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September 6, 2013

Marilynn Tavenner  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS- 1600-P  
Mail Stop  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**Re: CMS- Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Proposed Rule**

Dear Administrator Tavenner:

On behalf of our 85,000 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, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014,” published in the July 19, 2013 *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.

These comments address: 1) the therapy cap and its application to critical access hospitals; 2) the extension and implementation of the Physician Quality Reporting

System (PQRS) in 2014 and beyond; 3) incident to billing; 4) multiple procedure payment reduction; and 5) the functional claims-based data collection strategy for therapy services. Our comments on each of these provisions are discussed in further detail in the following paragraphs.

### **Physician Fee Schedule Update for CY 2014**

In the proposed rule, CMS projects that due to the SGR formula there would be a 24.4 percent reduction in the Medicare physician fee schedule conversion factor for CY 2014. Suffice it to say that APTA believes that a cut of such magnitude would seriously hinder the Medicare beneficiary's access to physical therapy by making it virtually impossible for physical therapists in any setting to be able to provide care to these beneficiaries. While APTA appreciates that such a sizable cut in Medicare payments is currently required by statute, we also recognize that Congress has been working to repeal the flawed SGR formula, to improve quality of care, and to transition to new payment models. We therefore, urge the Administration to continue to work with the Congress to prevent this drastic cut from occurring in 2014 and to develop new payment models.

### **Application of the Therapy Cap to Critical Access Hospitals**

As CMS states in the proposed rule, Congress enacted legislation, *the American Tax Relief Act (ATRA)* which included a provision extending the therapy cap exceptions process until December 31, 2013. APTA was pleased that Congress included this provision in the legislation. However, the exceptions process will expire in December 2013 and therefore this Congressional action offers only a temporary solution to the problem.

In the proposed rule CMS states that section 603(b) of ATRA requires that outpatient therapy services furnished by critical access hospitals (CAHs) during CY 2013 are counted toward the therapy caps using the amount that would be paid for those services under the physician fee schedule. CMS summarizes the history of the past exclusion of therapy services furnished by critical access hospitals from the therapy caps, and states that it now believes that therapy caps should be applied in critical access hospitals beginning January 1, 2014. CMS notes that the application of the therapy cap to hospitals could expire after December 1, 2013. However, CMS states that the critical access hospitals would not be considered in the hospital exemption, and therefore proposes that if Congress does not pass legislation the cap could apply to services furnished in CAHs but not those furnished in hospitals in 2014.

APTA is deeply concerned with CMS's proposal to expand the therapy cap so that it is applied permanently to critical access hospitals and disagrees with CMS rationale for this expansion in the future. The financial limitation has a detrimental impact on Medicare beneficiaries who need outpatient therapy services and this impact would be further exacerbated by application of the therapy cap to critical access hospitals. In its June 2013 report to Congress, MedPAC indicated that in 2011 19% of patients would exceed the physical therapy and speech therapy cap combined. Once exceeded, if there is no

exceptions process in place beneficiaries will not receive services that are medically necessary. As a result, the cap can be expected to have a significant harmful effect on beneficiaries needing rehabilitation services and could lead to complications, ultimately resulting in greater costs to the Medicare program. We recognize that it will take Congressional action to provide additional statutory authority and prevent the implementation of the therapy caps, and we continue to strongly urge Congress to take timely action to pass legislation that would repeal the therapy cap. In the interim, we urge CMS to refrain from taking steps that would cause further patient harm, such as expansion of the therapy cap policy that is already arbitrary to additional settings.

As we discussed above, the detrimental impact of the cap will be further compounded if CMS were to finalize its proposal to apply the therapy cap to the over 1300 critical access hospitals in the country. Approximately, one-fourth of Americans live in rural areas and for many of these individuals CAHs are the only access point to primary, emergency, acute care, outpatient therapy, and other services. These hospitals, which are vital to patients in rural areas, face significant challenges, including administrative workforce scarcity, shortages of physicians, physical therapists and other health care professionals, and limited financial resources.

Rural populations are vulnerable and on average this population is older, sicker and poorer than individuals in urban areas. According to DHHS rural areas have higher rates of poverty and chronic disease. Therefore, there is a greater likelihood that the Medicare beneficiaries treated in critical access hospitals would exceed the therapy cap amount. More than 50 percent of patients in rural areas of the U.S travel at least 20 miles to receive specialty medical care. Congress initially excluded outpatient hospital departments from the therapy caps with the rationale that beneficiaries with high care needs would have a safety net that would enable them to continue to receive therapy services.<sup>1</sup> If CMS were to apply the therapy cap permanently to critical access hospitals, patients in these rural areas would have great difficulty in accessing these services from another institution given the fact that they reside a considerable distance from the closest hospital.

