Advantage plan bids.

Details for MAQI are available on the Center for Medicare and Medicaid Innovation webpage at innovation.cms.gov/initiatives/maqi.

“Participation in APMs and MIPS will establish new standards of care,” says Alan Meade, PT, DSc, MPH, director of rehabilitation services at Holston Medical Group in Kingsport, Tennessee, and president of the Tennessee Physical Therapy Association. “Using tools such as EHRs and patient outcomes registries will facilitate reporting of data and hopefully make it easier to convince payers to grant PTs more visits.”

Christine Lehmann, MA, NTP, is a freelance writer.

REFERENCES

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NOT ‘SMALL ADULTS’

Here’s what PTs need to know about pediatric overuse injuries.

At Cincinnati Children’s Hospital Medical Center, Chris Kovacs, PT, DPT, evaluates a young patient who plays golf competitively. Kovacs, the facility’s coordinator of sports and orthopedic physical therapy and a board-certified orthopaedic clinical specialist, looks at the player’s strength, flexibility, and range of motion. He’s also analyzing the way the teen swings a golf club—recording the swing on video to show the young golfer what’s going wrong and how it can be fixed.

In this case, he may tell the teen that he’s thrusting his hips toward the ball too early in his downswing—forcing him to hyperflex his neck and causing his neck pain. The teen won’t understand, Kovacs explains, why the PT wants to treat the hip muscles and glutes when it’s the neck that hurts—until he watches the video footage.

“You can get buy-in with kids if you can speak their language and know about their sport,” Kovacs adds. PTs treating pediatric and adolescent overuse injuries need to get their patients to agree to treatment or to rest and let their bodies recover, he notes. Often, showing them what’s happening helps them understand and become willing participants.

Different Biomechanics

Julie Granger, PT, DPT, says PTs must remember that children’s injuries are unlike adults’ because their biomechanics are different. Kids are still growing physically, cognitively, and emotionally. Granger owns PRISM (Performance Rehabilitation & Integrative Sports Medicine) Wellness Center in Atlanta.

“Kids are not small adults,” she says. “They need to be treated in their own special, unique way—taking into account their age, continuing physical development, and general spirit.”

Granger continues: “They have more difficulty being consistent with the way they move from day-to-day because, for example, they may move one way on Monday, then something grows overnight. On Tuesday, their brains and emotions have to recalibrate along with the physical growth. The body grows really fast, but the brain has less time to recalibrate everything else. You see kids start to lose coordination, and there are more injuries. I equate them with puppies—they’ve got big feet and awkward bodies.”

PTs also should explain these changes to the children’s parents and coaches. “Say they have an 8-year-old with pretty good biomechanics,” Granger says. “When the child reaches 11, the coach or parents ask, ‘What happened? Who is this child? They aren’t moving the same way.’ We need to describe what’s going on with that child’s body, to inform the coach or parents and help them help the kid avoid injury.”

Injuries on the Rise

An estimated 60 million youth aged 6–18 are involved in some form of organized sports. Of those, 44 million are active in more than 1 sport. Of those 60 million, 27 million participate in
team sports. While the prevalence of overuse injuries varies depending on the particular sport—for example, 37% in skiing, compared with 68% in running—overall estimates range from 45.9% to 54%.1

More children also are specializing in 1 particular sport early in life, as opposed to sampling—playing various sports during different seasons throughout the year. “They’re performing that certain skillset over and over and over again, and as a result they develop overuse injuries,” says Granger.

But not only focused athletes are at risk. She says that more sedentary children—whose schools may offer less physical education because of funding cuts—become injured because they haven’t learned to train properly. Nutrition is another factor: Injuries may occur if kids aren’t eating enough or aren’t getting the best type of nutrition to either prevent injuries or heal from them.

“Youth need to diversify. High school athletes used to play 3 or 4 different sports throughout the year,” observes Teresa Schuemann, PT, DPT, ATC, who focuses on injury prevention in younger players. “When athletes use different techniques, they use different parts of the body.”

“Today,” Schuemann continues, “the sports industry wants kids to get hooked on a certain sport early.” Schuemann is director and owner of private practice TPT Inc in Loveland, Colorado. She’s also program director of a sports physical therapy residency program for postgraduate and continuing education provider Evidence in Motion. “This includes coaches. They see talent and want to develop it.” Schuemann is a board-certified clinical specialist in sports physical therapy.

While it’s often recommended that, at most, children’s sports participation match their age—for example, that 12-year-old girls play no more than 12 hours of sports per week2—Corey Kunzer, PT, DPT, notes that, unfortunately, the best athletes tend not to stop there. “They’ll play a lot more minutes than other athletes,” he says. “They also may play in multiple leagues, and typically are starting and playing the whole game.” “It’s increased intensity, volume, and exposure for injury.” Kunzer, a board-certified specialist in sports physical therapy, is the supervisor and coordinator of sports residency physical therapy at the Mayo Clinic in Minnesota.

That’s not to say that youth shouldn’t be active. “There are great benefits
to participation in youth sports, including development of self-esteem, socialization, and overall general fitness,” Kovacs says. But what’s needed is balance. She explains that when kids play on various types of teams—school, league, travel, club—it eventually catches up with them, as they’re also attending school and doing homework. Overuse injuries can come, too, from time spent traveling for these teams. Youth aren’t getting enough sleep, and they’re exhausted. Research suggests that youth are well-advised to play any single sport only 8 months of the year, as opposed to year-round.²

Young athletes sometimes play so much, says Kovacs, because of the “professionalization” of sports—meaning that their parents believe they can become good enough to receive college scholarships or go pro. The reality, though, is that only about 2% of high school athletes receive college scholarships, according to the National Collegiate Athletic Association.³

Granger notes that in addition to kids being pressured by their parents in some cases, they also may be pushed by peers, coaches, school systems, and even other parents who want to see the teams win. And sometimes athletes put pressure on themselves to keep playing—even when hurt.

**Early Specialization**

While most research stresses the importance of not specializing in a particular sport too early, there are exceptions to this rule. Casey Unverzagt, PT, DPT, DSc, says, “If you want to excel in gymnastics, figure skating, or diving, you really do have to specialize early—as in before the age of 8.” He is an assistant clinical professor and director of admissions for the doctor of physical therapy program at Baylor University in Texas. He also is a fellow of the American Academy of Orthopaedic Manual Therapists.

Research supports this: “Although there are many examples of early specialised sports training, it appears that such training may be necessary in those technical sports that require elite-level competitions prior to full maturation, such as gymnastics or rhythm gymnastics, figure skating and swimming/diving. This type of early specialised training typically occurs before the age of 12, and frequently as young as 5 or 6 years of age.”⁴

While this technically puts children more at risk of developing overuse injuries, there is an effective way to modify their training to try to prevent them. “Include integrative neuromuscular training into their practices,” says Unverzagt.

Integrative neuromuscular training (INT) is a conceptual training model that is operationally defined as a supplemental training program that incorporates general (eg, fundamental movements) and specific (eg, exercises targeted to motor control deficits) strength and conditioning activities—such as resistance, dynamic stability, core focused strength, plyometric and agility—that are designed to enhance health and skill-related components of physical fitness.⁵ According to one study, “INT programs that integrate a variety of fundamental movements designed to enhance both health and skill-related fitness may be most beneficial if initiated during pre-adolescence. Moreover, INT is more likely to have long-lasting effects if qualified professionals focus on the process of developing fundamental motor skills rather than producing enhanced sports performance. INT maintained throughout childhood and adolescences will likely improve movement biomechanics, minimize the risk of sports-related injury, and promote positive health outcomes during adulthood.”⁶

**Types**

The most common overuse injuries Granger sees are stress fractures—brought on by under-fueling and over-training—and injuries of the growth plates, both apophysis and epiphysis. “It’s important to know the difference between an adult injury and a pediatric injury that affects the growth plate, because they require different kinds of care,” Granger explains.

