

November 1, 2017

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

Submitted electronically

RE: Innovation Center New Direction – Request for Information

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit the following comments in response to the Centers for Medicare and Medicaid Services (CMS): Innovation Center New Direction Request for Information (RFI). The mission of APTA is to further the profession's role in the prevention, diagnosis, and treatment of movement dysfunctions and the enhancement of the physical health and functional abilities of members of the public. Physical therapists are highly trained professionals who see patients in a variety of settings. These professionals perform evaluations including a patient's history, a review of systems, and an administration of standardized tests and objective measures based on the patient's presentation and the findings in the review of systems.

Through a collaborative process with the patient, and other members of the health care team when indicated, the therapist develops goals and a plan of care to address the needs of the patient. The physical therapist then executes that plan of care by providing specific techniques and procedures designed to optimize movement and function and decrease and/or manage pain. Physical therapy is also integral to reducing the risk for adverse events including further functional decline, falls, progression of pain or the long-term need for pain medication, avoidable surgical procedures and/or hospitalizations, and disability.

Please find below our detailed comments responding to the agency's RFI.

Advanced Alternative Payment Models (APMs)

- CMS expects that the number of eligible clinicians choosing to participate in Advanced APMs will grow over time. To facilitate this growth, CMS seeks comment on ways to increase opportunities for eligible clinicians to participate in Advanced APMs and achieve threshold levels of participation to become Qualifying APM Participants (QPs).
- CMS has received feedback from the health care provider community on the extensive and lengthy process that is required for a model to qualify as an Advanced APM. CMS seeks feedback from stakeholders on ways the Agency can be more responsive to eligible clinicians and their patients, and potentially expedite the process for providers who want to participate in an Advanced APM.
- CMS also seeks guidance from stakeholders on ways to capture appropriate data to drive the design of innovative payment models and strategies to incentivize eligible clinicians to participate in Advanced APMs.

Expand APMs to Include Rehabilitation

Physical therapists are central to the quality of care throughout the health care continuum, and they work cohesively as members of the health care team to ensure the success of innovative delivery models such as bundled payments and accountable care organizations. We strongly believe that the success of APMs in improving the quality of care and reducing costs will depend on the collective efforts of all health care providers throughout the health care spectrum, including physical therapists in private practice, home health agencies, rehabilitation agencies, inpatient rehabilitation facilities, skilled nursing facilities, hospitals, and other provider settings. The care provided by physical therapists is critical to improving patients' function and successfully transitioning patients from one setting to the next. APTA strongly believes that for these reasons, the physical therapy profession is well-positioned to be a key player in innovative models. However, there are significant hurdles that impede physical therapists from fully participating in APMs.

Current Advanced APMs bar participation by specialty and nonphysician providers; however, we remain hopeful that CMS will find ways to be more inclusive. To accelerate the adoption and use of Medicare (and Medicaid) APMs, CMS should undertake a stronger effort to promote payment models that are accessible to all providers, including physical therapists. We recommend that CMS apply significantly more time and resources toward the development of rehabilitation-inclusive APMs. Greater action must be taken to integrate rehabilitation services into payment models. Further, as the development of APMs continues onward and APM engagement grows, we strongly recommend that CMS provide additional guidance, technical assistance, and other support to providers who have not yet participated in APMs. As illustrated by the current approved list of Advanced APMs and throughout the current roster of projects under way by the Center for Medicare and Medicaid Innovation (CMMI), rehabilitation has not been a focus, and, therefore, the participation of physical therapists in APMs has not been as robust as that of primary care physicians and hospitals.

The true potential to reduce costs and improve the health of individuals and populations will not be fully realized until CMS takes meaningful steps to include physical therapists and other rehabilitation providers within APMs, including Advanced APMs. We look forward to working with the agency to increase the participation of nonphysician providers within APMs. As CMS

leads the transition from fee-for-service (FFS) to value-based care, we encourage the agency to consider the benefits and clinical value that physical therapists, among other provider types, can bring to current and future APMs.