As CMS states in the proposed rule, section 1833 (g) applies the therapy cap to outpatient therapy services and suppliers other than the type of provider of services identified in section 1833(a)(8)(B). The language in section 1833(a)(8) (B) clearly excludes hospitals from the therapy cap. Although CMS states that critical access hospitals are not exempted from the therapy cap based on their statutory interpretation, we believe that this rationale is misguided and that critical access hospitals should be characterized as hospitals for purposes of application or non-application of the therapy cap.

Critical access hospitals were added to the Medicare program by statute in 1997. While Congress recognized that CAHs were not intended to be exactly like other hospitals (due to bed size criteria as well as other limitations to their legal structure as imposed under

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<sup>1</sup> Maxwell, S., C. Basseggio, and M. Storeygard. 2001. *Part B therapy services under Medicare, 1998–2000: Impact of extending fee schedule payments and coverage limits*. Washington, DC: Urban Institute.

the law), it nonetheless recognized that these CAHs served as hospitals in that they provide inpatient and outpatient hospital services in areas where access to care for Medicare beneficiaries was severely limited. This recognition is clear from the amendment made in 1997 to the definition of hospital under section 1861 (e) of the Social Security Act which indicates that a CAH access hospital may indeed be considered a hospital by CMS where it is required from the “context.” In this context (the furnishing of outpatient therapy services), a CAH is very much like a hospital and should be treated in the same manner vis-à-vis the exception to the therapy caps.

As stated earlier, section 1833(g) references 1833(a)(8)(B) to identify settings excluded from the therapy cap. Section 1833(a) sets out the rules for the various payment methodologies applicable to covered items and services as well as the copay percentage a beneficiary must pay. Section 1833(a) is essentially a roadmap to the other parts of title XVIII of the SSA to find the applicable payment methodology for a particular item or service which may (or may not) vary by the type of provider or supplier who furnishes that service. Thus, section 1833(a) (8)(B) directs the reader to section 1834(k) to determine the payment methodology for outpatient therapy services furnished by hospitals (and other providers of services). The reference to “subsection (a)(8)(B) [the hospital exception]” in the therapy caps provision of the statute (section 1833) is intended **only** to identify the type of provider **and not** to identify the payment methodology that would apply to the provider. In establishing the therapy cap exception for hospitals Congress was interested only in identifying with specificity the type of provider of services not subject to the therapy cap. This is apparent based on the fact that other providers of services listed in subsection 1833(a)(8)(A) (such as rehabilitation agencies, CORFs, SNFs, home health agencies, etc.) are clearly subject to the therapy cap even though they are paid under the same payment methodology as hospitals (vis. section 1834(k)) as hospitals).

In enacting this provision, Congress sought to distinguish between a hospital and these other types of providers. Thus, CMS can and should continue to interpret congressional intent to treat hospitals and CAHs in the same manner in the application or non-application of the therapy caps—essentially making a determination that in this context, a CAH is a hospital, under the definition of hospital in section 1861(e).

CMS should not focus on the payment methodology referenced under section 1833(a)(8)(B) as that is irrelevant to the underlying congressional purpose of identifying a type of provider that would be excepted from the cap, but rather it should focus on the similar functions these two hospital facility types perform in the furnishing of outpatient therapy services.

### **Multiple Procedure Payment Reduction (MPPR)**

In the rule, CMS discusses the application of the Multiple Procedure Payment Reduction (MPPR) to therapy services and references Section 633 of the ATRA, which revised the MPPR reduction from 20/25% to 50% effective April 1, 2013.

Due to implementation of MPPR, Medicare payments for outpatient therapy services under Medicare have been cut by approximately 14% since 2010. These are arbitrary across the board cuts and as a result providers are not being adequately compensated for the resources needed to provide medically necessary therapy services. The MPPR reduction is based on an incorrect assumption that duplicate clinical labor and supplies are included in the practice expense relative value units (RVUs) when multiple services are furnished to the same patient in a single session. This assumption is incorrect because during the development of the PE RVUs for therapy services the fact that certain efficiencies exist when multiple therapy services are provided in a single session was already taken into account. APTA believes that cuts of this magnitude could restrict Medicare beneficiary's access to physical therapy services. This cut would be further compounded by the projected reductions in the sustainable growth rate and the annual per beneficiary therapy cap.

