

September 11, 2017

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Room 445-G  
Attn: CMS-1676-P  
Hubert Humphrey Building  
200 Independence Ave, SW  
Washington, DC 20201

*Submitted electronically*

**RE: CMS-1676-P; Calendar Year 2018 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Medicare Part B**

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) submits the following comments regarding the Centers for Medicare and Medicaid Services (CMS) Calendar Year (CY) 2018 Physician Fee Schedule proposed rule. APTA's goal is to foster advancements in physical therapist 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. Physical therapy is an integral service provided to patients in a multitude of settings. Therefore, we appreciate the opportunity to provide the following comments regarding the physician fee schedule policy updates for CY 2018.

The physician fee schedule is currently the basis of payment for outpatient therapy services furnished by therapists in private practices, hospitals, outpatient rehabilitation facilities, public health agencies, clinics, skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities. Over the last several years, the number of Medicare beneficiaries accessing physical therapy has significantly increased.

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.

APTA is committed to being a vested partner with the Department of Health and Human Services (HHS) as it moves swiftly toward its goal of shifting from Medicare payment based solely on fee for service to a value-based payment system. To that end, APTA has put significant resources into collecting and aggregating data to analyze the impact of physical therapy, as well as to overhaul the current coding structure. We ask that the agency carefully consider the comments we have articulated below regarding pertinent sections of the proposed rule.

### **Recommendations**

- 1. APTA recommends that CMS establish a pilot or demonstration program to evaluate the clinical benefits of physical therapists, occupational therapists, and speech-language pathologists delivering telehealth services to Medicare beneficiaries.**
- 2. APTA supports CMS's proposed work and practice expense (PE) relative value units (RVUs) for the codes listed below under "Misvalued Services under the Physician Fee Schedule."**
- 3. APTA supports CMS's proposal to align the 2018 payment adjustment requirements for the former Physician Quality Reporting System (PQRS) with those of the Quality Payment Program (QPP) and to lower the previously finalized requirements of 9 measures to only 6 measures with no domain requirement associated with these measures.**
- 4. APTA supports the proposed patient relationship definitions. We encourage CMS to continue to work with stakeholders in creating these patient relationship codes. APTA encourages CMS to consider pilot testing resource-use measures prior to implementation in the QPP.**
- 5. APTA supports the expansion of the Medicare Diabetes Prevention Program (MDPP). We recommend that in the future, CMS incorporate within the program an individualized exercise or physical activity program directed by a qualified health care professional, such as a physical therapist.**
- 6. Request for Information**
  - a. APTA recommends 3 changes to the functional limitation reporting (FLR) requirements in 2019: allowing FLR through clinical registries, electronic health records, facility-based submission methods, and other means; requiring FLR only upon patient intake and discharge; and including FLR by therapy providers as a clinical practice**

**improvement activity under the Merit-Based Incentive Payment System.**

- b. APTA urges CMS to require Medicare administrative contractors to develop local coverage determinations in a more open, transparent manner.**
- c. APTA urges CMS to remove physical therapy from the in-office ancillary services (IOAS) exception list.**
- d. APTA strongly recommends that CMS modify or eliminate the plan of care 30-day initial certification and 90-day recertification requirements.**
- e. APTA urges CMS to exercise its discretionary authority under §1115A of the Social Security Act (Act) to allow physical therapists to perform telehealth services while participating in alternative payment models.**
- f. We strongly encourage CMS to establish an exception to the outpatient therapy requirements for observation-status patients.**

**Physical and Occupational Therapy and Speech-Language Pathology Services: CPT Codes**

Within the proposed rule, CMS states it is not proposing to add CPT codes 97161, 97162, 97165, 97166, 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, and 97762 to the telehealth list. CMS indicates that physical therapists, occupational therapists, and speech-language pathologists are not among the practitioners who may furnish and bill for Medicare telehealth services. Moreover, because the services identified by the above listed codes are predominantly furnished by physical therapists, occupational therapists, and speech-language pathologists, CMS does not believe it would be appropriate to add these codes to the list of telehealth services at this time.

APTA recommends that CMS establish a pilot or demonstration program to evaluate the clinical benefit of physical therapists, occupational therapists, and speech-language pathologists furnishing telehealth services to Medicare beneficiaries. Many states permit these providers to furnish telehealth services, and they do so safely and effectively. Proper application of telehealth rehabilitation therapy services, particularly in underserved areas, can potentially have a dramatic impact on improving care and reducing negative consequences and costs of care. In the skilled nursing facility (SNF) setting, telehealth therapy services in underserved areas may make the difference in preventing falls, functional decline, costly emergency room visits, and hospital admissions/readmissions.

