

September 4, 2012

Ms. Marilyn Tavenner  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1589-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

*Submitted Electronically*

**RE: CMS-1589-P Medicare Program; Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Electronic Reporting Pilot; Inpatient Rehabilitation Facilities Quality Reporting Program; Quality Improvement Organization Regulations**

Dear Ms. Tavenner:

On behalf of the American Physical Therapy Association (APTA) and its 82,000 member physical therapists, physical therapist assistants, and students of physical therapy, I would like to submit the following comments regarding the Medicare Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems (OPPS) proposed rule for Calendar Year (CY) 2013. Physical therapy is an integral service in the hospital setting, and therefore we are very concerned about the proposed changes.

Physical therapy is the profession devoted to restoration, maintenance, and promotion of optimal physical function. Physical therapists are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status in all age populations. Physical therapists help patients maintain health by preventing further deterioration or future illness. In outpatient hospitals and ambulatory surgical centers, physical therapists deliver medically necessary services to patients with varying medical diagnoses and conditions that are generally reimbursed under the Medicare Physician Fee Schedule (MPFS), but outside of reimbursement, physical therapists are subject to a number of the policies that are included under the OPPS.

As CMS moves forward with finalizing the policies set forth in this proposed rule, we strongly urge the agency to consider the following comments.

## **I. Proposed Policies for the Supervision of Outpatient Services in Hospitals and CAHs**

In this proposed rule, CMS clarifies that it did not establish different requirements for the same services in outpatient hospitals and critical access hospitals (CAHs) under the Medicare Conditions of Participation (COPs). Therefore, as under the OPSS, professional services that are billed separately under the MPFS or physical therapy services that are billed by the hospital as therapy services at the amount reimbursed by the MPFS are not subject to the “incident-to” billing rules and do not require direct supervision by a physician. This same policy holds true for the same services provided in CAH.

There is a small subset of services designated as “sometimes therapy” that are paid under the OPSS when they are not furnished as therapy under a certified plan of care in an outpatient hospital or CAH. CMS clarifies that when these services are paid under the OPSS, they are subject to the “incident-to” supervision requirements. When these services are furnished in these same settings but paid under the MPFS, they are not subject to the “incident-to” supervision requirements.

APTA applauds this clarification and strongly encourages CMS to ensure that this policy is accurately applied by all state surveyors and certifying bodies as well as Medicare Administrative Contractors (MACs). For many years, federal and state legislators, regulators, and payers have recognized that physical therapists work independently, as well as in collaboration with a variety of individuals, to treat their patients. In addition to outpatient hospital departments, physical therapists work in a number of different outpatient therapy settings, including rehabilitation agencies, comprehensive outpatient rehabilitation facilities, physical therapist private practice offices, and physician offices. In all of these settings, which are billed under the MPFS, physical therapists treat patients as independent providers without physician supervision. Therefore, we appreciate CMS’ consistent application of this policy in OPSS outpatient hospital departments and CAHs.

## **II. Outpatient Status Solicitation of Public Comments**

In the proposed rule, CMS discusses the implementation of the Medicare Part A to Part B Rebilling Demonstration. In this demonstration, participating hospitals are allowed to receive 90 percent of the allowable Part B payment for Part A short-stay claims that are denied on the basis that the inpatient admission was not reasonable and necessary. The hospitals can rebill denied Part A claims as Part B services and be paid additional reimbursement when an inpatient admission is found not reasonable and necessary. The demonstration will last from January 1, 2012- December 31, 2014.

CMS notes that this demonstration was established to address several issues that have been highlighted by hospitals and other stakeholders regarding what constitutes an inpatient hospital admission. CMS examines increases in the length of hospital observation periods which are most likely due to the large number of denials that hospitals receive from Medicare auditors that short inpatient stays were not medically necessary. In addition, CMS discusses recent comments that

it has received from hospitals regarding the burdens associated with these policies and how they often do not have the adequate staff resources to make proper decisions regarding patient classification before admission or discharge.

CMS poses several questions to stakeholders for comments:

- 1) Whether the agency should redefine inpatient status using parameters such as length of stay in addition to medical necessity and a physician order? Currently, CMS believes that a decision to admit a patient to the inpatient hospital should be made within 24 to 48 hours but does not have any requirements that limit the amount of time a hospital can keep a patient under observation status.*

APTA believes that CMS should set parameters regarding the amount of time a patient can remain on observation status. We recommend setting a timeframe for an observation period of no more than 24 hours. This will help to set a bright line standard for hospitals as well as post-acute care providers such as home health agencies and skilled nursing facilities. As noted in the proposed rule, in skilled nursing facilities, it is required that patients have a qualifying three day hospital stay in order to receive services under the Medicare Part A SNF benefit. Often times, SNFs find it challenging to discern whether this requirement has been met because of prolonged hospital observation periods. As a result, thousands of Medicare beneficiaries' are denied access to medically necessary services under the SNF Part A benefit each year.

The same holds true for home health agencies that are trying to distinguish inpatient hospital admissions to determine whether the patient has been discharged or readmitted to the home health agency during the 60 day home health episode. The increasing length of the observation period is creating administrative burden for post-acute care providers to comply with quality measurement programs regarding the prevalence of hospital readmissions for their patient populations and other regulatory requirements such as functional reassessments in the home health setting.

While APTA strongly recommends eliminating the three day hospital stay requirement for coverage of services under Part A in the skilled nursing facility, we understand that this is outside of the scope of this rulemaking. Therefore, we recommend that CMS establish an alternative category to allow coverage for a period of time for hospitals to assess and treat patients that fall outside of the realm of a determination to admit for an inpatient stay and that do not qualify for observation as currently defined by Medicare. In many instances, physical therapists are called upon in the emergency room to assist the physician and others in making clinical determinations of whether the patient should be admitted to the hospital as an inpatient. Often, this determination is based on whether the patient has an acute condition. Commonly, patients that come to the hospital are faced with limitations in function caused by a fall or some other accident. For example, a patient with severe lymphedema that is exacerbated has a fall and resulting functional limitations. While these patients do not have an acute condition that would necessitate an

inpatient admission, they are unable to leave the hospital and return home due to their condition, home environment, absence of a caretaker, and other factors.