Develop APM Pathways for Nonphysician Providers

APTA urges CMS to create APM pathways under CMMI and through the Physician-Focused Payment Model Technical Advisory Committee, which allow physical therapy practices, rehabilitation agencies, and other therapy providers to be the main conveners of approved APMs. Empowering these providers to develop and lead APMs will result in expanded access to medically necessary rehabilitative care for Medicare beneficiaries, leading to improved outcomes and higher quality of life. Numerous physical therapy practices and rehabilitation entities are at the forefront of innovation, and APTA strongly believes these entities should be able to become key players in health care transformation.

We also recommend that the agency solicit input from small practices when creating future payment models to ensure that a key demographic of providers is adequately represented. This will help to ensure that current challenges associated with APMs are resolved in future model iterations. Moreover, CMS should not advance any new payment model until it can ensure that the model would not perpetuate or intensify patient access issues. Further, implementation of any new model should not occur until CMS can confirm that all stakeholders are adequately prepared to participate in the model.

Quality and Outcome Measures Key to APM Success

As previously stated, rehabilitation services such as physical therapy are integral components of APMs. Unfortunately, many of the metrics that have been developed to assess progress are exclusive of nonphysician specialties, including physical therapy. Additionally, some metrics are not attributed to nonphysician specialties due to the measure attribution methodologies; this includes cost metrics and metrics for readmissions at the provider level. APTA believes that both team-based metrics and specialty-specific metrics are important to the delivery of high quality care.

As CMS undertakes the development of new APMs, we urge the agency to include quantitative and qualitative metrics, including meaningful performance-based and patient-reported outcome measures, by which CMS can ensure that coordinated, patient-specific, outcome-based care is being delivered safely by properly qualified professionals to patients. The variety of measures included within the APM must include measures applicable to multiple types of clinicians. Specialty sets should be developed and adopted for nonphysician providers, including physical therapists, speech-language pathologists, and occupational therapists. Such measures should contribute to coordinated care, be correlated to positive health outcomes, and not impose an undue burden on providers. The types of measures that we recommend CMS develop and adopt are measures that monitor and track patient outcomes, provider performance, and changes in utilization of services. Including a robust set of quality measures within APMs will help to show the positive effects of nonphysician providers' interventions on patient outcomes.

To ensure APMs are multidisciplinary, we recommend that CMS mandate the inclusion of functional measure items within APMs that show the value of providers who have traditionally

been excluded from APM participation. It is critical that new models include appropriate measures that address function and illustrate the value of each provider to the APM patient population. To assist CMS in its efforts, APTA welcomes the opportunity to serve as a resource to CMS and share data results at the clinician, practice, and national levels for the measures included in APTA's Qualified Clinical Data Registry (QCDR).

Registry Is Key to Future Success of Models

We believe it is important for CMS to continue to support the development and success of professional registries as we move toward outcomes-based payment and advanced quality reporting structures that will rely heavily on electronic data submission. CMS must look beyond claims to create an affordable, accessible health care system that puts patients first. In recent years, clinical data registries have evolved and are now embraced by more than 20 professional associations. Creation of these registries has been spurred by the need to create meaningful quality measures for providers to assist in the shift to value-based payment and models of care. APTA believes these registries will be critical to the success of innovative payment models in the future, as they have the ability to deliver real-time data to providers for monitoring, assessing, and responding to new and dynamic models of care delivery.

QCDRs, such as the [Physical Therapy Outcomes Registry](#), capture relevant data from electronic health records (EHRs) and billing information and transform this data into meaningful, intuitive, and actionable feedback for providers on the frontline of patient care. New models of care will require providers to have access to real-time data so they can successfully identify and modify care design to maximize patient outcomes. The use of real-time data will allow for better coordination throughout the continuum of care and can be used to break down traditional silos of care. APTA encourages CMS to incorporate the use of data from registries into new models of care. We believe the use of real-time data should be a guiding principle for these future models. Additionally, we encourage CMS to look for ways to incorporate real-time patient data such as patient-reported outcomes, and other patient-generated data such as from wearable devices, into innovative models.

