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Marilynn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS- 1590-P
Mail Stop
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: **CMS-1590-P Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013**

Dear Ms.Tavenner:

On behalf of our 82,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments on the Centers for Medicare & Medicaid Services (CMS) Proposed Rule regarding "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013," published in the July 30, 2012 *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 physician fee schedule update; 2) the claims-based data collection strategy for therapy services; 3) pre-payment review; 4) the therapy cap; and 5) the extension and implementation of the Physician Quality Reporting System (PQRS) in 2013 and beyond. Our comments on each of these provisions are discussed in further detail in the following paragraphs.

Physician Fee Schedule Update for CY 2013

In the proposed rule, CMS acknowledges that current law would lead to a 27 percent reduction in the Medicare physician fee schedule conversion factor for CY 2013. While APTA appreciates that such a sizable cut in Medicare payments is currently required by statute, we also recognize that Congress is being strongly urged to prevent a cut of this magnitude. Suffice it to say that APTA believes that a 27 percent reduction in the conversion factor would seriously impair Medicare beneficiary access to physical therapy by making it virtually impossible for physical therapists in any setting to be able to provide care to these beneficiaries. We, therefore, urge the Administration to continue to work with Congress to preclude such an outcome.

Claims-Based Data Collection Strategy for Therapy Services

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 has outlined a proposed data collection strategy to meet the above requirement in this rule.

Under this proposal 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 proposes that the use of these G codes would allow for patient progress to be tracked throughout the episode of care. CMS outlines further details in the proposal regarding the data collection process. After reviewing this extensive functional limitations data collection proposal, APTA has serious concerns about this proposal. Our concerns and recommendations regarding how this proposal might be modified are detailed below.

General Concerns Regarding the Proposal for Collection of Data on Functional Limitations

In the rule CMS states that "by collecting data on beneficiary function over an episode of therapy services, we hope to better understand the Medicare beneficiary population that

uses therapy services, how their functional limitations change as a result of therapy services, and the relationship between beneficiary functional limitations and furnished therapy services over an episode of care." CMS also describes that their long-term goal is to develop an improved payment system for therapy services that would pay appropriately and similarly for efficient and effective services furnished to beneficiaries with similar conditions and 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. We recommend 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 proposal is overly complex and burdensome and may not result in the collection of 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 multiple 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. **In the final rule, we recommend that CMS make it clear that the functional limitation data would be used primarily to track the individual patient's progress rather than for any other data collection purposes.**

Proposed Nonpayable G-Codes

CMS proposes to collect information regarding primary and secondary functional limitations through the use of nonpayable G-codes which will be reported on the claims. CMS also outlines a process for reporting additional limitations in the event the identified primary limitation should be resolved. CMS cites the Development of Outpatient Therapy Payment Alternatives (DOPTA) data as the rationale for collecting data on both primary and secondary limitations, as this project showed that the majority of Medicare beneficiaries, approximately 80%, presented with two or more limitations.

CMS also solicits feedback on whether they should begin to collect data on select categories of functional limitations by adapting the reporting system described in the rule to include some category specific reporting. To demonstrate this approach, in Table 19 of the rule a list of G codes that describe the two most frequently reported functional limitations by each therapy discipline is included. For physical therapy, the two areas included on the list would be: walking and moving around; and changing & maintaining body position. For occupational therapy the two would be: carrying, moving & handling objects; and self-care.

Instead of reporting on primary and secondary functional limitations as described in the rule, the APTA recommends that therapists report the information regarding the patient's functional limitation using one of these more specific categories. However, we recommend that physical therapists be able to report any one of the four categories: walking and moving around; changing and maintaining body position; carrying, moving and handling, and self care. All of these categories describe limitations that a physical therapist could be addressing with the patient. In addition, APTA recommends that CMS establish another G code that would be titled "Other" that would be reported for functional limitations that do not fit into these four categories. For example, wound care may not be described well by any of the four specific categories identified by G codes. We believe that having therapists report on these categories will provide CMS with more useful information than generic reporting on a functional limitation. The APTA recommends that therapists only be required to report on one of these functional limitations in Table 19 (which would be the principal limitation); however, if they choose to do so, they could report on more functional limitations that exist based on the categories.

