

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

October 9, 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 (October 5th 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 October 5<sup>th</sup> meeting in addition to the March and September MedPAC meetings. 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 reforms to outpatient therapy services under Medicare and the thorough discussion during the October 5<sup>th</sup> meeting. As the Commission considers reform to outpatient therapy, we urge you to adopt recommendations that improve access to care, improve the quality of care, minimize fraud and abuse, and ensure appropriate payment for services.

During the MedPAC meeting, three draft recommendations were presented which were subsequently discussed by the Commissioners. The draft recommendations which have been discussed at prior meetings included: extending the therapy cap permanently to hospital outpatient departments, changing the certification period from 90 days to 45 days; implementation of national payment edits and collection of information on functional status from a standardized tool. At this meeting, MedPAC staff also discussed two additional recommendations which were; application of an multiple procedure payment reduction (MPPR) reduction of 50% to the practice expense component of the fee schedule for the same patient on the same day; and reducing the level of the therapy caps to a lower level while allowing manual medical review for requests that exceed the cap. APTA has already submitted comments to

MedPAC regarding the recommendations discussed at the September meeting, and therefore these comments focus primarily on the additional recommendations introduced at the October meeting.

First, we commend the Commissioners for their recognition that a hard therapy cap with no exceptions would pose serious problems for Medicare beneficiaries needing care. As many of the Commissioners stated, therapy is a very important service for Medicare beneficiaries and ultimately reduces hospital admissions and readmissions and other downstream costs. Physical therapists maintain, restore, and improve movement, activity, and health enabling individuals of all ages to have optimal functioning and quality of life, while ensuring patient safety and applying evidence to provide efficient and effective care. These services support the goal of the Affordable Care Act to improve the quality of life and quality of care for Medicare beneficiaries and other Americans.

APTA also strongly supports the MedPAC recommendation to develop and have providers report to CMS standardized core data items that measure function and would be used to determine payment for services. APTA is taking a lead on developing such core data items as well as the development of an alternative payment system for outpatient therapy services.

While APTA supports several of MedPAC's draft recommendations, we have serious concerns with the recommendation to apply an MPPR reduction of 50% to the practice expense (PE) component of outpatient therapy services and to lower the therapy cap amount. In the following paragraphs we discuss our concerns in further detail.

**Draft Recommendation 2: Apply an MPPR reduction of 50% for therapy services provided to the same patient on the same day.**

We strongly urge MedPAC **to rescind its** recommendation that would apply a 50% MPPR reduction to the PE component of outpatient therapy services provided to the same patient on the same day. Implementing a 50% MPPR reduction would result in arbitrary across the board cuts and as a result providers will not be adequately compensated for the resources needed to provide medically necessary therapy services. Currently, physical therapists, occupational therapists, speech-language pathologists and the facilities in which they provide patient care have very small margins between the cost of delivering their care and the payments they receive under Medicare. Such a policy will likely result in impeded access to outpatient therapy services and further exacerbate the current workforce shortage for therapy services. This cut would be further compounded by the projected reductions in the sustainable growth rate and the annual per beneficiary therapy cap.

As MedPAC staff stated, this policy was first proposed by CMS in the 2011 physician fee schedule rule and CMS stated in that rule that efficiencies justified reductions to practice expense ranging from 28%-56%. The analysis used by CMS to justify these reductions in the rulemaking was significantly flawed. Therefore, we urge MedPAC not to rely on the results of this analysis in making recommendations with regard to reform of outpatient therapy services. For MedPAC's review, APTA is attaching our comments submitted in response to the 2011

physician fee schedule rule in which we describe in detail the problems with the methodology used by CMS to determine that the MPPR should be applied to outpatient therapy services.

As described in these comments, CMS's MPPR proposal was flawed for several reasons. First, CMS incorrectly assumed that duplicate clinical labor and supplies are included in the practice expense relative value units (RVUs) when multiple services are furnished to the same patient in a single session. This basic assumption is incorrect because during the development of the PE RVUs for therapy services the fact that certain efficiencies exist when multiple therapy services are provided in a single session was already taken into account. While CMS did acknowledge in the rule that the time spent on pre-service and post-service activities had already been spread across the number of services in a typical therapy session to avoid duplication, CMS mistakenly assumed that time spent on pre-service and post-service activities is spread across two units of services. In fact, the time spent on these activities was spread across three units of services based on the assessment that the typical therapy visit is approximately 45 minutes.

Second, in the rule CMS alleged that the median number of therapy units billed per visit is four and therefore there is duplication. However, CMS's analysis of the median number of units per visit is flawed. CMS excluded all claims with a single unit of service when identifying the median. To determine the median number of units of service in the Medicare claims data by first eliminating all the claims with a single unit of service is inconsistent with standard statistical methods. By excluding any visits during which one unit of service is billed, CMS inappropriately skewed the median upward, resulting in a higher median number. In addition, CMS only examined the median number of services in private practice physical therapist and occupational therapist settings and physician offices. Based on analysis of 2007 claims data conducted by CMS contractor Research Triangle Institute, the private practice setting and physician office setting account for only 35.9% of the total outpatient therapy expenditures, the remaining 64.1% of expenditures for outpatient therapy services are provided in the hospital outpatient setting, skilled nursing facilities, outpatient rehabilitation facilities, home health and comprehensive outpatient rehabilitation facilities (CORF). The MedPAC data regarding outpatient therapy spending in 2011 shows similar spending distributions based on setting. It is unfair and inappropriate to determine a median number of units of services that is based on settings in which only 35% of the spending occurs and to assume that a private practice setting represents and reflects the same practice patterns as an institutional setting.

