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Submitted Electronically

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9070-P
P.O. Box 8012
Baltimore, MD 21244-1850

RE: CMS-9070-P; Medicare and Medicaid Program; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction

Dear Ms. Tavenner:

On behalf of our 82,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) appreciates the opportunity to submit comments to the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), in response to the notice and request for comments published in the *Federal Register* on October 24, 2011, for the “Medicare and Medicaid Program; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction” proposed rule. APTA commends CMS for proposing reforms to certain regulations that are unnecessary, excessively burdensome and divert resources from patient care.

Physical Therapist and Occupational Therapist Qualifications

APTA strongly supports CMS’s proposal in the rule to remove outdated personnel qualifications language in the current Medicaid regulations at 42 CFR section 440.110 (a)(2) and align the Medicaid qualifications for physical therapists with the Medicare personnel qualifications at 42 CFR section 484.4. The current personnel qualifications at section 440.110 are outdated and as a result certain states, such as New York, are unintentionally excluding qualified physical therapists from providing services to Medicaid beneficiaries. The exclusion of qualified personnel has resulted in decreased access to medically necessary physical therapy services.

APTA is committed to advancing the safety and quality of healthcare and we are eager to work with CMS and the States in promoting access to appropriate health care services in the current environment of States' resource constraints. Physical therapy is an essential service provided to adults and children under Medicaid and CHIP. APTA supports the qualified practitioner's ability to deliver individualized and culturally sensitive patient care that is medically necessary. To optimize health outcomes, services, such as physical therapy that improve a beneficiaries' ability to function, participate in daily living, and maintain productivity are essential. In this current environment of practitioner shortages, it is imperative that this vulnerable population of beneficiaries be able to access the appropriate health care services.

APTA believes that CMS's alignment of Medicare and Medicaid definitions of qualified personnel will reduce State's confusion in making determinations of qualified physical therapy personnel, and ensure that Medicaid beneficiaries receive high quality services from qualified personnel. In 2007, APTA submitted comments in response to the notice of proposed rulemaking, *CMS-1385-P: Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008*, which resulted in the current Medicare physical therapist and physical therapist assistant personnel qualifications under 42 CFR § 484.4. In 2007, one of APTA's proposed revisions (which was adopted) related to recognition of individuals who were educated outside of the United States and individuals trained by the military.¹ At that time, APTA emphasized to CMS the importance of recognition under Medicare of foreign educated or military trained physical therapists who graduated from programs that are substantially equivalent to physical therapy entry level education in the United States, and are licensed in their state. Also, APTA urged CMS to recognize physical therapists who graduated from physical therapist programs prior to the existence of the Commission on Accreditation in Physical Therapy Education. APTA was concerned about the effects on beneficiaries' ability to access care under the Medicare program if qualified foreign-trained and military trained physical therapists (and physical therapist assistants) were excluded as qualified providers.

Medicaid's current definition, under 42 CFR § 440.110(a)(2)(i), has similarly led to unintentional exclusion of otherwise qualified therapists because of misinterpretation of the regulatory definition by States.² New York serves as a recent example in which many physical

¹ **“APTA recommends that CMS modify the proposed language to clarify that a foreign educated physical therapist must be a “graduate of an education program that by credentials evaluation conducted by an organization approved by the APTA is deemed to be substantially equivalent with respect to physical therapist entry level education in the United States... We believe CMS should adopt a policy that allows for the evaluation of educational programs and military training to determine whether that education is substantially equivalent to physical therapist assistant entry level education in the United States.** If individuals meet these educational requirements along with licensure or other applicable state laws, then they should be recognized.” (See APTA's comment letter, dated August 31, 2007.)

² The Code of Federal Regulations states that a “qualified physical therapist” is an individual who is “a graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association **or its equivalent** [emphasis added]; and licensed by the state.” The language, “or its equivalent,” encompasses equivalent programs, experience and education as allowed by State law, including equivalent programs which were acceptable prior to 1977, the year the qualifications were updated for individuals graduating in 1977 and beyond (i.e., the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy

therapists - who have been considered qualified under federal and state law and have been practicing for many years (including those physical therapists who have been practicing prior to The Commission on Accreditation in Physical Therapy Education's (CAPTE) existence) - have been terminated from employment over the past year due to the State's **new** interpretation of the Medicaid definition of what constitutes a qualified physical therapist. This proposed alignment of definitions will help eliminate this unintended consequence of regulatory misinterpretation which has resulted in decreased access to care of Medicaid beneficiaries and practitioner job loss.

