Sept. 6, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244–1850

Submitted electronically

RE: Medicare and Medicaid Programs: Calendar Year 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Medicare Shared Savings Program Requirements, etc. (CMS-1770-P)

Dear Administrator Brooks-LaSure:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association submits the following comments on the Centers for Medicare & Medicaid Services Calendar Year 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Medicare Shared Savings Program Requirements, etc. (CMS-1770-P) proposed rule. APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span, helping individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

Please find below our detailed comments on the proposed rule.

Medicare Physician Fee Schedule Reform

APTA appreciates that CMS is bound to maintain budget neutrality in the Medicare Physician Fee Schedule through several mechanisms, primarily through adjustment of the conversion factor. Historically, this process has ensured that the Medicare trust fund is protected from annual adjustments that exceed $20 million as required by Section 1848(c)(2)(B)(ii)(II) of the Social Security Act. Should CMS implement any changes in payment or coverage, the costs of those policies can be offset by reducing the conversion factor, which reduces payment for all services under the PFS and maintains budget neutrality. Unfortunately, health care costs in the United States are not budget neutral.

The original conversion factor, $31.00 in 1992, has only increased approximately 11% to the 2022 amount of $34.6062. Using the consumer price index's inflation calculator, had the conversion factor merely been adjusted for inflation since 1992 it would currently stand at $63.11; a 203% increase. APTA acknowledges that CMS has no authority to adjust the conversion factor for inflation and is required by statute to implement specific update adjustment factors. We also acknowledge that much reform has

been implemented in Medicare since 1992, and a direct comparison is not a true reflection of the totality of payment updates made since that time. However, we still believe the stark difference between general inflation and the updates to the conversion factor demonstrates the unsustainable trends at work under the PFS.

CPT	Service	2013 Payment	2023 Payment	Percent Change
97110	Therapeutic exercises	$ 32.00	$ 29.11	-9.02%
97112	Neuromuscular reeducation	$ 33.36	$ 33.41	0.15%
97140	Manual therapy 1/> regions	$ 29.95	$ 26.79	-10.55%
97530	Therapeutic activities	$ 35.06	$ 36.39	3.78%

When examining the most commonly used physical therapy codes over a more recent period of time, the same trends are reflected. The four codes in the table above represent the most frequently billed codes by physical therapists. In 2013, CPT 97110, Therapeutic exercises, was reimbursed at a rate of $32.00 per unit of service. Under CMS' proposed 2023 PFS it will be reimbursed at $29.11: a 9% reduction over 10 years. Similarly, CPT 97112, Neuromuscular reeducation, is being reimbursed only $0.05 more than it was in 2013, a 0.15% increase. Lastly, CPT 97410, Manual therapy, has suffered a 10.55% reduction in the same amount of time. While not all of the reduction in payment is attributable to the conversion factor, this calculation also does not include the reductions attributable to multiple procedure payment reduction, the physical therapist assistant differential, or sequestration. **The bottom line remains that physical therapists will be paid significantly less in 2023 than they were in 2013.**

Much of the most recent frustrations with the conversion factor and the PFS in recent years stem from CMS' overhaul of evaluation/management codes. APTA has never taken issue with the policy of updated E/M codes but rather the impacts of those policy changes in a budget-neutral system. For the 2018 PFS, CMS estimated this policy would result in an 8% payment reduction for physical/occupational therapy (84 FR 63155), and the 2021 PFS increased the amount of the cut to 9% (85 FR 85001). Fortunately, on Dec. 27, 2020, just days before the 9% cut was to take effect, the Consolidated Appropriations Act of 2021 modified the fee schedule final rule by increasing the conversion factor by 3.75% and delaying implementation of an add-on code for E/M services (code G2211) until 2024, among other measures. The result was a 3.3% cut to physical therapy payments in 2021. Unfortunately, the increase to the conversion factor was only effective for one year, and in CMS' 2022 PFS the conversion factor was reduced again by 3.75%. Although CMS did not include the effects of the conversion factor reduction in their regulatory impact analysis that year, APTA estimated that physical therapy would have a 3.5% reduction in payment. Yet again, Congress intervened, providing CMS with a 3% increase to the conversion factor, leaving physical therapy with a 1.2% cut. Cumulatively, physical therapy has been cut 4.5% over the past two years.