CMS Must Address Lack of EHR Standards for Nonphysician Providers

To facilitate an increase in the number of eligible clinicians choosing to participate in Advanced APMs, CMS should establish a policy that permits physical therapy EHR vendors to have certified EHR technology (CEHRT). No physical therapy EHR vendors have certified EHR technology (CEHRT), and the U.S. Department of Health and Human Services (HHS) has not yet addressed how these vendors would meet the CEHRT requirements. While the Office of the National Coordinator of Health Information Technology certification process has established standards and other criteria for structured data that EHRs must use, there is no standard certification criteria for EHRs for physical therapists. APTA strongly urges CMS to provide appropriate resources and support to enable small practices, such as physical therapy practices, to participate in future models.

As CMS moves to establish guidance for physical therapy CEHRT, APTA recommends that CMS implement a temporary waiver for physical therapists and other specialty providers not yet included in meaningful use. Physical therapists have been exempt from EHR meaningful use and have not been afforded the same resources as physicians and hospitals for health information

technology adoption. This waiver would permit physical therapists and similar specialty service providers to participate in Advanced APMs until CMS has adopted a policy for physical therapy-specific CEHRT.

Create Incentives for Collaborative, Coordinated Care

To enhance the quality and safety of patient care, we encourage HHS to consider revising current regulations so that different disciplines—including physical therapists, occupational therapists, speech-language pathologists, physicians, nurses, physical therapist assistants, occupational therapy assistants, social workers, psychologists, psychiatrists, and nutritionists—are encouraged to work as a unified care team across the care continuum. HHS should incentivize health professionals to work as an interdisciplinary team to not only increase communication and cooperation among providers but also improve the effectiveness of care delivered to patients. Cohesive teamwork across disciplines will only lead to improved patient outcomes.

Current Medicare policies fail to promote interdisciplinary collaboration; as such, there is limited communication among providers across settings. Accordingly, APTA recommends that to improve patient outcomes and quality of care, CMS more effectively encourage coordination and communication between health care professionals in such a manner that does not create an increased financial or administrative burden on health care providers. APTA strongly believes that the success of APMs in improving the quality of care and decreasing costs depends on the collective efforts of all health care providers throughout the health care spectrum.

Finally, we recommend that CMMI better support the creation of models that no longer rely on the FFS structure, as it will become increasingly difficult to make the appropriate cost adjustments using these types of retrospective cost setting methodologies in the future.

Medicare Advantage Innovation Models

- CMS is potentially interested in a Medicare Advantage (MA) demonstration that incentivizes MA plans to compete for beneficiaries, including beneficiaries currently in Medicare FFS, in a transparent manner based on quality and cost.
- CMS is also interested in what additional flexibilities are needed regarding supplemental benefits that could be included to increase choice, improve care quality, and reduce cost.
- Additionally, CMS seeks comments on options beyond FFS and MA for paying for care delivery that incorporate price sensitivity and a consumer-driven or -directed focus and might be tested as alternatives to FFS and MA.

Reduce Barriers to Access

To reduce barriers to access, drive down costs, and improve the quality of care within the MA program, APTA recommends that CMS better support the utilization of telehealth services, promote preventive services, and eliminate referral/prior authorization requirements.

Promote Access to Telehealth Services

APTA believes that consumer health is key to the success of many care models, allowing providers to serve beneficiaries in many communities while enhancing the patient experience and improving the efficiency of the delivery of care. Technology can help MA enrollees overcome access barriers to high quality rehabilitative services. However, until MA plans expand access to

these services, enrollees will be unable to reap these rewards. Increasingly, providers, patients, and payers are seeking more effective and cost-efficient ways to deliver care. Coverage of telehealth services gradually is becoming more widespread, particularly with commercial payers and state Medicaid programs. Currently, 48 states and the District of Columbia have a definition for telehealth, telemedicine, or both within law and/or policy and regulations; these jurisdictions also reimburse for live video through Medicaid.¹ APTA recommends that CMS lift many of the current restrictions on telehealth services, including where these services can be provided and the types of health care professionals who may furnish telehealth services. There must be more flexibility to allow physical therapists and other providers to use telehealth when treating individuals who are enrolled in MA plans.

