September 6, 2013

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1601-P
P.O. Box 8013
Baltimore, MD 21244-1850

Submitted Electronically

RE: CMS-1601-P Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determinations and Appeals

Dear Ms. Tavenner:

On behalf of the American Physical Therapy Association (APTA) and its 85,000 member physical therapists, physical therapist assistants, and students of physical therapy, I respectfully submit the following comments regarding the Medicare Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems (OPPS) proposed rule for Calendar Year (CY) 2014. Physical therapy is an integral service in the hospital setting, and therefore we are very interested in the proposed changes and their effect on physical therapy.

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 Items and Services to be "Packaged" or Included in Payment for a Primary Service

In this rule, CMS proposes to create 29 comprehensive Ambulatory Payment Classifications (APCs) to prospectively pay for the most costly device-dependent services. The proposed definition for a comprehensive APC is a classification for the provision of a primary service and all adjunct services provided to support the delivery of the primary service. The comprehensive APC would treat all individually reported codes as representing components of the comprehensive service, resulting in a single prospective payment based on the cost of all individually reported codes that represent the delivery of a primary service as well as all adjunct services provided to support that delivery. CMS proposes to make a single payment for the comprehensive service based on all charges on the claim, excluding only charges for services that cannot be covered by Medicare Part B or that are not payable under the OPPS.

APTA is concerned about the effect this proposal may have on necessary physical therapy services that are provided in conjunction with these 29 APCs and any comprehensive APCs that may be added in the future. Therefore, we strongly urge CMS to make extensive revisions as outlined below before this policy is finalized. As CMS notes in the rule, generally, section 1833(t)(1)(B)(4) of the Social Security Act excludes therapy services from the OPPS. Instead, the majority of therapy services in the hospital setting are provided by therapists under a plan of care, and are paid under the physician fee schedule (refer to section 1834(k) of the Social Security Act) . However, there is a small subset of services designated as "sometimes therapy" services that are paid under the OPPS when they are not furnished as therapy under a certified plan of care in an outpatient hospital or critical access hospital (CAH).

With regard to payment for these new comprehensive 29 APCs, CMS proposes that certain services provided by therapists and reported with therapy codes could be considered "adjunctive services" if certain factors identify the services as outpatient department (OPD) services paid under OPPS. These factors would include whether the services are not independent services but are delivered as an integral part of the OPD service on the order of the physician who is providing the service; whether they are not typically provided under an established plan of care but on a direct physician order; if they are performed by non-therapists; and when they frequently do not contribute to a rehabilitative process. It is our position that physical therapy should not be considered an adjunctive service. In the OPD setting, physical therapists are important members of the interdisciplinary team who work in consultation with the physician. Physical therapy services are skilled, intensive services provided by qualified professionals that are integral to compliment other services provided in the outpatient hospital setting. Therefore, these services should not be enveloped in the proposed comprehensive APCs.

CMS gives an example of when a therapist provides detailed documentation of patient weakness to help a physician identify a possible procedure-associated stroke or help with mobilization of the patient after surgery to prevent blood clots as a service that would be considered adjunctive under the proposed rule. The rule clarifies that the service is limited to the immediate

perioperative period, consistent with their inclusion as part of the larger service to deliver the device, and is distinct from subsequent therapy services furnished under a therapy plan of care which serve to establish rehabilitative needs and begin the process of rehabilitation.

APTA appreciates the recognition in the proposed rule that therapy services offered under a plan of care following one of these device-dependent procedures would be separately reimbursable under section 1834(k) and subject to the Medicare Physician Fee Schedule regulations. However, we are concerned that therapy services provided in the perioperative period for these proposed 29 APCs, particularly for 0425 Level II Arthroplasty or Implantation with Prosthesis, will inappropriately be considered adjunctive services under the proposed rule.

Perioperative generally refers to the three phases of surgery: preoperative, intraoperative, and postoperative. The goal of perioperative care is to provide better conditions for patients before operation, during operation, and after operation. As highlighted in the rule, early mobilization of the patient immediately following surgery is integral to the patient's overall recovery as it improves the health care of the patient by preventing complications associated with bed rest and increases functional ability which allows the patient to transition to a less expensive setting.