Now, in this year's PFS, the conversion factor again is set to be reduced 4.42%. CMS again has not offered a regulatory impact analysis on specialty impacts of the conversion factor reduction, but APTA estimates that physical therapy payment will be reduced a further 4% in 2023. The implementation of the add-on code for E/M services (code G2211) in 2024 will result in another 3%. **Accordingly, by 2024 physical therapy payment under Medicare will have been reduced approximately 10% in a four-year period and has also been harmed by reductions in payment attributable to the PTA differential (15%), sequestration (2%), and MPPR (approximately 15% per therapy visit).**

This constant reduction in payment is not sustainable. APTA and other provider advocates have already begun to seek congressional intervention again, knowing that relief from CMS is unlikely. However, we urge the agency to use whatever regulatory authority it has, including working with Congress, to preserve access to services under Medicare. Ultimately, access is what is at stake. Outpatient practices will suffer first, but patients will ultimately be harmed as private practices will not be able to stay solvent given soaring inflation and reduction in payment. Physical therapy in particular is experiencing extreme staffing shortages that ultimately boil down to salary: Physical therapy clinics are not reimbursed enough by Medicare to hire PTs. In the past, the physical therapy workforce was supplemented by PTAs, but the PTA differential has made that solution financially unviable as well.

The constant reduction in payment for physical therapy services has become so unsustainable that APTA has undertaken the effort to have legislation passed that would allow physical therapists to opt out of Medicare and privately contract with Medicare beneficiaries. This would give physical therapists the same authority enjoyed by physicians and many other practitioners, such as physician assistants, dentists, podiatrists, optometrists, social workers, psychologists, nurse midwives, and dietitians. While these providers are barred from providing services to Medicare beneficiaries for two years, they at least have the option to refuse Medicare's burdensome billing process and inequitable payment. Physical therapists currently do not even have the choice. They must enroll in Medicare or else they cannot provide Medicare-covered services to Medicare beneficiaries.

Accordingly, APTA has supported the Medicare Patient Empowerment Act (H.R. 3322/S. 826), legislation that would enable physical therapists to privately contract with Medicare beneficiaries, remove of the two-year bar on treating Medicare beneficiaries, and allow beneficiaries to submit out-of-network claims for reimbursement.

We only bring this bill to the agency's attention to stress the seriousness of the payment inequity under Medicare. APTA fully supports a robust, efficient, and effective Medicare program that does not burden beneficiaries with having to seek out-of-network care and submit claims themselves. However, for many physical therapy practices, accepting Medicare payment rates as they currently stand, not to mention continued reductions expected under current policy, would put the financial health of the clinic at risk. While APTA strongly encourages its members to participate in Medicare and supports the efforts of CMS to sustain the program, ultimately it is better for patients to have to seek out-of-network clinics than to have no available clinics at all.

Accordingly, we urge CMS to work with Congress to implement large scale reforms to the PFS.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

APTA greatly appreciates the opportunity to provide additional evidence in support of telehealth services furnished by physical therapists and physical therapist assistants; as such, we urge CMS to formally recognize the clinical benefit associated with these services by moving high-value CPT codes to the Medicare telehealth services list.

APTA asks that CMS include the following CPT codes at Category 1: 97110, 97112, 97116, 97150, 97161-97164, 97530, 97535, 97537, 97542, 97750, 97755, and 97763; and include CPT codes 97150, 97530, 97542 — currently on the Medicare Telehealth Services list temporarily — at Category 3, making them available through the end of CY 2023. On top of this, CMS should at a minimum maintain the current access to telerehabilitation services.

While it is widely understood that telehealth is feasible and acceptable during stay-at-home measures, its usefulness in the "new normal" of post-pandemic life is still being evaluated. Continued coverage of these services by Medicare will enable further research to be conducted. However, understanding that clinical evidence is essential to approving additional services to be permanently covered when delivered via telehealth, APTA has provided a review of the literature, demonstrating the ability of telehealth to be furnished outside of the PHE without jeopardizing patient safety or quality of care.

Clinical Evidence Supporting Similar or Better Outcomes

Virtual platforms promote clinician-patient interactions outside of a clinical setting. Telerehabilitation can reduce pain and increase function, allowing patients to lead healthier and happier lives. Patients using telehealth for their pre-and post-operative care reported reduced complications, fewer future hospitalizations, and better recovery times compared with traditional modes of rehabilitation.

The evidence below validates these assumptions, indicating similar or superior patient outcomes with telehealth compared with traditional care.

