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**Combined Sections Meeting**

January 21-24, 2013  
San Diego, CA

**PT 2013**

June 26-29, 2013  
Salt Lake City, UT

September 10, 2012

Mr. Glenn Hackbarth, J.D.  
Chairman  
Medicare Payment Advisory Commission (MedPAC)  
601 New Jersey Avenue, NW  
Suite 9000  
Washington, DC 20001

***Re: Mandated report: Outpatient therapy services in Medicare (September 7th MedPAC meeting)***

Dear Mr. Hackbarth and Members of the Commission:

On behalf of our 80,000 physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments regarding the mandated report to Congress on outpatient therapy services under Medicare, which was discussed at MedPAC's September 7<sup>th</sup> meeting. APTA's goal is to foster advancements in physical therapy practice, research, and education. The mission of the 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.

APTA appreciates MedPAC's efforts to recommend meaningful and sustainable reforms to outpatient therapy services under Medicare. We share the Commission's objective to reform the outpatient therapy benefit in a manner that improves access to care, reduces fraud and abuse, ensures appropriate payment for services and does not create undue or unnecessary administrative burden on providers or patients. Therefore, APTA would like to offer the following recommendations and comments based on the Commission's discussion at the September 7<sup>th</sup> meeting for consideration.

**Medicare Therapy Benefit Designs**

During the meeting, Commissioners inquired about the current Medicare therapy benefit designs. Specifically, a central focus was the relation of the outpatient therapy benefit and therapy provided under the home health (HH) or skilled nursing facility (SNF) Part A benefits. As noted during the meeting, physical therapists provide services in the HH and SNF setting that may be covered under either the Medicare Part A or B benefits. If provided under Medicare Part B, physical therapy services are reimbursed under the Medicare Physician Fee Schedule. In the alternative, physical therapy

services provided under the Part A benefit are paid under the HH or SNF prospective payment systems.

The criteria for determining whether physical therapy services are covered under the Medicare Part A SNF benefit or home health benefit is clearly defined by statute. In the home health setting, whether services are provided and billed under the home health PPS is indicative of whether the patient is homebound and has a need for skilled intermittent services such as nursing, physical therapy or speech-language pathology. Beneficiaries who meet these qualifications are provided care under the home health Part A benefit in 60-day episodes of care. In the SNF setting, beneficiaries receive services under SNF PPS for up to 100 days after a 3-day qualifying hospital stay if it is established that the patient requires skilled nursing and/or rehabilitation. During the first 21 days, Medicare pays for 100% of the services and after that time, reduces coverage to 80 percent with the patient being responsible for the remaining 20 percent. Depending on the patient's coverage, it is possible that a secondary insurance such as Medicaid or private insurer may cover the 20% copayment. Once the patient exhausts their Medicare Part A benefits in the SNF, they may continue to receive physical therapy services, which are then billed under the outpatient therapy benefit. In addition, physical therapy services provided in a SNF to patients who did not have a 3-day qualifying hospital stay, would be covered under the Medicare Part B outpatient therapy benefit. Increasingly, patients are being placed on observation status instead of being admitted to the hospital and therefore do not meet the criteria for Part A coverage. As noted by MedPAC's data, 37 percent of outpatient therapy spending occurred in the SNF setting. A large portion of this is comprised of SNF residents receiving outpatient therapy services after exhaustion of the Part A benefit.

APTA is highly aware of the Commission's concerns about the provision of therapy under each of these respective payment systems. While the focus of this congressionally mandated report is outpatient therapy, we strongly encourage the Commission to continue its work to ensure that reforms to the provision of therapy services furnished under the Medicare Part A benefit also result in improved access, mitigate fraud and ensure appropriate payment.

### **Reforming the Outpatient Therapy Benefit**

In its proposed options to reform the outpatient therapy benefit, the Commission divided the discussion into short-term and long-term initiatives. We applaud the Commission on this approach, as we also believe that any future reforms should take a phased-in approach that allows adequate time for structure design as well as proper education of providers for seamless transition.

