American Physical Therapy Association

1111 North Fairfax Street
Alexandria, VA 22314-1488
703 684 2782
703 684 7343 fax
www.apta.org

June 30, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1607-P
P.O. Box 8011
Baltimore, MD 21244-1850.

Submitted electronically

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program

Dear Administrator Tavenner:

On behalf of our 88,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) submits the following comments regarding the Centers for Medicare and Medicaid Services (CMS) Fiscal Year (FY) 2015 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment Systems proposed rule. 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.

Physical therapy is an integral service provided to patients in the inpatient acute care and long term care settings. Therefore, we appreciate the opportunity to provide the following comments regarding the inpatient and long term care policy updates for FY 2015.

Medicare Payment for Short Inpatient Hospital Stays

In the proposed rule, CMS requests feedback regarding the concept of an alternative payment methodology under the Medicare program for short inpatient hospital stays.

CMS seeks suggestions from stakeholders for the definition of a short stay and the determination of appropriate payment for short inpatient stays.

This request follows the promulgation of rulemaking in FY 2014 intended to address concerns about hospitals' use of observation stays and short inpatient stays. Specifically, CMS has expressed concerns about the increase in Medicare beneficiaries receiving observation services for more than 48 hours and the potential financial impact of these services on beneficiaries. In addition, CMS is concerned about the impact of improper payments for short inpatient stays because the services should have been provided in the outpatient setting.

APTA is opposed to the two-midnight policy implemented in the FY 2014 IPPS/LTCH PPS final rule.[1] The two-midnight policy presumes that a hospital inpatient admission is appropriate for a Medicare beneficiary who requires a hospital stay that spans at least two midnights. Thus, a hospital stay that is less than two midnights should be considered outpatient and billed under Medicare Part B, with limited exceptions. APTA believes that the decision to admit a patient for an inpatient stay should be made by the physician and interdisciplinary team, including the physical therapist, and solely based on the clinical condition of the patient. Setting an arbitrary two-midnight rule can be harmful to patients, particularly those who are short stay with acute illnesses. Therefore, we strongly urge CMS to craft an alternative policy that is based on patient characteristics and allows for the flexibility of the clinician to make appropriate decisions regarding inpatient admissions based on the unique clinical condition of the patient.

Alternative Payment Category

APTA recommends that CMS establish an alternative payment category to allow coverage for a designated period of time for hospitals to assess and treat patients that fall outside of the CMS criteria for admission to an inpatient stay. We believe that certain patient populations would benefit from a new hospital coverage category, and hospitals will be able to make more educated inpatient admission and outpatient stay determinations.

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

[1] 78 Fed. Reg. 50906 (August 19, 2013).

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 CMS. This expanded assessment period would allow physicians, physical therapists, and other health care professionals a sufficient time period to evaluate the patient and recommend the appropriate settings for continued treatment (e.g. acute, sub-acute or long-term care).

As with inpatient stays, therapy provided during the assessment and intervention stay should not be subject to any outpatient therapy requirements, such as functional limitation reporting and the therapy cap. We believe that by providing this alternative payment category, hospitals will not be faced with the dilemma of turning patients away because they do not qualify for admission to the inpatient hospital, and it will minimize financial liability for patients due to lengthy observation stays. In addition, we believe the policy change will result in better use of hospital resources to manage patients in the emergency room and acute care facilities.

APTA also 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. After that time period, patients should be either admitted if appropriate or placed into the aforementioned alternative payment category. 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 (SNFs). In SNFs, it is required that patients have a qualifying three-day hospital stay to receive services under the Medicare SNF Part A benefit. Often times, SNFs find it challenging to discern whether this requirement has been met because of prolonged hospital observation periods without an ultimate admission. 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.

<u>Exception to Outpatient Therapy Requirements for Inpatient Therapy</u>

Due to the confusion that still exists around inpatient admission criteria, APTA continues to be concerned about therapy provided on an inpatient basis that is later denied by auditors and rebilled under Part B. Policies such as the therapy cap and functional limitation reporting were intended for patients receiving therapy in the outpatient setting, and are nonsensical in their application to inpatient or observation stays. It is critical that the hospital have a clear understanding of inpatient or observation status due to the

inability to retroactively achieve compliance with the Part B outpatient therapy requirements. Therefore, we recommend that CMS establish an exception to the outpatient therapy requirements, as outlined in the Medicare Benefit Policy Manual[2], for observation status patients as well as patients that fall in the recommended assessment and intervention category above.