- In a 2022 observational, longitudinal study, for patients with acute and subacute musculoskeletal pain, telerehabilitation was effective at **improving pain and function.**
- In a 2022 pilot study of patients with 23 patients with Parkinson disease, telerehabilitation was **safe, feasible, effective, and likely rewarding** for motor symptoms in mild-to-moderate patients, making telehealth advantageous for people with limited access to health care services.
- A 2021 systematic literature review of four studies compared women who had face-to-face versus virtual pelvic floor treatment, concluding that virtual treatment reported **significant improvements in urinary symptoms, pelvic floor muscle function, and quality of life.**
- In a 2021 randomized control trial measuring the feasibility of a telerehabilitation program for older adults on a waiting list for physical therapy after hospital discharge, a multi-component telerehabilitation intervention proved to be **clinically effective and cost-effective**. Avoiding delays in care by pragmatically using telerehabilitation is not only cost-saving, but also **improves patient outcomes** by working with older adults who would otherwise not receive any form of care.
- A 2020 study showed that for patients with chronic obstructive pulmonary disease, telehealth **improved function** and quality of life with **similar benefits** to in-person outpatient treatment options.
- A 2020 study found that within the context of shoulder, knee, hip, and upper limb procedures, results from postsurgical telerehabilitation are **promising, even superior, when compared with usual methods of care**, reporting **reduced pain and improved function** in patients.
- A 2020 pilot study examined the use of telehealth for perioperative physical activity interventions in older adults with cancer. The results were promising, describing personalized, multimodal telehealth in older patients and their caregivers as **feasible and acceptable.**
- In a 2020 qualitative study of home-based stroke telerehabilitation, patients reported **enhanced physical recovery and mental and social-emotional well-being.** Telerehabilitation was easy to use, engaging for patients, and accessible in a convenient home-based location.
- In a 2019 study following COPD patients, telerehabilitation demonstrated a **reduction in 30-day readmission rates** following hospitalization.
- A 2019 randomized control trial advanced the notion that telerehabilitation can **complement conventional therapy** and **increase motor function** for poststroke patients.

- A 2019 randomized control trial showed how telerehabilitation that is focused on activity-based training in stroke patients produces **substantial gains in motor function**, implying that telerehabilitation could **increase access to care** if it were initiated on a larger scale.
- A 2019 randomized control trial measured the efficacy and feasibility of home-telehealth programs to prevent falls in older adults, concluding that when integrated with medical/nursing telesurveillance, the program is **feasible and effective in preventing falls** for chronic disease patients who are at a higher risk of injury.
- In a 2018 systematic review and meta-analysis of telerehabilitation services, results demonstrated the potential of telehealth to **increase quality of life, become a feasible alternative to in-person care, and be as effective as usual care in surgical populations.**
- In a 2018 study, a physical therapist first assessed and treated musculoskeletal disorders via a live, secure video. All patients **reported improvements in symptoms and function** in fewer than four visits and **all maintained a reduction in symptoms** after three months.
- A 2018 case series demonstrated how patients with chronic low back pain could greatly benefit from the telerehabilitation sessions for the long-term management of their condition, with evidence supporting **high programmatic satisfaction, excellent adherence and improved self-efficacy.**
- In a 2018 study of PTs who virtually assessed and treated musculoskeletal disorders, patients reported **improved symptoms and function** and were able to maintain a **reduction in pain** over time.
- A 2017 study found that patients who received rehab from knee arthroplasty via real-time videos had **similar clinical outcomes and satisfaction** to those of patients who received traditional care, demonstrating the use of videos as a practical alternative to in-person care.
- Another 2017 study of patients following knee arthroplasty reported telerehabilitation as a **practical alternative** to conventional face-to-face therapy.
- In a 2016 study for post-acute rehabilitation, patients with a circulatory disease who used telehealth were **more likely to have significant improvements in function and independence** from admission to discharge than those who did not use telehealth.
- For SNF patients, a 2016 study demonstrated that telehealth implementation in a SNF for the purpose of physical therapy reevaluation is a **feasible alternative to in-person encounters.**
- A 2015 systematic review and meta-analysis for poststroke patients reported **improved activities of daily living.**
- A 2014 randomized control trial points to the acceptance of telerehabilitation in poststroke patients with **improvements as much as or more than with conventional therapy for the reacquisition of motor skills and daily functions.**

The breadth of this research demonstrates telerehabilitation outcomes to be comparable to and, for certain patients and certain situations, potentially better than conventional methods of care. Within the literature, studies also characterized telehealth as an alternative when in-person care is not available or could otherwise not be consistently provided, such as the 2021 randomized control trial in which patients were already discharged and sitting on a waiting list for physical therapy services; and the 2020 pilot study in which in-person physical therapy services would have not been routinely available for high-risk cancer patients. By providing a more rapid beneficial resolution of the disease process treatment, telehealth creates better outcomes for patients, reporting consistent or increased quality of care and clear clinical benefit for the Medicare population.