APTA strongly encourages the agency, through the Center for Medicare and Medicaid Innovation (CMMI), to conduct a pilot or demonstration program to evaluate the clinical benefit of physical therapists, occupational therapists, and speech-language pathologists furnishing telehealth services to Medicare beneficiaries in all settings, including SNFs—in states that permit such services. The results of this demonstration would help to inform policymakers as they consider whether to include physical therapists, occupational

therapists, and speech-language pathologists as authorized practitioners of telehealth services.

### **Misvalued Services under the Physician Fee Schedule**

APTA appreciates CMS's thorough consideration of the Health Care Professionals Advisory Committee's (HCPAC) recommendations. In the CY 2017 Medicare Physician Fee Schedule rule, CMS identified 19 CPT codes used by physical therapists as part of its continued efforts to update payment accuracy through the potentially misvalued codes initiative. These 19 codes were reviewed at the January 2017 American Medical Association RVS Update Committee (RUC) HCPAC Review Board Meeting. HCPAC subsequently made work and PE RVU recommendations to the agency.

Within the CY 2018 proposed rule, CMS proposes the following:

- Accept the HCPAC recommendations for CPT code 97014 (HCPCS G0281, G0283);
- Accept HCPAC's recommended work RVUs for 97012, 97016, 97018, 97022, 97032, 97033, 97533, 97034, 97035, 97110, 97112, 97113, 97116, 97140, 97530, 97533, 97535, 97537, 97542, and G0283 (97014);
- Maintain the existing CY 2017 PE inputs for the 19 codes;
- Keep the current values for the supervised modality services reported with CPT codes 97012, 97016, 97018, and 97022, and HCPCS code G0283 (97014) and not accept the HCPAC's proposed values; and
- For the management and/or training of patients with orthotics and/or prosthetics, adopt the HCPAC recommended work RVUs of 0.50 for CPT codes 97760 and 97761 and a work RVU of 0.48 for CPT code 977X1.
  - Maintain the current PE inputs for CPT codes 97760, 97761, and 977X1.
    - 97760: Add the term initial encounter to orthotics management and training upper and lower extremities.
    - 97761: Add the term initial encounter to prosthetics training upper and lower extremities
    - 977X1: New code - Orthotics/prosthetics management and training, upper and lower extremities, and/or trunk, subsequent orthotics/prosthetics encounter.
    - Delete 97762 (checkout for orthotic/prosthetic use).
  - CPT codes 97760 and 97761 were previously used to report both the initial and subsequent encounters. For CY 2018, CPT codes 97760 and 97761 are intended to be reported only for the initial encounter, and CPT code 977X1 is intended to be reported for all other orthotic and/or prosthetic services for an established patient that occur on a "subsequent

encounter” or a different date of service from that of the initial encounter service.

APTA supports CMS’s proposed work and PE RVUs for the above listed codes. Our comments on the specific recommendations are provided below.

#### *Work RVUs*

APTA supports the agency’s proposed work RVUs for the 19 identified codes. The data our organization collected and analyzed in 2016 aligns with the HCPAC’s recommendations. We believe CMS’s proposal to adopt the HCPAC’s suggested work RVUs is appropriate. Millions of Medicare beneficiaries access physical therapy services each year, and that number only continues to rise. We believe maintaining adequate reimbursement for these codes will help to ensure beneficiaries continue to have access to the full range of therapy services to which they are entitled under the law.

#### *Supervised Modality Services*

APTA supports CMS’s proposal to maintain the current values for the supervised modality services reported with CPT codes 97012, 97016, 97018, and 97022, and HCPCS code G0283. Provided below are several clinical scenarios incorporating supervised modality services that we believe demonstrate the need for maintaining the current values for these services.

#### **97012**

A patient presents with low back pain and lumbar radiculopathy secondary to nerve root impingement at L4-L5. Following initial examination a plan of care is established that includes active interventions and the use of lumbar mechanical traction to impact the physiology of the intervertebral disc via increased water diffusion and increased disk height in order to reduce impingement.<sup>1</sup>

#### **97016**

##### Case 1

A patient presents with a venous ulcer on the left leg. Following the initial examination a plan of care is established to include the use of a vasopneumatic device to reduce venous hypertension and edema by assisting venous blood flow back toward the heart and improve the environment for wound healing. Vital signs are monitored throughout the treatment.

