APTA
American Physical Therapy Association℠

September 8, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code-CMS-1631-P; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Proposed Rule

Dear Acting Administrator Slavitt:

On behalf of our 90,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule regarding "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for 2016, published in the July 15, 2015 *Federal Register*. APTA's goal is to foster advancements in physical therapy practice, research, and education. 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.

The physician fee schedule is currently the basis of payment for outpatient therapy services furnished by therapists in private practice as well as outpatient therapy services furnished by hospitals, outpatient rehabilitation facilities, public health agencies, clinics, skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities (CORFs). Therefore, any changes to payments under the physician fee schedule for outpatient therapy services have a significant and direct effect on Medicare payments across the entire spectrum of the therapy delivery system.

Recommendations

Specifically, we recommend the following:

1) CMS should use objective screens to identify potentially misvalued codes instead of identifying codes for review merely due to high costs.
2) Instead of requesting the RUC to review codes identified as potentially misvalued in in the physical medicine and rehabilitation series (97000), CMS should allow the CPT Workgroup to continue to develop new codes to report physical medicine and rehabilitation services. These new codes will ultimately be valued through the RUC process.
3) CMS should maintain the refinement panel process to ensure that there is a fair and objective appeals process in effect for all organizations to appeal decisions by CMS with regard to values for specific CPT codes.
4) With respect to the target reduction for misvalued codes, when determining the net impact of service-level input changes in a given year, it is important for CMS to identify specific codes that are part of new payment initiatives (eg. Advance care planning) which should not be included in the net reduction target calculation.
5) CMS to consider an alternative name for the Physician Compare website which includes data not only from physicians, but other eligible professionals (EPs), such as physical therapists.
6) CMS should allow PTs to report under the EHR option by expanding the definition of successful reporting requirements to providers who are not currently included in the meaningful use (MU) program.
7) CMS should to continue to incentivize participation in quality reporting programs (e.g. PQRS) for PTs and the other non-physician providers that were excluded from the initial group of EPs in MIPS.
8) It is important for CMS to continue to support the development and success of professional registries, such as the PT Outcomes Registry, as we move towards outcomes-based payment and advance quality reporting structures which will rely heavily on electronic data submission.
9) APTA recommends that therapy associations and organizations and CMS collaborate in the near future to develop a core data set or a finite list of measures that could be used in any tool to gather information about the patient function.
10) CMS required the collection of the functional limitation data via the claims-based mechanism in the CY2013 final rule, however, APTA would recommend that CMS consider other forms of data submission in the future.
11) At a minimum CMS should require a unique modifier on the claim form to denote who is providing the services that are billed as "incident to" services. APTA also recommends targeted audits and medical review, particularly of physicians billing for physical therapy services, to ensure compliance with Medicare rules and regulations.
12) The proposed timeshare arrangement exception to the self-referral law should exclude the provision of designated health services, such as physical therapy services, to patients on the licensed premises, to protect both beneficiaries and program integrity.

Our comments on each of these recommendations are discussed in further detail in the following paragraphs.

Potentially Misvalued Services Under the Fee Schedule

The Affordable Care Act requires CMS to identify and review potentially misvalued codes and make appropriate adjustments to the relative values of those services identified as being misvalued. The PAMA amended the law to expand the categories of services that CMS is directed to examine for the purpose of identifying potentially misvalued codes to an additional 9 categories, in addition to the 7 categories that already existed.

In its identification of misvalued codes, CMS includes in the rule a list of 118 CPT codes for the RUC to review that fall into the category of "High Expenditure across Specialties with Medicare Allowed Charges of $10,000,000 or more." In addition to an array of codes from other specialties, this list includes CPT code 97140 (manual therapy), 97530 (therapeutic activities), 97112 (neuromuscular reeducation), 97032 (electrical stimulation), 97035 (ultrasound therapy), 97110 (therapeutic exercises), 97112 (neuromuscular reeducation), 97113 (aquatic therapy), 97116 (gait training), and G0283 (electrical stimulation other than wound).