Specifically regarding arthroplasty or implantation with prosthesis, physical therapists are an essential member of the health care team who provide evaluation and treatment for the total joint replacement population. Physical therapists provide services to these patients in a variety of treatment settings with the goals of improving muscle performance, activity and participation, and promoting physical activity to decrease the risk of subsequent disability. Physical therapy interventions are designed to restore, maintain, and promote maximal physical function for people with total joint replacements. For example, physical therapist interventions for individuals with total knee replacements aim to reduce pain; increase and maximize joint mobility, muscle strength, flexibility, and aerobic capacity; and prevent functional loss. Interventions may include: therapeutic exercise; manual therapy; functional training in self-care, home management, and work; physical agent modalities; and use of orthotic, assistive, adaptive, protective, and supportive devices, combined with patient-related instruction/education. During the perioperative period, the physical therapist would evaluate the patient to develop a plan of care including skilled therapy interventions. In addition, instruction from the physical therapist in what the patient can expect after surgery is critical in the perioperative phase. Rehabilitation after surgery will be prolonged if some perioperative physical therapy intervention is not provided to increase the patient's mobility, function, and endurance prior to surgery. APTA contends that such services should be separately reimbursed under the physician fee schedule when provided independently by the physical therapists.

APTA is not wholly convinced that a single prospective payment will be adequate to account for the extensive services that the physical therapist provides during the perioperative period. If the classification is limited to adjunctive services provided in the perioperative period, important time-intensive services that require the skills and clinical judgment of the therapist, such as an extensive evaluation of the patient that would aid in the creation of a post-operative plan of care, may not be adequately accounted for or reimbursed. Therefore, we request that CMS rescind its

proposed interpretation of physical therapy services provided in the perioperative period as adjunct services included in the comprehensive APCs as outlined in this proposed rule and in the alternative, provide separate reimbursement for these services under the physician fee schedule.

Additionally, we strongly urge CMS to provide extensive training and clear guidelines to its Medicare contractors to ensure that hospitals and physical therapists are not wrongly penalized when undergoing medical review for physical therapy services provided during the perioperative period that are incorrectly interpreted as adjunct services and included in the comprehensive APC. With increasing scrutiny by Recovery Audit Contractors and the Program for Evaluating Payment Patterns Electronic Report (PEPPER) program on outpatient hospital services, APTA is very concerned about unfair targeting of physical therapy services provided in the outpatient hospital setting for medical review and subsequent denials.

Further, in the CY 2009 OPPS/ASC final rule, CMS established a requirement of direct physician supervision for all hospital outpatient therapeutic services covered by the OPPS (73 FR 68702-68704). As a result, APTA is concerned about a direct physician supervision requirement for the adjunctive therapy services paid under the proposed OPPS comprehensive APCs, which the rule explicitly states will not be considered independent therapy services. We do not believe that direct physician supervision for adjunctive therapy services is appropriate. Considering the collaborative, team approach to physical therapy, we contend that direct physician supervision of physical therapy services is inappropriate. It has been recognized and codified that physical therapy is a separate benefit, and physical therapists are qualified to practice without direct physician supervision. Congress has defined physical therapy services without requiring physician direct supervision in §1861(p) of the Social Security Act. The provision allows outpatient physical therapy services to be furnished in a physical therapy private practice office, outpatient hospital, rehabilitation agency, and other outpatient settings without physician supervision.

Specifically, the physical therapy benefit is defined under Social Security Act §1861(p), which states:

> "The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient --who is under the care of a physician, and with respect to whom a plan prescribing the type, amount, and duration of physical therapy services that are to be furnished such individual has been established by a physician or by a qualified physical therapist and is periodically reviewed by a physician"

The Medicare Benefits Policy Manual[1] states that:

[1] Pub. 100-02, chapter 15, § 230.5

> "Therapy services have their own benefit under § 1861 of the Social Security Act and shall be covered when provided according to the standards and conditions of the benefits described in Medicare manuals."[2]

Therefore, CMS has clearly established bright line standards that distinguish skilled therapy services from other services rendered and has created a distinct benefit when these services are performed by a qualified physical therapist.