If CMS decides not to use the specific categories in Table 19, then APTA recommends in the first phase of data collection, that therapists <u>only</u> be required to report a patient's principal functional limitation in order to minimize the complexity of reporting this information. Although APTA recognizes that CMS is

mandated by Congress to collect functional information on the claim form about patients, we believe that collecting both primary and secondary functional limitations as proposed in the rule is overly burdensome and poses clinical challenges.

As CMS proceeds with implementation of this requirement, it is important for CMS to recognize that the functional status is not currently reported on claims, and therefore any requirement to include this data will be a significant practice change requiring major educational initiatives for providers and Medicare Administrative Contractors (MACs) related to documentation, coding, and billing. Many patients receiving therapy services have multiple comorbidities and limitations and to report multiple functional limitations supported by tools translated to scores would be time intensive and complicated. In addition, the fact that therapy services occur over an extended period of time would make this requirement complex and burdensome.

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 three G codes (e.g low, moderate, and high) 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 into the final rule.

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

In the rule, CMS proposes that therapists report patient goals throughout the course of treatment by reporting G codes on the claim form. CMS does not discuss in detail how the goals will be calculated, but we assume that CMS would use the same type of measurement tool translation as proposed in the severity/ complexity modifier section of the rule.

APTA appreciates that CMS would like to collect goal data; however we do not feel that goal data should be collected in this initial year of functional limitation code reporting for several reasons. First, there is wide variability in goals identified by

therapists for their patients. Second, patients may wish to change their goals for reasons that have nothing to do with their progress. As goals can change throughout the course of care, we feel that capturing this element may be confusing for therapists and will not offer great value for CMS.

Third, as we have pointed out previously, functional status is not currently reported on claims and therefore including this data will be a significant practice change requiring major educational initiatives, changes to medical documentation and electronic health records (EHR), and billing process changes. Finally, there are methodology issues with the measurement tool translation as proposed by CMS that we will describe in the next section. Given all these difficulties, CMS will most likely not obtain the information desired while placing a large burden of reporting on therapists.

CMS will be able to identify whether or not the patient is making progress over the course of their episode through the reporting of the G codes with the severity modifiers describing the patient's functional limitation at the initial therapy encounter, the progress report time, and at discharge. Therefore, we recommend that CMS eliminate the proposed requirement that goal information be reported on the claim form recognizing that this information is contained in the medical record and could be obtained in the case of medical review.

In the rule, CMS discusses the use of measurement tools by therapists to quantify functional limitations. CMS cites examples of several valid and reliable tools and recommends in this section of the proposal that these types of tools be utilized to select the appropriate severity modifier. CMS further states that it will not endorse one specific tool at this time citing several reasons for this decision.

APTA supports the use of valid and reliable measurement tools as part of the patient evaluation process in determining the extent of functional limitations and supports CMS's decision not to endorse a specific tool at this time. While it would be ideal to have one standardized tool that could be used for all outpatient therapy patients, APTA feels that there currently is not one tool that would effectively identify the functional limitations of all patients treated by therapists in outpatient settings.

We recognize, of course, that there are many reliable and valid measurement tools available to clinicians; however these tools can differ greatly. Two major groups of measurement tools used to gather information about a patient's functional limitations are performance measures and patient-reported outcome measures. APTA believes that both groups of measures provide important, but distinctly different information about patient function.

For example, a Medicare beneficiary presents for physical therapy with osteoarthritis of the knee. The physical therapist may choose to have the patient complete a patient self-reported outcome tool such as Focus on Therapeutic Outcomes (FOTO) or the Activity Measure for Post-Acute Care (AM-PAC) as well as completing a performance measure

during the evaluation such as the Timed Up and Go (TUG) test. All of these validated measurement tools yield different and complementary information. The plan of care is guided by these measurement tools as well as additional clinical findings such as, but not limited to, muscle strength, pain rating, and range of motion. Lastly, the patient's goals should also guide the plan of care.

As discussed previously, providers will be using different tools to determine the patient's functional limitation that will be reported on the claim form and therefore CMS needs to recognize that the information reported can only be used for the purpose of identifying an individual's progress over the course of that individual's episode of care.