APTA agrees with the importance of ensuring that services are appropriately valued. However, APTA does not understand why charges greater than $10 million should necessarily result in a code being potentially misvalued. CMS should provide the RUC with any data used that would explain why charges of greater than $10 million would potentially translate into misvalued codes. APTA urges CMS to use objective screens to identify potentially misvalued codes instead of identifying codes for review merely due to high costs.

A Physical Medicine and Rehabilitation workgroup at CPT is in the process of developing a new coding structure for the CPT codes in the 97000 series. **We recommend that CMS allow the workgroup to continue to focus its efforts on the development of these new codes. With the development of these new codes already underway, it would not be a good use of resources for the RUC to spend time reexamining the values of the 10 CPT codes in the 97000 series identified by CMS in the rule.** These new codes will ultimately be valued through the RUC process.

Refinement Panel Process

In the rule CMS proposes to eliminate the Refinement Panel process currently in effect that has been used by CMS to consider comments on interim relative value units. CMS states that they believe that since proposed work RVUs will not be published in the Proposed Rule, the Refinement Panel Process will no longer be necessary. For almost two decades, the CMS Refinement Panel Process was considered to be an appeals process by stakeholders. The Refinement Panel has consisted of members from primary care organizations, contractor medical directors, the specialty organizations who commented on the values, and specialty organizations related to the commenting specialty group. The Refinement Panel members voted and for many years CMS deferred to the vote of the Refinement Panel with regard to the values. More recently, CMS independently reviews each of the Refinement Panel's recommendations in deciding which CPT code values to finalize.

We are seriously concerned with the elimination of the Refinement Panel because this would mean that CMS would no longer solicit the views of contractor medical directors, practicing physicians and physical therapists to determine if there is a need to modify proposed values. While we support the change to including proposed RVUs in the fee schedule proposed rulemaking each year, we do not agree that this new process eliminates the need for a Refinement Panel. These two processes are distinct from each other and together would allow for multiple avenues to appeal. **We recommend that CMS ensure that there is a fair and objective appeals process in effect for all organizations to appeal decisions by CMS with regard to values for specific CPT codes**.

Target for Relative Value Adjustments for Misvalued Services

The Protecting Access to Medicare Act of 2014 (PAMA) enacted on April 1, 2014 established an annual target for reductions in Medicare Payment Schedule expenditures resulting from adjustments to relative values of misvalued codes. Following this, the Achieving a Better Life Experience Act of 2014 (ABLE) enacted on December 19, 2014 accelerated the application of the expenditure reduction target, setting a 1 percent target for CY 2016 and 0.5 percent for CYs 2017 and 2018. With estimated total allowed charges of $88.4 billion for CY 2016, 1% would be approximately $884 million. CMS estimates in the proposed rule that the estimated net reduction in expenditures based on changes to codes would be approximately 0.25% in 2016. This reduction target does not include all of the services reviewed by the RUC that will be included in the final rule.

We are deeply concerned with the magnitude of the target reduction of $884 million. Since 2006 the RUC has subjected many codes to review and has redistributed more than $3.5 billion dollars in reductions. By implementing this target, the legislation is penalizing physicians and other health care professionals for already taking on the difficult task of identifying and revaluating codes over the past 10 years.

We recommend that CMS make the process more transparent in the future by publishing each issue's estimated impact on the net target reduction. This information should be published based on each CPT code or each family of services to evaluate service level impacts.

CMS discusses several ways to identify a subset of the adjustments in RVUs for a year to reflect an estimated "net reduction" in expenditures. Ultimately, the Agency decides that the best approach to define the reduction in expenditures as a result of adjustments to RVUs for misvalued codes is to include the estimated pool of all services with revised input values.

CMS states that the requirement to calculate net reductions implies that both decreases and increases must be considered. **When determining the net impact of service-level input changes in a given year, it is important for CMS to identify specific codes which should not be included in the net reduction target calculation**. **For example, CMS has been working to develop policies that recognize the importance of care management in improving patient outcomes and reducing costs. New codes for advance care planning and chronic care**

management were developed to report and receive reimbursement for these important services. We believe that CMS should exclude these services from the net reduction target.