For telehealth assessments, the research is limited but preliminary studies are promising:

- A 2021 systematic review of a range-of-motion assessments concluded that for limited populations, remote assessment is **valid and reliable;** however, limitations fall around the bandwidth of the patient and the provider to assess the patient comparably with in-person care.
- For gait therapy and teleassessments, a 2020 interrater reliability study looked at the limitations of remote assessments. Using internet and video quality, the study concluded that this form of assessment is **feasible, valid, and reliable.**
- In a 2020 study comparing telehealth and in-person service delivery models for wheeled mobility devices and functional mobility assessments, there were no significant differences between the two groups. However, using telehealth, the PT was able to evaluate the client in their natural home environment, making teleassessments more advantageous by providing **better patient care and gaining higher levels of functional abilities**.
- For wheelchair assessments, a 2019 scoping review found that telehealth may be as **effective as in-person care and is viewed favorably by wheelchair users.** There is great potential for telehealth assessments to **improve access and equity in rehabilitation**.

For teleassessments, PTs must acknowledge the difficulties surrounding telehealth appointments for certain populations with more limited access to high-quality technology that is required for reliability purposes. However, for populations with steadfast internet and access to technologies either on hand or provided to them by the PT, there are no concerns for teleassessments. Inequitable access to reliable internet is not a challenge faced solely by physical therapy patients and should therefore not be used to prevent coverage of these services where feasible.

Telehealth allows providers to see a patient without access to clinically appropriate in-person options, diagnose their condition, and treat them accordingly. With limited providers, rural communities are uniquely positioned to benefit the most from telehealth programs because telerehabilitation decreases the burden of geographic, economic, and physical barriers for patients who need routine care. A 2020 study demonstrated the potential of telerehab programs to improve daily function and manage chronic diseases within older adults in rural areas. Examples such as the Rural Veterans TeleRehabilitation Initiative find that home-based programs significantly improve functional independence, cognition, and patient satisfaction within these populations. Expanding and increasing the availability of these programs will bring further autonomy to these communities and increase access to essential health care services. APTA implores CMS to examine the possible impact of telerehabilitation in communities like these that have limited access to providers and would profit from unhindered access to all modes of therapy.

While rural and underserved populations could benefit the most from telehealth services, all populations would gain from improved access to care. The following studies examine the impact of telehealth on broad populations receiving therapy services:

- In a 2021 case report, early benefits of telehealth were reported in musculoskeletal patients including **improved access to services, better continuity of care, and a better understanding of the patient experience.**
- A 2020 international study reported that PTs treating chronic back pain believe that the use of telehealth can **reach a greater number of patients**, **save health care costs**, and serve as an **effective form of care** for patients.
- A 2020 review stated that telehealth provides **easy access to a provider** for patients with ALS who have lower functionality and live further from treatment clinics.
- In a 2020 literature review, telerehabilitation for multiple sclerosis was shown to be "**beneficial, cost effective, and satisfactory** for patients and providers."

- In a 2019 study looking specifically at telerehabilitation in the total and unicompartmental knee arthroplasty postoperative period, telehealth platforms demonstrated **cost-savings**, **convenience** with at-home patient monitoring, and **higher levels of coordinated care.**
- Multiple studies also spoke to the benefits of reduced travel time and transportation costs for clinical video technology rather than in-person gait and balance training.

Telehealth increases regular access to physical therapy for all populations but serves as a unique opportunity to reach a broader audience that often goes without consistent physical therapy services. If telehealth services were offered beyond the duration of the PHE, communities of older adults who have limited access to care would have more options for prevention, treatment, and rehabilitation.