In regards to the Commission's proposed short-term options, APTA offers the following recommendations:

- *Elimination of V-codes as appropriate for reporting diagnosis by the physical therapists under Medicare.* As noted during the Commission's discussion, the

V57.1 code lacks specificity as it offers no clinical data as to the patient condition or the interventions that the physical therapist is providing. APTA supports reforms that will allow physical therapists to report a diagnosis related to the functional limitation, impairment or disability in which therapy is being utilized to address and improve. APTA has long supported the adoption of the International Classification of Function (ICF) as a framework for more appropriate diagnosis reporting under Medicare. APTA also supports the reporting of additional information regarding the patient's complexity, including comorbidities, on the claim form.

- *Establishing uniformity in Medicare payment policy across all settings in which therapy is provided.* APTA supports reforms that provide consistent and uniform payment policies across all settings. As part of the current legislative mandate, CMS has been directed to apply the therapy cap across all settings, including outpatient hospital departments. While we strongly feel that the ultimate goal should be the repeal of these arbitrary caps, we believe that the consistent application of Medicare policies across all settings will yield a more accurate picture of what reforms are necessary to ensure appropriate payment policies across all settings under the outpatient therapy benefit. Additionally, APTA recommends that there be a means on the claim form to identify the therapist who provided the services in all settings. This would enhance accountability for services and allow the opportunity for participation in quality programs, such as the Physician Quality Reporting System.
- *Focus on medical review, audit and program integrity efforts for aberrant providers and high-use geographical areas.* As discussed in the MedPAC meeting, under the CMS Office of Program Integrity, there has been a concerted effort to utilize predictive analytics to capture aberrant patterns and fraudulent billing in real-time. APTA supports the use of data to target high-use providers and the utilization of the Secretary's expanded authority to apply these efforts within the 25 high-use counties in the United States and to providers that meet aberrant practice patterns. We believe that this targeted approach will minimize undue penalization and administrative burdens on physical therapists that are in compliance with Medicare regulations and providing medically necessary services to beneficiaries. In the September 7<sup>th</sup> meeting, there was uncertainty of whether there were any program integrity efforts currently monitoring the therapy cap exceptions process and the use of the KX modifier. It should be noted that the Recovery Audit Contactors (RACs), as well as several other medical review initiatives currently underway, have highlighted the excessive use of the KX modifier as a red flag for audits. Also, CMS's contractor, Safeguard Services, Inc., has issued comparative billing reports to physical therapists regarding their use of the KX modifier over the past 2 years.
- *Elimination of the in-office ancillary services exception under Federal Stark laws to reduce inappropriate billing of physical therapy services when a physician has a financial interest in the service.* MedPAC has done considerable work in

potential issues surrounding this policy and APTA encourages the Commission to consider recommending policy reform, including the elimination of physical therapy as a designated health service (DHS) that meets the exception to the self-referral provision as an in-office ancillary services exception.

- *Reform to the Medicare Improvement Standard.* APTA supports policy changes to the Medicare Improvement Standard to better utilize cost-effective physical therapy to prevent functional decline. This policy limits the use of physical therapy for progressive neurology conditions, such as Multiple Sclerosis or Parkinson's disease where physical therapy can be of significant benefit to prevent decline or more costly interventions. APTA believes that improvement should not be the prevailing determinant in whether a Medicare beneficiary should receive physical therapy and as noted several times by the Commission, skilled physical therapy services are often needed to prevent further deterioration of the patient's condition. Therefore, we strongly recommend that application of the Improvement Standard not be applied based on the diagnosis of the patient.
- *No Adjustment of Cost-sharing for Outpatient Therapy Services.* APTA strongly opposes increasing cost-sharing amounts for Medicare beneficiaries under the outpatient therapy benefit. As the Commission is aware, physical therapy is a repetitive service provided to patients several times a month. Currently, beneficiaries have significant cost sharing amounts of 20%. We have seen the detrimental effect that high co-pays have had on access to physical therapy services under Medicare Advantage plans, and we strongly believe that the obligation to streamline costs and reform the therapy benefit should not be made at the expense of this nation's seniors and other vulnerable patient populations.
- *No Reduction of the Medicare Certification Period for Outpatient Therapy Plans of Care.* APTA believes that reducing the current certification period from 90 to 45 days is unnecessary and does not meet MedPAC's objectives to reform the outpatient therapy benefit to address patient acuity, condition or therapy needs. APTA strongly believes that Medicare beneficiaries should be able to directly access the services of a physical therapist without unnecessary referral or certification requirements. Physical therapists are well-qualified, both through formal education and clinical training, to evaluate a patient's condition, assess his or her physical therapy needs and, if appropriate, safely and effectively treat the patient. Physical therapists are also well-qualified to recognize when patients demonstrate conditions, signs, and symptoms that should be evaluated by other health care professionals before therapy is instituted. Physical therapists recognize when it is appropriate to refer patients to these other health care professionals for consultation. The professional training and expertise that characterizes physical therapists has been recognized by 47 states, which have allowed physical therapists to practice independent of a physician referral. Reducing the recertification period will result in delays in care if the referring physician is not available to review the plan and recertify at the 45-day