We recognize that it will take Congressional action to prevent the 50% MPPR reduction and continue to strongly urge Congress to take timely action to pass legislation that would delay or stop these large cuts until an alternative payment methodology is implemented. In the interim, we urge CMS to take steps that would mitigate the negative impact of these cuts. One such step that CMS has authority to take would be to amend the MPPR policy so that it no longer applies across multiple therapy disciplines. Application of the policy on a per day basis and across disciplines mistakenly assumes that there is duplication in such circumstances. In certain settings, such as skilled nursing facilities, it is common for a patient to receive services from one discipline, such as physical therapy in the morning, and another discipline, such as speech-language pathology, in the afternoon. Clearly, there is no duplication and no economies of scale when services are provided at two separate times during the course of the day. Likewise, there is no duplication of practice expenses when distinct and separate professions are providing services. We question why CMS would assume that the practice expense inputs required of two separate professions (e.g. speech language pathology and physical therapy) would be duplicative. If this were the case, CMS would need to reduce by 50% payment to physicians who furnish services in settings that are multidisciplinary. For example, if patient goes to a cardiologist and an internal medicine physician in the same day, would CMS presume that it is necessary to reduce the practice expense payments for the internal medicine physician by 50%? Such a reduction would be nonsensical.

Rather than continuing the arbitrary MPPR cuts, we urge CMS to continue to emphasize to Congress that there should be a focus on long term reforms that develop alternatives to the therapy cap. To achieve long-term reform, the first step would be implementation of reporting of core data items that measure patient function and other factors that impact payment. In addition, we recommend changes to the coding structure that would result in per visit payment amounts based on the severity of the patient's condition and intensity of the treatment.

### **“Incident to Billing Provisions”**

In the rule, CMS proposes to make modifications to the “incident to” billing provision included in the Social Security Act (section 1861(s)(2)(A) that allows physicians to furnish and bill for “incident to” services under Medicare. The regulations setting forth the specific requirements are located at 42 CFR section 410.26. CMS states that there

have been situations where Medicare was billed for “incident to” services that were provided by auxiliary personnel who did not meet the state standards for those services in the state in which the services were furnished. CMS acknowledges that its regulations do not make compliance with state law a condition for payment for “incident to” services, and therefore proposes to revise its regulations to require that the individual performing “incident to” services meets any applicable state requirements to provide the services, including licensure. This would enable the federal government to recover funds paid when services are not furnished in accordance with state law.

APTA commends CMS on proposing regulations requiring individuals performing “incident to” services to meet state requirements to provide the services and urges CMS to ensure that it is included in the final rule. This policy will contribute to ensuring quality of care to Medicare beneficiaries. Interventions should be represented and reimbursed as physical therapy only when performed by individuals who are qualified under state law to provide those services.

### **Physician Quality Reporting System**

The Physician Quality Reporting System 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.

#### ***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. We are pleased to see the expansion of EHR reporting to include more vendors which may encourage increased PQRS reporting through this option. APTA is also excited to see the addition of registry reporting via qualified clinical data registry. 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. For example, while we certainly see value in registries, we do not believe it would be prudent at this time to assume that all practitioners are ready and able to use them.

CMS will provide eligible professionals with the opportunity to earn the PQRS incentive payment in 2014 by reporting either individual measures or measures groups. CMS proposes that eligible professionals, including physical therapists, who report on individual measures via the claims-based reporting option or registry option in 2014 must report on at least 9 measures covering at least 3 of the National Quality Strategy

domains, at least 50% of the time. If less than 9 measures apply to the eligible professional, they must report 1-8 measures.

The increase from 3 to 9 measures for successful reporting is significant. APTA strongly urges CMS to maintain the number of individual required measures at 3 for successful reporting in 2014. The vast majority of providers continue to report via the claims based reporting mechanism and this proposed change in the number of measures will increase provider burden in reporting. Additionally, as the focus of many measures in the PQRS program remains geared toward the general and family practice physician, many specialty professions will struggle to achieve these new thresholds resulting in a higher number of practitioners who will be subject to the MAV process. Maintaining the claims based reporting threshold, and lowering the registry reporting threshold to 50% will substantially increase the proportion of physical therapists, physicians and other health care professionals who will qualify for the PQRS incentive and will therefore encourage broader participation.