Proper application of telehealth services, particularly in rural and underserved areas, can have a dramatic impact on improving care and patient outcomes, and reducing costs of care, by ensuring access to specialized services in isolated rural areas where providers face difficulties in maintaining and staffing full-service hospitals.² Telehealth services also have been shown to improve quality and reduce cost of care among the pediatric patient population. A recent (not yet published) pediatric medicine study conducted by Nemours Children's Health System demonstrated that conducting a sports medicine-related telemedicine visit saved the health system \$24 per patient, helped patients avoid an average of \$50 in travel costs, and maintained high levels of patient satisfaction.³ Another study, published in *Journal of Bone and Joint Surgery* in 2015, found that in-home telerehabilitation was an effective alternative to face-to-face service delivery after hospital discharge of patients following a total knee arthroplasty.⁴

With increased use of telehealth to deliver health care, clinicians need to be able to practice across geographic boundaries. To improve licensure portability for physical therapists and physical therapist assistants, the Federation of State Boards for Physical Therapy, with support from APTA, recently developed an interstate licensure compact for physical therapy.⁵ The purpose of the Physical Therapy Licensure Compact is to increase consumer access to physical therapy services by reducing regulatory barriers to interstate mobility and cross-state practice. Under the compact, physical therapists and physical therapist assistants will be able to apply for privileges to practice in participating states while maintaining licensure in their home state. This compact, currently adopted in 14 states, also will allow physical therapists located in states that have signed onto the compact to use telehealth to expand their practices and enhance patient access. Currently, the Physical Therapy Compact Commission is forming and finalizing rules and bylaws; the data systems required to implement and maintain the compact also are being developed. We anticipate that the compact will be operational in 2018. As CMS, through CMMI,

¹ Center for Connected Health Policy. Webpage. Telehealth and State Medicaid Policy. <http://www.cchpca.org/telehealth-medicaid-state-policy>. Accessed October 11, 2017.

² Medicare Payment Advisory Commission June 2016 Report to Congress, Chapter 8. <http://www.medpac.gov/docs/default-source/reports/chapter-8-telehealth-services-and-the-medicare-program-june-2016-report-.pdf?sfvrsn=0>. Accessed September 20, 2017.

³ Telemedicine visits save families time and money. *EurekaAlert*. September 15, 2017. https://www.eurekaalert.org/pub_releases/2017-09/n-tvs091417.php. Accessed October 11, 2017.

⁴ Moffat H, Tousignant M, Nadeau S, et al. In-home telerehabilitation compared with face-to-face rehabilitation after total knee arthroplasty: a noninferiority randomized controlled trial. *J Bone Joint Surg Am*. 2015;97(14):1129-41. <https://www.ncbi.nlm.nih.gov/pubmed/26178888>. Accessed October 11, 2017.

⁵ Physical Therapy Licensure Compact. Webpage. Federation of State Boards of Physical Therapy. <http://www.fsbpt.org/FreeResources/PhysicalTherapyLicensurecompact.aspx>. Accessed October 11, 2017.

looks to expand access to telehealth services, including telerehabilitation, the compact is a viable solution to the agency's interstate licensure concerns. Ultimately, the expansion of MA coverage for telemedicine would be a cost- and life-saving solution to the critical concerns about access to care that impact the MA population.

Annual Checkup by a Physical Therapist

To reduce the risk of functional decline, falls, and hospitalizations, we encourage CMS to more strongly invest in and promote preventive services, including an annual "wellness" visit by a physical therapist for MA enrollees. Physical therapists have the education, experience, and expertise necessary to provide a broad health screening and track the patient's health status over time. Such a screening may also lead to a referral for a physical therapist evaluation and treatment plan or to another health care professional for potential problems identified during the checkup. Moreover, visiting a physical therapist annually promotes optimal health, wellness, and fitness, and slows the progression of impairments, functional limitations, and disabilities. Expanding the capacity of preventive services and increasing their availability to the MA population will have a powerful effect on the health of MA enrollees, their families, and communities.

We encourage CMS to more closely evaluate the importance of preventive services for MA enrollees and increase access to such services across states and communities.

Promote Direct Access/Limit Prior Authorization Requirements

CMS should establish policies that reduce unnecessary regulations, improve access, and build models of care delivery that best serve the patient and the health care system. To that end, we believe MA enrollees should have direct access to the services of a physical therapist without being subject to the physician-signed plan of care or authorization requirements.