Physician Quality Reporting System

The Physician Quality Reporting System (PQRS) was initially implemented in 2007 as a result of section 101 of Division B of the Tax Relief and Health Care Act of 2006. Physical therapists are currently participating providers in PQRS and can report individual measures and measure groups. APTA supports the goal of improving quality of health care. Physical therapists are committed to providing high-quality, timely care and to the promotion of evidence-based practice and patient-centered practice. However, the APTA does have some concerns regarding provisions in the proposed rule regarding the PQRS program. These concerns are discussed below.

Physician Compare Website

Section 10331(a)(1) of the Affordable Care Act (42 U.S.C. 1395w-5 note) requires that CMS, by no later than January 1, 2011, develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program under section 1866(j) of the Act as well as information on other eligible professionals who participate in the Physician Quality Reporting System under section 1848 of the Act (42 U.S.C. 1395w–4). In addition, section 10331(a)(2) of the Affordable Care Act also requires that, no later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, CMS implement a plan for making information on physician performance publicly available through the Physician Compare Website. CMS did meet the initial requirements and plans to expand the data on the Physician Compare Website in 2016.

CMS proposes to add additional Board Certification information from the American Board of Optometry (ABO) and American Osteopathic Association (AOA) to the Physician Compare website. Currently, CMS includes American Board of Medical Specialties (ABMS) data as part of individual EP profiles on Physician Compare. **APTA would recommend that CMS add board certification information from the American Board of Physical Therapy Specialties (ABPTS).** ABPTS has certified more than 16,000 individuals who have demonstrated advanced clinical knowledge and skills in physical therapy specialty areas. Currently, the ABPTS offers board-certification in eight specialty areas of physical therapy: Cardiovascular and Pulmonary, Clinical Electrophysiology, Geriatrics, Neurology, Orthopaedics, Pediatrics, Sports, and Women's Health. The addition of this board certification to the physician compare website is of interest to consumers as it would provide additional information to use to evaluate and distinguish between physical therapists on the website.

APTA recommends that CMS continue to provide health care professionals the opportunity to preview data and measures in confidential formats and provide methods for feedback prior to posting the information on the site. We have concerns that CMS may be challenged in getting timely feedback reports to all providers to view prior to the public release of data on Physician Compare with the expansion of public reporting for all EPs and groups across all reporting

formats. EPs should be allowed a reasonable period of time for review of reports in order to access and gather supporting information to correct errors, discrepancies, and other concerns.

Additionally, we strongly encourage CMS to consider an alternative name for the Physician Compare website which includes data not only from physicians, but other eligible professionals (EPs), such as physical therapists. We believe that as the website grows, the name of the website will not accurately reflect the inclusion of other providers and will only increase consumer confusion.

Satisfactory Reporting Requirements

CMS proposes to retain the claims-based, registry-based and EHR based reporting options. We support CMS's decision to retain multiple reporting options as we believe that this will encourage broader participation in the program. It is important to keep several options open so as not to require providers to incur additional costs when they may not be in a position to incur these costs. While we certainly see value in electronic data submission, we do not believe it would be prudent at this time to assume that all physicians and health care professionals are ready and able to use the available technology.

APTA recognizes that CMS would like to move toward electronic data reporting in the future. CMS stated in the final CY2015 physician fee schedule rule *"it is our intention to eliminate the claims-based reporting mechanism in future rulemaking. During this time, we encourage eligible professionals to use alternative reporting methods to become familiar with reporting mechanisms other than the claims-based reporting mechanism."* **APTA believes that CMS could increase data submission via Certified Electronic Health Record Technology (CEHRT) by allowing PTs to report under the EHR option by expanding the definition of successful reporting requirements to providers who are not currently included in the meaningful use (MU) program.** By implementing this change, CMS will allow providers such as physical therapists who are not eligible for MU to report quality measures using their CEHRT if they so choose. This will drive the adoption of CEHRT and thousands of providers who depend on other mechanisms for data submission for PQRS compliance will now have a new, additional option of being able to achieve compliance through the use of ONC-certified CEHRT programs.

Under the current reporting requirements for the Meaningful Use (MU) program, eligible professionals can report Clinical Quality Measures (CQMs) using CEHRT to fulfill the reporting requirements under both the PQRS program and MU program. The current successful reporting requirements for PQRS using EHR is as follows:

> "Report 9 measures covering at least 3 of the NQS domains. If an EP's direct EHR product or EHR data submission vendor product does not contain patient data for at least 9 measures covering at least 3 domains, then the EP would be required to report all of the measures for which there is Medicare patient data. An EP would be required to report on at least 1 measure for which there is Medicare patient data."