Additionally, CMS proposes to eliminate the ability to submit measure groups via claims submission, instead only allowing measure groups data to be submitted via registry and EHR reporting. APTA strongly urges Medicare to continue to allow the reporting of measure groups via the claims based reporting option to encourage broader participation as we move towards the payment adjustment phase of the PQRS program in 2015 and 2016. As the most recent national participation data still demonstrates a low participation rate overall, we believe it is impossible to predict the number of providers who may opt to participate using measure groups via claims until the 2013 data analysis is complete. To eliminate this reporting option prior to having that data seems premature and may hurt providers who are early in their reporting experience in the PQRS program.

CMS proposes to provide eligible professionals with the opportunity to avoid 2016 payment adjustments by successfully participating in the PQRS program in 2014. Additionally, CMS has proposed that eligible professionals, who report 3 individual measures at least 50% of the time, will be exempt from payment adjustments in 2016. We have concerns that there continues to be a lack of awareness about the reporting program given that in CY 2011 only 32% of MD/DO's and 17.9% of other eligible providers, including physical therapists, participated in PQRS. Many providers are still unaware of the impending changes to the structure from a payment incentive to a payment adjustment program. We urge CMS to continue to disseminate information about the PQRS program to increase awareness about the program and to recognize the efforts of providers who attempt to participate in the program even if they are unsuccessful.

### ***Proposed Related to Participation in a Qualified Clinical Data Registry***

Under section 1848(m)(3)(D) of the Act, as amended and added by section 601(b)(1) of the American Taxpayer Relief Act of 2012 (Pub. L. 112-240, enacted January 2, 2013), for 2014 and subsequent years, the Secretary shall treat an eligible professional as satisfactorily submitting data on quality measures if, in lieu of reporting measures under

subsection (k)(2)(C), the eligible professional is satisfactorily participating, as determined by the Secretary, in a qualified clinical data registry for the year.

CMS has proposed a definition for a “qualified clinical data registry” for purposes of the PQRS as a CMS-approved entity (such as a registry, certification board, collaborative, etc.) that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care furnished to patients. CMS provides proposed details on endorsement, transparency and data transmission for these registries. APTA is committed to improving the quality of care and believes that clinical registries offer a platform for quality improvement and collection of outcomes data. We are excited to see the allowance of such registries in the PQRS program; however, we also have some concerns about the details related to the definition and requirements of the qualified clinical data registries in the proposed rule.

In the proposed rule, CMS outlined the endorsement requirements for qualified clinical data registries, including a requirement that the registries be well established and in existence on January 1 of the year prior to the year for which the entity seeks to become a qualified clinical data registry (for example, January 1, 2013, to be eligible to participate for purposes of data collected in 2014). APTA believes that this requirement is too restrictive especially in the first year as the finalized requirements for qualified clinical data registries will not be published until early November of 2013. For many, this quick turnaround time will not allow sufficient time to make adjustments to existing registries or finalize launch specifications for new registries. APTA would suggest that CMS consider moving this date back at a minimum to April 1 (April 1, 2014 to be eligible to participate for purposes of data collected in 2015).

CMS has proposed many data transmission requirements for qualified clinical data registries. Overall, APTA urges CMS to consider phasing in some of the overall data requirements for these registries based on registry and measures maturity. CMS stated in the proposed rule:

“The majority of commenters in response to the February 7, 2013 Request for Information stated that these qualified clinical data registries should serve additional roles aimed at quality improvement other than collecting and transmitting quality data to CMS. The commenters saw qualified clinical data registries as entities that should be at the forefront of quality improvement. We agree with the commenters. Therefore, we believe that a “qualified clinical data registry” specified under section 1848(m)(3)(E) of the Act, as added by section 601(b) of the American Taxpayer Relief Act of 2012, should serve additional roles that foster quality improvement in addition to the collection and submission of quality measures data.”

APTA agrees with these comments. We acknowledge that there are some registries in existence that will meet these proposed definitions, however, these same definitions, if applied in totality at one time, might prohibit, discourage, or delay the creation and certification of new registries. We discuss our specific concerns below.