Additional Benefits From Care Delivered Outside of the Traditional Health Care Setting

Telehealth promotes recovery and resiliency within the patient's home environment by creating the setting that traditional, in-person therapy is trying to simulate. Multiple studies have suggested that virtual PT visits can be more favorable for patients because they are situated within their own home. An umbrella and mapping review of home-based telerehabilitation produced positive clinical results, revealing that the benefits telehealth provides cannot be reached in a traditional outpatient rehabilitation setting. The following excerpt from the International Journal of Telerehabilitation speaks to practicality of telerehabilitation:

> … [I]nstead of practicing stair climbing on an artificial staircase available in a clinic setting, telerehabilitation practitioners use the stairs and railings in a person's dwelling; instead of preparing meals in an adapted kitchen, telerehabilitation practitioners provide meal preparation instruction using tools and equipment available in a client's personal kitchen; and instead of working on reading with generic books or magazines available in a clinic or accessible online, telerehabilitation practitioners use materials a client has and wants to read for leisure or work purposes …

This passage shows how telerehabilitation establishes patients in an environment where they will carry out their routines outside of their PT sessions and enables patients to complete tasks as they would continue to perform them in their daily lives. During these telerehabilitation sessions, patients reported feeling "safe and comfortable" in their own environment, enabling a more successful recovery. In a study examining functional mobility assessments, the PT used telehealth to evaluate the client in their natural environment and determined how accessible that environment was for the patient, leading to better patient care and higher levels of long-term functional ability. Similarly, a 2021 study looking at patient education for a total joint arthroplasty examined the use of virtual care for preop education administered in the patient's home environment, stating that it **maintained flexibility, encouraged performance, and improved the patient's ability to recall the imparted information.**

By requiring patients to show up in person to their appointment, providers place them in a setting they are unaccustomed to, possibly hindering their recovery process. **CMS must examine the potential of telerehabilitation to improve health care outcomes and make patients more comfortable performing therapeutic exercises and interacting with their providers remotely.**

Cost-savings serve as another additional benefit to telehealth services. The following studies show how telehealth services are often more cost-effective than traditional methods of care:

- The landmark 2021 Intermountain study assessed patient outcomes after a hip arthroscopy, discovering that patients had **similar short-term results** and **more cost-effective care compared** with in-person postoperative rehabilitation.
- In an aforementioned 2021 randomized control trial measuring the feasibility of a telerehabilitation program for older adults on a waiting list for physical therapy after hospital discharge, a multi-component telerehabilitation intervention proved to be not only clinically effective but also **cost-effective**.
- In an international article published in 2021, along with positive clinical results, telerehabilitation in patients with neuromuscular disorder also demonstrated **lower costs and provided less interference with the recovery process.**
- In a 2021 retrospective matched cohort analysis of 51 patients undergoing postoperative physical therapy after a hip arthroscopy, telehealth was deemed **cost-effective** compared with in-person physical therapy with similar short-term outcomes.
- A 2020 study examined patients after a total knee arthroplasty reporting **similar clinical effectiveness to in-person care with lower three-month health care costs.** Given that rates of this procedure are projected to double in the U.S. by 2050, CMS must consider the implications of saving health care dollars on common procedures using telehealth services.
- After a hip arthroscopy, a 2020 cost-analysis looked at the difference between in-person and virtual care; the result was a **lower or about the same cost.**
- A 2019 study examining telehealth for stroke care reported increased access for acute care in a neurologically underserved population and improved functional outcomes; the practice of telehealth also **was cost-effective, shortened hospital stays, and avoided unnecessary patient transfers.**
- A 2016 clinical video telehealth program for gait and balance **increased access** to specialty services, **reduced travel time, and lessened related costs of care.**

Telehealth can provide some benefits beyond those seen in traditional rehabilitation environments. It increases patient's comfortability with the therapeutic process and introduces large cost savings by reducing the use of unnecessary resources and services. **CMS must see the value in the flexibility of telehealth and not limit patients to a formal clinical setting that may hinder their recovery process.**

High patient satisfaction with telehealth supports the need for permanent access to virtual physical therapy services. When undergoing telerehabilitation, patients are likely to report moderate to high levels of satisfaction and approve of the care provided to them through virtual platforms, as indicated in these studies:

- In a 2021 study examining patient satisfaction with in-person and telehealth PT during the pandemic, **patients reported equal satisfaction** no matter which modality was used.
- In another 2021 study, discussing telerehabilitation for patients with lower extremity injuries, patients undergoing telerehabilitation reported **higher satisfaction with virtual platforms due to less time spent at the hospital and more time for exercises within their own home.**
- A 2021 nonrandomized, prospective cross-sectional survey for outpatient telehealth in cardiovascular patients led to **overall satisfaction with telehealth** due to enhanced patient convenience. In this study, non-White ethnicity, younger age, and female gender correlated with higher rates of satisfaction.
- Following total hip replacements, patients in a 2020 study reported the use of telerehabilitation programs that were available within their own homes with **high levels of satisfaction**; outcomes were the same for both in-person and virtual rehabilitation programs.