Per statutory requirements, CMS places an annual per beneficiary Medicare financial limitation on outpatient therapy services ("therapy cap"). Each year this annual amount is updated, and the 2014 therapy cap amount is $1920 for physical therapy and speech language pathology services combined. There is a separate $1920 amount allotted for occupational therapy services in 2014. In previous years, outpatient hospitals were exempt from the therapy cap, but the Middle Class Tax Relief and Job Creation Act of 2012[3] applied the financial limitation to the outpatient hospital setting from October 1, 2012 until December 31, 2012. The application of the therapy cap to hospitals was extended until March 31, 2015 by the Protecting Access to Medicare Act of 2014.[4] As part of the therapy cap requirements for 2014, outpatient therapy providers are required to append a KX modifier to claims over the $1920 limit to receive an automatic exception. For claims exceeding $3700, Congress has mandated that therapy claims go through a manual medical review process in which providers are required to send specific documentation to Recovery Audit Contractors (RAC) to receive either pre- or post-payment approval for the additional therapy services.

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 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 hospital, which sometimes spans as much 16 days, is classified as an outpatient hospital stay. Therefore, all physical therapy services received during this period are counted toward the 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. Further, acute care hospital systems are designed for compliance with IPPS Part A requirements. It is administratively burdensome and requires extensive staff and financial resources to implement new processes and electronic software to manage Part B cases. Moreover, the additional cost of compliance with Additional Documentation Requests (ADRs) for manual medical review and other audit requests can be untenable.

In addition, the Middle Class Tax Relief Act mandated that CMS, as of July 1, 2013, collect information on the claim forms regarding the beneficiaries function and condition. All practice settings that provide outpatient therapy services must include this information on the claim form. Specifically, the policy applies to PT, OT, and SLP

---

[2] Centers for Medicare and Medicaid Services, Medicare Benefit Policy Manual, CMS Pub. 100-02, Chap. 15, Sec. 220 (Rev. 186, April 16, 2014); available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

[3] Pub.L. 112–96, H.R. 3630, 126 Stat. 156, enacted February 22, 2012

[4] Pub.L. 113–93, H.R. 4302, 128 Stat. 1040, enacted April 1, 2014

services furnished in hospitals, critical access hospitals, skilled nursing facilities, CORFs, rehabilitation agencies, home health agencies (when the beneficiary is not under a home health plan of care), and in private offices of therapists, physicians and non-physician practitioners. Under the functional limitation reporting requirement for outpatient therapy services, nonpayable G-codes and modifiers is mandated on the claim forms to capture data on the beneficiary's functional limitations at the outset of the therapy episode, a minimum every 10th visit and discharge. By collecting data on beneficiary function over an episode of therapy services, CMS hopes to better understand the beneficiary population that uses therapy services and how their functional limitations change as a result of therapy services. As stated in the Middle Class Tax Relief Act, the purpose of the claims-based data collection strategy is "to assist in reforming the Medicare payment system for outpatient therapy services". Clearly, inpatient stay and observation status patients do not serve this purpose to inform data that should assist in reforming outpatient therapy payment.

To the contrary, APTA believes that the data gained from observation status patients does not exemplify the typical outpatient therapy episode and may make data analysis more difficult, as these patients may be impossible to distinguish through the current claims-based data collection methodology. Therefore, the data gained from observation status patients will likely not contribute to or benefit the reform of the outpatient therapy service benefit. Likewise, the functional data from the Medicare Part A patients who are rebilled as Part B patients would not be relevant in reform of an outpatient therapy payment system given the fact that these would primarily be short stay patients. For this reason, APTA strongly urges CMS to exempt observation status patients and Medicare Part A patients rebilled under the Part B benefit from reporting functional limitation data.

The ability to clearly discern whether the patient is receiving services under the outpatient therapy benefit or physical therapy services provided as part of the patient's inpatient stay is critical to compliance for hospitals under these new functional limitation reporting requirements and with regard to the therapy cap. Therefore, APTA recommends that CMS exempt hospitals from the therapy cap and the functional limitation reporting requirements for physical therapy services that are furnished under the inpatient stay, even if the services provided during the inpatient stay are later denied and subsequently rebilled under the Part B Inpatient Billing policy. CMS could easily establish this exemption with the use of a modifier when billing. This same modifier could be affixed to therapy services billed under observation status as well as when rebilled under Part B for denied admissions.