CMS proposes that qualified clinical data registries “by March 31 of the year in which the entity seeks to participate in PQRS as a qualified clinical data registry, the entity must publically post (on the entity’s website or other publication available to the public) a detailed description (rationale, numerator, denominator, exclusions/exceptions, data elements) of the quality measures it collects to ensure transparency of information to the public.” APTA has concerns about this requirement specifically as it related to newly developed quality measures. To allow for the development of new clinically meaningful measures, registries should be permitted to engage in measure development and quality improvement activities prior to publically reporting the measure specifications. Measure development remains resource prohibitive, especially for smaller specialty practices. At a minimum, we feel that measures that are under development should be designated as such, as measure definitions can be altered during the development process. We do believe, however, that clinicians should receive credit for reporting data for the purposes of developing new measures that will lead to improvement in the quality of care delivered to patients.

CMS has also proposed that qualified clinical data registries must report a minimum of 9 measures that cross 3 National Quality Strategy domains, and that they must report on at least one outcomes-based measure. Again, APTA believes that these requirements should be phased in, with a lesser number of measures required for reporting initially, particularly for newer registries. CMS should recognize that as reporting requirements continue to grow, specialty practices, like physical therapy, will be challenged by the number of measures available for reporting.

Currently, the vast majority of measures included in programs such as PQRS are focused on primary care physicians making it a challenge for physical therapists to find meaningful measures for the purpose of reporting. We recognize that in the rule CMS is proposing to align requirements for qualified clinical data registries with other registries for the purposes of successful reporting under the PQRS program. However, as we discuss above, the proposal to increase reporting requirements from 3 to 9 measures over the course of one reporting year given the lack of measures for specialties would be problematic. Such a drastic increase in measure reporting in one year would significantly increase provider burden and put specialties with less measures available for reporting under PQRS at a disadvantage.

Additionally, a current search of the National Quality Forum’s Quality Positioning System database yielded less than 25 outcomes measures, roughly 14% of the total number of NQF measures, currently endorsed and available for reporting in the PQRS program. While APTA recognizes and supports the movement toward more outcome measures, placing requirements before measure development may prevent eligible professionals from participating under this valuable reporting option.

Lastly, CMS proposes to require that qualified clinical data registries plan to publicly report their quality data through a mechanism where the public and registry participants can view data about individual eligible professionals, as well as view regional and

national benchmarks. APTA feels that public data reporting should not be required at the outset. As CMS appreciates, publically reported data should be vetted through a thorough validation process prior to being released to the public. APTA does support the CMS alternative of requiring that the entity benchmark within its own registry for purposes of determining relative quality performance where appropriate. CMS should continue to focus on increasing provider participation in quality reporting programs for the purposes of quality improvement.

### ***Proposed Measures Individual & Group and Measure Specification Changes***

APTA is concerned about several of the proposed changes to available measures in CY 2014. CMS proposes, as discussed above, to eliminate the ability of professionals to submit measure groups data via claims. Additionally, CMS has proposed to eliminate the ability to report PQRS #126: DM: Diabetic Foot and Ankle Care, Peripheral Neuropathy-Neurological Evaluation and PQRS #127 (NQF# 0416): Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear via claims. APTA strongly urges Medicare to continue to allow the reporting of measure groups and measures #126 and #127 via the claims based reporting option to encourage broader participation. We reiterate, as the most recent national participation data still represents only a small percentage of the overall eligible professionals, it is impossible to predict the number of providers who may opt to participate using measures groups or measures or measures #126 or #127 via claims until the 2013 data analysis is complete. To eliminate this reporting option prior to having that data seems premature and may hurt providers who are early in their reporting experience in the PQRS program.

### ***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. In the past, these provider level reports have been issued annually and distributed about seven months after the reporting period has ended. This delay in distribution of these reports has made it difficult for providers to make any changes to improve their reporting under the program. 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. Ideally, quarterly feedback reports should be incorporated into PQRS to promote continued quality improvement in 2014 and beyond.

### ***Future Program Changes***

CMS asked for comments regarding the elimination of claims based reporting from the PQRS program beginning in CY2017. While APTA agrees that in the future, the elimination of claims-based data reporting should be considered, we feel that 2017 is premature. Increased participation of eligible professionals through the other reporting mechanisms, such as EHR and registry reporting, should be demonstrated in the national

data prior to the removal of the most common reporting mechanism of the PQRS program. We urge CMS to continue to monitor reporting trends and wait to see if reporting via qualified clinical data registries and other reporting mechanisms increases prior to eliminating the claims-based option. Early elimination of the claims based reporting mechanism may discourage program participation, particularly for small practices.