For example, what might at first appear to be an ankle sprain in an 11-year-old girl may well not be that at all. Given the patient’s age and the status of her growth plates, it’s more likely, Granger says, that the issue is not a sprain but, rather, a fractured growth plate. In that case, the youth would not be allowed to put weight on that ankle. The ankle instead would be immobilized in a cast.

“Kids are not small adults. They need to be treated in their own special, unique way—taking into account their age, continuing physical development, and general spirit.”

— JULIE GRANGER
or a boot for a period of time. “Physical therapists need to err on the side of assuming it’s a growth-plate injury until proven otherwise,” she asserts.

Granger gives another example: throwing injuries. Suppose a 13-year-old boy reports shoulder pain while throwing a baseball. Were he an adult, a PT might first suspect a rotator cuff injury. In the teen, however, it could be a fracture of the proximal humeral growth plate. “The latter requires immobilization in a sling rather than physical therapy,” Granger notes.

When in doubt, she advises her peers to refer the patient to a PT who specializes in treating pediatric and adolescent athletes—or to an orthopedic physician if an X-ray is needed to determine if the injury has affected the growth plate.

In rare instances, high-risk defects can occur. Unverzagt says, “When we start to see stress fractures along the femoral neck, or patellar stress fractures or even anterior tibial stress fractures, those are the ones that send up a red flag.”

“We’ve even seen a handful of effort-driven or exertional thromboses—it’s essentially like a deep vein thrombosis, but in the upper quarter,” Unverzagt continues. “While there are many risks for this, pretending you’re not fatigued and pushing through dysfunction certainly doesn’t help. It’s super-rare, but it’s out there.”

According to the International Olympic Committee consensus statement on youth athletic development, “… unsuspected cardiovascular disease represents the most common cause of sudden death in competitive youth athletes.”

**Treatment**

The role of the PT in treating young athletes begins as it would with any other injury: “We need to reduce pain and restore range of motion and strength,” says Granger. “But it’s essential that the treatment be age-appropriate,” she adds. “If they are athletes, their care needs to be sport-specific. Finally, because they’re growing and changing, both physically and emotionally, the way we teach them needs to be simple, so that they can fully understand what we want them to do.”

She says that videotaping youth and breaking down their movements by showing them what’s going on—as Kovacs does with his patients—is key. “When their pain has decreased, you need to look at the sport-specific movement that the child is doing and find out what’s going on. With the treatment, you’re not only developing their motor skills but also engaging the young person. They’re like, ‘Sweet! You care about my sport!’ You get quick buy-in.”

When patients are motivated and the PT understands the movement needed for a given sport, Granger adds, “You can design sport-specific exercises that address the issue. For example, if the sport is baseball, you may be able to attach a bat to an elastic band to help strengthen the player’s core while he’s in a lunge position. That will help to ready him for batting.”

“We need to engage kids,” Granger continues. “If we sit them on a table and have them do repetition after repetition of a single muscle type exercise, they’re going to get bored. They’re not going to want to do it for their home exercise program. But if we make exercise specific to their sport, it increases their motivation and improves both motor control and coordination. We’re setting them up for long-term success.”

PTs should have a parent present, Granger says—not only so they know what’s going on, but also for safety during hands-on treatment. The parent can leave the room during the actual treatment, Granger adds, “but it’s important to wrap up the session by educating parents on what happened, what the child learned, and what needs to happen for accountability at home.”

Kunzer says that the strongest predictor of an overuse injury is a prior injury. “Many athletes will have a prior injury such as an ankle sprain. But they initially didn’t spend enough time to rehab it correctly—that puts them at significant risk,” he notes. “So, we have to emphasize the need for the body to recover.” Athletes need to know about proper nutrition and sleep, and be apprised whether any kind of imbalance or weakness puts them at particular risk of injury, Kunzer adds.

**Prevention**

“Overuse or repetitive trauma injuries represent approximately 50% of all pediatric sport-related injuries,” one

“**Youth need to diversify. High school athletes used to play 3 or 4 different sports throughout the year. When athletes use different techniques, they use different parts of the body.”**

— TERESA SCHUEMANN
study found. “It is speculated that more than half of these injuries may be preventable with simple approaches.” The PT’s role in prevention begins with education, Granger says—of the athletes, parents, and coaches. “Educate on the role of overtraining, while preventing burnout or dropout,” she says.

“Go out and educate your communities. When they understand what to do or not do, there will be fewer injuries,” says Kunzer.

Unverzagt agrees. “We’ve got this information in academia, but it’s not being disseminated out into the public. As PTs, we need to step in and intervene.” As part of this education, she says that PTs should provide resources on nutrition, rest, and injury-prevention exercises, such as stretches, that can ease the strain on the young athletes’ bodies.

Schuemann says it’s important to talk with parents about making sure their children are developing good all-around sporting skills. “They need to be able to run, jump, skip, hop, swing, and have some eye-hand coordination,” she says.

Schuemann, a consultant to the volunteer sports medicine team of the United States Olympic Committee, adds that cultivating core strength is important for everyone—including youth athletes. “You need a solid base. It’s crucial for athletes to not develop compensatory patterns, as muscles they’re not using will weaken. A strong core helps prevent this.”

Emphasize to parents, kids, and coaches that early specialization is risky, Unverzagt advises. Encourage youth to sample sports and leave time for free play. “Fifty years ago, kids were outside climbing trees and playing stickball in the street. Now they’re on their phones and in front of their computers,” he notes. “Individuals who don’t get unstructured free playtime are the ones who tend to develop overuse

“Fifty years ago, kids were outside climbing trees and playing stickball in the street. Now they’re on their phones and in front of their computers.” — CASEY UNVERZAGT
“Go out and educate your communities. When they understand what to do or not do, there will be fewer injuries.”

— COREY KUNZER

injuries—as do those who play too much of 1 sport in a year.” He cites an article from the Orthopaedic Journal of Sports Medicine: “Youth who specialize in a single sport should plan periods of isolated and focused INT to enhance diverse motor skill development and reduce injury risk factors.”

Since coaches are the ones spending the most time with young athletes, they need to know if there are any physical problems with their team members. Schuemann does everything from prevention screenings (to see if their physical form is correct) to movement screenings (to guard against harmful compensatory patterns). She also screens entire teams and tells them if she detects certain patterns. “For example, I might see that 80% of the players are too tight in their hamstrings,” she says. “I then educate coaches and players by telling them they should do some hamstring stretches at the end of practices.”

Schuemann also works with coaches to design appropriate warmups. Likewise, she’ll step in to tell a coach the importance of having all athletes function well. “Their hearts are in the right places, and they’re doing it for the kids,” says Unverzagt. “But we need to make sure that they’re training the kids right. FIFA [the Federation Internationale de Football Association] has done a great job creating injury-prevention programs and education for coaches—but most of them don’t even know it exists. They can get all this information online [http://grassroots.fifa.com/en/for-kids.html] for free.”