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 short stays, observation stays, and the creation of an assessment and intervention stay. We believe that addressing payment and defining these categories will help hospitals who are operating with limited resources

while resolving issues regarding the three-day qualifying hospital stay for SNFs and other complicating factors. In addition, we recommend an exception to outpatient therapy requirements for those services provided to patients in the inpatient, observation, and assessment and intervention stay.

Changes to the Hospital Readmissions Reduction Program

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. APTA supports the Hospital Readmissions Reduction Program as approximately 20% of all Medicare patients are readmitted within 30 days of an acute care discharge and readmissions account for an estimated $17 billion in health care spending.

Physical therapists play an integral role in the prevention of acute hospital readmissions as essential members of the health care team facilitating transitions in care for patients. Physical therapists, in conjunction with other of the health care professionals, assist in discharge planning, including the determination of the most appropriate setting for a patient taking into account their medical status, functional status, prognosis and other factors, such as their home environment and family support. The need for coordinated efforts across the continuum of care is imperative in reducing preventable readmissions.

APTA is pleased to see the proposed methodology changes for the existing condition-specific measures that will improve the ability of facilities and providers to target preventable readmissions. CMS is proposing to refine the calculation methodologies for the existing conditions, which include 30-day readmission rates for acute myocardial infarction, heart failure, pneumonia, Chronic Obstructive Pulmonary Disease (COPD), and total hip arthroplasty and total knee arthroplasty patients. The refinements are aimed at further targeting the unplanned readmission for the condition specific measures.

APTA also supports the CMS proposed addition of a condition specific 30-day, all-cause risk-standardized rate readmission measure in FY 2017 for Coronary Artery Bypass Graft (CABG) surgical procedures.

Changes to the Long Term Care Hospital Quality Reporting (LTCHQR) Program

The Secretary established the Long-Term Care Hospital Quality Reporting (LTCHQR) Program in accordance with section 1886(m)(5) of the Act, as added by section 3004 of the Affordable Care Act. CMS has proposed three new measures for the LTCH quality program in FY 2018:

- National Healthcare Safety Network (NHSN) Ventilator-Associated Event (VAE) Outcome Measure
- Functional Outcome Measure: Change in Mobility among LTCH Patients Requiring Ventilator Support; and

- Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function.

In the LTCH setting, physical therapists provide physical therapy services to patients through a plan of care to engage and optimize the patient's participation in achieving improved functional performance. Physical therapists provide an examination that includes the history, systems review, and tests and measures to determine the patient's therapeutic, rehabilitative, and functional status and any environmental factors that may impact the patient's activity and/or participation. Through the evaluative process, physical therapists develop a comprehensive plan of care to achieve the goals and outcomes of improved function.

Overall, APTA supports the 2 new functional measures proposed for inclusion in the LTCH setting. Physical therapists are committed to providing high-quality, timely care and the promotion of evidence-based practice and patient-centered practice. Furthermore, APTA believes it is essential that we move towards a core set of functional items to assess patients across the continuum of care. However, the APTA does have some concerns regarding the proposed measure methodologies. These concerns are discussed below.

APTA supports the concept of this measure, but does recommend revisions to the prior function components of the measure. APTA believes that the prior functioning level indoor ambulation categories should be further separated. We believe that combining "Independent, or not applicable, or unknown (reference category)" would not appropriately allow for the stratification of patients with differing pre-morbid functional status. Although we recognize that the number of unknown or not applicable patients may be small, we do not feel it is appropriate to categorize these patients with those patients who had a pre-morbid functional status of independent. Instead we propose four categories: dependent, some help, independent and unknown/not applicable.

APTA is concerned about the introduction of these core items in the absence of appropriate staff training in completion of these items. In the LTCH setting, these core items may be completed by therapists or nurses and we believe that there should be appropriate standardized training with the introduction of these new items to ensure that there is inter-rater reliability.

Conclusion

Once again, we thank CMS for the opportunity to comment on these policy changes. We look forward to working with the agency to make substantial revisions to the proposed policy prior to its finalization to ensure that Medicare beneficiaries have access to medically necessary physical therapy services in the inpatient hospital setting. If you have any questions regarding our comments, please contact Gillian Leene, JD, Senior Regulatory Affairs Specialist at (703) 706-3189 or gillianleene@apta.org or Heather Smith, PT, MPH, Director of Quality at (703) 706-3140 or heathersmith@apta.org. Thank you for your time and consideration.

Sincerely,

Paul Rockar, Jr. PT, DPT, MS
President

PR: grl, hls