Physical therapy services are provided in a variety of settings, including home care, Intermediate Care Facilities for People with Mental Retardation (ICF/MR), hospitals, outpatient clinics or offices; inpatient rehabilitation facilities; skilled nursing, extended care, sub-acute facilities; patients' education or research centers, hospices and schools. Physical therapy efficiently aids a beneficiary in gaining the best possible function within the context of their medical condition. These services ensure the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health. Often, physical therapy is an effective and less costly option than alternative treatments, such as surgery.³ Costs associated with hospital readmissions after surgical procedures can often be reduced by utilizing physical therapy, where appropriate. Physical therapists are critical to ensuring patients attain an optimal level of mobility and safety in their environment. Physical therapists are uniquely qualified to provide functional training and educate the patient and caregivers on important factors such as prevention of further injury, illness and/or decline in functional status and the resulting effects of immobility. In addition, physical therapists are able to recognize subtle changes in a person's status that may require further evaluation or referral to other healthcare providers before the problems are exacerbated and require readmission.

Qualified physical therapists trained outside the United States offer Medicaid beneficiaries crucial therapy services not only in expanding the availability of the physical therapy workforce, but in being able to provide health care services to a recipient often in their native language and with cultural sensitivity.

Under Medicaid, physical therapy falls into the category of "optional services", and is currently covered in approximately 37 states. When covered, this benefit serves the most vulnerable Medicaid population – including children, individuals with disabilities and dual eligible beneficiaries. In the current fiscal environment, States are weighing all options to reduce costs, particularly benefits that are defined as "optional." APTA is concerned that as the Medicaid system is restructured by States that optional benefits will be discontinued and cautions CMS on maintaining regulations that are subject to misinterpretation which may cause States to inadvertently reduce access to medically necessary services, such as physical therapy, when their elimination could result in increased costs to States due to increased inpatient hospital admissions, development of more severe health conditions, or institutionalized care. APTA

Association), as well as foreign-trained physical therapists who have graduated from programs approved by the American Physical therapy Association or its equivalent. These physical therapists graduating prior to 1977 requirements and foreign-trained individuals from approved programs are "qualified" and, therefore, are eligible to render and bill for Medicaid services.

³ Spine (Phila Pa 1976). 2008 Jul 15;33(16):1800-5.

agrees with the MACPAC statement in examining access to care issues that “[o]ne of the key tests of the effectiveness of a health care coverage program is whether it **provides access to appropriate health care services** in a timely manner and whether those services promote health improvements.”⁴ This proposed cross-referencing of §440.110 to §484.4 promotes this goal of ensuring access to medically necessary services to this vulnerable population.

Provider Enrollment

In the proposed rule, CMS states that they will continue to assess existing regulations, and that they are seeking ideas from the public to help identify areas for possible reform.

In addition to the areas identified in this rulemaking, APTA requests that CMS modify the policies set forth in the final provider enrollment rule (76 Federal Register 5862) published on February 2, 2011 regarding additional screening requirements, application fees, temporary enrollment moratoria, payment suspensions and compliance plans for providers and suppliers under the Medicare, Medicaid and Children’s Health Insurance Programs (CHIP). Specifically, APTA is concerned about the designation of “moderate” risk for physical therapists in private practice (PTPPs) and the decision that physical therapists, physicians, and other health care professionals who provide DMEPOS items in their practice as an integral part of care would be subject to the “high” risk category. The American Physical Therapy Association (APTA) believes that CMS’s decision to place PTPPs in the moderate risk category is mistaken and that the rule should be revised as soon as possible to place them in the “limited risk” category, which includes physicians, therapy providers other than physical therapists in private practices, nurse practitioners, and all other health care professionals.

In the final rule, physical therapists that enroll in the Medicare program as individuals and physical therapy groups were unexpectedly classified in the “moderate” risk category despite the fact that physicians and all other non-physicians were placed in the “limited” risk category. As its rationale for this decision, CMS pointed to a single OIG report entitled “Questionable Billing for Medicare Outpatient Therapy Services” (December 2010) [herein referred to as the OIG report] as well as an anecdotal comment that law enforcement has identified fraudulent billing schemes involving physical therapy. This irrational designation unfairly singles out physical therapists in private practice for increased scrutiny and burdensome administrative review without merit.

Assignment to this moderate risk category means that physical therapists in private practice must undergo a site visit prior to enrolling in the Medicare program. Medicare contractors are requiring that a site visit be conducted for each new practice location. In addition, they are requiring a site visit for each individual physical therapist that joins a practice. For example, if a practice hires five new physical therapists during the year, there would be at a minimum 5 site visits at that practice location during the year. These site visits have resulted in delays in Medicare enrollment. Therefore, we believe that this final policy is seriously flawed and strongly urge CMS, HHS, and OIG to reverse this policy.