In addition, in the 2010 Outpatient Hospital PPS final rule CMS explicitly states that direct physician supervision of outpatient physical therapy services provided in the hospital setting is not required because these services are provided under their own separate therapy benefit in the hospital setting. Specifically, CMS states the following:

> "Section 1833(t) of the Act excludes physical therapy, occupational therapy, and speech-language pathology from hospital outpatient services paid under the OPPS. In addition, in the April 2000 OPPS final rule (65 FR 18525), we stated in response to a comment about physical therapy services that the coverage provision in section 1861(s)(2)(D) of the Act does not require that physical therapy services be provided incident to the services of a physician. Finally, in Section 20 (Hospital Outpatient Services) of Chapter 6 of the Medicare Benefit Policy Manual, we state, "[t]he following rules pertaining to the coverage of outpatient hospital services are not applicable to physical therapy, speech-language pathology, occupational therapy, or end stage renal disease (ESRD) services furnished by hospitals to outpatients." This section instructs readers to consult sections 220 and 230 of Chapter 15 of the Medicare Benefit Policy Manual for rules on the coverage of outpatient physical therapy, occupational therapy, and speech-language pathology furnished by a hospital."

(74 Fed Reg 60316 (November 20, 2009).

CMS further defines "physical therapy services" as, "those services provided within the scope of practice of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in physical functions and health status."[3]

The example given of an adjunctive therapy service under the proposed rule of a therapist providing detailed documentation of patient weakness would require an evaluation of the patient using the clinical judgment and skills of the therapist to determine and document impairments, functional limitations, and disabilities. As a result, adjunctive services such as the example given in the proposed rule would meet the criteria of a physical therapy benefit, and physical therapists are qualified to perform those services independent of direct physician supervision. Under Medicare regulations, only physician certification of the therapy plan of care is required, and certification of the facility plan of care, including the physical therapy component, is

[2] References 1861(s)(2)(A), 42 C.F.R. 410.10(b), and 42 C.F.R. 410.26
[3] Pub. 100-02, chapter 15, § 230.1

satisfactory. Therefore, direct supervision of the proposed adjunctive therapy service would be unnecessary.

Given these concerns, the APTA recommends that CMS remove physical therapy services provided by qualified physical therapists and physical therapist assistants from the list of potential adjunctive services included in the new 29 comprehensive APCs.

II. Proposed Policies for the Supervision of Outpatient Therapeutic Services in CAHs and Rural Hospitals

Although the CY 2009 OPPS/ASC final rule implemented the requirement of direct supervision for hospital outpatient therapeutic services, since March 2010, due to expressed concerns from CAHs and small rural hospitals, CMS has instructed its contractors not to evaluate or enforce the supervision requirements for therapeutic services provided to outpatients in CAHs. In this proposed rule, CMS announces that it will let this enforcement instruction expire at the end of CY 2013 because CMS believes that this will ensure the quality and safety of CAH outpatient therapeutic services paid by Medicare.

Direct physician supervision for all outpatient therapeutic services is not feasible for many CAHs and small rural hospitals in an environment of continuing health care professional staffing shortages. In addition to creating an unnecessary burden, this requirement may impede patient access to quality services in rural and underserved areas. Therefore, we recommend the removal of the direct supervision requirement for outpatient therapeutic services in CAHs under OPPS because it is burdensome, unnecessary, and not based on clinical need.

III. Application of Therapy Cap to CAHs

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 stated earlier, 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 1,300 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.[4]

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.

[4] 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.

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 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 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.

IV. Requirements for Payment of Outpatient Therapeutic ("Incident To") Hospital or CAH Services

In the rule, CMS proposes to make modifications to the "incident to" billing provisions in the Social Security Act (section 1861(s)(2)(A)) that allow physicians to furnish and bill for "incident to" services under Medicare. The regulations setting forth the specific requirements are located at 42 CFR 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.

Conclusion

APTA thanks CMS for the opportunity to comment on the Medicare Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems proposed rule (CY 2014), 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 Gillian Russell, Senior Regulatory Affairs Specialist, at (703) 706-3189 or gillianrussell@apta.org.

Sincerely,

Paul Rockar Jr.

Paul Rockar, Jr. PT, DPT, MS
President

PR: glr