### ***Public Reporting***

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. In the rule, CMS proposes to “take an initial step by making public the performance rates of the quality measures that group practices submit under the 2012 Physician Quality Reporting System group practice reporting option (GPRO)”.

We strongly recommend 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. The health care providers should be allowed a reasonable period of time for review in order to access and gather supporting information to correct errors, discrepancies, and other concerns.

### **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 CY2014 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***

APTA strongly supports the long term goal of improving the payment system for outpatient therapy services and using data collection to achieve this goal. Last year, we recommended that CMS takes steps toward achieving this long-term goal in several phases which we will discuss later in these comments. The first phase would involve gathering some data about functional limitation and patient complexity, the second phase would involve the reporting of core items by therapists to better inform patient complexity, and the third phase would involve implementation of an alternative payment system for outpatient therapy. APTA has been working extensively on development of an alternative payment system for outpatient therapy services aimed at achieving this goal.

While the APTA strongly supports gathering information to develop an alternative to the current arbitrary payment limits (or “caps”) on Medicare therapy services, we believe that CMS’s approach should be refined in the future in order to collect more meaningful and accurate patient information that could be used to develop an alternative payment system. We will discuss this issue in further detail in these comments.

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. APTA recommends that therapy associations and organizations and CMS collaborate in the near future to develop core measures that could be used in any tool to gather information about the patient that could be used in an alternative payment system.

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. This approach is consistent with the recommendation by CMS’s contractor, Computer Science Corporation (CSC), in the Short Term Alternatives for Therapy Services (STATS) report published in 2010. Option 1 included in that report involved the use of G codes and modifiers to report patient information regarding functional limitations. As explained in the STATS report, the G codes were intended to be used to track progress over the course of an individual episode of care.

### ***Nonpayable G-Codes***

Providers would like a means by which to share meaningful information with CMS that shows the complexity of the patient, including factors such as comorbidities that impact the condition, cognition, and their ability to participate in activities of daily living. APTA recommends that CMS establish an additional modifier that could be used to report the level of complexity of the patient. We would propose that the levels of complexity be based on multiple variables as they impact the patient's condition; these variables would include: age, comorbidities, prognosis, patient safety considerations, and current clinical presentation. APTA is currently working on an alternative payment system that will be able to define three levels of complexity. APTA would welcome the opportunity to work in collaboration with CMS on this effort should the documentation of patient complexity be adopted in the future.

As a means of clearly demonstrating the three levels of complexity, we can describe case examples of patients with osteoarthritis of the knee. The patient classified as "low" would be an active, healthy patient with mild osteoarthritis who has difficulty going up and down stairs due to pain. A "moderate" patient, using this classification, would be a patient with obesity and bilateral knee osteoarthritis who has difficulty ambulating and caring for herself due to pain. A patient with a "high" classification would be a patient with chronic emphysema, recent cardiac bypass surgery, and severe knee osteoarthritis that had contributed to two falls in the past week

### ***Claims Requirements***

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 three mechanisms: claims, registry, and electronic health record data submission. 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. To that end, we would suggest that CMS explore additional data submission mechanisms to decrease provider reporting burden in the future.

### ***Early Reporting Challenges***

Although the functional limitation reporting program is in its early stages, it is clear that there are some challenges with the reporting structure. One significant challenge relates to reporting requirements for patients treated in the acute hospital setting. CMS has stated that functional limitation reporting is required for patients in the hospital that are observation status patients, and for those patients' stays that are rebilled under Medicare part B following a part A denial. It can be very difficult for therapists in an acute hospital setting to predict which Medicare patients' therapy services will be ultimately billed

under the part B benefit instead of Part A. In the case of observation patients, often their status may fluctuate unpredictably from observation to pending admit while in the emergency department. Likewise, Medicare patients who are admitted may have their part A inpatient stay denied and need to have services rebilled under part B. Beyond these issues there is the important distinction in the acute care setting that these patients have very different overall goals as compared to other beneficiaries receiving outpatient therapy services under the part B benefit. For those patients being seen in the acute care setting under observation status the ultimate goal is to transition the beneficiary to the most appropriate postacute care setting and not necessarily to achieve large functional gains.

