March 13, 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 (March 8th 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 March 8th 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. We appreciate MedPAC's interest in exploring the provision of outpatient therapy services and development of alternatives to the therapy cap.

We strongly urge the Commission to include therapy stakeholders such as APTA in the development to ensure that a comprehensive and accurate assessment of outpatient therapy services is conducted that results in recommendations that ensure access to high quality therapy services for Medicare beneficiaries. We stand ready to work with the Commission to ensure payment reform in outpatient therapy services improves access to care, reduces fraud and abuse, ensures accurate and appropriate payment for services and does not create undue administrative burden on patients or providers.

Based on the discussion that occurred during the MedPAC meeting, it is clear that the Commissioners were interested in obtaining a better understanding of the types of patients needing outpatient physical therapy services, the value of physical therapy services, and circumstances in which physical therapy services are considered skilled and are covered and paid for under the Medicare program. In this correspondence, we provide background on physical therapy services, information regarding the current Medicare physical therapy benefit, and comments on MedPAC's potential approaches to major systems reform, tighter coding in the short term, and improving management of the benefit.

Background on Physical Therapy

Physical therapists are health care professionals who 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. Physical therapists are licensed and regulated in all 50 states and the District of Columbia, and as of January 1, 2016, a doctor of physical therapy degree (DPT) will be required for all entry-level physical therapist education programs.

Physical therapists are an essential member of the health care team who perform evidenced-based screening, evaluations, and assessments for musculoskeletal, neuromuscular, cardiovascular, and integumentary conditions. Physical therapists treat individuals in a number of different outpatient practice settings, including hospital-based, skilled nursing facilities, home health agencies, rehabilitation agencies, and private practice outpatient clinics. There is evidence to support the use of physical therapy to address important and costly patient harm events such as hospital readmissions and falls.[1-11] In addition, in the recently released report to Congress regarding the Post Acute Care Payment Reform Demonstration (PAC-PRD) there was evidence to suggest that outpatient therapy improved patients' self care functional ability.[12] Physical therapy services also improve quality of life and save the Medicare program costs by enabling individuals to return to their homes and communities.[13-17]

Utilization of Physical Therapy Services

During the MedPAC meeting staff presented 2009 data on utilization of outpatient therapy services and raised concerns with this increase in utilization. As MedPAC examines utilization of outpatient physical therapy services, it is important to recognize that other changes in policies under the Medicare Part A program can often result in shifts to Medicare Part B. Over the past several years there have been significant changes in Medicare policies related to skilled nursing facilities (Part A), home health agencies (Part A) and inpatient rehabilitation facilities. The policy changes include the implementation of therapy coverage and medical necessity requirements for home health and inpatient rehabilitation facilities as well as stricter requirements on the amount and therapy delivery mode under Medicare Part A for skilled nursing facilities. There has also been a concerted effort by the Centers for Medicare and Medicaid Services (CMS) to move patients from institutional settings to home and community-based settings to receive care. We believe that it is imperative that individuals with disabilities and the elderly are afforded the opportunity to receive services in home and community-based settings rather than being restricted to institutionalized settings. With the emergence of these new delivery models of care, the site of service for physical therapy services has shifted from skilled nursing facilities, inpatient rehabilitation facilities and home health (Medicare Part A) to assisted living facilities and the patient's home. As evidenced in the Medicaid program (namely the work conducted under the "Money Follows the Person" demonstration project), a shift from receiving services in an institutional setting to an outpatient therapy setting ultimately can save costs in the long-term.

In addition, in its presentation from the March 8th meeting, MedPAC notes that the average growth in spending for outpatient physical therapy for physical therapists in private practice

increased by 13 percent between 2008 and 2009. It must be noted that physical therapists providing services in the physician's office may obtain their own NPI and bill for services in the same manner as physical therapists in private practice. Payment is then reassigned to the physician office. Therefore, in the Medicare claims data, there is no distinction between physical therapists in private practices and physical therapists working in a physician's office. Any growth in the provision of physical therapy services in the physician's office would show up in the category of physical therapists in private practice. We believe that this billing provision has also contributed to increased utilization of outpatient therapy services in recent years.

Medicare Policies Pertaining to Outpatient Physical Therapy

As discussed during the MedPAC meeting, Medicare covers outpatient therapy services furnished in a variety of settings and all these settings are reimbursed under the physician fee schedule. As of January 1, 2011 physical therapy services are also subject to a multiple procedure payment reduction policy (MPPR) that reduces payment. In addition, an $1880 annual per beneficiary financial limitation is applied to physical therapy and speech language pathology services in 2012. A separate cap of $1880 applies to occupational therapy.