Finally, Schuemann says injury-prevention clinics are valuable because they help athletes identify small injuries and learn how to prevent them from getting larger. In the clinic, Unverzagt likewise conducts prevention screenings of teams—making sure athletes don’t have any neurodevelopment patterns that predispose them to injury.

Michele Wojtechowki is a freelance writer and frequent contributor to PT in Motion.

REFERENCES

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Health Care Employment Rose 33,000 in August

Health care added 33,000 jobs in August, reversing a slowing trend of 16,700 jobs in July and 25,200 in June, according to the US Bureau of Labor Statistics (BLS). That brought the total number of people nationwide employed in that field to 16,071,300.

Ambulatory health care services added 21,100 jobs, up from 9,900 jobs added in June. That included increases of 4,900 in physician offices, 1,600 in outpatient care centers, and 7,900 in home health care services. Hospital employment added 8,200 employees. Community care facilities for the elderly added 300 jobs. Nursing care facilities added 100 jobs, following a loss of 2,500 jobs in July.

During the past 12 months, health care added 301,000 jobs.

Total nonfarm payroll employment increased by 201,000 in August. Employment grew in several sectors—including professional and business services, wholesale trade, transportation and warehousing, and mining.

Meanwhile, according to payroll services company ADP’s monthly National Employment Report, private sector employment increased by 163,000, down from 219,000 in July. ADP, which uses a different methodology from that of BLS, calculated that employment in health care and social assistance increased by 19,000.

Other large gainers included leisure/hospitality (25,000), trade/transportation/utilities (21,000), and administrative/support services (23,000). Natural resources/mining was the only sector to lose jobs, down 1,000.

Ahu Yildirmaz, vice president and co-head of the ADP Research Institute, remarked, “Although we saw a small slowdown in job growth, the market remains incredibly dynamic. Midsized business continue to be the engine of growth, adding nearly 70% of all jobs this month, and remain resilient in the current economic climate.” Mark Zandi, chief economist of Moody’s Analytics, said, “The job market is hot. Employers are aggressively competing to hold onto their existing workers and find new ones. Small businesses are struggling the most in this competition, as they increasingly can’t fill open positions.”


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2014 Foundation’s Miami-Marquette Challenge Research Grant

“The Miami-Marquette Research Grant was the first grant I received and it certainly gave credit to my ideas. Once your ideas have been put out there and are vetted by your peers people are more likely to want to know more, and so getting this award really set the path for more support. It was nice to have someone embrace my vision and that in itself is an incredible feeling.”

Ann Marie Flores, PT, PhD
2016 Moffat Geriatric Research Grant

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Some Changes in Care Occurred After Jimmo Settlement

The 2013 Jimmo v Sebelius settlement was supposed to end the “improvement standard” myth under Medicare Part B. But has the agreement actually made a difference in care? Authors of a new study say yes—but there’s more work to be done.

A 2013 court settlement required the US Centers for Medicare and Medicaid Services (CMS) to clearly reject the idea that Medicare coverage can be extended only if that care will improve the patient’s condition. The fallacy, known as the “improvement standard,” was widely used as the basis for denials of claims for individuals with chronic conditions in need of skilled maintenance therapy.

Researchers focused on 2 datasets from Medical Expenditure Panel Surveys—one from 2011–2012 and another from 2014–2015—for a representative sample of 1,183 patients receiving physical therapy and/or occupational therapy. Researchers assessed the impact of the Jimmo settlement by looking at changes to the number of physical therapy and/or occupational therapy visits per year, per patient, focusing specifically on the number of individuals who had 12 or more therapy visits during a 12-month period. APTA member Justine Dee, PT, MS, coauthored the study.

The results, published in The Archives of Physical Medicine and Rehabilitation, show that the treatment landscape did in fact change, with the post-Jimmo patients 1.41 times more likely to have 12 or more visits than did those receiving care prior to the agreement. In the presettlement time-frame, 22% of patients received 12 or more therapy visits; the percentage postsettlement rose to 28%. There were no significant demographic or other differences between the groups except for age, which was lower in the postsettlement group.

The study also found that the total estimated number of Medicare recipients receiving physical therapy or occupational therapy rose between the 2 time periods studied—from 6.3 million in 2011 and 2012 to 9.3 million in 2014 and 2015.

“We can estimate that, at a minimum, the Jimmo settlement will increase utilization by about 12 million visits per year,” the researchers wrote. “Given typical reimbursements of $80 per therapy visit, costs will increase by approximately $960 million/year. However, if outpatient therapies can help minimize functional decline, avoidable hospitalizations, and nursing home admissions, the Jimmo settlement may result in lower total costs.”

“It’s likely that numbers are higher now that CMS is doing a better job of education,” said Kara Gainer, director of regulatory affairs for APTA. “But now isn’t the time for CMS to let up. If anything, CMS needs to be doing even more on Jimmo, particularly in relation to payment changes in the home health and skilled nursing facility settings, where maintenance therapy can play a major role.”

APTA offers multiple resources related to the Jimmo settlement and the broader concept of skilled maintenance at a webpage devoted to the topic.

www.apta.org/PTinMotion/News/2018/09/10/JimmoStudy/
New Pediatric mTBI Guidelines From CDC Take Comprehensive Approach

In light of what it describes as a “significant public health concern,” the US Centers for Disease Control and Prevention (CDC) has issued what it says are the first-ever comprehensive clinical guidelines for the diagnosis and management of mild traumatic brain injury (mTBI) in children. The 19 sets of recommendations address the condition from diagnosis through management and treatment, and cover settings including primary, outpatient and inpatient care; schools; and emergency departments.

The resource, published in JAMA Pediatrics and available for free, is organized into 3 main areas—diagnostic recommendations, prognostic recommendations, and recommendations related to management and treatment—with each area containing several recommendations based on extensive literature reviews. The 46 discrete recommendations are organized into 19 topic areas, and range from use of serum testing to diagnose mTBI to best approaches to talking with families about the injury.

APTA members John DeWitt, PT, DPT, ATC, and Anne Mucha, PT, DPT, MS, were members of the CDC Pediatric Mild Traumatic Brain Injury Workgroup that developed the recommendations. Additionally, APTA submitted extensive comments on the guidelines during the public comment period in fall 2017. A number of issues highlighted by APTA were included or addressed in the final version.

In addition to the guidelines themselves, providers can download CDC resources that include screening tools, online trainings, and fact sheets in support of the recommendations.

According to the researchers, pediatric mTBI is increasing, with more than 2 million outpatient visits and just under 3 million emergency department visits for mTBI in children between 2005 and 2009.

The Good Stuff: Members and The Profession in the Media

“Good Stuff” is an occasional series that highlights recent media coverage of physical therapy and APTA members, with an emphasis on good news and stories of how individual PTs and PTAs are transforming health care and society every day.

A Good Stuff update: Back in 2016, Good Stuff shared the story of Leigh Anne Anger, PTA, who was fighting back after a triathlon bicycling accident that left her with multiple skull fractures, a broken clavicle, a fractured jaw, and detached ligaments in her shoulder. The road to recovery looked long and hard.

Guess what? She’s back. Leigh Anne’s husband, Jay, tells PT in Motion News that not only is Leigh Anne competing again, but she just earned the top podium spot for her age group in the Rufus Racing Summer Roundup Triathlon.