While the MU program does accept zeros in the denominator, CMS does not accept zero in the denominator for PQRS with EHR data submission. EPs who are considered eligible under both the PQRS and the MU programs are able to successfully report using CEHRT even when there are less than 9 applicable measures for reporting as CMS accepts zero denominators for those professionals. Although physical therapists are not eligible for MU, they should be able to successfully submit PQRS / CQM data electronically using a CEHRT to submit measures, even if they may have zeroes in the measure denominator. In such a situation, CMS should accept the PQRS data even if 9 measures are not present across 3 domains. The clinicians should get credit for the zeroes, like MU eligible EPs would when reporting for MU, which will further CMS's goal of driving adoption of CEHRT use and enable successful PQRS/CQM reporting from providers as long as they use an approved CEHRT to submit those measures.

Feedback Reports

Section 1848(m)(5)(H) of the Act requires the Secretary to provide timely feedback to eligible professionals on their performance with respect to satisfactorily submitting PQRS data. CMS currently provides annual PQRS performance reports through Quality Net, as well as interim dashboard reports. Annual reports are typically available 8-9 months after the end of the calendar year, while the interim reports are delayed by roughly 1-2 quarters. The delay in the distribution of these reports has made it difficult for providers to make any changes to improve their reporting under the PQRS program. Providers are required to register through EDIM in order to create an account prior to accessing the PQRS reports. Our members have expressed confusion and frustration about the registration process for these reports. In a survey of our private practice section members in the summer of 2014, only 23.5% of those who reported participating in PQRS, had accessed a feedback report. APTA believes that performance feedback is an essential component of successful performance improvement, and increasing the availability of these reports, as well as providing more timely releases of such reports, would greatly assist providers in improving the quality of care they deliver. The ability to receive provider feedback in a timely fashion will become even more critical as we move towards value-based payment programs such as the Merit-Based Incentive System.

<u>Merit-Based Incentive System (MIPS)</u>

Section 1848(q) of the Act, added by section 101(c) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), requires creation of the Merit-based Incentive Payment System (MIPS), applicable beginning with payments for items and services furnished on or after January 1, 2019. In the MACRA legislation the MIPS program begins in the 2019 year with the inclusion of physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. With other nonphysician eligible professionals to be added beginning in year 3 (2021) of the MIPS program under the discretion of the Secretary, to include: physical therapists, occupational therapists, speech language pathologists, clinical social worker, clinical psychologist, registered dietician, nutrition professional, and audiologists.

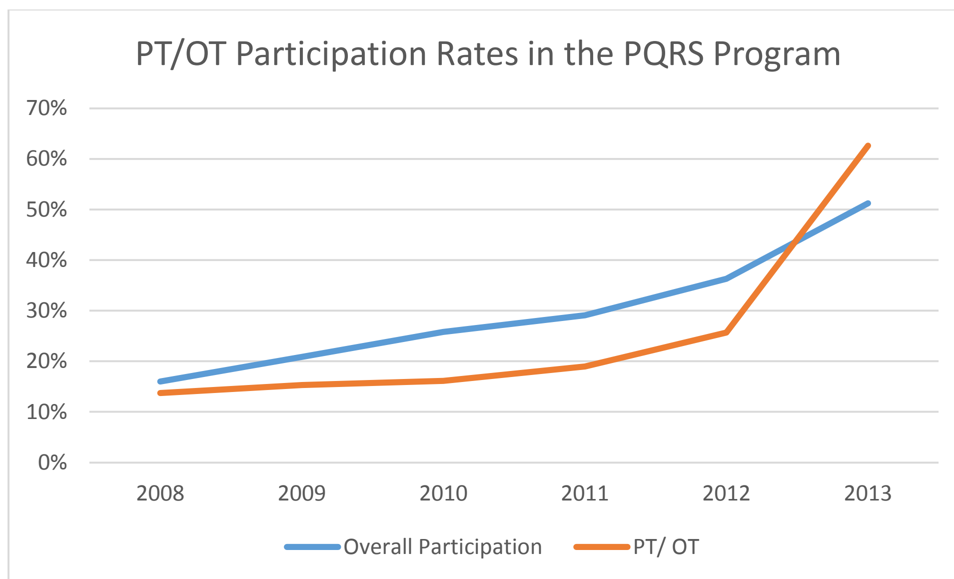
Given the legislative mandate the following table demonstrates the impact on physical therapists in private practice reporting under Medicare part B quality reporting programs.