##### Case 2

A patient presents with a crush injury to the left hand with decreased function and increased edema. Following the initial evaluation a plan of care is established to include the use of a vasopneumatic device to decrease edema and increase patient’s ability to

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<sup>1</sup> See <https://www.ncbi.nlm.nih.gov/pubmed/28624722>;  
<http://www.tandfonline.com/doi/full/10.1080/09593985.2017.1345026>;  
<https://www.ncbi.nlm.nih.gov/pubmed/28347933>

perform therapeutic exercise to improve range of motion and increase functional use of the hand.

### **97018**

A patient presents with decreased functional use of the right hand secondary to osteoarthritis. Following the initial examination a plan of care is established to include the use of paraffin as a preparatory treatment to reduce pain and tenderness and promote participation in therapeutic exercise to improve functional performance.<sup>2</sup>

### **97022**

A patient presents with increased pain and decreased function secondary to knee osteoarthritis. Following the initial examination a plan of care is established to include whirlpool to reduce pain and improve performance in therapeutic exercise designed to increase muscle strength, power, and endurance.<sup>3</sup>

### *PE Inputs*

APTA supports the 2018 PE RVUs for the 19 physical medicine and rehabilitation codes proposed by CMS. The proposed rule addenda indicates that the 2018 PE RVUs associated with the 19 codes would remain equivalent to 2017 levels or experience a small increase. APTA believes the proposed 2018 PE RVUs appropriately reflect the costs of maintaining a practice and we encourage CMS to finalize its proposal to use the existing CY 2017 PE inputs.

APTA greatly appreciates that CMS gave thorough consideration to the fact that the PE RVUs were already reduced as a result of the multiple procedure payment reduction (MPPR) and is seeking to avoid imposing duplicative cuts on providers. We thank the agency for recognizing that if they were to use the recommended inputs to develop the PE RVUs, the 50% MPPR on the PE for these services would duplicate the payment adjustments to account for efficiencies that had already been addressed through code-level valuation.

APTA believes that while MPPR is in place, there is no alternative approach that would avoid duplicative downward payment adjustments while still allowing for the direct PE inputs to be updated to better reflect current practice. We recognize that MPPR cannot be removed, and, as such, it is fruitless to revisit the PE values unless and until such policy is no longer in place. However, APTA continues to pursue the development of payment models that would replace MPPR while constraining overutilization of “always therapy” codes.

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<sup>2</sup> See <https://www.ncbi.nlm.nih.gov/pubmed/23187044>

<sup>3</sup> See <https://www.ncbi.nlm.nih.gov/pubmed/28733093>

*Management and/or Training: Orthotics and Prosthetics (CPT codes 97760, 97761, and 977X1)*

For CY 2018, CMS is revising the descriptors associated with CPT codes 97760 and 97761, deleting CPT code 97762, and adding code 977X1. 97760 and 97761 are intended to be reported only for the initial encounter and CPT code 977X1 is intended to be reported for all other orthotic and/or prosthetic services for an established patient that occur on a subsequent encounter or a different date of service from that of services during the initial encounter.

For CY 2018, CMS proposes the HCPAC recommended work RVUs of 0.50 for CPT codes 97760 and 97761 and a work RVU of 0.48 for CPT code 977X1. The HCPAC recommendations also included utilization crosswalks for each of the 3 codes that were each assigned a one-to-one crosswalk to the utilization of the prior codes: all the prior services of CPT codes 97760 and 97761 were each cross walked to the same newly revised codes; additionally, all the utilization from CPT code 97762 was cross walked to the new CPT code 977X1. CMS seeks comments on the proposed and alternative values for CPT code 977X1. CMS also seeks comments about the utilization and types of services that would be furnished under the new CPT coding structure, particularly services for new CPT code 977X1 and how they differ from services under predecessor 97762.

APTA supports CMS's proposals to revise the descriptors of CPT codes 97760 and 97761 and implement new code 977X1. The revised descriptors better align with the descriptions used within the ICD-10 system. Moreover, modifying the descriptors of CPT codes 97760 and 97761 to include the term "initial encounter" will eliminate billing confusion. We also agree with the addition of the term "subsequent encounter" to the descriptor associated with CPT code 977X1, as it clarifies for providers when to use this code. The descriptions will help providers interpret when it is appropriate to utilize CPT code 977X1 (e.g., that there would first need to have been an initial encounter in which orthotic and/or prosthetic training and management is provided to the patient and coded under 97760 or 97761).