Turning over a new leaf at the Forest Service: Jess Kehoe, PT, DPT, and Leah Versteegen, PT, are helping members of the US Forest Service avoid injury and move more efficiently thanks to their experience working with tactical athletes from other professions.

Exercise? Just do it: Ryan Woods, PT, DPT, explains why any amount of exercise is better than none at all.

Planting the seeds of prevention: Greg Bachman, PT, points out why it’s important for gardeners to stay flexible year-round to avoid gardening-related injury.

The realities of seeing a PT first: Mark Donald Bishop, PT, PhD, FAPTA, makes the case for physical therapy for pain management—and identifies obstacles in the health care system that make it hard for patients to connect with PTs.

Weakness cometh before a fall: Strengthening exercises can help people who are older guard against falls, says Greg Hartley, PT, DPT.

Concussion is a player in baseball, too: Jessica Schwartz, PT, DPT, quoted in the New York Times, says more awareness of concussion is needed in baseball and many other “noncontact” sports.

Oh, baby! Ronit Sukenick, PT, quoted in the New York Times, emphasizes the importance of rehabilitation for new mothers during the fourth trimester.

No slouch when it comes to good advice: Eric Robertson, PT, DPT, provides insight in Popular Science on taking a realistic approach to improving posture.

Diving into falls: Sylvie de Rham Tortorelli, PT, answers questions in the Bellingham Herald about falls and falls prevention.

Mighty Miss Maya: Anna Semelbauer, PT, DPT, has been helping 4-year-old Maya Tisdale in Traverse City, Michigan, achieve her dream of walking unassisted.
Widespread Fall-Risk Screening Efforts, Followed by Appropriate Interventions, Could Produce ‘Striking’ Results

Consistent, widespread screening for fall risk could make a significant difference in health outcomes, according to the authors of a new study. They assert that assessments, followed by connecting patients to interventions that address their specific risk areas, could result in a “striking” reduction in falls and associated medical costs—as many 45,000 fewer falls in a single risk area, with a resultant $442 million drop in expenses.

The study, published in the American Journal of Preventive Medicine, paired a review of meta-analyses on various fall interventions with data on the percentage of older adults with various risk factors for falls. The researchers established an “effectiveness” score for each intervention’s ability to reduce falls over the course of 1 year. They also estimated the direct medical costs that could be averted through each intervention.

The risk factors and related interventions studied were: poor balance associated with neurologic gait disorders or mobility problems, addressed through tai chi or the Otago exercise program managed by a PT; taking a medication possibly linked to falls, addressed through a medication review; vitamin D insufficiency, addressed through vitamin supplementation; cataracts, addressed through expedited first-eye cataract surgery; poor depth perception due to multifocal eyewear, addressed through single-vision distance lenses for outdoor activities; and home hazards, addressed through home modifications delivered by an occupational therapist. Here’s what the study’s authors found:

- The fall risk affecting the largest number of adults aged 65 and older was home hazards, with an estimated 38 million individuals demonstrating a risk factor for falls. The intervention—home modifications delivered by an occupational therapist—was estimated to result in the prevention of nearly 400,000 falls, with $442,000 in medical cost reductions.

- Visual impairments, either from cataract or poor depth perception related to eyewear, was a risk factor for 27.3 million older adults, with the related interventions (cataract surgery and single-vision distance lenses) preventing an estimated 500,641 falls combined.

- The Otago program managed by a PT potentially could be used on a subset of 11.5 million older adults with neurologic gait disorders and 13.1 million older adults with mobility problems, resulting in a reduction of more than 62,000 falls and $229 million in medical costs.

- Even a basic medication review and modification program could produce results if applied consistently, with an estimated reduction of 114,000 falls leading to drop in medical cost of $418 million.

“The potential for reducing falls and averting the associated direct medical costs was striking,” the researchers wrote, adding that the falls reduction and savings estimates are likely on the conservative side. “Health care providers are well positioned to implement evidence-based clinical interventions such as those described in this analysis,” they added.

APTA provides extensive resources on falls prevention on its Balance and Falls webpage. Offerings include consumer-focused information, online courses, and links to other sources of information, including the CDC and the National Council on Aging. In addition, APTA’s PTNow evidence-based practice resource offers a unilateral vestibular hypofunction clinical summary; a summary on falls risk in community-dwelling elders; an osteoporosis clinical summary; and tests and measures such as a fracture risk assessment, a clinical test of sensory interaction and balance, and a self-paced walk test. The association’s scientific journal, PTJ (Physical Therapy) has also published a clinical guidance statement from the APTA Academy of Geriatric Physical Therapy on management of falls in community-dwelling older adults.

www.apta.org/PTinMotion/News/2018/08/27/FallsScreeningPreventionSavings/
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Hospital Emergency Departments Should Incorporate PTs

More hospitals should incorporate PTs into their emergency department (ED) workflow, according to the authors of a review in the *American Journal of Emergency Medicine*. Hospitals that have done so have seen “positive impacts in clinical care and patient and physician satisfaction” due to PT expertise, “extended bedside care,” and patient education.

Researchers examined the typical ED PT practice patterns and clinical outcomes, intangible impacts of ED PT services, and considerations for building an ED PT program. Study coauthors included APTA members Kyle J. Strickland, PT, and Michael T. Lebec, PT, PhD.

According to the authors, ED PTs most often are consulted for patients with acute musculoskeletal issues—not only to provide patient education and develop a plan of care for these conditions, but also to help physicians make a more specific initial diagnosis. “Nearly half of all medical schools do not require curriculum in musculoskeletal medicine,” the authors commented, adding that emergency medicine training is geared toward identifying and managing life-threatening conditions.

According to preliminary reports, hospitals with ED PT programs have noticed increased patient and provider satisfaction, decreased wait times, and decreased admission rates for patients with orthopedic symptoms. Physical therapists also may be consulted for patients with suspected peripheral vertigo after a physician has excluded more serious causes. Due to the protracted assessment time for such patients, PT involvement and expertise takes some of the burden off physicians.

ED PTs are increasingly being called upon to assist with gait training and patient disposition planning, the report says, adding that the ED physicians who have access to PTs cite PT evaluation of patient mobility and safety as “a significant added value.”

For hospitals wishing to create such a program, important implementation steps “include engaging with key stakeholders in physical therapy and emergency medicine, estimating initial clinical volume and staffing needs, and targeting appropriate personnel for the unique practice environment of the ED,” the authors wrote.

“This review is consistent with a position that APTA has supported for several years—that PTs have an important role to play in the ED,” said Anita Bemis-Dougherty, APTA’s vice president of practice. “In 2008, the association’s House of Delegates adopted a position promoting physical therapy as a professional service in the emergency care environment. That official statement reflected beliefs that have been widely shared in the profession for some time.”

[www.apta.org/PTinMotion/News/2018/08/17/PTsInEDs/](www.apta.org/PTinMotion/News/2018/08/17/PTsInEDs/)
Ambulatory Cardiac Rehab Underused, Study Finds

Ambulatory cardiac rehabilitation (CR) should be routine for patients with cardiovascular events such as myocardial infarction, according to a study in the European Heart Journal. But despite evidence of its effectiveness—including a nearly 50% drop in all-cause mortality for patients who receive it—CR “remains significantly underused,” the authors wrote.

The researchers compared the long-term outcomes of an early-discharge CR program for patients with ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction, planned percutaneous coronary intervention (PCI), and coronary artery bypass graft (CABG) versus no CR at all. At one hospital, all 839 patients received early CR; at a second, none of the 441 patients received CR.