Quality Reporting for Physical Therapists Under Medicare Part B				
Calendar/ Current Year (Data Year)	**Year Penalty/ Payment Applied**	**PQRS Penalty**	**VM Incentive/ Penalty**	**MIPS Incentive/ Penalty**
2015	**2017**	**-2.0%**		
2016	**2018**	**-2.0%**	4.0x to -4.0% Includes specified non physician EPs (excludes PTs)*	
2017	2019			3.0x to -4.0% Includes MDs and other specified EPs*
2018	2020			3.0x to -5.0% Includes MDs and other specified EPs*
2019	**2021**			**3.0x to -7.0% CMS *may* add remaining EPs** (including PTs) to program**
2020	**2022**			**3.0x to -9.0% CMS *may* add remaining EPs** (including PTs) to program**
* Last year of VM and initial years of MIPS will only apply to MDs, physician assistants, nurse practitioners, clinical nurse specialists, and nurse anesthetists **Physical therapists, occupational therapists, speech language pathologists, clinical social worker, clinical psychologist, registered dietician, nutrition professional, audiologists				

As the Table indicates, under MACRA, the PQRS program becomes voluntarily in 2019 (based on performance in 2017) and the MIPS program begins in 2019 for physicians, physicians' assistants, nurse practitioners, clinical nurse specialists, and nurse anesthetists. CMS has the discretion to add physical therapists and other nonphysicians to the MIPS program 2 years later in 2021 (based on performance in 2019). APTA has concerns regarding these legislative changes to the quality reporting program, specifically with the lack of inclusion of several non-physician groups including physical therapists. In January HHS officially announced that it will establish milestones in its efforts to create payment systems based on outcomes rather than

services provided: by 2016, it plans to tie 30% of Medicare payments to alternative payment models, and increase that level to 50% by the end of 2018. At the same time, the department plans to link 85% of remaining fee-for-service payments to some outcome measures by the end of 2016 and bump that to 90% 2 years later**. Given the current healthcare payment environment and the focus on outcome-based payment models we believe the exclusion of physical therapists from the MIPS program in the initial years is a step backwards, and may have many unintended consequences.** We outline our concerns in detail below.

Physical therapists have been included in quality reporting under Medicare part B in the PQRS program since its inception in 2007. As with many eligible professionals, reporting in the PQRS program in the early years of the program was low. APTA has spent significant effort and resources in providing member outreach and education to increase awareness about the program and to improve the reporting rates for physical therapists. We amplified these efforts leading up to the 2013 reporting year as this was the first year the PQRS reporting was tied to penalties for providers. The below table demonstrates the significant increase in the number of physical therapists reporting in PQRS. (Based on data included in annual PQRS Experience Reports).



The PT/OT participation rate in PQRS in 2013 was 62.6%, which exceeded the overall eligible professional (EP) participation rate of 51.2% and the MD/DO participation rate of 59.1%. APTA has significant concerns that PT exclusion from the MIPS program in 2017 and 2018 will have a strong negative impact on the reporting rate of quality measure by physical therapists. Furthermore, APTA is concerned that PT's will struggle to return successfully into the quality reporting space in 2019 under the constructs of an entirely new program after this two year hiatus. **APTA strongly encourages CMS to continue to incentivize participation in quality reporting programs (e.g. PQRS) for PTs and the other non-physician providers that were excluded from the initial group of EPs in MIPS.** One example of incentivizing PTs to

continue to reporting quality measures in the 2017 and 2018 reporting year would be to give providers credit towards their MIPS performance when they join that program in 2019. We would welcome the opportunity to work with CMS on developing mechanisms to incentivize physical therapists to continue to participate in PQRS.