Currently, there is a prolonged, burdensome process to obtain treatment authorizations for MA enrollees. A delay in authorization could severely hinder a patient's condition, requiring physical therapists and other providers to decide between furnishing an uncovered service at their own expense and risking the patient's health and well-being by waiting for a plan to authorize a particular service. Additionally, compliance with the requirement for physician signature is a logistical and administrative burden on therapy providers, taking valuable time and resources away from delivering patient care. In many instances, the plan of care is incomplete, and it may take up to several weeks for the physician to furnish a complete plan of care. Unsigned plans of care result in therapy providers having to delay treatment in order to obtain a physician signature, thus placing the beneficiary at risk and/or being unable to bill for the services rendered.

Providing MA enrollees with direct access to physical therapists is cost-effective, reduces costs by eliminating additional physician visits, prevents more costly interventions, such as hospitalization or surgery, and allows patients more timely access, thus improving their health outcomes. We recommend that CMS require MA plans to furnish same-day authorizations and eliminate the physician signature plan of care requirement. By doing so, MA plans would enhance patient access to timely, high quality care that is appropriate for the patient's condition and avoid preventable adverse events, saving the plans, providers, and patients from expending resources on unnecessary care.

Mental and Behavioral Health Models

- CMS is actively exploring potential models focused on behavioral health, including focus areas such as opioids, substance use disorder, dementia, and improving mental health care provider participation in Medicare, Medicaid, and CHIP through models that enhance care integration and/or use episode payment.
- CMS is interested in stakeholders' views of the best payment models and state and local interventions to improve care in these areas.

Comprehensive Pain Management Model

APTA is committed to fighting the opioid epidemic and positively influencing public health and well-being by enhancing prescriber, patient, and legislator understanding of safe and effective pain management through interdisciplinary care to improve movement and function. Physical therapists and other nonphysician providers are uniquely positioned to improve patient access to pain management. Physical therapists play an important role in managing acute or chronic pain by administering nonpharmacological treatments that include strengthening and flexibility exercises, manual therapy, posture awareness, and body mechanics instruction. They offer an alternative to opioids and other pharmacological options for long-term pain management by helping patients improve their function and range of motion, while also helping patients learn to understand the underlying causes of their pain.

Pain management needs an integrated team approach that focuses on nonpharmacological multidisciplinary management and interventions for acute pain to decrease the potentially disabling effects of chronic pain. As CMS assesses how to address the opioid epidemic, we encourage the agency to examine the benefits of multidisciplinary treatment models for patients with pain and addiction and consider how such models of care can be more widely adopted. For example, CMS could develop a comprehensive pain-management model that encourages providers to choose nonpharmacological, evidence-based treatments, where appropriate. Interdisciplinary, comprehensive pain-management models that evaluate and treat the different factors influencing the presence of pain will only serve to enhance the effectiveness, efficiency, and safety of the care delivered.

This pain management model could promote greater patient engagement and educate both patients and providers on better addressing pain through increased movement, which can lessen the opportunity to overuse pain medication and prevent abuse. The model could also have a positive impact on outcomes among patients who receive treatment for mental and behavioral health conditions. Further, this model could help to shape future opioid policy by allowing CMS to gather specific data on the impact of nonpharmacological interventions on patient recovery and long-term mental and physical health. Future pain management models should encompass multiple disciplines—including rehabilitation, nursing, social work, and behavioral health, and encourage providers to work as a unified team in the delivery of care. Interdisciplinary treatment models promote communication and cooperation among providers, resulting in an increase in the quality and effectiveness of care delivered to patients.

We recognize there are a number of barriers to interdisciplinary care programs or treatments for acute or chronic pain, including geography, payment and coverage, and lack of education and training. While opioid addiction has affected all communities, rural and underserved areas have

been disproportionately harmed by the increased use of opioids. As CMS, through CMMI, develops payment models focused on behavioral health issues such as opioids or substance use disorder, we encourage the agency to consider how such models can reach medically underserved and rural communities, and identify ways to incentivize the broader delivery of care in such areas, such as expanded student loan repayment programs or greater flexibilities related to delivering telehealth services. Given the seriousness of the opioid crisis (and more broadly, the chronic pain crisis), CMS should better support the ability of providers to deliver pain management services to patients virtually, as this will only help to expand the availability of chronic pain treatment options.