The CR program included evaluations, cycle-ergometer tests, and echocardiograms for all patients. Patients with STEMI or CABG received 5 weeks of exercise bicycle training, followed by 6 weeks of gym training, supervised by a nurse and a physical therapist (PT).

After 5 years, researchers found:

- All-cause mortality in the CR group was lower (10%) than that in the non-CR group (19%).
- Cardiovascular mortality was 2% for the CR group and 7% for the non-CR group.
- Hospitalization for cardiovascular causes was 11% for the CR group and 25% for the non-CR group.
- Combined hospitalization for cardiovascular causes and cardiovascular mortality was 13% for the CR group and 29% for the non-CR group.

PTs in Emergency Departments Reduce Likelihood of ED Revisits For Falls

According to a recent study, consultation by a PT in the emergency department (ED) reduced the odds of a fall-related patient revisit within 30 days by 35%, and within 60 days by 32%, compared with patients treated in EDs without PT consultation.

The study, published in Journal of the American Geriatrics Society, is based on Medicare claims data for individuals 65 and older who visited an ED for treatment related to a ground-level fall between 2012 and 2013. Researchers divided the claims data into 2 groups: individuals who received PT services during the ED visit (N=17,975) and a control group that didn’t (N=542,302). Then, they tracked the rates of ED revisits for fall-related injury within 30 and 60 days of the initial visit.

While all-cause revisits were only slightly higher for the non-PT group at 30 days (21.7% for the non-PT group compared with 20.4% for the PT group) and just about the same at 60 days (about 30% for both), researchers found more striking differences when it came to revisits related to a fall. At 30 days, 1.7% of the PT group had revisited the ED for a fall, compared with 2.6% of the non-PT group; at 60 days, the rate was 2.6% for the PT group, compared with 3.6% of the non-PT group.

Among the factors related to greater chances of an ED revisit were being male, Medicaid-eligible, and having a comorbidity. Age, however, was not a factor. Of the comorbidities most strongly linked to increased odds of revisit, Alzheimer’s disease was associated with the strongest impact.

The authors acknowledged that a PT consult in the ED may not always be appropriate, either due to the severity of injuries sustained or the intensity and prevalence of comorbidities such as dementia. Still, they argued, the consultation rates fall far short of where they should be, given the data they uncovered.

APTA is a strong supporter of PTs in the ED. A House of Delegates position promotes physical therapy as a professional service in the emergency care environment, and the association offers a webpage on the topic that includes an online toolkit, a video, and links to resources from the US Department of Health and Human Services.

www.apta.org/PTinMotion/News/2018/08/31/PTsINEDsForFalls/
Study Finds Functional Limitation Reporting Isn’t Delivering the Data Goods

Since the beginning of Medicare’s Functional Limitation Reporting (FLR) program, APTA has maintained that the system is overly burdensome and unlikely to provide meaningful information. A new APTA-funded study strengthens the case against FLR’s usefulness, finding that the codes simply have not been submitted in ways that are consistent with regulations. The holes in data make it difficult to rely on FLR as a source for tracking improvement and outcomes—a deficiency pointed out by APTA to the US Centers for Medicare and Medicaid Services (CMS), and a factor in a CMS decision to propose dropping the FLR altogether.

The study, published in PTJ (Physical Therapy), used a 5% random sample of Medicare Part B fee-for-service claims for outpatient physical therapy provided in 2014, the first year non-participation in the FLR system was tied to claim rejection. The authors tracked FLR and Severity Modifier (SM) coding used throughout episodes of care—analyzing not only the completeness of the reporting, but the projection and documentation of patient improvement from physical therapist PT initial examination (IE) to discharge. A total of 114,558 unique patients were included in the study.

The good news for FLR was that PTs had a high level of submitting complete FLR information at IE, with more than 90% of claims including both a current FLR status code and a projected goal status code. The bad news was that complete reporting fell off dramatically after that, with fewer than 17% of claims required during interim reporting periods—at least once every 10 treatment days—including current and projected status coding.

Similarly, discharge claims showed a significant drop in reporting, with an average completion rate of 36.8% for FLR discharge status.

When it came to planned and documented improvement in functional status as reflected in changes to the SM code, most of reports did identify goals for positive change. For the FLR code sets related to specific functional limitations, at least 85% included estimates of planned improvement. The percentage was slightly lower—78.7%—for the code sets related to “other” PT/occupational therapist (OT) care categories. The actual level of improvement ratings varied, but, overall, the most frequently used SM for projected goal status was “CI,” indicating an improvement to 1%-20% impaired or restricted.

The study arrives as CMS has proposed the elimination of FLR as part of its move to include PTs among the providers participating in the Quality Payment Program—a major shift toward value-based payment included in the proposed 2019 physician fee schedule.

The low rates of interim reporting are a big problem for the FLR system, according to the authors.

“The reason for the very low completion rate for the interim reporting periods is unknown, and to our knowledge this is the first study to report on this,” they wrote, speculating that the “time burden” involved in completing reports at least once every 10 days could be a factor.

“We know that the collection of functional data is core to physical therapist practice, so the question becomes why the FLR system has such significant data gaps,” said Heather Smith, PT, MPH, APTA’s program director for quality, who co-authored the study with APTA member Meghan Warren, PT, PhD. “Our study indicates that the real issue is the mechanism through which these data are collected—FLR adds burden and complexity without producing much in the way of useful data.”

The authors say it’s clear that the FLR system is not producing the data it was intended to produce—at least not when it comes to physical therapy.

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Best Post-TKA Intervention in the Acute Care Setting Hard to Identify

For patients who undergo total knee arthroplasty (TKA), this much is known: Physical therapy in the acute care setting is a key component in successful rehabilitation. What’s not so easy to pinpoint are the individual interventions associated with the best outcomes, according to the authors of a new systematic review. Their investigation into 20 years of clinical trials and other studies revealed no clear standout interventions, but did find “very low” evidence for the use of cryotherapy, accelerated rehabilitation, and neurostimulation within the first 7 postoperative days (PODs).

The study, published in the Journal of Acute Care Physical Therapy, involved extensive reviews of research published between 1996 and 2016 on various physical therapy-related interventions used in the acute care setting post-TKA. The authors were looking for evidence of effectiveness of a particular approach, because, they write, “despite seemingly routine use of physical therapy and its potential importance in reducing complications after [total joint replacement] in the acute hospital setting, no approach to rehabilitation in this setting appears to be standard.”

In the end, the authors conclude that existing evidence isn’t strong enough to declare any clear winners when it comes to post-TKA physical therapist interventions in the acute care setting.

The studies that yielded no or weak evidence looked at approaches including additional sessions of rehabilitation; compression and manual lymph drainage; knee range-of-motion (ROM); continuous passive motion; knee ROM manual passive exercise; knee ROM active assistive exercise; biofeedback; and acupressure, acupuncture, and traditional Chinese medicine. Evidence was insufficient, included a significant risk of bias, or both.

Three other interventions fared somewhat better than the rest, although none were supported by strong evidence. They were:

**Cryotherapy.** Reviewers identified 2 systematic reviews supporting the use of cryotherapy to reduce early postoperative pain and improve ROM, though the evidence was described as “very low” quality by the authors of both reviews.