Additionally, we agree with CMS's proposed work RVUs of 0.50 for CPT codes 97760 and 97761, and a work RVU of 0.48 for CPT code 977X1. While we agree with CMS's cross walking of the therapist time for CPT code 977X1 to CPT code 92508, given that codes within the 9700 series were under review and CMS was limited in its ability to crosswalk 977X1 to a more comparable code, we believe the work RVU of 0.48 is more representative of the time and work associated with the code as opposed to a work RVU of 0.33. There is significant similarity in the time and PE in delivering prosthetic and orthotic training services during an initial encounter and a subsequent encounter. This was acknowledged by the HCPAC in the AMA HCPAC report, stating "The HCPAC has agreed that the subsequent visit is very similar in work to the initial visit as the orthotics and prosthetics are now customized." Although we anticipate an increase in utilization of CPT code 977X1, which has a proposed work RVU of 0.48, there will be a corresponding decrease in utilization of codes 97760 and 97761, which have work RVUs of 0.50.

Hence, CMS will experience an overall decline in reimbursement for these services, without assigning an undervalued work RVU of 0.33 for CPT code 977X1.

#### Types of Services:

Described below are the types of services that have previously been categorized under 97760, 97761, 97762, as well as those that will be categorized under 977X1 in the future.

- 97760: Services such as making a shoe orthotic or conducting initial training with a patient with a new orthotic are generally coded under CPT code 97760. This code also has been used to indicate extensive training after applying a serial cast to ensure the family and patient are independent in donning, doffing, wearing, caring for the splint, etc. Occupational therapists use this same code for extensive training post application of a custom upper extremity thermoplastic splint. In an unregulated setting, this would be the only code representative of splint or orthotic fabrication, as therapists are unable to charge the splint codes in such settings (although they are allowed to do so in regulated settings).
- 97761: Generally, the types of services submitted under this code are for prosthetic training and management.
- 97762: Services billed under this code typically include checking and making minor adjustments to a splint, serial cast, or lower extremity orthosis (such as flaring an edge, adding different straps, cutting something, and/or smoothing a rough edge). The code also is used when a prosthesis is checked for fit and requires increased padding.
- 977X1: If approved, this code will be used for all prosthetic and orthotic training provided subsequent to the initial visit. The services aligned with predecessor code 97762 will also be included.

#### Utilization of Services:

While APTA does not have access to the comprehensive set of Medicare claims data and cannot fully predict the utilization and types of services that will be billed under new CPT code 977X1, we did conduct an internal analysis of the distribution of utilization between physical therapy and occupational therapy for CPT codes 97760 and 97761. For services categorized under CPT code 97760, occupational therapists are the primary billers. For services categorized under CPT code 97761, physical therapists are the primary billers.

In reviewing CPT code 97762, we found the utilization relatively low compared with the combined utilization of CPT codes 97760 and 97761. While CPT code 977X1 will primarily encompass services that were reported under 97762, we anticipate there will be a redistribution in coding between codes 97760 and 97761 to 977X1. This is based on the assumption that the majority of patients have more than 1 billing session for an orthosis

or prosthesis; hence, we estimate some volume of services previously billed under CPT codes 97760 and 97761 will be billed under CPT code 977X1.

While we do not anticipate an increase in the overall utilization of these services, we do expect that some volume of the services previously billed under 97760 or 97761 *after* the initial date of service will be billed under CPT code 977X1 in the future. As such, the volume of services billed under 977X1 will increase and the volume of services billed under codes 97760 and 97761 will decline. We encourage CMS to evaluate its claims data and review the billing patterns of CPT codes 97760 and 97761 to better understand, and predict, future utilization of CPT codes 97760, 97761, and 977X1.

### **PQRS**

CMS proposes to align the 2018 payment adjustment requirements for PQRS with those of the QPP, specifically the Merit-based Incentive Payment System (MIPS). The agency also proposes to lower the previously finalized requirements of 9 measures across 3 National Quality Strategy (NQS) domains, where applicable, to only 6 measures with no domain requirement associated with these measures. APTA supports this proposal.

### **MACRA Patient Relationship Categories and Codes**

CMS proposes to implement the reporting of defined patient relationship codes using modifiers in accordance with §1848(r)(4) of the Act beginning January 1, 2018 for physicians and applicable practitioners. Applicable practitioners are defined in §1848(r)(9)(B) of the Act as a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in §1861(aa)(5)), and a certified registered nurse anesthetist (as defined in §1861(bb)(2)), and beginning January 1, 2019, such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary.