As stated in the Middle Class Tax Relief act the purpose of the claims-based data collection strategy is “to assist in reforming the Medicare payment system for outpatient therapy services”. APTA believes that the data gained from observation status patients does not exemplify the typical outpatient therapy episode and may make data analysis more difficult, as these patients may be impossible to distinguish through the current claims-based data collection methodology. Therefore, the data gained from observation status patients will likely not contribute to or benefit the reform of the outpatient therapy service benefit. Likewise, the functional data from the Medicare Part A patients who are rebilled as Part B patients would not be relevant in reform of an outpatient therapy payment system given the fact that these would primarily be short stay patients. For this reason, APTA believes it is important to be able to differentiate these patients from other beneficiaries being seen under the part B benefit, potentially through the use of an additional G-code modifier. Alternatively, we propose that observation status patients and Medicare Part A patients rebilled under the Part B benefit could be exempt from reporting through the use of a one-time G-code.

Another challenge is the episode of care definition that CMS released this summer. Under the definition issued in the MLN (refer), Medicare will close out a therapy episode of care for functional limitation reporting 60 calendar days after the last date of service in cases where the beneficiary did not have a formal discharge for the prior therapy episode. In the event that a patient returns to see therapy within the 60 day window therapists are instructed to either continue reporting if the patient presents again for the same primary limitation or end reporting and begin reporting on a subsequent limitation in the event the patient presents for a new condition. In practice, most facilities will close out an episode of care on a patient who unexpectedly discontinues services within 30 calendar days of their last visit. Therefore, we recommend that CMS change the 60 day window to a 30 day window to be more consistent with practice.

### ***APTA Recommendations for the Claims-Based Therapy Data Collection***

In summary, APTA appreciates CMS’s efforts to collect information regarding patient’s functional limitation through claims-based data collection for outpatient therapy services as mandated by the MCTRJCA. Overall, APTA feels that the claims-based data collection should be changed to make the information gathered more meaningful. APTA believes that the proposal can be altered to decrease provider burden, while still providing

CMS with some useful beneficiary information regarding functional limitations by implementing it in several phases.

**Phase 1** began on January 1, 2013 with the implementation of the data collection, followed by the payment adjustment phase beginning on July 1, 2013. APTA would recommend the following future modifications to the functional limitation data collection which are described below:

**Phase II:** In the second phase APTA recommends that CMS build on phase one by:

- Collecting information on the complexity of the patient as described above.
- Refining the information on patient complexity through the use of a core data set that providers would use to collect information regarding their patients.
- Expansion of the ICF categories to allow for more specific functional information to be collected on patient function.

The implementation of a core data set for reporting and the collection of patient complexity information will help to ensure more accurate ratings and consistency among providers as they identify severity levels for their patients. APTA plans to begin work on development of items that would be contained in the core data set over the next several months and would be interested in collaborating with CMS on this initiative.

Additionally, APTA would recommend increasing the number of specific ICF categories available to therapists. Categories that APTA would suggest adding in the future are: household tasks, carrying out daily routine, communication, and work and employment. APTA would advocate that CMS continue to make further expansions to the ICF categories in the future, in order to get more detailed information about the beneficiaries' functional limitation. Information obtained about primary limitation, using the ICF system, may assist in efforts to move toward alternative payment models based on per session and episodic payment.

**Phase III:** In the final phase, APTA recommends the implementation of an alternative payment system for outpatient therapy services. APTA currently is engaged in developing recommendations for a reformed payment methodology for physical therapy services that would facilitate payment based on the patient's presentation, functional deficits and potential for return of function with less emphasis on the reporting of individual procedures with no correlation to functional change. APTA is supportive of the concept of moving toward per session codes that would be based on the severity of the patient and the intensity of therapist clinical judgment and work involved in the provision of the therapy services. APTA has been involved along with other organizations over the past year in an AMA CPT Workgroup that is discussing the development of these new codes. Eventually, these codes would be valued through the RUC process.

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. Additionally, APTA will continue to move forward, in collaboration with CMS and other stakeholders, in the development of an alternative payment system for outpatient therapy services.

### **Conclusion**

Thank you for your consideration of these comments. We hope the above input is helpful. If there are any questions about our comments or additional information is needed, please contact Gayle Lee, JD, Senior Director, Health Finance and Quality, at 703-706-8549 or [gaylelee@apta.org](mailto:gaylelee@apta.org) or Heather Smith, Program Director of Quality, at 703-706-3140 or [heathersmith@apta.org](mailto:heathersmith@apta.org).

Sincerely,

A handwritten signature in black ink that reads "Paul Rockar Jr." in a cursive script.

Paul A. Rockar, Jr, PT, DPT, MS  
President

PAR: grl, hls