“Early” or “enhanced” physical therapy—for example, having patients walk within hours after surgery. The authors identified “very low level” evidence supporting these approaches to improve ROM and walking ability, and to reduce length-of-stay.

**Neurostimulation.** “Very low level” evidence suggested that neurostimulation may help reduce pain—but only when electrodes are placed near the surgical site, according to the authors.

Further clouding the evidence in most (31 of the 40) studies was that some form of “physical therapy” or exercise intervention was used—in both the special intervention and the comparison groups—in addition to the intervention being studied. Also, all study participants likely received medical pain management, which made it even harder to isolate the effects of a particular intervention.

For now, the authors say, don’t count on any clear recommendations on the single best intervention to use for patients post-TKA in the acute care setting.

APTA members Alisa Curry, PT, DPT, Meri Goehring, PT, PhD, and Diane Jette, PT, DSc, FAPTA, were among the study’s coauthors.

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Mobility Is Key Quality-of-Life Issue for Individuals With TSCI, Study Says

While individuals who have experienced a traumatic spinal cord injury (TSCI) can face a wide range of challenges affecting their health-related quality of life (HRQoL), a new study is helping to clarify that 1 particular functional ability stands out as the most important factor: independent mobility.

Researchers analyzed data from 195 patients who had sustained a TSCI between 2010 and 2016 and participated in a series of assessments conducted between 6 and 12 months after the injury.

The study population included individuals 17 years and older who sustained a TSCI between C1 and L1 that required surgery. More than half of the study population—65%—experienced tetraplegia (also referred to as quadriplegia) as a result of the injury; the remaining 35% experienced paraplegia. Results were published in the American Journal of Physical Medicine & Rehabilitation.

The researchers found:

> Overall, the strongest correlation was between mobility in the abilities assessment and...
Are Pain Measures Asking the Right Questions?

In terms of measuring how a patient is affected by chronic pain, there is a gap between what commonly used questionnaires ask and what patients most care about, according to the authors of a study in the July issue of PTJ. It’s time, they wrote, to “embed patients’ values and preferences” into the instruments providers use to evaluate the effects of chronic pain.

In the first phase of an effort to develop a “patient-driven” instrument, researchers in the Netherlands conducted focus groups and developed an online survey to identify the attributes of pain that have the most impact on participants’ daily lives. Survey respondents were asked to provide information about their diagnosis and level of pain, complete the Pain Disability Index, and select the most important attributes of pain.

The authors observed that while many instruments measure areas such as pain sensation, psychological impact, functional disability, related symptoms, activities of daily living, social functioning, coping strategies, environmental factors, and financial burden, those factors aren’t necessarily the most important to patients. In the end, the 8 most frequently chosen pain factors identified by the 949 survey respondents were fatigue, social life, cramped muscles, sleeping, housekeeping, concentration/focus, feelings of not being understood, and control over pain.

The researchers also broke down the results by sex, age group, diagnosis, and pain intensity. The only significant difference between men and women was the rating for “housekeeping”—the fifth most frequently chosen attribute by women but 29th by men. Individuals with back pain rated “concentration” and “not being understood” much lower than did other diagnostic groups.

Comparing the results against attributes measured in several widely used instruments and item banks yielded some overlap. However, many standard test items were not deemed important by survey respondents. Similarly, some items rated important to patients are absent from these instruments. For example, researchers note that fatigue was consistently identified as an important attribute in their survey, but it is not included in many instruments used for patients with chronic pain.

The results of the study are being used to develop a prototype pain survey, based on the 8 areas identified through the survey and focus groups, that will measure the impact of chronic pain on health-related quality of life (HRQoL). “A preference-based measuring method allows attributes to be weighted so that HRQoL can be calculated,” the authors wrote, adding, “a substantial amount of information can be ascertained from these 8 attributes.”

“These attributes in [themselves] are not in fact new, but discovering which attributes are most important to people with chronic pain leads to new insights, which should be used to guide further development of a truly patient-centered, preference-based instrument,” the authors stated.

www.apta.org/PTinMotion/News/2018/7/20/RightQuestions/
Researchers in Finland have conducted a study that used “placebo surgery” to conclude that a frequently used arthroscopic procedure likely offers little to no benefit.

Subacromial decompression surgery for shoulder impingement was found to be no better than diagnostic arthroscopy alone. The procedure also was compared with physical therapy alone, but researchers are uncertain about the reliability of those results.

The study, published in *BMJ*, compared shoulder pain at rest and with arm activity among 122 participants, aged 35 to 65, who presented with shoulder impingement occurring for at least 3 months that was unresponsive to “conventional treatment.”

Participants agreed to undergo arthroscopic surgery and understood that they might receive either simple diagnostic arthroscopy with no other surgical procedure or arthroscopic subacromial decompression surgery (ASD)—a procedure that involves smoothing the undersurface of the acromion in hopes of easing the passage of the rotator cuff tendon through the subacromial space. The authors characterized ASD as “one of the most frequently performed orthopaedic procedures in the world.”

The researchers were careful to avoid introducing any hints as to who received which procedure, even going so far as seeing to it that the surgeons themselves didn’t know which procedure they were performing until after the initial diagnostic arthroscopy—when a nurse opened a sealed envelope telling the surgeon whether to proceed with ASD or to end the procedure. Additionally, patients who did not receive ASD were kept in the surgical room for the time it would have taken to conduct the procedure, and no other facility staff were told which patients received which kind of surgery.

Both groups received the same postoperative care—a single visit to a PT “for guidance and instructions for home exercises.” The PT also was in the dark about whether the participant had received ASD or placebo surgery.

After 24 months, the researchers measured participants’ shoulder pain at rest and during arm activity by using a 0-100 visual analogue pain scale. Secondary outcomes were related to shoulder function and assessed through a Constant-Murley score and the 15D, a health-related quality of life measure. All 24-month assessments were compared with those captured at baseline and 3, 6, and 12 months postsurgery.

Researchers noted “marked improvement” among all participants. But that’s what was so revealing—it didn’t seem to matter whether the patient had received ASD or the placebo. The results were consistent for both pain and function assessments.

The study’s authors wrote that the findings are strengthened by what they described as the “stringent eligibility criteria” used to select only participants “most likely to benefit from ASD.”

“Classically, stringent eligibility criteria are considered to decrease the validity of a study,” the authors wrote. “Although our patient population was indeed highly selected…we think that the use of stringent eligibility criteria paradoxically increases the generalizability of our findings. When ASD was proven futile under this best case scenario, there is no reason to assume that it
would work better under less optimal circumstances or in a more heterogeneous population.”

The researchers also compared the surgery groups with a third group of participants who participated in 15 sessions of physical therapy. While they found no significant differences in outcomes at 24 months, the authors cautioned against reading too much into those results, primarily because participants in the exercise group weren’t weeded out as thoroughly as were those in the surgery group beforehand. “Thus the ASD versus exercise therapy comparison is likely to be biased in favor of ASD owing to systematic removal of patients with likely poorer prognosis [in the ASD group],” the authors wrote.

The study’s approach was similar to that of a 2014 research project—also from Finland—that looked into arthroscopic surgery for meniscal tears. Like the shoulder study, the meniscal study involved the use of placebo surgery and found a similar lack of difference in outcomes between those who received the sham meniscal surgery and those who received the real thing.