⁴ MACPAC, *Report to the Congress on Medicaid and CHIP*, March 2011, p. 125.

We contend that this final policy related to physical therapists in private practice is incorrect for several reasons:

- 1) Similar to physicians, physical therapists in private practice (PTPPs) enroll in the Medicare program, obtain individual provider numbers, and bill Medicare directly for the outpatient therapy services they furnish. Physical therapists are licensed in all states and clearly do not pose an elevated risk to the Medicare program.
- 2) The OIG report referenced by CMS in the final rule and used as the basis for the decision, examined therapy claims, not claims submitted only by physical therapists in private practice. These therapy claims included those submitted by physicians, outpatient hospitals, skilled nursing facilities (Part B), rehabilitation agencies, and comprehensive outpatient rehabilitation facilities (Part B). Further, the OIG report considered outpatient therapy in its entirety (including physical therapy, occupational therapy and speech-language pathology services) in one specific region of the country (Miami-Dade County). Yet, the CMS final rule targeted physical therapists in private practice across the entire country (and only them) by placing them in the moderate risk category even though the OIG report found that schemes involving fraudulent billing for physical therapy services resulted in charges against doctors or providers, and even that the fraudulent activity involved services not performed by licensed physical therapists, as required.
- 3) Further, subjecting physical therapists in private practice to site visits prior to enrollment will serve as a barrier to timely enrollment. Already APTA is getting reports that providers are being told they will need to wait 2-3 months for a site visit.

In sum, placement of physical therapists in private practice in the moderate risk category does not appropriately address fraud and abuse concerns, much of which relate to therapy services provided by individuals other than physical therapist in private practice. Moreover, such placement wastes federal resources on site visits that could be directed to other essential fraud and abuse initiatives.

In the final provider enrollment rule, CMS indicates that physical therapists in private practice (and other health professionals) that furnish durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) to their patients as an integral part of patient care will be subject to the same enrollment requirements as DMEPOS suppliers. Physical therapists in private practice enroll in the Medicare program, obtain individual provider numbers, and bill Medicare directly for the outpatient therapy services they furnish. Currently, if a physical therapist in private practice bills Medicare for DMEPOS items, the therapist must obtain a National Supplier Clearinghouse (NSC) supplier number in addition to his or her individual National Provider Identifier (NPI). This means that physical therapists in private practice and physicians would be placed in the high risk category when enrolling as new suppliers and would be required to pay the enrollment and revalidation fee. We are concerned that these requirements are unduly onerous, unnecessary, and could diminish beneficiary access to medically necessary items

DMEPOS items are provided by physical therapists as an integral part of their physical therapy plan of care. The clinical judgment and expertise of the physical therapist is critical in selecting a

particular DMEPOS item for the patient and is based on the therapist's evaluation of the individual patient. The physical therapist ensures that the item is appropriate to achieve the patient's functional goals, is properly sized and fitted for the patient, and that the patient and/or caregiver is educated in the proper use of the item. In many cases, it is essential that the patient have timely access to these items because the DMEPOS item may be necessary to immobilize and support an injured body part or to facilitate safe mobility or post-surgical recovery.

In most physical therapist practices, DMEPOS items make up a very small portion of the Medicare-covered services furnished by the therapist. Thus, if the enrollment standards are financially and administratively onerous, it will not be feasible for physical therapists to continue to provide these services to their patients which will result in restricted access to needed services for Medicare beneficiaries.

We recommend that CMS changes its regulations so that physicians, physical therapists in private practice, and other professionals who also enroll as DMEPOS suppliers to provide items as an integral part of their plan of care be placed in the "limited" risk category when enrolling (or re-enrolling) as a DMEPOS supplier. In addition, we recommend that CMS exempt these health professionals from the application fee requirement when they enroll as DMEPOS suppliers with the National Supplier Clearinghouse.

Conclusion

Thank you for your consideration of these comments. We hope the above input is helpful. If there are any questions about our comments or additional information is needed, please contact Gayle Lee, JD, Director, Federal Payment Policy and Regulatory Affairs, at 703-706-8549 or gaylelee@apta.org or Deborah Crandall, Associate Director of Payment, Policy and Regulatory Affairs Policy, for Medicaid related issues, at 703-706-3177 or deborahcrandall@apta.org.

Sincerely,



R. Scott Ward, PT, PhD
President

RSW/DC/GL