Severity/ Complexity Modifiers

As discussed in the previous section, CMS proposes the use of valid and reliable measurement tools to determine the severity of the patient's functional limitation. CMS proposes twelve levels of severity that would be reported through the use of modifiers to be used with the G codes. According to the proposal, therapists would translate the scores from the selected measurement tool to determine the severity modifier. The scores on the tool would be converted to a percentage and then that percentage score would be subtracted from 100 percent to determine placement on the 12 point scale. CMS uses the Berg Balance Scale as an example of this data translation.

While APTA appreciates the concept of cross walking these scores from tools to the severity modifiers, we do not believe that this translation would result in accurate placement into a severity level. Some functional measurement tools would translate well to a 12 point scale; however, this translation will not work for many of the valuable functional measurement tools used by therapists as these instruments were not designed and tested for that purpose. Many instruments which measure function consist of additive (or summative) scales, which are typically based on ordinal measures (e.g., 0, 1, 2, 3, 4, 5). Scores on each item on the instrument are added to calculate a total score. Although the number obtained may be perceived as an interval measure, the score should be considered as ordinal. Advanced testing such as Rasch analysis (i.e., item-response theory) is required to determine if the instrument can be implemented as an interval measure. To date only a few instruments have been analyzed in this manner (e.g., SF-36, AM-PAC).

Even tools that may appear to translate to a severity level, may not yield meaningful information about patient progress when considered more closely. There are serious limitations in assessing function and measuring change in function using ordinal scales as they can lack sensitivity to change. Many of these tests have specific scores that indicate risk. If a patient scores below or above a specific identified level, the patient would be categorized as being at risk.

For example, the Berg Balance Scale example from the proposed rule may result in a translated score that does not necessarily accurately reflect improvements in the safety risk of the patient. If a beneficiary scored a 33 on evaluation (out of a total 56 points),

using the CMS proposal, the 33 of 56 total points would be converted to a percentage of 59% and subsequently subtracted from 100% yielding a resultant functional limitation of 41% for a modifier value of "XF". At the interim reporting period 30 days later, the beneficiary now scores a 39 of 56 points which would be converted to a percentage of 70% and subsequently subtracted from 100% yielding a resultant functional limitation of 30% for a modifier value of "XE". The patient appears to have made gains based on the numerical translation, 11% using the proposed translation method, but the interpretation of the Berg as it was meant to be used would still categorize the patient as a fall risk. In fact, gains in the Berg score do not lend themselves to this numerical translation because it assumes that the Berg uses a ratio scale, when it is ordinal in nature.

Another example involves tests used by therapists to measure improvements in ambulation. The ability to get from one place at a reasonable speed is essential. Gait requires input from the brain, spinal cord, and peripheral nerves, muscular power and joint and cardiovascular health. Because all of these systems are factors that contribute to ambulation, gait speed is an indicator of the functioning of many physiological systems. Gait speed often decreases with age and is predictive of an individual's ability to function in society. Therapists typically measure gait by distance walked, amount of assistance needed and observation of gait quality. Sometimes therapists will use standardized tests like the Tinetti balance and gait evaluation, 6-minute walking test or the timed 'up and go' test (TUG), and gait speed tests.

Timing a 10-meter walk, which provides information on gait speed, is considered a scientifically reliable and valid test. The norms for gait speed vary depending on age, gender, height and other variables. Therefore, it would be extremely difficult to translate this tool to a severity level given the fact that there is not a clear maximum achievable score for gait speed. The speed that would constitute the maximum achievable amount would be a moving target and pose translational challenges.

Furthermore, there are over 400 different measurement tools used by physical therapists. **Physical therapists frequently use multiple tests to assess a patient's functional level and guide the formulation of a plan of care. An instrument which measures one domain of function (e.g., balance or gait) may not provide an assessment of overall function.** The therapist uses information combined from multiple tests as well as information gathered from the patient in order to determine the overall functional level of the patient.

Also, it is important for CMS to recognize that there are large variations in instruments with some measuring one domain of function while others measure multiple domains. **The choice of the instrument selected by the therapist could potentially impact the reporting of functional limitation if CMS were to require translation from one instrument alone as the methodology for categorization into one of the 12 levels proposed.**

Even though a patient has a significant functional limitation, that patient could score well on a particular tool if the tool used by the therapist is not sensitive enough to reflect the

functional limitations for that patient's specific condition. For instance, a beneficiary who presents with knee osteoarthritis with primary issues related to pain with activity that is very high functioning may score very high on a particular tool if the measurement tool selected is not sensitive enough to identify that patient's difficulties with function. However, if the same patient presented in a clinic that uses a computer adaptive test (e.g. FOTO, AMPAC) with item response theory, the patient's functional limitations for activities may be scored very differently as the technology of that test and the questions presented to patients are driven by the patient's response which would allow for more specificity in item selection based on the current functional abilities of the patient.