interval. Physical therapists are well-trained professionals who are able to use their professional judgment to identify whether services are medically necessary.

In regards to the Commission's proposed long-term options, APTA offers the following recommendations:

- *Use of standardized patient assessment instruments, use of functional measures on the claim form for all providers and settings that furnish physical therapy under Medicare Part B.* APTA supports the use of a standardized core data set to report functional measures for therapy services. Currently, physical therapists billing Medicare Part B services use multiple tests to assess a patient's functional level and guide the formulation of a plan of care. There are over 400 different measurement tools used by physical therapists and these instruments vary in the type, such as patient-reported or performance measures, and some measures are more appropriate in certain patient populations. 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. One solution to this issue is the creation of a core data set. This core data set could provide information on patient complexity and function. The core data set would be a standardized component that could be used in any assessment tool. APTA plans to begin work on development of items that would be contained in the core data set over the next several months.
- *Rescission of Consideration of Private Sector Initiatives such as Prior Authorization.* While APTA believes that it is beneficial to examine the management of outpatient therapy under private sector initiatives, we believe that the adoption of a prior authorization policy is a step in the wrong direction. Such policies are arbitrary and do not have any clinical basis for the limitation of the number of therapy visits allowed. We have heard from a large portion of our members that are currently subject to these policies under private pay plans that prior authorizations are time consuming, repetitive, and lead to interruptions in patient care. In addition, prior authorization policies in the private sector are not consistently applied and vary greatly with each request; therefore, yielding no meaningful information on how to appropriately pay for medically necessary services and offering zero checks and balances to ensure that patients who need therapy receive it in a timely manner.
- *Transition to an alternative payment system that integrates short-term reforms and provides the data and infrastructure to build an accurate and sustainable episodic payment system for therapy services.* APTA's commitment to reforming payment for physical therapy services has been demonstrated in our efforts towards the development of an alternative payment system for outpatient therapy services. APTA's alternative payment system concept integrates several of the reforms that the Commission currently has under consideration. This alternative payment system would be a per session based payment system based on the

severity of the patient's condition and the intensity for physical therapist evaluation, examination and intervention needed to address those needs. APTA is committed to enhancing this system through the use of core data items that would be reported on patient assessment instruments used by the therapist. These core items would be used to provide objective information regarding the patient's severity level. APTA plans to submit a coding proposal to the American Medical Association's Current Procedural Terminology (CPT) panel in the near future with a goal of implementation under the Medicare program on January 1, 2015.

While APTA is aware that MedPAC is interested in an episodic payment system for outpatient physical therapy, we urge MedPAC to recognize that before making such broad payment reform it is necessary to collect more data regarding outpatient therapy services. We believe that a per session approach to payment will enable policymakers to begin to gather more accurate data regarding payment, patient severity, and intensity of services that could be used as a basis for development of an episodic system at some future time. Accurate information is needed in order to build a system that would ensure appropriate access while managing the cost of care over the episode.

APTA is committed to working with the Commission to address this needed area of reform and to better define and demonstrate the value that physical therapy can provide the Medicare program, including its potential to reduce spending across the program, improve quality of life for beneficiaries, and advance health care reform initiatives. For more information, please feel free to contact Gayle Lee, Director, Health Quality and Finance at [gaylelee@apta.org](mailto:gaylelee@apta.org) or 703-706-8549.

Sincerely,

A handwritten signature in cursive script that reads "Paul Rockar Jr." The signature is written in black ink and is positioned above the typed name and title.

Paul J Rockar Jr, PT, DPT, MS  
President

PJR: jm, rdd