APTA supports the proposed patient relationship definitions. We believe the proposed definitions will allow providers, such as physical therapists, to describe their patient relationships across the continuum of care in a variety of settings with patient populations representing many different conditions and diagnoses. APTA also supports the phased-in approach in 2018 for providers to become familiar with the patient relationship codes. We ask that CMS allow the same phased-in approach in future years for providers such as physical therapists, should they be added to MIPS.

APTA believes that HCPCS modifiers are a viable mechanism for CMS to use to operationalize this work to include the patient relationship category on the Medicare claim. We suggest that CMS require the reporting of the patient relationship HCPCS modifier to occur 1 time per claim on a given date of service. As providers often bill multiple services on a given date, we believe reporting the patient relationship category 1 time will decrease reporting burden. Additionally, we recommend that the relationship codes not be required for submission with non-payable reporting codes such as those used for MIPS quality measures or other quality-reporting programs, including FLR.

APTA encourages CMS to continue to work with stakeholders in the creation of these patient relationship codes, as they will be used for resource-use attribution in the future. APTA believes that using these patient relationship codes in creating new episode-based resource-use measures will require extensive testing and provider feedback throughout the development process in order to ensure that the measures are meaningful for all types of providers, including physical therapists. We encourage CMS to consider pilot testing resource-use measures prior to implementation in MIPS.

### **Proposed Changes to the MDPP Expanded Model**

Within the rule, CMS proposes additional needed policies in order for suppliers to begin providing MDPP services nationally in 2018, including the MDPP payment structure, as well as additional supplier enrollment requirements and supplier compliance standards aimed at ensuring program integrity. APTA supports the policies of the MDPP program and offers the following comments on CMS's proposal.

#### *Diabetes Diagnosis during the MDPP Services Period*

CMS seeks comments on whether individuals who develop diabetes during the MDPP services period should continue to be eligible for coverage of those services for the full duration of the services period.

APTA recommends that CMS permit individuals who develop diabetes during the MDPP services period continue to be eligible for coverage of those services for the full duration. MDPP services are furnished by health professionals who teach individuals how to lower their risk of progressing to type 2 diabetes by providing them with practical training in increased physical activity, dietary changes, and behavior change strategies for weight control. This type of education is beneficial for patients with prediabetes as well as those with type 2 diabetes, and is different from the type of interventions furnished to patients under the diabetes self-management training (DSMT) program.

Patients who develop type 2 diabetes will continue to benefit from the services furnished under the MDPP program, which could help them control their type 2 diabetes. APTA believes this may lead to improved quality of life, reduced morbidity, improved glycemic control, and reduced health care costs. Such benefits outweigh the potential "duplicative" nature of furnishing both MDPP and DSMT services to patients who have developed type 2 diabetes.

#### *Beneficiary Engagement Incentives*

The clinical goals of the expanded MDPP model include beneficiary weight loss, long-term dietary change, and adherence to long-term health behavior changes. While the MDPP provides participants with counseling and motivational support on diet, exercise, and behavior modification, we strongly believe that incorporating within the program an individualized exercise program developed and directed by a physical therapist or other qualified health professional could significantly advance the program's success in future years. We appreciate CMS's clarification that a gym membership may be used as a

beneficiary engagement incentive as long as the gym membership is reasonably connected to the CDC-approved curriculum and not being furnished to steer the MDPP beneficiary to a particular supplier. However, requiring Medicare beneficiaries enrolled in the MDPP to engage in physical activity overseen and directed by a qualified health care professional throughout the 3-year service period could lead to additional benefits, including lowered cardiovascular and mortality risks associated with diabetes; improved balance and gait, which may reduce the incidence of falls; and enhanced insulin management.

Physical activity, along with diet and medication, is a cornerstone of treatment for diabetes—physical activity is also a cornerstone of diabetes prevention. After performing an evaluation, including a review of the individual’s medical history and medications, a physical therapist can develop a personalized exercise program for those who have prediabetes or diabetes. Physical therapist-directed exercise counseling combined with fitness center-based exercise training results in high adherence and significant improvements in muscular strength and exercise capacity in people with prediabetes or type 2 diabetes, with outcomes comparable to those of supervised exercise training.<sup>4</sup> Physical therapists make evidence-based choices by prescribing either exercise counseling combined with fitness center-based exercise training or supervised exercise training for people with prediabetes or type 2 diabetes.