Also, the same score obtained in patients with one condition may not predict the same level of function as compared to patients with other conditions. Two completely different patients could score the same on an instrument that assesses global function but have very different responses to the individual measure items. For instance a patient who presents status-post a knee replacement surgery and a patient with chronic low back pain may both be administered the same instrument and both of these patients may score the same number on the test, however, the items that each patient expressed issues with may be completely different. The total knee patient may have issues with bending or squatting versus the back pain patient that may have issues with sitting or walking.

In addition, APTA believes that the 12 level severity scale should be reduced to a 7 point scale as proposed in option one of the CSC STATS project to categorize functional limitations of patients. As proposed by CSC in its 2010 report for CMS the scale could be as follows:

Proportion-based modifiers (7)
XA – 0% impairment, difficulty or barrier
XB – 1-19% impairment, difficulty or barrier
XC – 20-39% impairment, difficulty or barrier
XD – 40-59% impairment, difficulty or barrier
XE – 60-79% impairment, difficulty or barrier
XF – 80-99% impairment, difficulty or barrier
XG – 100% impairment, difficulty or barrier

There is no research suggesting that the use of a 12 point measurement scale to measure functional limitation is more reliable, valid, or sensitive to change as compared to a seven point scale. While the proposed rule asserts that 5- and 7-point scales are inadequate, it does not provide much in the way of rationale for this conclusion. We do not have confidence that the 10% increments in the 12 point scale would be reflective of significant gains in the patient's functional abilities for several reasons. We believe that in many instances a change of greater than 10% would be needed to be meaningful and to exceed any measurement error rates. It is important to capture true change that is meaningful for that patient and demonstrates true improvements in function. Gait speed

provides a good example of the challenges associated with having too many levels of severity. If gait speed is measured at the initial therapy encounter to be 8.2 meters per second and then at the progress report time frame to be 9.2 meters per second, there would be more than a 10 percent gain and the patient would move to a different severity level. However, if the measurement error in gait speed is plus or minus 10% this would not truly indicate change and could just be a measurement error.

As we have discussed, therapists have a large number of instruments, and these instruments vary in the type, such as patient-reported or performance measures. Therapists often utilize multiple tests and measures during their evaluation in combination with information obtained from the patient to formulate the plan of care and goals. It is, therefore, difficult to pick one test to translate into the functional limitation score in many instances as the patients overall functional limitation is best depicted by the cumulative information that the therapist gathers on evaluation. **In order to determine the patient's severity level, APTA recommends that therapists use valid and reliable measurement tools in combination with other information ascertained about the patient through the evaluation to guide the decision and selection of the functional limitation level. Other factors that would impact the patient's functional limitation score would include comorbidities that impact the patient, cognition, safety risk, and age. To support the placement of the patient into the severity level reported on the claim form, t**he therapist's documentation should include information regarding the valid and reliable tools used and an explanation of other factors that the therapist's considered in determining the severity level.

For example, a 67 year old female patient presents for an initial evaluation for right knee osteoarthritis. The therapist has the patient complete a Western Ontario and McMaster Universities Arthritis Index (WOMAC); the patient scores a 44 on the WOMAC. The therapist then performs other tests and measures during the evaluation with the following notable findings: right knee range of motion active (passive) 7-110 (5-112) degrees, right quadriceps strength grossly 4/5 through the available range, gait speed of 1.11 m/s, and a Berg balance score of a 39. Based on this information, the patient has moderate limitations due to her knee condition and her risk of falls. The therapist uses the cumulative knowledge gained by performing both patient reported outcome measures and performance based measures to determine the patient's functional limitation which the therapist rates at 40%.