With the increasing emphasis on the role of quality measures and the movement towards more outcomes-based payment systems, APTA decided to move forward in developing the Physical Therapy Outcomes Registry in 2013. APTA is currently in the pilot testing year for our registry and we have intentions to pursue QCDR status in the near future. APTA is concerned that the exclusion from the MIPS program will hurt our ability to achieve and maintain QCDR status unless we have an ability to continue to report quality data. APTA believes the registry is a vitally important resource for physical therapists to engage in quality improvement activities and to prepare for the changing payment and delivery models, including being prepared to enter into collaborative payment models such as the comprehensive care joint replacement model currently proposed by CMS. **We believe that it is important for CMS to continue to support the development and success of professional registries as we move towards outcomes-based payment and advance quality reporting structures which will rely heavily on electronic data submission.**

Furthermore, professional registries will allow specialty practices like physical therapy to work towards more advanced quality measures that can be incorporated into value-based payment programs, such as MIPS. As many of the measures that are currently included in the PQRS reporting program were created for primary care physician practice, we view the Physical Therapy Outcomes Registry as an opportunity to develop measures that are more meaningful to physical therapist practice and will more accurately reflect the quality of care physical therapists deliver to their patients. Currently, physical therapists are eligible to report on 15 measures in the PQRS program, 8 of which are process measures and none of which are cost or resource use measures. We recognize the need for more measures for physical therapists given the move to a value-based quality program; this would include outcome and resource use measures specific to the profession.

Another concern APTA has is the gap in the reporting of public data that will occur on the physician compare website as result of the exclusion form the first two years of the MIPS program. As CMS continues to launch data on the physician compare website, APTA is concerned about the public perception of physical therapists during the 2017 and 2018 years when they are not participating in the MIPS program. We believe that a lack of data during these years may give the public an incorrect impression that physical therapists are choosing not to participate in the MIPS program when they are legislatively excluded. Again, we encourage CMS to develop mechanisms that will incentivize PTs and the other non-physician providers to continue reporting quality measures during these interim years (2017, 2018) in order to avoid these unintended consequences.

Lastly, APTA feels it is important to continue to be involved at the national level in quality organizations such as the National Quality Forum (NQF) and Physician Consortium for Performance Improvement (PCPI) to ensure that physical therapists are represented as quality

measurement continues to evolve. APTA has been an active member of these national quality organizations as well as being represented in a variety of CMS convened technical expert panels dealing with quality measures across the continuum of care. We are hopeful that exclusion from the MIPS program in its inception years will not impact our ability to participate and advocate for physical therapists. Given the changes that are simultaneously occurring in the post-acute care space with the implementation of the IMPACT Act, APTA believes that the next several years will be a critical period for the development and implementation of measures of that impact physical therapists in various quality programs across the continuum of care.

Claims-Based Data Collection of Functional Limitation Information

Section 3005(g) of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) requires CMS to implement, beginning on January 1, 2013, a claims-based data collection strategy that would be designed to collect data on patient function during the course of therapy services in order to better understand patient condition and outcomes. CMS finalized the data collection strategy to meet the above requirement in the final Physician Fee Schedule rule of CY2013.

Under the rule, nonpayable G-codes and modifiers would be included on the claim forms that would capture data on the beneficiary's functional limitations (a) at the outset of the therapy episode; (b) at specified points during treatment; and (c) at discharge. In addition, the therapist's projected goal for functional status at the end of treatment would be reported on the first claim for services and periodically throughout the episode. Modifiers would indicate the extent of the severity of the functional limitation.

CMS has not included any planned changes to the data collection regulations in the CY 2016 proposed Physician Fee Schedule rule. Nonetheless, APTA would like to take this opportunity to provide feedback about the future evolution and possible changes to this claims-based data collection process.

General Concerns Regarding the Collection of Data on Functional Limitations

As CMS is aware, therapy providers faced numerous challenges with the implementation of the Functional Limitation Reporting (FLR) requirements. Currently, submission of FLR data is a condition of payment for therapy services provided under Medicare Part B. Early in the implementation of this program in 2013 and through the first half of 2014, due to problems with Medicare's claims processing systems, many providers were not paid for therapy services. As a result, physical therapy providers experienced significant financial hardship.