- A report published on Aug. 14, 2020, in the American Journal of Physical Medicine and Rehabilitation, described feasibility of and satisfaction with telerehabilitation based on the completion of online surveys by 205 participants following a telerehabilitation visit:
    - Most commonly, participants were women (53.7%), were 35-64 years old, and completed physical therapy (53.7%) for established visits of 30-44 minutes in duration for primary impairments in sports, lower limb injuries, and pediatric neurology.
    - Overall high ratings ("excellent" or "very good" responses) were observed for all patient-centered outcome metrics (ranging 93.7%-99%) and value in future telehealth visit (86.8%) across telerehabilitation visits.
    - Women participated more frequently and provided higher ratings than did men participants.
- Another 2020 study evaluated telehealth physical therapy implementation, examining patient satisfaction during stay-at-home-measures. Overall, 92% of patients would attend another telehealth session and 94% were satisfied with their visits. Results implied that telehealth physical therapy was **feasible and acceptable** based on patient-reported satisfaction.
- In a 2019 case series following the use of telerehabilitation for pelvic floor dysfunction**, participants felt that their needs were met and affirmed that they received good care.**

Patients are generally satisfied with telehealth visits; however, more research must be conducted to assess the patient's desire to use telehealth consistently. While not all Medicare enrollees will want to use telehealth or feel comfortable doing so, many enrollees will see telerehabilitation as an easier, more flexible therapeutic option. **Therefore, failure to provide continued access to telehealth modalities from PT providers within the Medicare population will limit care and patient satisfaction.**

PTs Should Have Permanent Access to Telehealth Services

APTA applauds CMS for extending coverage of physical therapy codes delivered via telehealth through 2023. However, we strongly request that telehealth services be made permanently available for all Medicare beneficiaries, as therapy services now have been safely and effectively delivered via telehealth in the Medicare program for over two years. CMS should not reverse Medicare's historic increase in access to physical therapy services, as patients have come to rely on telehealth and expect it when it provides a viable option for the delivery of medically necessary skilled care, serving not as a substitute for but a supplement to high-quality physical therapy.

Given the large-scale shift in health care delivery, APTA recommends that CMS encourage the permanent use of varying methods of care delivery. The new normal should include telehealth services, and the constraints that CMS has placed on the physical therapy profession in the proposed rule hinder the potential of telehealth to improve care delivery, ensure care coordination, and reach a wider audience.

We believe that the blanket exclusion of PTs from telehealth services is arbitrary and antiquated, and restricts beneficiaries' access to many safe and effective skilled services necessary for Medicare beneficiaries to achieve, restore, and maintain optimum health and function. APTA appreciates that Congress must act to ensure physical therapists and physical therapist assistants are permanently authorized as providers eligible to bill Medicare for services delivered via telehealth. There are a number of legislative options in Congress that would either directly or indirectly do so. In the meantime, CMS should move to ensure that physical therapy codes are included as services eligible to be delivered via telehealth so that there are no gaps in coverage once physical therapists and physical therapist assistants are permanently authorized to deliver telehealth services under Medicare.

Once physical therapists and physical therapist assistants are permitted to bill telehealth under Medicare permanently, patient geography will no longer be a barrier to receiving timely, appropriate medical care. As a result, Medicare will see a reduction in health care expenditures, increased patient access to care, enhanced patient satisfaction, and improved management of chronic disease and quality of life, particularly in rural and underserved areas. The expansion of payment and coverage policies to allow physical therapists in private practice and based in facilities to furnish telehealth during this PHE has demonstrated that many beneficiaries' needs can be effectively met via the use of technology and that patients can have improved access to skilled care by leveraging these resources.

APTA recognizes that rehabilitative services furnished via telehealth would not replace traditional clinical care, but instead be used as a valuable resource for physical therapists and physical therapist assistants in expanding their reach to meet the needs of patients when and where those needs arise. In conclusion, this pandemic has demonstrated safe and effective delivery of telehealth physical therapist practice that should become part of evidence-based care for Medicare and Medicaid beneficiaries.