Reporting Frequency

CMS proposes to collect data at the outset of therapy, specified points during treatment, and at the conclusion of the episode of care. CMS proposes that providers will provide interim information about functional limitations every 10 treatment days or 30 calendar days, whichever is less; this is consistent with the requirements for the timing of Medicare beneficiary progress reports. The reporting at these interim points will take place both at the end of the period and at the next visit, or the beginning of the subsequent reporting period. Additionally, CMS also plans to have providers of therapy

services report a G-code (GXXX7) at all other visits where functional status data is not being reported.

This proposed reporting frequency will be overly burdensome for providers and therefore APTA recommends that the G codes be reported only at the initial therapy encounter, at the progress report time, and at discharge. We recommend that CMS use the 10 visits instead of 30 calendar days to determine the progress report time for purposes of reporting functional limitation codes.

We also strongly urge CMS to eliminate the proposed requirement that the G-code (GXXX7) be reported on every therapy patient claim, even for dates of service for which no collection of functional limitation data is required. Such reporting on every claim does not provide Medicare with any additional information regarding the patient and would be administratively burdensome for providers. Some providers, such as physical therapists in private practice, submit claims on a daily basis. As proposed, if a provider were to inadvertently leave the GXXX7 code off the claim form, payment would be denied. In order to get paid, the provider would have to resubmit the claim form, which would result in delayed payment.

We also strongly recommend that CMS eliminate the requirement that functional information be reported along with the progress report visit and the visit immediately following the progress report visit. Such reporting would be very burdensome and does not provide CMS with any additional information of value. As mentioned earlier, we support the reporting of the functional information at the 10th therapy visit.

Another concern which was raised by CMS in the rule relates to reporting at discharge. As CMS acknowledges in the rule, a significant number of patients may discontinue therapy prior to the date of discharge. **If the patient does not come to their last visit the provider should be exempt form providing the functional limitation data at discharge.** If a patient stops therapy before his/her discharge date, the provider would not be able to complete the tool as proposed to determine the severity level of the patient at discharge. Also, it would be overly burdensome to require a provider to submit a claim with no patient charges in order to report a G code for the patient "at discharge."

Claims Requirements

CMS proposes to continue the use of the therapy modifiers GO, GP, and GN to indicate therapy services and to distinguish the functional limitations reported by each therapy discipline. APTA supports the continued use of these modifiers to distinguish therapy providers. We strongly recommend that the functional limitations be determined distinctly for each therapy discipline. Each therapy discipline measures distinct functional limitations. A patient who has had a stroke could, for example, have significant functional limitations related to walking and moving and have less severe functional limitations related to his/her speech. Therefore, it is important for each distinct discipline to capture the relevant functional limitation and the patient's progress.

Implementation Date

CMS proposes to begin data collection of the functional limitation information through the use of G-codes on January 1, 2013, and proposes that claims submitted after July 1, 2013 for outpatient therapy services that do not include the functional G-codes will be returned to providers unpaid.

After receiving feedback from multiple key stakeholders in a variety of outpatient settings, APTA strongly recommends that CMS extend the time frame so that claims are not rejected for lack of compliance with the functional limitation reporting requirement until at least the end of 2013. Another alternative CMS should consider is testing the functional reporting requirement under a pilot or demonstration program on a smaller scale in certain regions of the country.

As proposed, the functional limitation (G code) reporting requirement will require major changes to electronic health records, documentation and coding, and significant outreach and education to therapists and to the vendors and clearinghouses they use. In addition, CMS will need to provide extensive education to the 15 Medicare Administrative Contractors (MACs) to make sure that they implement the functional limitation reporting requirements accurately.

The requirement that functional limitations be reported on the claim form through the use of G codes has many similarities to the approach to reporting quality measures under the PQRS program. As CMS is aware, the PQRS (formerly PQRI) program, which was first implemented in 2007, has involved major outreach and education efforts in order for eligible professionals to be successful. Many eligible professionals are still having challenges with understanding the PQRS measures and the documentation, coding and reporting requirements associated with them. When the program was first implemented, there were also many difficulties with billing that were not anticipated. For example, systems were rejecting codes that were accompanied with 0 dollar amounts. At this time the use of G code reporting through PQRS has only applied to physicians, nonphysicians and physical therapists in private practice who submit claims using the 1500 claim form or 837P. Institutional providers, such as SNFs, rehabilitation agencies, and hospitals have not reported using these G codes and therefore they (and the therapists who work in these settings) may experience unexpected problems when reporting these G codes for functional limitations.