As for the shoulder study, the authors were nothing if not direct in their assessment of the findings: “The results of this study…show that [ASD] provides no clinically relevant benefit over diagnostic arthroscopy in patients with shoulder impingement syndrome,” they wrote. “The findings do not support the current practice of performing subacromial decompression in patients with shoulder impingement syndrome.”

www.apta.org/PTinMotion/News/2018/07/24/ShoulderSurgeryStudy/

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As APTA continues to advocate for the maintenance of essential health benefits (EHBs) in insurance offered through Affordable Care Act (ACA) marketplaces, the association and other stakeholders are facing another potential challenge to patient access to care: private insurer short-term, temporary health plans that can skirt many ACA requirements around EHBs, preexisting conditions, and continued coverage.

The Department of Health and Human Services (HHS) in August adopted a final rule on the short-term plans that allows the policies to provide 1 year of coverage, renewable for up to 3 years. Previously, the plans could only be used for a maximum of 3 months.

The plans are intended to offer a cheaper insurance option than plans available through the ACA (although most individuals who purchase insurance through the ACA marketplaces receive subsidies that lower out-of-pocket costs). These plans are not required, however, to comply with many of the consumer protections included in ACA plans. Rather, they can deny coverage of a preexisting condition, drop coverage should a customer’s health status change, and refuse coverage of services such as mental health, prescription drugs—and, possibly, physical therapy.

“These plans create more options, but they also create more uncertainty for patients and PTs,” said Kate Gilliard, APTA regulatory affairs senior specialist. “We’re concerned that, perhaps unknowingly, patients who purchase them may be moving onto plans that don’t cover physical therapy, or that offer very limited physical therapy benefits.”

Gilliard said the short-term plans were a hot topic at a recent National Association of Insurance Commissioners (NAIC) conference she attended as an APTA representative.

“The plans received mixed reviews from the commissioners,” Gilliard said. “Some states openly thanked HHS for allowing more consumer options and for giving states more control over their own markets. But other states criticized the plans for the weaker consumer protections and predicted that they will cause prices in the ACA marketplace to rise.” According to Gilliard, NAIC attendees described a variety of approaches being taken by states in reaction to the HHS rule—from accepting the provisions as written, to placing shorter time limits on coverage, to banning the plans completely.

“Many of these states are trying to frame these plans as options that should only be used when consumers are in between major medical plans—for example, when they are between jobs or waiting for ACA marketplace open enrollment—and should not to be relied upon as real, full health insurance,” Gilliard said.

APTA has gone on record in support of consistent EHBs, and has voiced its opposition to an HHS rule change that allows states to lower the bar on required EHB coverage provisions in so-called “benchmark” plans that set the floor for coverage offered in a state marketplace. Many of the short-term plans are even skimpier than what’s being offered through the ACA exchanges, even with the recent benchmark changes.

“While APTA always has supported the importance of patient choice in health care, we also are committed to advocating for access to needed care and consumer certainty that the care patients receive today will be there tomorrow,” said Kara Gainer, APTA’s director of regulatory affairs. “Short-term plans offer choice, but they run the risk of decreasing access and creating uncertainty—and the recent final rule from HHS would appear to make matters worse.”

www.apta.org/PTinMotion/News/2018/08/13/ShortTermInsuranceRule/
A Stark Reality: APTA Continues Efforts To Shore Up Self-Referral Law

As the US Centers for Medicare and Medicaid Services (CMS), lawmakers, and others continue to press for more value-based approaches to care, attention has turned to a law that bars physicians from referring Medicare patients to services in which the physician has a financial interest—aka “self-referral.” CMS has hinted that the prohibition, known as the Stark law, may interfere with the adoption of new, more integrated models of care, and a US House of Representatives subcommittee held a hearing on “modernizing” the law, perhaps through loosening up restrictions. APTA argues that at least part of reform efforts should be aimed at eliminating exceptions, as a way to increase value-based care opportunities.

Recently, APTA staff were on Capitol Hill to encourage legislators and their staff to take a careful approach to decisions about the Stark law, which was the subject of a House Ways and Means Health Subcommittee hearing. During that hearing, legislators were weighing the law’s effect on the ability to create alternative payment models (APMs)—systems that often seek to streamline and coordinate entire episodes of care. The hearing echoed a recent CMS request for information from the public on the Stark law, such as whether there is a need for “revisions or additions to exceptions to the physician self-referral law, and terminology related to alternative payment models and the physician self-referral law.”

In comments provided to the House subcommittee, APTA argued that a reformed Stark law with fewer loopholes could promote the growth of value-based care by leveling the playing field for PTs.

As APTA noted in its comments, the current version of the Stark law includes an exception that allows physicians to self-refer for so-called “in-office ancillary services” (IOAS) that include physical therapy. That exception winds up hurting the development of APMs because it “fail[s] to promote collaboration with small- and medium-sized physical therapy and nonphysician practices,” APTA wrote.

The association isn’t alone in its commitment to eliminating Stark law loopholes. In 2017, APTA joined with the Alliance for Integrity in Medicare to support a bill in the House of Representatives that seeks to eliminate IOAS exceptions. That bill, also supported by AARP, has not been scheduled for House committee review.

“We see the recent subcommittee meeting as a chance to highlight the need for more opportunities for physical therapists to participate in alternative payment models—all while protecting patient choice, increasing transparency, and strengthening access,” said Justin Elliott, APTA’s vice president of government affairs. “Effective value-based care is important. Eliminating conflicts of interest in health care is important. There’s no reason why the two can’t coexist.”

www.apta.org/PTinMotion/News/2018/08/07/StarkUpdate
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Tiered Coding for PT Evaluations: New APTA Podcast Series Answers Common Questions

As the payment landscape for 2019 comes into focus, it’s becoming clear that PTs will continue coding evaluations according to a 3-tiered system based on patient complexity. It’s also clear that for now, at least, Medicare will not be using a tiered payment system, even as some commercial payers and state Medicaid plans adopt systems that reflect complexity levels. Through it all, APTA continues to offer resources to help reinforce accurate and consistent coding.

CMS has suggested that its flat reimbursement policy, opposed by APTA, will allow the agency to evaluate the distribution of utilization of the tiered codes to better determine the payment model. That distribution is beginning to come into focus: APTA research into nearly 4 million evaluations billed by providers has revealed that 47% of evaluations were billed in the low-complexity category, 45% in the moderate-complexity category, and 8% in the high-complexity category.

“At this point we have a sampling of baseline data that reflects practice in the first year of the tiered codes,” said Alice Bell, APTA senior payment specialist. “CMS is also looking at this and has indicated it feels it will take 2 years of data to have an accurate representation. That means it’s important that coding remain accurate and consistent.”

In its efforts to help underscore the importance of continued accurate coding, APTA has produced a series of free podcasts on CPT evaluation codes. The 5-part series offers a general overview of the coding change and addresses common questions related to determining levels of stability, documenting elements, the relationship of examination time to code selection, and coding in reevaluation. With episodes ranging from 5 to 8 minutes in length, the individual podcasts are convenient for quick listens on the go or during breaks at the clinic.

“APTA is committed to supporting physical therapists through this transition to tiered coding to ensure that code selection reflects the level of complexity of the evaluation,” Bell said. “Before we see further changes in reimbursement based on the tiered codes, we want to make sure that therapists have the tools and resources necessary to make the appropriate code selection. Accuracy in coding is critical if we are to make a compelling case for achieving our long-term goal of establishing reimbursement rates that reflect patient complexity.”

www.apta.org/PTinMotion/News/2018/08/01/CPTCodingPodcasts/
Raising Physical Therapy Awareness Throughout the Year

Although October and National Physical Therapy Month are history, strategies to raise the public’s awareness of physical therapy are appropriate year-round. Among them:

1. **Get T-shirts, magnets, handouts, social media graphics, and other #ChoosePT resources.** APTA’s award-winning #ChoosePT campaign has reached millions to promote treatment by PTs for pain management.