Medicare has established detailed requirements regarding which physical therapy services would be considered "reasonable and necessary" under Medicare and the documentation that must be provided by the therapist to support the provision of these services. (Medicare Benefit Policy Manual (Publication 100-02), chapter 15, sections 220 and 230). In order for services to be covered under Medicare, the patient must have an illness or injury, the skills of a therapist must be needed to treat that illness or injury, and there must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time. The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. Also, a physician must review, certify and recertify the therapy plan of care. In addition to the extensive requirements contained in the Medicare Benefit Policy Manual, most Medicare Administrative Contractors have detailed local coverage determinations that govern the provision of outpatient physical therapy services.

During the meeting, the Commissioners inquired about Medicare's oversight of physical therapy services and whether medical documentation is often reviewed to determine whether coverage requirements are met. CMS has a number of auditors that conduct medical reviews of physical therapy claims under the Medicare program. These include Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs) and Zone Program Integrity Contractors (ZPICs). In recent years, the auditors have focused more attention on physical therapy. APTA has made extensive efforts to educate our membership on documentation of medical necessity to ensure that Medicare beneficiaries are receiving the appropriate amount, duration and frequency of skilled physical therapy services. We strongly believe that these current efforts should be examined by MedPAC before recommending any further reviews of physical therapy services.

Major Systems Reform

During the MedPAC meeting, the commission identified the possibility of conducting work on major systems reform for outpatient therapy as part of the congressionally mandated report.

As MedPAC is aware, Congress enacted *The Middle Class Tax Relief and Job Creation Act of 2012 (PL 112-96)* on February 17, 2012, which included a provision extending the therapy cap exceptions process until December 31, 2012. APTA was pleased that Congress took action to extend the exceptions process and to promote further study of alternatives to the therapy cap through the MedPAC report. However, the exceptions process will expire in December 2012.Therefore APTA is deeply concerned about the negative impact that a financial limitation on therapy services without the extension of the exceptions process will have in the future on Medicare beneficiaries needing therapy services. As MedPAC has indicated, approximately 23% of patients would exceed the physical therapy cap. Once exceeded, if there is no exceptions process in place beneficiaries will not receive services that are medically necessary unless they pay out-of-pocket for their care. As a result, the cap can be expected to have a significant detrimental effect on beneficiaries needing rehabilitation services and could lead to complications, ultimately resulting in greater costs to the Medicare program.

CMS has conducted a significant amount of work over the past few years in an effort to identify an alternative to the therapy cap. Specifically, the agency has set forth funding for both a long-term project conducted by Research Triangle Institute (RTI) and a short-term project conducted by CSC, to develop alternatives to the therapy cap. This research is a key factor in identifying more clinically appropriate ways to control the growth in Medicare spending. In light of these extensive efforts, APTA has continued to seek Congressional action to extend the exceptions process to the therapy cap in order to bridge the gap that will exist for beneficiaries and providers during a transition to any alternative payment methodology. We strongly believe that therapy care should be based on the needs of the patient, not governed by an arbitrary financial limit or by any other arbitrary payment policy such as the MPPR policy.

In the 2011 physician fee schedule final rule, CMS discussed several potential alternatives to the therapy caps that could lead to more appropriate payment for medically necessary and effective therapy services that are furnished efficiently. The three options discussed were:

- Modifying the current therapy caps exceptions process by requiring the reporting of new patient function-related Level II HCPCS codes and severity modifiers (in order to facilitate medical review).
- Enhancing the existing therapy caps exceptions process by applying medical necessity edits when per-beneficiary expenditures reach a predetermined level.
- Adopting a per-session bundled payment that would vary based on patient characteristics and the complexity of evaluation and treatment services furnished in the session.

Over the last year, APTA has been further developing the potential alternative discussed in the 2011 rule that involves adopting per session bundled payment based on the patient's characteristics and intensity of the services provided. Specifically, this would involve reforming payment for outpatient therapy services by transitioning from the current fee-for-service, procedural-based payment system to a per visit/session payment system. APTA believes that a system that categorizes patients based on the severity of their condition and the intensity of the interventions required could result in more appropriate valuation of therapy services that better reflects the patient's condition and the clinical judgment of the therapist. To achieve this

reformed payment system for outpatient physical therapist services, changes to the existing Current Procedural Terminology (CPT) coding system, which describes services based on 15 minute time-based units and direct one on one contact, would be necessary. New per session CPT codes describing the session would replace the individual therapy procedures current reported. Payment for the new outpatient therapy codes would be based on the beneficiaries' clinical presentation and the intensity of the intervention provided during the particular session. Following these coding changes, the new codes will be valued through the AMA Relative Value Update (RUC) process and implemented in federal, commercial, and state-based payment systems.