Physical activity has the potential to yield numerous health benefits for individuals with prediabetes or diabetes. Therefore, APTA strongly recommends that in the future, CMS incorporate within the program an individualized exercise or physical activity program directed by a qualified health care professional, such as a physical therapist.

### **Request for Information on CMS Flexibilities and Efficiencies**

#### **Claims-Based Data Collection of Functional Limitation Information**

The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) §3005(g) required CMS to implement, beginning January 1, 2013, a claims-based data-collection strategy 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 CY 2013.

Under the rule, non-payable G-codes and modifiers were to 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 these data-collection regulations in the CY 2018 proposed physician fee schedule rule. Nonetheless, APTA would like to take this

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<sup>4</sup> <https://www.ncbi.nlm.nih.gov/pubmed/19589851>

opportunity to provide feedback about the future evolution of and possible changes to this claims-based data-collection process.

As CMS is aware, therapy providers faced numerous challenges with the implementation of the FLR requirements. In the inception years of the program, problems with Medicare's claims-processing systems caused payment issues for many providers. Providers consistently report that FLR is one of their most burdensome reporting requirements, and they would like feedback on their performance. Given the time and effort spent collecting and reporting on FLR, providers have reached out to APTA to inquire about the data, specifically questioning if, how, and when CMS might analyze or use the data in the future.

Due to the increasing questions from members and our desire to foster evolution of the FLR requirements, APTA purchased a sample of the 2014 data to perform an analysis. Our analysis included both facility-based and private practice Medicare B claims, revealing that although FLR data was collected 93% of the time on evaluation, only 36% of episodes had discharge data. As claim submission of a billable code is required in order to submit discharge data, we believe that some percentage of cases may be lost in follow-up for patients who do not have a formal discharge visit. Additionally, intra-episode reporting, at a minimum of every 10 visits, ranged between 12%-16%.

Based on this analysis we recommend 3 changes to the FLR requirements in 2019 as a first phase of changes to make improvements to the program:

1. Allow FLR through clinical data registries, EHRs, facility-based submission vehicles, and other means.
2. Require FLR only upon patient intake and patient discharge from a course of outpatient therapy services. No longer require reporting at intervals.
3. Include FLR by therapy providers under MIPS as a clinical practice improvement activity.

Ultimately, we believe that the FLR requirements should move toward reporting standardized measures of function. These measures may reflect global function or may be specific to a condition. We encourage CMS to focus on the development of setting-appropriate outpatient therapy quality measures that address the domains of function, cognitive function, and changes in function and cognitive function:

1. *Measuring functionality.* Measures developed shall reflect outcomes for the achievement of improvements in cognitive, physical, and psychosocial function for Medicare beneficiaries with recovery potential; and outcomes for successfully maintaining function or delaying decline in beneficiaries with chronic and progressive conditions.
2. *Harmonization of patient assessment data and measures of functional limitation with relevant IMPACT Act measures.* This directs the Secretary to take steps (as appropriate for the outpatient therapy settings and type of therapy provider involved) to ensure that any patient-assessment data and measures that may be specified by the Secretary for the collection of data on patient function during the course of therapy services under this subsection are coordinated and aligned with patient-assessment data under the IMPACT Act.

APTA strongly supports the long-term goal of improving the payment system for outpatient therapy services, using data collection to achieve this goal. We believe that implementing the above changes to the FLR program will be a step in the direction of achieving the ultimate goal of uniform measures of function across care settings, and we look forward to working with CMS on these and future evolutions of the FLR program.

### **Local Coverage Determination Transparency**

APTA encourages CMS to require Medicare Administrative Contractors (MACs) to develop local coverage determinations (LCDs) in a more open, transparent manner. Currently, MACs are given broad authority to decide whether to cover an item or service when they develop an LCD. While a LCD cannot contradict a National Coverage Determination, many MACs adopt the same or similar LCD, effectively creating uniform coverage determinations nationwide.

APTA recognizes that MACs are well within their authority to determine whether to cover an item or service. The concern is that many MACs are opaque when crafting LCDs and many determinations appear arbitrary and unsubstantiated by fact or academic research. Similarly, in our experience, comments concerning draft LCDs and questions regarding the process often have gone unanswered. CMS's Program Integrity Manual instructs MACs on how to develop LCDs, but there are additional steps that could be taken to ensure that the process is more transparent and takes into account input from affected stakeholders.

Recently, the Local Coverage Determination Clarification Act of 2017 was introduced in Congress (S. 794/H.R. 3635). Under the legislation, MAC Carrier Advisory Committee meetings would be required to be open to the public and on the record. The bill also would require MACs to describe the evidence considered when drafting an LCD and the rationale relied on to make the determination, as well as prohibit a single MAC from making determinations to be used on a nationwide basis on a given specialty.