CMS should take into consideration that this program could be extremely complex from a billing perspective for the settings that bill as institutional settings under Medicare. These settings bill on a monthly basis and therefore their claim forms would contain numerous CPT codes and G codes regarding functional limitation. These settings also often bill for the services of multiple therapy disciplines (physical therapy, occupational therapy, and speech therapy) on the same claim form. Coding and billing for the services provided for all of these disciplines and the functional limitations on a monthly basis could be very difficult.

APTA Recommendations for the Claims-Based Therapy Data Collection

In closing, 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 CMS proposal for the claims-based data collection is complex and 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 which are described below:

Phase I: In the first phase, we recommend that CMS implement the requirement in the statute that there be functional information reported on the claim form as follows:

- Use the functional data only to show progress of an individual over the course of that individual's episode of care.
- Collect data regarding the beneficiary's functional limitation from the physical therapist for the following specific categories identified in Table 19 of the rule: walking and moving around; changing and maintaining body position; carrying, moving and handling; and self-care. An additional category of "Other" should also be added for patients with functional limitations that are not identified by one of these four categories.
- Eliminate the requirement that information be reported on the claim form regarding the goals.
- Collect data to reflect the complexity of the patient's condition by categorizing the patient into one of three levels: low, moderate, or high that could be reported through the use of 3 G codes.
- Require therapists to utilize a valid and reliable measurement tool as part of the determination of patient functional limitation severity.
- Eliminate the proposal that scores from the measurement tool used be translated to a specific severity percentage in determining the severity modifier. The ultimate decision on severity should be based on all data and information collected in the evaluation and subsequent ongoing assessment by the therapist.
- Use the seven level severity modifiers for functional limitation as described in the STATS project instead of the 12 proposed levels in the rule.
- Require submission of the beneficiary's current functional limitation at the start of care, at progress report time, and at discharge. Change the progress report time reporting requirement to 10 visits instead of the lesser of 10 visits or 30 day requirement.
- Clarify that if the patient does not come to their last visit, the therapist should be exempt from providing the severity level at discharge.
- Eliminate the proposed requirement that GXXX7 be reported on every claim when no functional limitation is reported.

- Eliminate the requirement that information be collected at the progress report visit and the visit immediately following the progress report visit. Reporting this information at the progress report visit would be more appropriate.
- Delay implementation or enforcement of this functional reporting requirement for at least one year or test it first on a demonstration or pilot basis.

Phase II: In the second phase APTA recommends that CMS build on phase one by refining the information on patient complexity through the use of a core data set that providers would use to collect information regarding their patients. The implementation of a core data set for reporting 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. CMS could also consider the addition of information regarding goals in phase two.

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 had preliminary discussions regarding the development of these new codes with the AMA RUC and CPT staff and looks forward to moving forward at some point in the future after further refinement with a formal coding proposal that will further define the services and eventually value these codes through the RUC process.

We acknowledge that adopting our recommended alternative (or the original CMS proposal) in phase I without the use of one standard measurement tool will limit the ability of CMS to aggregate and analyze data on a national scale, but we are hopeful that this first step in 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.

Pre Payment Review

CMS contractors currently perform non-random prepayment complex review. On September 26, 2008 CMS published a rule in the *Federal Register* that implemented a requirement in legislation that required CMS to specify criteria contractors would use for the termination of providers and suppliers from non-random prepayment complex medical review. The rule required contractors to terminate the non-random prepayment complex medical review no later than one year following the initiation of the review or

when calculation of the error rate indicates the provider has reduced its initial error rate by 70 percent or more. Congress recently passed legislation eliminating the one year requirement for prepayment review termination. Therefore, in this rule CMS proposes to remove the one year or 70 percent requirement established in the September 2008 rulemaking. As a result, contractors would not be required to terminate non-random prepayment medical review by a set time frame and instead would terminate each medical review when the provider has met all billing requirements as evidenced by an acceptable error rate.