In addition to the new CPT codes, APTA also recommends that additional information regarding the patient's function be reported on the claim form. As referenced above, CMS's contractor, Computer Sciences Corporation (CSC) had introduced one method that involves reporting of G codes on the claim form that would provide functional information at the onset of the episode and during periodic intervals. The G codes would reflect the severity of the patient's: 1) impairments to body functions and/or structures; 2) activity limitations and/or participations restrictions; and 3) environmental barriers. These or other approaches need to be further developed and refined. The Association believes strongly that identifying and utilizing meaningful patient-centered functional mobility measures will better demonstrate the impact physical therapists have on functional outcomes across the continuum of care.

APTA is supportive of concepts that would allow for measurement of patient complexity, severity, progress towards stated functional goals and outcomes of treatment that could be used in a payment system. The Association encourages MedPAC to consider APTA's approach to an alternative payment system as you proceed with your consideration of the best approach to payment for outpatient therapy services and to gathering meaningful information about these services. We look forward to working with the Agency and MedPAC to develop this concept.

Tighter Coding

During the MedPAC meeting, one of the potential areas of work suggested by MedPAC staff is to require clear diagnosis codes on claims, eliminate use of the V-codes and require more information about the reason for exceeding therapy caps. It has been difficult to develop equitable alternatives to the therapy cap because necessary information is missing on the claim form. In the past, requirements were in place that required certain settings, such as hospitals to report V-codes which are general and do not describe the patient's condition. Also, the weaknesses of ICD-9-CM diagnosis codes in describing the condition of the rehabilitation patient has made it difficult to determine why one patient may need more therapy services than another. For therapy patients, diagnosis alone is a poor predictor of the type and duration of therapy needed.

Given the lack of available data, we believe that gathering more information related to the patient's function on the claim form is a step in the right direction toward gathering data that would provide relevant information that could be used to predict the duration and type of therapy services needed. Congress included a provision in the legislation (*The Middle Class Tax Relief and Job Creation Act of 2012 (PL 112-96*) that would require reporting of functional

information on the claim form by January 1, 2013. APTA endorses the International Classification of Functioning, Disability, and Health (ICF) concept as the framework for physical therapy practice. Impairments to body functions and/or structures, activity limitations and/or participation restrictions; and environmental barriers are domains that we believe would influence the patient's function and therefore the course of the physical therapy plan of care.

According to CMS, the transition to ICD-10 is occurring because ICD-9 produces limited data about patients' medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms, and is inconsistent with current medical practice. ICD-10 has updated terminology that is consistent with current clinical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full. ICD-10 will have more detail and a higher degree of specificity for claims coding, which will likely result in less guesswork when physical therapists are submitting a primary diagnosis for their claims. Physical therapists will have the ability to capture more specific data related to outcomes and the ability to monitor practice utilization based on an increased specificity of diagnoses.

Improving Management of the Benefit

MedPAC also discussed ways to improve management of the physical therapy benefit, including a suggestion to require a physician attestation of medical necessity when ordering therapy and to tighten the list of conditions that lead to exceptions to the therapy cap.

APTA recognizes that there is a potential to address concerns about utilization by refining the exceptions process to identify more specific conditions that qualify for an exception to the therapy cap. APTA would be interested in working with CMS and MedPAC if they choose to go the route of setting forth more specific guidelines regarding the conditions that qualify.

In regards to the recommendation of requiring a physician attestation, APTA strongly opposes this recommendation. Under current Medicare requirements for outpatient physical therapy, the physical therapist develops a comprehensive plan of care and is required to obtain physician certification of the plan of care in the initial 30 days of treatment and recertification every 90 days. The purpose of this certification is to ensure that the patient is under the care the of a physician, but the sole decision to determine medical necessity of therapy services, rightly, lies within the discretion of the physical therapist. As aforementioned, the physical therapist is a highly qualified provider who possesses the best education, skills and knowledge to make this determination. Therefore, in the alternative to the physician attestation, we agree with the comments offered by Commissioner Thomas Dean, that if such a requirement is recommended by the Commission, the physical therapist be required to attest to the medical necessity of the physical therapy services furnished to the patient.

Conclusion

APTA appreciates the opportunity to comment on the MedPAC discussion regarding potential approaches to the outpatient therapy mandated report. We look forward to assisting MedPAC as you move toward development of alternatives to the therapy cap based on patient need. If you have any questions, or require clarification of our comments, please feel free to contact Senior

Director, Health Finance and Quality at 703- 706-8549 or gaylelee@apta.org or Justin Moore, Vice President, Public Policy, Payment, and Practice at 703-706-3162 or justinmoore@apta.org.

Sincerely,

R. Scott Ward, PT, PhD
President

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