Third, application of the policy on a per day basis and across disciplines mistakenly assumes that there is duplication in such circumstances. In certain settings, such as skilled nursing facilities, it is common for a patient to receive services from one discipline, such as physical therapy in the morning, and another discipline, such as speech-language pathology in the afternoon. Clearly, there is no duplication and no economies of scale when services are provided at two separate times during the course of the day. Likewise, there is no duplication of practice expenses when distinct and separate professions are providing services. We question why CMS and MedPAC would assume that the practice expense inputs required of two separate professions (e.g. speech language pathology and physical therapy) would be duplicative. If this were the case, CMS would need to reduce by 50% payment to physicians who furnish services in settings that are multidisciplinary. For example, if patient goes to a cardiologist and an internal medicine physician in the same day, would CMS and MedPAC presume that it is necessary to reduce the

practice expense payments for the internal medicine physician by 50%? Such a reduction would be nonsensical.

Rather than recommending a 50% MPPR PE reduction, which is an arbitrary across the board payment cut, we urge MedPAC to continue to emphasize to Congress and CMS that there should be a focus on long term reforms that develop alternatives to the therapy cap. To achieve long-term reform, the first step would be implementation of reporting of core data items that measure patient function and other factors that impact payment. In addition, we recommend changes to the coding structure that would result in per visit payment amounts based on the severity of the patient's condition and intensity of the treatment.

**Draft Recommendation 2: Reduce the therapy cap amount (PT/SLP and OT) and implement manual medical review for requests to exceed the cap.**

APTA also has serious concerns with the draft recommendation of reducing the therapy cap amount and implementing manual medical review requests. While we appreciate the recognition by MedPAC Commissioners that a hard cap would be problematic, we believe that lowering the therapy cap dollar amount could result in significant access problems and delays in care. As MedPAC data shows, in 2011 19% of Medicare beneficiaries exceeded the combined physical therapy and speech language pathology cap and 22% exceeded the occupational therapy cap. MedPAC data also shows that in 2011, \$5.7 billion dollars were spent by Medicare on outpatient therapy services. This means that a very large amount of claims, approximately 1.15 billion dollars worth would need to undergo manual medical review. Such review would require a considerable amount of resources on the part of CMS and its contractors, and Congress would need to allocate funding to CMS and its contractors to implement this process.

If the therapy cap dollar threshold were to be lowered even further, the amount of resources needed for review would be increased substantially. At a certain point, the cost of implementing manual medical review would be significantly greater than any savings obtained by lowering the therapy cap threshold. Also, we caution MedPAC about making this recommendation because if the therapy cap is set at a level that is too low, ultimately all of the care would be approved through the manual medical review process and such review would be a waste of valuable government resources.

In October 2012 CMS implemented a manual medical review process for claims exceeding \$3700, the 95<sup>th</sup> percentile, and therefore therapy providers have some very recent experience with this process. Even though only 5% of Medicare beneficiaries exceed the \$3700 dollar amount, we are already seeing major challenges with the manual medical review process. First, providers were unable to determine the dollar amount accrued toward the therapy cap on October 1 due to system challenges. As a result, they are unsure as to whether a patient has exceeded \$3700 of services over the course of the year and when they should submit a request for manual medical review. Even if the system were working accurately, it is not completely possible for a provider to know whether the dollar amount in the system is accurate because of different billing cycles for providers. While physical therapists in private practice can submit claims on a daily basis, other providers, such as hospitals and skilled nursing facilities submit claims on a monthly

basis. Also, providers can submit up to a year from the date of the service. Therefore, it is impossible to completely rely on the accuracy of the dollar amount reported by Medicare.

Second, CMS has not created a standardized process in which to implement manual medical review. Therefore, each Medicare Administrative Contractor (MAC) has issued different instructions regarding manual medical review and these instructions have been confusing to providers. The MACs are only accepting requests by mail or fax and so there can be a lag time between receipt of the request. Providers have reported that they are unable to submit documents for the request by fax because the fax machines are busy. Providers have to wait 10 business days for a MAC to make a decision regarding the request. While in some instances, it may be possible to submit a request before the patient has exceeded the \$3700, in other cases this is not possible when the patient comes for treatment at a practice for the first time and has already exceeded his/her \$3700 threshold. During the 10 day waiting period, providers are faced with the difficult decision of having to withhold treatment until the MAC makes a decision regarding coverage unless the beneficiary is willing to pay out of pocket for the service. For many patients waiting two weeks before receiving therapy services can result in deterioration of their condition. If the patient decides to go forward and receive therapy services during this 10 day waiting period, the patient will ultimately be responsible for paying for the services if the MAC denies the request for continued treatment. As discussed, there are numerous challenges for the therapists, patients, and the MACs with implementation of a manual medical review process.

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. Over the next several weeks, we will work on suggestions for MedPAC to implement in the interim until enough data is available for long term payment system reform. For more information, please feel free to contact Gayle Lee, Senior Director, Health Quality and Finance at [gaylelee@apta.org](mailto:gaylelee@apta.org) or 703-706-8549.

Sincerely,

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

Paul J Rockar Jr, PT, DPT, MS  
President

PJR: grl