APTA opposes the elimination of a time frame during which prepayment review is terminated. As CMS is aware the federal government has been performing an increasing number of Medicare audits to reduce the amount of improper payments. APTA is committed to ensuring that physical therapy services meet coverage, coding, and documentation requirements set forth by CMS and recognizes the important role that Medicare auditors play in ensuring payments are paid properly. We support efforts to enhance program integrity. However, once a provider is selected for a prepayment audit, it is very difficult to have that prepayment audit terminated despite efforts by the provider to remedy any problems**. There should be a clear process and time frame that a provider can follow to be removed from prepayment review.**

In addition, we recommend the following initiatives to improve the prepayment audit process:

- Trained professionals should conduct the audits of medical records.
- Auditors should apply policies uniformly when conducting medical reviews.
- The auditors should provide and communicate to the provider a case-specific rationale for each denial so that providers can remedy any problems.
- Time frames should be established for ZPICS/PSCs to make determinations on whether a service is covered and to notify the provider of those determinations.
- Auditors should have public websites with customer service contact information, and tracking of open audits.
- An appeals process should be provided that allows for timely appeal of prepayment and postpayment denials.
- There should be provider education about the documentation problems and providers should be given a time frame (e.g. 2 months) to change their documentation to address any concerns.

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

The Therapy Cap

As CMS states in the proposed rule, Congress enacted legislation, the Middle Class Tax Relief Act, which included a provision extending the therapy cap exceptions process

until December 31, 2012. APTA was pleased that Congress enacted legislation extending the therapy exceptions process. However, the exceptions process will expire in December 2012 and therefore this Congressional action offers only a temporary solution to the problem.

APTA is deeply concerned about the negative impact that a financial limitation on therapy services without an exceptions process will have on Medicare beneficiaries in the future. As CMS is aware, the *AdvanceMed* study published in November 2004 indicated that in 2002 14.5% of patients would exceed the physical therapy cap. A report issued in June 2010 by CMS's contractor, CSC, showed that in 2008 15.3% of patients exceeded the physical therapy/speech language pathology cap in 2008. Most recently, MedPAC data showed that 23% of Medicare beneficiaries would exceed the physical therapy cap in 2009. Once exceeded, if there is no exceptions process in place beneficiaries will not receive services that are medically necessary unless they seek treatment from hospital outpatient departments or pay out-of-pocket for their care. As a result, the cap can be expected to have a significant detrimental 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.

We urge CMS to place a high priority in resources and funding for research to identify alternatives to the cap that would ensure patients receive medically necessary therapy services.

We recognize that the Research Triangle Institute is working on a project on behalf of CMS aimed at identifying alternatives to the therapy cap. We strongly believe that research is a key factor in identifying more clinically appropriate ways to control the growth in Medicare spending. APTA currently is also engaged in developing recommendations for a reformed payment methodology for physical therapy services that would facilitate payment being 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 tied into the claims or payment process. APTA has had preliminary discussions regarding the development of the new codes needed for such a reformed payment methodology with the AMA RUC and CPT staff and looks forward to moving forward with a formal coding proposal that will further define the services and eventually value these codes through the RUC process.

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, group and registry measures. 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 for 2012 and beyond. **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.** 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 2013 and 2014 by reporting either individual measures or measures groups. Eligible professionals, including physical therapists, who would like to report on individual measures via the claims-based reporting option in 2012 must report on at least three measures at least 50% of the time. However, if the eligible professional is reporting via an EHR or registry, the 80% reporting threshold will still need to be met. **We are pleased to see the continuation of the same successful reporting thresholds for 2013 and 2014. Maintaining the claims based reporting threshold at 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 has proposed to decrease the number of required patients under the group measures reporting requirements from 30 patients to 20 patients. Again, APTA is pleased to see this proposed change, as it will allow more practitioners to choose group measures as a reporting option.

CMS will provide eligible professionals with the opportunity to avoid 2015 and 2016 payment adjustments by successfully participating in the PQRS program in 2013 and 2014 respectively. Additionally, CMS has proposed that eligible professionals who meet a lesser threshold by reporting only one measure or measures group in 2013 and 2014, but not fulfilling the successful reporting requirements, will be exempt from payment adjustments in 2015 and 2016, respectively. **While we appreciate that this minimal requirement of reporting may help some eligible providers in avoiding payment adjustments, we have concerns that there still exists a lack of awareness about the reporting program given that in CY 2010 less than 25% of all eligible providers participated in PQRS.** Additionally, for those who are aware of the PQRS program, but have chosen not to participate in the program to date, there is a lack of awareness regarding the impending changes to the structure from a payment incentive to a payment adjustment program, as well as, knowledge about the use of 2013 and 2014 data to inform the 2015 and 2016 payment adjustments. We would urge CMS to continue to

disseminate information about the PQRS program in an effort to combat these program awareness issues.