2. **Take the #ChoosePT message somewhere fun—and take a picture!** Sometimes raising awareness is as simple as getting out in the world wearing a #ChoosePT shirt or holding a #ChoosePT sign (available in the toolkit). So, go find a landmark, a park, a mountaintop, or anywhere in between, and take photos of you showing your #ChoosePT pride. Post them to social media using the #ChoosePT hashtag or email them to public-relations@apta.org.

3. **Promote MoveForwardPT.com.** APTA’s official consumer information site serves millions of Americans each year. From symptoms and conditions guides to patient stories, podcasts, and tips pages, MoveForwardPT.com is your go-to resource for showing all the ways PTs and PTAs transform lives.

Questions? Ideas? Contact APTA’s public relations staff at public-relations@apta.org

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By Karen Thatcher, PT, DPT

February 18, 2010: It’s our third game at the Olympic Games in Vancouver. I’m flying through the neutral zone with the puck, like I have a million times before, when suddenly I’m soaring through the air. Crash. Pop. Lightning down my legs. I don’t know it at that moment, but this is the start of what will be the most challenging 15 months of my athletic career.

Imaging revealed an L5/S1 ruptured disc. But this was the Olympics. So, I was on crutches for 2 days, in the training room 24/7, and then, only 4 days after the injury, I was back on the ice for our semifinal game against Sweden with a modified brace over my sacroiliac joint. I skated in the gold medal game 2 days later. We came home with a silver.

Later that summer, after physical therapy that did not yield desired results and after multiple ineffective epidurals, I underwent an L5/S1 microdiscectomy—surgery to remove part of the herniated disc. The lessons I’d learn in the ensuing months would shape who I am as a person and how I now practice as a physical therapist.

Injuries can be devastating to an individual’s identity, particularly an athlete’s. The back injury I experienced and the sequela that followed forever altered my life, leading me to a career in physical therapy because of the profound influence that my physical therapist (PT) had on me after surgery. My journey to recovery and the lessons it instilled in me drive me every day to help my patients.

After surgery in July 2010, I was completely dependent on others for even the most basic needs. I was in no way prepared for this. Five months before surgery I’d been a world-class athlete, competing at the highest level and representing my country. After surgery, I was a 25-year-old woman who needed her mother’s help to use the toilet and roll over in bed. I’d gone from celebrating an Olympic medal to throwing a (figurative) party the day I finally was able to walk, with my father’s assistance, to the mailbox and back.

The experience utterly and completely humbled me. It taught me never again to take my independence for granted.

Karen Thatcher, PT, DPT, works at the Jameson Crane Sports Medicine Institute at The Ohio State University. She was a member of the US Women’s National Hockey Team for 8 years.

Defining Moment spotlights a particular moment, incident, or case that either led the writer to a career in physical therapy or confirmed why he or she became a physical therapist or physical therapist assistant. To submit an essay or find out more, contact Associate Editor Eric Ries at ericries@apta.org.
The months of rehabilitation were tumultuous. I experienced the difficulties I would later see my patients face when they get mixed signals about what to expect and experience communication gaps across disciplines. My biggest challenge was bridging the gaps between the expectations of my physical therapist, those of my hockey coaches, and the goals I’d set for myself.

My PT was pleased when I could walk around the block and sit for 30 minutes at my desk without pain. My hockey coaches, on the other hand, always wanted to know why I wasn’t skating yet and when I could participate in training. Somehow I became the messenger between these 2 groups. In the process, no one thought to ask me what my goals were.

Welcome to rehab purgatory! I’ve wondered ever since how many of our patients dwell in this same uncomfortable space along their journey from injury to rehabilitation.

It felt as if my PT was rehabbing me to get back to the life of my mother—an office worker, then in her mid-50s, who enjoyed an occasional yoga class and walked her dog for exercise. Not that there’s anything wrong with that life, but I was a young athlete seeking to return to international competition. So, strike 1 against having a satisfying rehab experience. My coaching staff, for their part, did not understand the extent of my surgery or the timeframes and limitations of my recovery. That was strike 2.

All the while, I was experiencing the daily pain—physical, psychological, and emotional—of being caught between 2 groups seeking to place very different demands on my body. Strike 3?

This arrangement was destined to fail. And it did. So, after some very frustrating months, I found myself a new PT. This time around, my rehab was coordinated with my strength and conditioning coach, which facilitated realistic goal-setting and enhanced my overall rehabilitation. My rehab exercises aligned with the demands of ice hockey. My conditioning program was appropriately adjusted to take into account the biomechanical loading of my healing spine.

Most important, I at last felt heard. I started to feel like myself again. Fifteen months after surgery, I returned to the ice, to international competition. Reunited with my teammates on Team USA, we won the gold medal in the Four Nations Cup in Nyköping, Sweden.
Although I wish I could say that was the end of my rehab voyage, and my career played out naturally thereafter, that wasn’t how it went. In February 2013 I sustained my third loss-of-consciousness concussion. It forced me into retirement from ice hockey and toward pursuing academic goals I’d set aside when I chased my athletic dreams.

I’d always intended to return to graduate school, initially to pursue a career as an orthopedic surgeon. However, my experience with rehabilitation after my back surgery (and for many other injuries over the years) fostered a passion for physical therapy.

I enrolled in a dual-degree DPT/PhD program at The Ohio State University and graduated with my DPT in May 2017. I have continued at Ohio State since then, working full-time as a PT in sports medicine while continuing to pursue my PhD in health and rehabilitation sciences on a part-time basis. My goal once I complete my PhD training is to contribute to the progress of the physical therapy profession through clinical practice, research, and teaching.

My path has not been traditional, direct, or easy. But the route I took was formative. “Adversity is the stage upon which character reveals itself,” a mentor once told me. The many and varied obstacles I’ve faced to get to this point undoubtedly have shaped my character. They’ve also primed me to make a positive impact on the lives of the patients with whom I’m fortunate to work.

My story serves as an illustration and reminder of the need for PTs to approach each patient with compassion for that individual’s unique journey. We must always remember that no 2 individuals are the same, that no 2 rehabilitations are identical, and that a little bit of empathy can make all the difference.
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**SOURCE**


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**SOURCE**


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**“Healthy Days Measures”**

developed by the Centers for Disease Control and Prevention to gauge population health-related quality of life. Questions cover (1) how an individual rates his or her general health, (2) how many days the individual’s physical health was “not good,” (3) how many days mental health was “not good,” and (4) how many days poor physical or mental health kept the individual from doing usual activities.

**SOURCE**


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**4**

Appearances of the terms “physical therapy,” “physical therapist[s],” physical therapist assistant[s],” “PT[s],” or “PTA[s]” in the proposed 2019 Medicare physician fee schedule, as published in the *Federal Register*.

**SOURCE**


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**6%**

Projected cost increase from 2018 to 2019 to treat patients covered by employer-provided health insurance—consistent with 5.5%–7% annual increases over the past 5 years. Insurance companies use the projection to calculate health plan premiums for the coming year.

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