For this category of patients, it would be beneficial if CMS provided a third option to hospitals of an assessment and intervention period, that could last up to three days, to provide appropriate treatment to these patients and to make preparations for these patients to be admitted to the appropriate care setting. During this time frame, these patients would not be considered an inpatient admission or on observation status and payment to the hospital would be set at a different rate determined by Medicare. This expanded assessment period would allow physical therapists or other rehabilitation professionals a sufficient time period to evaluate the patient, determine the rehabilitation diagnosis and recommend the appropriate settings for continued treatment (e.g. acute, sub-acute or long-term care). We believe that by providing this third option, hospitals will not be faced with the dilemma of turning patients away because they do not qualify for admission to the inpatient hospital. In addition, we believe that policy change will result in better use of hospital resources to manage patients in the emergency room and acute facilities.

Lastly, we believe that for patient's with certain conditions (e.g. limitations in function due to a fall), physical therapists are the most appropriate professionals to aid in making these determinations and should be designated as the individual involved in these decisions in the emergency room and other departments within the inpatient hospital. As noted by CMS in the proposed rule, stakeholders have expressed difficulties in employing utilization review teams and other management to make these determinations outside of normal business hours; thus physical therapists can fill a much needed capacity. Most often, physical therapists are readily available and are increasingly serving in the consultation role within the emergency room. Therefore, this would be an easy transition for physical therapists and hospitals.

- 2) *Whether CMS should establish specific clinical criteria for admission and payment, such as prior authorization?*

APTA does not recommend that CMS move forward with creating specific clinical criteria. We believe that the clinical determination of whether a patient is admitted should be made by the appropriate qualified professional. By mandating specific clinical criteria, CMS may severely limit the beneficiaries' access to medically necessary services and cause undue hardship on the hospital to meet additional regulatory requirements.

- 3) *Whether CMS should align hospital payment rates more closely with the resources utilized to provide outpatient care versus a short inpatient stay to address financial disparities and mitigate decisions to admit based on financial implications?*

APTA strongly believes that hospitals should be appropriately reimbursed for the services they provide during the observation period and the inpatient short stay. The

decision to admit should be solely based on the clinical condition of the patient and in which setting their medical needs can be safely and effectively addressed. Therefore, we recommend that CMS take the necessary steps to ensure that payments are accurately aligned in tandem with setting parameters for the observation period. We believe that by addressing both payment and defining the observation period will help hospitals who are operating with limited resources while resolving issues regarding qualifying stays for SNFs and other complicating factors.

Secondly, when considering payment implications, APTA strongly recommends that CMS consider the effect that payment for inpatient hospital services under Medicare Part B such as during the observation period, may have on calculations of the Medicare financial limitation on outpatient therapy services (therapy cap). Due to risk of denials when classifying patients for an inpatient stay, there are instances where a patient's entire stay in the hospitals, which sometimes spans as much 16 days, is classified as an outpatient hospital stay. Therefore, all physical therapy services received during this period as of October 1, 2012 will count towards the therapy cap. We believe that this is unfair to the patient as it may limit their access to physical therapy in the outpatient setting, when in fact these services should have been billed as inpatient services.

- 4) *Whether considerations such as the responsibility of the hospital to utilize all of the tools necessary to make appropriate initial admission decisions such as having case management and utilization review staff available in hospitals outside of regular business hours may improve the accuracy of admission decisions?*

While, we understand that it is important for hospitals to have the appropriate qualified professionals to determine whether the patient should be admitted to the inpatient hospital, we strongly believe that CMS should not impose administrative or financial burdens on the hospital to provide these additional resources.

### **III. Changes to the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program**

The Inpatient Rehabilitation Facility (IRF) Quality Reporting Program was established by section 3004 of the Affordable Care Act, and subsequently implemented in the FY 2012 IRF PPS final rule (76 FR 47836). In this proposed rule, CMS has outlined 3 changes to the IRF Quality Reporting Program: (1) adopt updates on a previously adopted measure for the IRF QRP that will affect annual prospective payment amounts in FY 2014; (2) adopt a policy that would provide that any measure that has been adopted for use in the IRF QRP will remain in effect until the measure is actively removed, suspended, or replaced; and (3) adopt policies regarding when notice-and-comment rulemaking will be used to update existing IRF QRP measures.

APTA supports these proposed changes to the IRF Quality Reporting Program. The changes proposed in this rule seek to harmonize the processes for the maintenance of technical specifications and measure removal from the IRF quality program with other quality reporting programs such as those in inpatient hospital setting. APTA believes that aligning these processes

for the adoption and removal of measures in quality reporting programs will be helpful for providers in all settings. Additionally, APTA recognizes that it is essential that CMS have the ability to update measures throughout the year, should changes in the specifications for adopted measures be warranted.

### **Conclusion**

APTA thanks CMS for the opportunity to comment on the Medicare Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems proposed rule (CY 2013), and we look forward to working with the agency to craft patient-centered reimbursement policies that reflect quality health care for all Medicare beneficiaries. If you have any questions regarding our comments, please contact Roshunda Drummond-Dye, Director, Regulatory Affairs at (703) 706-8547 or [roshundadrummond-dye@apta.org](mailto:roshundadrummond-dye@apta.org).

Sincerely,

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

Paul Rockar, Jr. PT, DPT, MS  
President

PR: rdd