To truly be effective in improving care for Medicare beneficiaries suffering from acute or chronic pain, CMS must actively work to address the payment and coverage barriers to nonpharmacological pain management treatments, which pose one of the biggest challenges in ensuring patient access to such treatments. There continue to be restrictions in the form of time and visit limits, high copays, previous diagnosis requirements, limited patient populations, or requiring a referral for certain types of treatment. As such, patients are unwilling to or cannot receive care due to financial limitations, payer restrictions, time constraints, or lack of motivation. For example:

- A Medicare beneficiary is responsible for a copay or coinsurance per physical therapy session. His physical therapy plan of care dictates treatment interventions 2-3 days per week for 4-8 weeks. Being required to pay a copay that ranges from \$25 to \$45 per therapy visit is not financially feasible for this patient and his family. As a result, this patient will avoid treatment, either allowing his pain to worsen or seeking immediate albeit short-term relief, via an opioid.

Unfortunately, this situation is all too common among patients. Future payment models must eliminate the access barriers to physical therapy and other nonpharmacological therapies that have been proven to be effective for the prevention or treatment of pain. Until such barriers are addressed, access to nonpharmacological therapies will continue to be limited, and opioids will remain a go-to quick fix for pain despite their dangerous side effects and, in some instances, long-term ineffectiveness.

Additionally, we encourage CMS to recognize that very few primary care providers receive education on how to treat chronic pain. These health care professionals, as well as their patients, often lack sufficient knowledge about the range of available therapies for acute or chronic pain, which therapies may be helpful for the treatment of pain, and when a nonpharmacological therapy should be used as part of a multidisciplinary approach to pain management. Without sufficient education on nonpharmacological pain management solutions and how such options may suit patients' needs, providers will neither discuss nor offer treatments that address the biological, psychological, and social needs of the patient. This not only places patients at a significant disadvantage during the course of treatment but also encourages overuse of opioids to treat pain.

To ensure all treatment options are considered, clinicians must be equipped with the knowledge and resources necessary to be able to examine the variety of existing treatments for pain and

provide a well-informed recommendation on the best treatment for pain management, specific to the needs of each patient. In turn, by receiving adequate information from their care providers, patients will feel more empowered and better able to articulate their needs, goals, and desires, which in turn will lead to more effective treatment plans.

Moving forward, it is imperative that CMS acknowledge the important role that physical therapists and other nonphysician health care professionals play in the prevention and treatment of acute and chronic pain. Future models must promote collaboration, assessment, and care coordination across multiple disciplines. If providers such as physical therapists are excluded, CMS will reinforce the idea that only pharmaceutical options are available for the treatment of pain, which will continue to encourage the overuse of opioids to treat pain. By promoting a multidisciplinary approach to pain management and treatment, CMS will help to ignite the much needed paradigm shift away from opioid overutilization and toward safe and effective nonpharmacological treatment models. Such actions will not only move this nation forward in its efforts to improve pain management but also foster and promote safe opioid prescribing.

Program Integrity

- CMS is seeking comment on ways that CMS may reduce fraud, waste, and abuse and improve program integrity. Different approaches to program integrity could be tested to help CMS find the ideal balance between burdens on patients, additional workload the physician, and effectiveness of the review. Such an approach could be tested as part of a new model and/or be layered on top of other models.

APTA recommends that CMS streamline its program integrity efforts by enhancing education for medical review contractors and providing more specific information to providers to avoid unnecessary audits, medical reviews, and claim denials. APTA works continuously to reduce the number of unnecessary regulations that interfere with physical therapists' ability to provide the best care for their patients. In 2014, APTA developed Integrity in Practice, a comprehensive campaign to promote high quality care. The campaign helps physical therapists navigate complex regulations and payment systems and offers tools and resources for physical therapists to encourage and promote evidence-based practice; ethics; professionalism; prevention of fraud, abuse, and waste; and more. APTA's Integrity in Practice campaign will help preserve and promote the excellent reputation of the physical therapy profession and ensure high quality physical therapy care for our patients.

We offer the following suggestions on ways CMS may reduce fraud, waste, and abuse and improve program integrity.