APTA strongly supports the long term goal of improving the payment system for outpatient therapy services and using data collection to achieve this goal. To gather meaningful information that could be used to compare one provider to another regarding their patient care or one patient to another patient with respect to their condition, functional limitations, and outcome of care, would necessitate the use of one standardized data collection tool by all therapists. Unfortunately, at this time due to the variety of outpatient therapy settings and the wide

diversity of patient conditions treated by therapists, no such standardized tool exists that could be used by all providers to report a patient's functional limitation.

In the absence of one standardized tool, we believe that the information reported on the claim form regarding the patient's functional limitations supported through the use of one or more tools could be useful in enabling CMS to more efficiently determine the impact of therapy services for an individual patient over the course of that individual's *episode of care*. This data could provide CMS with easily obtainable information about the individual beneficiary's progress without requiring an in depth medical review and could assist CMS in identifying cases for potential medical review.

APTA recommends that therapy associations and organizations and CMS collaborate in the near future to develop a core data set or a finite list of measures that could be used in any tool to gather information about the patient function. We acknowledge that the current data collection is limited without the use of one standard measurement tool which hinders the ability of CMS to aggregate and analyze data on a national scale, but we are hopeful that this initial data collection may better inform decisions about future uniform data elements, whether they be single questions, or measurement tools, that can be applied more universally to beneficiaries receiving outpatient therapy services.

Suggestions Related to FLR Data Submission

CMS required the collection of the functional limitation data via the claims-based mechanism in the CY2013 final rule, however, APTA would recommend that CMS consider other forms of data submission in the future. Currently, outpatient private practice physical therapists are required to report in quality programs, such as PQRS, under Medicare. The PQRS program allows for the transmission of data to CMS via four mechanisms: claims, registry, qualified clinical data registry, and electronic health record data submission. Although FLR was designated to be a claims-based data collection program in the MCTRJCA, we hope that it will evolve to allow for data submission through electronic mechanisms to decrease provider reporting burden in the future. Although not specifically designated as a "quality reporting program" APTA does believe that the functional limitation reporting requirements are in fact very similar to other Medicare quality reporting programs and we plan to develop quality measures in the future to use this functional data to meet measure requirements in quality reporting programs such as MIPS.

"Incident to" Billing

CMS proposes to revise the "incident to" regulations to clarify that the physician who bills for the incident to service must also be the physician who furnishes the service or who directly supervises the service. It must be the physician upon whose professional service the incident to service is based. CMS proposes to explicitly prohibit auxiliary personnel from providing incident to services who have either been excluded from Medicare, Medicaid and any other federally funded health care programs or who have had their enrollment revoked for any reason. CMS also invites comments about possible approaches to ensure services are provided by

qualified individuals. (e.g. mechanism for registration, the use of claim elements such as modifiers to identify who is providing the services, post-payment audits).

APTA strongly supports CMS proposal to ensure that the physician who bills for the "incident to" services is the supervising physician and that services billed "incident to" are performed by qualified individuals. This policy will contribute to ensuring quality of care to Medicare beneficiaries. Currently, there is no mechanism for identifying the personnel who provided the services that are billed as "incident to" services. There is no requirement that the individuals providing the "incident to" services enroll in the Medicare program. **We recommend at a minimum that CMS require a unique modifier on the claim form to denote who is providing the services that are billed as "incident to" services. APTA also recommends targeted audits and medical review, particularly of physicians billing for physical therapy services, to ensure compliance with Medicare rules and regulations.**

Self-Referral

The physician self-referral statute (section 1877 of the Act) prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership interest or compensation arrangement), unless an exception applies. CMS discusses the history of the Act and of its implementation, including changes made under the ACA and more recently the MACRA.

CMS proposes to update its regulations to accommodate delivery and payment system reforms, to reduce burdens, and to facilitate compliance. It also proposes two new exceptions: (1) Assistance to employ a nonphysician practitioner, and (2) Timeshare arrangements.