Expiration of PHE Flexibilities for Direct Supervision Requirements

APTA appreciates CMS' continued consideration of whether the flexibility to meet the immediate availability requirement for direct supervision through the use of real-time, audio/video technology should potentially be made permanent. This flexibility has been considerably valuable to the therapy profession in private practice, given that physical therapist assistants in private practice are subject to direct supervision. APTA encourages CMS to implement policies to allow providers to practice at the top of their licensure, including PTAs who practice in a wide range of clinical settings. We therefore ask CMS to make permanent the flexibility to allow for direct supervision through the use of real-time, audio/video technology as it applies to PTAs. Ultimately, APTA supports general supervision for PTAs in all settings, but making this flexibility permanent would significantly reduce the burden of providing therapy services in private practice.

The Role of the Physical Therapist Assistant

Physical therapist assistants are either licensed or certified in all U.S. jurisdictions. PTAs must pass the National Physical Therapy Exam to be eligible for state licensure or certification and must meet the continuing education and competency requirements in their state to maintain their licensure or certification. PTAs are governed by their state physical therapy licensure law and corresponding regulations adopted by their states' physical therapy licensure board. Appropriately, they must adhere to practice standards and work within other guardrails to ensure public protection and safe patient care, including supervision standards. The majority of state licensure laws and regulations outline additional practice standards and guidelines that PTAs must adhere to when working under the general supervision of a PT. For example, even though Medicare requires only general supervision in a skilled nursing facility when a PTA provides services, if a state practice act requires the PT to provide direct supervision, then the state practice act must be followed. Currently, 49 states call for general supervision. Only New York and the District of Columbia require on-site supervision of PTAs, and Medicare currently allows for general supervision of physical therapist assistants in all settings except for private practice, which requires direct supervision.

APTA has provided explicit guidance on the duties and abilities of a physical therapist assistant, defining a PTA as a provider who assists the physical therapist in the provision of physical therapy. The PT is directly responsible for the actions of the PTA in all practice settings, and the PTA may provide services

only under the direction and at least general supervision of the physical therapist; under general supervision the PT is not required to be on site but must be available at least by telecommunication.

The ability of the PTA to provide services is assessed on an ongoing basis by the supervising PT, whether general or direct. Services provided by the PTA must be consistent with safe and legal physical therapist practice and are predicated on the complexity and acuity of the patient's needs; proximity and accessibility to the physical therapist; supervision available in the event of emergencies or critical events; and type of setting in which the service is provided. The PTA makes modifications to elements of the intervention either to progress the patient as directed by the physical therapist or to ensure patient safety and comfort.

The degree of direction and supervision necessary for ensuring quality physical therapy services is dependent upon many factors, including the education, experience, and responsibilities of the parties involved, as well as the structure of the facility. APTA recognizes that when supervising the PTA in any offsite setting, a PT must be accessible to the PTA at least by telecommunication at all times while the PTA is providing services, and there must be regularly scheduled and documented conferences with the PTA regarding patients, the frequency of which is determined by the needs of the patient and the needs of the PTA.

Consistent with these guidelines, APTA stresses to CMS that a plan of care is never delivered solely by a PTA. The plan of care is executed by either a PT or a PT-PTA team. The PT always develops the plan of care, determines the delegation of components of the plan of care to a PTA, provides ongoing management of the plan of care, and determines the need to modify the plan of care. PTAs then carry out that plan of care through an onsite reexamination of the patient, onsite review of the plan of care with appropriate revision or termination, and evaluation of need and recommendation for utilization of outside resources.

These guidelines promote patient safety and encourage high-value medical care. **Accordingly, APTA recognizes the ability of PTAs to use general supervision to perform at the top of their licensure as is consistent with the guidelines of the profession.**

Modify Supervision Requirements of PTAs in Private Practice

It has been claimed that PTAs are not permitted to provide care under general supervision within private practices because of the stringent conditions of participation requirements that private practices are not subject to. However, these safety standards, while valid, have nothing to do with the services provided by a PTA in private practice, no relation to the quality of physical therapy services being provided, and no right to govern a therapist's ability to provide sound medical care. Within the CoP for home health agencies, a plan of care must be furnished by a physician or PT, and an adequate number of qualified personnel must be staffed to offer the necessary services. Other requirements in the CoP do not pertain to physical therapy services but instead regulate the physical environment of the facility. Similarly, in the CoP for hospitals with outpatient programs, there is only a requirement of adequate equipment, staff, and facilities to provide the services offered in accordance with acceptable standards of practice. In both CoP examples, there is no mention of supervision, training, education, or practice of a PTA beyond what is required of the profession in any setting. Accordingly, the CoPs that govern other health care settings do not alter the PTA's role in any way and should not be used as an excuse to maintain direct supervision in private practice.