Association Registries

As previously stated, APTA launched the Physical Therapy Outcomes Registry to provide a user-friendly system for collecting uniform data on patient and client outcomes. APTA's registry and similar registries housed by professional associations can provide comprehensive data and benchmarking on practice standards, which can be employed to reduce fraud, waste and abuse, and create significant savings to health care programs. The support of registry data sets will help drive practice changes and illuminate variances in care delivery. Therefore, APTA recommends that CMS establish policy that encourages the use of these registries in new models of care.

Prepayment Review

The federal government has been performing an increasing number of Medicare audits to reduce the amount of improper payments. APTA is committed to ensuring that physical therapy services meet coverage, coding, and documentation requirements set forth by CMS and recognizes the important role that Medicare auditors play in ensuring payments are paid properly. We support efforts to enhance program integrity. However, once a provider is selected for a prepayment audit, it is difficult to have that audit terminated despite efforts by the provider to remedy any problems. We recommend the following initiatives to improve the prepayment audit process:

- Trained professionals should conduct the audits of medical records.
- Auditors should apply policies uniformly when conducting medical reviews.
- Auditors should provide and communicate to the provider a case-specific rationale for each denial so that providers can remedy any problems.
- Time frames should be established for ZPICS/PSCs to make determinations on whether a service is covered and to notify the provider of those determinations.
- Auditors should have public websites that allow providers to track the status of their open audits.
- Contractors that conduct prepayment review should offer providers a discussion/education period, similar to the targeted medical review process conducted by the Supplemental Medical Review Contractor. For example, when providers are selected for prepayment review due to insufficient documentation, contractors should provide education and offer a specified time frame (e.g., 60 days) for providers to change their documentation to address any concerns.
- Contractors should exempt from prepayment review those providers engaged in continuous quality improvement through the use of QCDRs.

These steps will enable the government to ensure that resources are focused on identifying and auditing the providers that are inappropriately billing Medicare and making sure that providers are not placed on prepayment audits for indefinite time frames.

In-Office Ancillary Services (IOAS) Exception

APTA strongly urges CMS to narrow the scope of the IOAS exception of the physician self-referral law by removing physical therapy from the exceptions list. Physical therapy does not meet the original purpose of the IOAS exception, because patients typically require multiple therapy visits, which cannot be completed in-office during the patient's visit with the physician. Further, physicians have misused this exception to hire physical therapists and bill therapy services to the physician's practice, rather than to the therapist. Further, the inclusion of physical therapy in the exceptions list does not further the law's original purpose, which was to ban profits through referrals altogether. In fact, physicians often profit from referrals for therapy services due to this exception.

The IOAS exception to the physician self-referral laws was intended to improve coordination of care and promote patient convenience by allowing physicians to self-refer for designated health services integral to their primary care that are furnished in their group practices. Unfortunately, the current use of this exception goes well beyond its original intent.

Abuse of the IOAS exception has been examined by the Government Accountability Office, the Office of the Inspector General of HHS, and the New England Journal of Medicine, among others. The Medicare Payment Advisory Commission (MedPAC) also raised questions about abuse under the IOAS exception in its June 2010 report. Both MedPAC and CMS have found that the existing IOAS exception has substantially diluted the self-referral law and its policy objectives, allowing Medicare providers to avoid the law's prohibitions by structuring arrangements that meet the technical requirements for physical therapy services while violating the true intent of the exception.

We believe the promulgation of laws to end the unintended abuses under the IOAS exception are essential to the success of APMs. Physician ownership of physical therapy services creates a thriving environment for fraud and abuse, and, therefore, we strongly recommend that the Secretary exercise his authority to add physical therapy as a nonqualifying designated health service that cannot be furnished to Medicare patients under the IOAS exception.

Conclusion

APTA thanks CMS for the opportunity to provide feedback in response to the request for information regarding the future of CMMI. We look forward to working with the agency in the future to help craft new models that improve the quality of patient care while also ensuring that the models preserve access to quality rehabilitation services. Should you have any questions regarding our comments, please contact Kara Gainer, Director of Regulatory Affairs, at karagainer@apta.org or 703/706-8547. Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Sharon L. Dunn". The signature is written in a cursive, flowing style.

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

SLD: krg