Proposed Changes to GPRO reporting

CMS proposes to modify §414.90(b) to define group practice as "a single Tax Identification Number (TIN) with 2 or more eligible professionals, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN." **APTA believes that changing the group practice definition as proposed would encourage mid to small size practices to consider participation in the program.** Many of our physical therapy practices are smaller and a change in this definition, along with the other proposed changes to the Group Physician Reporting Option (GPRO) would provide an opportunity for specialist practices to become involved as a group in the PQRS program.

CMS has proposed to continue the requirement that group practices self nominate, and undergo a selection process prior to being allowed to participate as a group in PQRS. In the proposed rule, CMS outlines the mechanism for the self nomination which will be done through the web. CMS notes that the development of the web portal for self nomination is still under development and that in the event this is not completed in time to receive self nominations for the CY 2013 PQRS reporting period, groups would self nominate through the mail. **APTA is concerned about the efficiency of this process as outlined in the proposal both due to the potentially increased number of self nominations for GPRO and the potential delays in the web portal.**

In addition, CMS proposes to allow group practices to report PQRS measures via claims, EHR, registry, web-interface, and administrative claims. **APTA believes that including all reporting mechanisms under the group reporting option will allow for specialty practices, such as physical therapy, to participate in the PQRS program as a provider group.** Again, APTA appreciates that physical therapists will have an opportunity for the first time to report in PQRS under the GPRO option.

Proposed Measures Individual & Group and Measure Specification Changes

APTA recognizes the importance of continuing to grow the repository of quality measures as there are still gaps in care measures. We are pleased to see CMS's proposal to add a new measure ***0493 Participation by a Physician or Other Clinician in a Systematic Clinical Database Registry that Includes Consensus Endorsed Quality*****. APTA would advocate for the inclusion of physical therapists in the reporting of this measure** in combination with either CPT code 97001 and/ or 97002. Physical therapists along with many other eligible professionals reporting in the PQRS program are beginning to demonstrate increased participation in data registries. For instance, both physical therapists can currently participate in data submission to Focus on Therapeutic Outcomes (FOTO), Connect, and several other products that offers a registry reporting. **APTA would also like to request to be included in an existing PQRS measure *134 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up***

***Plan*.** Information obtained in screening for depression can be utilized by a physical therapist to determine an appropriate prognosis and influence the plan of care.[1,2] If the screening indicates depression is likely, as part of the evaluative process, the physical therapist will consider a referral to an appropriate provider for additional follow-up.[3] Depression screening can also lead to collaboration of providers if services for depression are required.[4] This collaboration can be mutually beneficial for the health providers in reaching positive outcomes. Therefore, APTA would advocate for the inclusion of CPT codes 97001 and 97002 for reporting on this measure.

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. **The APTA was pleased that CMS finalized interim feedback reports to providers in 2012, as this will enable providers to correct any potential problems in their PQRS reporting.** As you are aware, these Q1 2012 reports are currently scheduled to be released in September of 2012. 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, may greatly assist providers in improving the quality of care they deliver. Ideally, interim feedback reports should be incorporated into PQRS to promote continued quality improvement in 2013 and beyond.

Future Payment Adjustments

CMS finalized the use of 2013 data to inform the 2015 payment adjustment in last year's Physician Fee Schedule Final rule. **APTA continues to have concerns about this decision, given the continued low participation rates and overall lack of awareness of these programmatic changes to PQRS as we discussed above.** There are still a large number of providers who are not participating in PQRS. Based on the most recent participation data available from CY 2010, only 16% of physical and occupational therapists are participating in the program. CMS has yet to begin to publish regular data releases of PQRS measures on an individual practitioner basis and in fact, as discussed in the next section, proposes to release only a subset of the total data collected to date in the first data release on Physician Compare.

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)". [5,6]

We strongly recommend that CMS 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.

Conclusion

Thank you for your consideration of these comments. 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, or Heather Smith, PT, MPH, Program Director of Quality, at 703-706-3140 or heathersmith@apta.org.

Sincerely,

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

PAR: grl, hls

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