APTA supports the Local Coverage Determination Clarification Act of 2017. We do not feel it is necessary, however, for legislation to be passed in order to improve the LCD process. It is within CMS's power to require MACs to comply with many of the measures that are proposed in the Local Coverage Determination Clarification Act of 2017. Compelling MACs to comply with these measures will not have a negative impact on the MACs' profitability or operational status. Rather, implementing such requirements would ensure that LCDs are created in a transparent manner that involves all stakeholders. This will lead to a more efficient coverage process and, ultimately, improved patient outcomes.

### **Physician Self-Referral**

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

specifically in regards to physical therapy. While including physical therapy in the IOAS exception list was intended to offer convenience to patients, it is incredibly rare for a patient to receive physical therapy services during a regularly scheduled physician visit.

The IOAS exception allows physician practices to legally own a practice with multiple satellite offices that furnish physical therapy services without the physician on site. These physicians are able to refer their patients to these satellite offices and bill Medicare for the services furnished to them. Unfortunately, physician self-referral of ancillary services creates incentives to increase volume under Medicare's current payment system, resulting in overutilization. As previously acknowledged by the Medicare Payment Advisory Commission (MedPAC or Commission), there has been a significant increase in physician ownership of entities that provide physical therapy. Moreover, there is an inherent financial conflict created by physician ownership of health care businesses to which they refer.

Both MedPAC and CMS have found that the 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 meeting the technical requirements for physical therapy services while violating the true intent of the exception. Abuse of the IOAS exception also 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.

APTA believes that care furnished under the IOAS exception is often degraded, raising serious quality concerns. In fact, there is evidence that beneficiaries may actually receive higher-quality care—and therefore better outcomes—when self-referral is not involved. A study on low back pain episodes of care, published in the July 2015 issue of the *Forum for Health Economics and Policies* by Jean Mitchell, PhD, of Georgetown University, found that non-self-referred episodes of care were far more likely to provide “active,” or hands-on, services than self-referral episodes—52% compared with 36%. This, according to the study's authors, suggests the care delivered by physical therapists in non-self-referred episodes is more tailored to promote patient independence and a return to performing routine activities without pain. It is important to note that “passive” treatments, which are more likely found in self-referring episodes, can be performed by a person who is not a licensed physical therapist. The authors of this paper also cite evidence that these passive physical therapy modalities are “ineffective” in treating low back pain.

Of note, the study highlights the difference in overall expenditures for episodes of care between self-referring and non-self-referring physicians. The study examines the total insurer-allowed amounts for low back pain episodes of care and parses out expenditures on physical therapy only. On average, spending for services by self-referring providers was \$144 as opposed to only \$73 for services by non-self-referring providers. This is a significant difference for a very common episode of care. Even more, when the expenditures for the entire episode of care are calculated—not just physical therapy but all care for the episode—self-referral episodes averaged \$889 compared with only \$602

for non-self-referral episodes. The implication is clear: not only is this a problem for physical therapy, it has spread far beyond.

As illustrated, the physician ownership of physical therapy services creates a thriving environment for fraud and abuse. Therefore, we urge CMS to remove physical therapy from the IOAS exception list. If CMS continues to include physical therapy as a designated health service under the IOAS exception, then APTA strongly recommends that CMS tighten elements of the exception to restrict abusive practices.

### **Plan of Care 30-Day Initial Certification and 90-Day Recertification**

APTA strongly recommends that CMS modify or eliminate the plan of care 30-day initial certification and 90-day recertification requirements.

#### *Initial certification*

In many instances, Medicare beneficiaries may seek therapy services without first being evaluated by a physician or obtaining a referral. However, once a therapist determines that therapy is medically necessary, Medicare requires that the patient be under the active care of a physician or non-physician practitioner.

As outlined in §1861(r) of the Act, as well as 42 CFR §424.24(c) and 42 CFR §410.61(e), outpatient therapy services must be furnished under a plan of care. Certification of the plan by the physician or non-physician practitioner satisfies all certification requirements for the duration of the plan of care or for 90 calendar days from the date of the initial treatment, whichever is less. The provider or supplier should obtain certification as soon as possible after the plan of care is established and must obtain it within 30 days of the initial therapy treatment. Payment may be denied if the physician does not certify the plan of care. Timely certification of the initial plan is met when the certification is documented, by signature or verbal order, and dated within the 30 days following the first day of treatment. If the order to certify is verbal, it must be followed within 14 days by a signature.