Assistance to Employ a Nonphysician Practitioner (§411.357(x))

CMS proposes a new limited exception for hospitals, FQHCs, and RHCs to provide remuneration to a physician to assist with the employment of a nonphysician practitioner (NPP) in a geographic area served by the hospital, FQHC, or RHC (hereinafter referred to collectively as "hospital"). This proposed exception would protect both direct compensation arrangements between the hospital and an individual physician and indirect compensation arrangements between the hospital and a physician "standing in the shoes" of a physician organization to which the hospital provided remuneration. The new exception is intended to recognize the increased role NPPs play in meeting primary care needs and in improving patient outcomes and reducing costs, and to expand access to primary care services, especially in rural areas.

The exception would apply for NPPs who furnish only primary care services (meaning general family practice, general internal medicine, pediatrics, geriatrics and obstetrics and gynecology); specialty care services (e.g., cardiology or surgical services) would not be protected. CMS seeks comment on whether more or fewer types of primary care services should be included and whether there is a compelling need for NPPs who furnish non-primary care services.

We support the concept of expanding access to primary care services. However, we have serious concerns with any policy that would allow recruitment assistance for physicians to employ nonphysicians who provide other services, such as physical therapy.

There has been a long history of problems relating to physician-owned physical therapy arrangements. Studies have demonstrated that physician-owned physical therapy arrangements have a significant adverse economic impact on consumers, third-party payers, and physical therapists.[1] Specifically, a 2006 report by the Department of Health and Human Services' Office of the Inspector General (OIG)[2] showed that physical therapy billed directly by physicians represents a large and growing percentage of Medicare's total expenditures for these services. The OIG found that 91% of PT billed by physicians and allowed by Medicare did not meet Medicare guidelines which resulted in a significant amount of improper payments. In addition, Medicare claims from 2002 to 2004 were analyzed and aberrant patterns of billing and unusually high volumes of claims were identified. In a report issued in August 2009, the OIG examined physician "incident to" services billed in 2007 under the Medicare program, and found that 49 percent of rehabilitation therapy services (including primarily therapeutic exercise, massage therapy, ultrasound therapy, therapeutic activities, and electrical stimulation) performed by non-physicians were furnished by staff not trained as therapists that the OlG found to be unqualified. Therefore, we would have major concerns with any expansion of recruitment assistance to employ other nonphysicians, such as physical therapists.

New Exception for Time-Share Arrangements

In the rule. CMS proposes a new exception to protect timeshare arrangements that meet certain requirements. Timeshare arrangements are typically used in situations where a hospital or local physician practice may ask a specialist from a neighboring community to provide specialy services in a space owned by the hospital or practice on a limited or as needed basis. This is used typically to increase access to specialty care in rural or underserved areas. Because timeshare arrangements are currently analyzed under the exception for rental of office space, they fail to satisfy the requirements of that exception generally because a license does not provide for exclusive use of the premises and the term may be less than one year.

As proposed, this new exception would not allow for arrangements to include advanced imaging equipment, radiation therapy equipment, or clinical or pathology laboratory equipment. APTA applauds CMS for recognizing that there are certain services that should not be permitted under the time share arrangement. In addition to the services identified, **APTA recommends that the timeshare arrangement exception exclude the provision of designated health services, such**

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[1] Mitchell JM, Scott E. Physician ownership of physical therapy services: Effects on charges, utilization, profits, and service characteristics. JAMA. 1992; 268:19-23; Swedlow A, Johnson G, Smithline N, Milstein A. Increased costs and rates of use in the California Workers' Compensation System as a result of self-referral by physicians. N Engl J Med. 1992;327:1502-1506; Office of the Inspector General, Department of Health and Human Services. 1994.

[2] *Physical Therapy in Physician's Offices*, no. OEI-02-90-00590. Washington, DC: OIG and OIG, Physical Therapy Billed By Physicians (May 1, 2006).

as physical therapy services, to patients on the licensed premises, to protect both beneficiaries and program integrity.

Conclusion

Once again, we thank CMS for the opportunity to comment on these policy changes. If you have any questions regarding our comments, please contact Gayle Lee, Senior Director Health Finance and Quality at (703) 706-8549 or gaylelee@apta.org or Heather Smith, Director of Quality at 703-706-3140 or heathersmith@apta.org. Thank you for your time and consideration.

Sincerely,

Sharon L. Dunn, PT, PhD, OCS
President

SLD: grl, hls