#### *Recertification*

Pursuant to 42 CFR §424.24(c) and 42 CFR §410.61(e), re-certifications that document the need for continued or modified therapy should be signed whenever the need for a significant modification of the plan becomes evident, or at least every 90 days after initial treatment under that plan, unless they are delayed.

APTA encourages CMS to modify or eliminate the plan of care 30-day initial certification and 90-day recertification requirements. Compliance with the physician signature requirement 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. Although it is not intended, 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. Moreover, in instances of delayed certifications, the therapist must then identify and

compile evidence that is necessary to justify the delay, further increasing the burden on the provider.

While the medical record may illustrate the medical necessity of therapy services, CMS will deny payment or seek recoupment if the plan of care is missing a signature, if the signature was not obtained within the required timeframe, or if the signature is of marginal or questionable legibility. The administrative burden of this regulation is untenable, and we strongly encourage CMS to modify or eliminate these requirements.

### **Telehealth Services**

Allowing providers such as physical therapists to provide telehealth services under Medicare will help to reduce health care expenditures, increase access to care, and improve management of chronic disease in rural and underserved areas. Telehealth services may also help to ensure access to specialized care in isolated rural areas facing difficulties in maintaining and staffing full-service hospitals.<sup>5</sup>

To realize these benefits, APTA strongly recommends that CMS exercise its discretionary authority under §1115A of the Act to allow physical therapists perform telehealth services while participating in alternative payment models. As noted by MedPAC in its June 2016 Report to Congress, several CMMI models involving bundled payment and accountable care organizations include coverage of telehealth services broader than the standard Medicare benefit. Within such models, CMS exercised its authority to waive the requirement that benefits offered in these programs be equivalent to the standard benefit. Also in the report, MedPAC stated that CMS could consider expanding these waivers to include a broader range of telehealth services in either current or future CMMI programs.<sup>4</sup>

To that end, APTA will continue to work with Congress to secure the appropriate statutory language. We have been steadfast in our advocacy efforts for the passage of the Medicare Telehealth Parity Act (H.R. 2550), which would add physical therapists and several other therapy provider groups to the list of authorized telehealth providers under Medicare. We also are supportive of the CONNECT for Health Act of 2017 (S. 1016/H.R. 2556), which would expand where telehealth can take place, as well as which patients and providers can participate, including physical therapists participating in some bundled payment models, accountable care organizations, and Medicare Advantage plans.

### **Therapy Cap**

Created in 1997 through the Balanced Budget Act, the Medicare therapy cap imposes an annual financial limit on outpatient physical therapy and speech-language pathology services and a separate cap on occupational therapy. The rationale for creating an arbitrary cap on these types of services was not based on data, quality-of-care concerns, or clinical judgement; instead it was based solely on the desire to balance the federal

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<sup>5</sup> 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> (Last accessed July 22, 2017)

budget. Since 1997, Congress has acted 16 times to prevent implementation of the cap, including the 2006 creation of the exceptions process allowing patients to receive necessary services exceeding the annual cap amount.

APTA asserts that the therapy cap presents a barrier to access for seniors and individuals with disabilities from receiving medically necessary services. APTA continues to work with the House Energy and Commerce Committee, House Ways and Means Committee, and the Senate Finance Committee to advance our legislation – The Medicare Access to Rehabilitative Services Act (H.R. 807/S. 253), which would repeal the therapy cap. When considering how to reduce burdens on providers and patients, improve the quality of care, and decrease costs, we strongly recommend that CMS work with Congress to permanently repeal the therapy cap and replace it with a more a permanent fix that would ensure the delivery of care to vulnerable patients, streamline the ability of providers to deliver needed care, and ensure the long-term viability of the Medicare program.

### **Conclusion**

We thank CMS for the opportunity to comment on the CY 2018 Medicare Physician Fee Schedule proposed rule. We look forward to working with the agency in making revisions to the proposed policies in this rule prior to its finalization to ensure that Medicare beneficiaries have access to medically necessary physical therapy services in the outpatient setting. If you have any questions regarding our comments, please contact Kara Gainer, Director of Regulatory Affairs, at [karagainer@apta.org](mailto:karagainer@apta.org) or Heather Smith, Director of Quality, at [heathersmith@apta.org](mailto:heathersmith@apta.org).

Thank you for your time and 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, OCS  
President

SLD: krg, hls