Therefore, APTA recommends that CMS modify the supervision requirements for physical therapist assistants as outlined in 42 CFR 410.60(a)(3)(ii) and (c)(2) from direct to general for physical therapist assistants in private practice.

Under the Social Security Act 1861(p), CMS has the requisite authority to amend the supervision requirements of physical therapy services furnished in private practice under Medicare. With the newly implemented payment differential for physical therapy services furnished in whole or in part by physical therapist assistants, APTA has serious concerns about the future viability of the physical therapy profession and continued Medicare beneficiary access. Amending the supervision requirements to better align with state law would provide much needed relief for physical therapists and physical therapist assistants in private practice.

APTA has already gathered widespread support for legislation that permanently removes barriers to care in private practice. Passing the Stabilizing Medicare Access to Rehabilitation and Therapy Act, or SMART Act (H.R. 5536), and providing an exception for the differential in rural and underserved communities would allow for general supervision of PTAs in all outpatient settings under Medicare Part B, eliminating disparities in access to therapy services. **We ask that CMS cooperate with Congress and allow all outpatient practices to use general supervision, providing further access to high-quality providers within the profession.**

The American Physical Therapy Association, American Health Care Association, American Occupational Therapy Association, Alliance for Physical Therapy Quality and Innovation, National Association of Rehabilitation Providers and Agencies, National Association for the Support of Long-Term Care, and the Private Practice Section of the American Physical Therapy Association commissioned Dobson DaVanzo & Associates to evaluate that provision of the *SMART Act*. The results show Medicare could save between $168 and $242 million over 10 years by standardizing the supervision requirement for PTAs and OTAs. This cost savings to Medicare would also reduce the administrative burdens on physical and occupational therapists, make therapy services more accessible to millions of Americans experiencing challenges accessing health care and implement common-sense consistency with state laws and across all other Medicare settings. A detailed Dobson DaVanzo report which includes data, assumptions, and methodology can be found here.

Restraining PTAs through direct supervision requirements restricts patient access to therapy services. Henceforth, **CMS should permit general supervision for all PTAs. However, if CMS does not feel compelled to do so, the agency at a minimum should amend the regulation to allow direct supervision of physical therapist assistants to be satisfied through virtual means on a permanent basis for all PTAs, including those in private practice.**

Prevent Further Health Disparities in Rural and Underserved Areas

APTA also reiterates its request that CMS take action to ensure rural and underserved communities can maintain access to therapy services in light of the PTA differential payment policy. Beginning in 2022, section 1834(v)(1) of the Act implemented a 15% payment reduction for outpatient physical therapy services provided in whole or in part by a physical therapist assistant. (A similar 15% reduction is in place for occupational therapy services provided by an occupational therapy assistant.) Since being inserted into the Bipartisan Budget Act of 2018, the differential has become a point of confusion for providers and has essentially targeted rural and underserved areas who disproportionately rely on PTAs.

CMS must take action to halt the differential in rural and medically underserved areas. PTAs are a vital component of most outpatient physical therapy practices, serving as a cost-effective staffing solution to practice owners. If not effectively mitigated, the differential will continue to magnify health disparities in these areas. Physical therapist assistants play a crucial role in bridging gaps in access to care overall, but the payment reduction puts at risk the financial viability of physical therapy businesses in rural and underserved areas. These businesses, already operating with razor-thin margins, are dependent on PTAs to deliver services, as personnel shortages make the hiring of PTs difficult. Naturally, a payment differential, no matter what profession, will encourage management to assign patients to the providers in order to maximize revenue for the facility. Furthermore, not only are practices staffed with PTAs receiving lower payment, they are also taking on more administrative burden by adding modifiers to their billing codes, further motivating practices to question the value of PTAs even though PTAs deliver high-quality care and can have a profound impact on a patient's condition and progress. **Ultimately, the higher use of PTAs in rural and underserved communities means the differential will disproportionately challenge these communities, and patients will suffer the consequences. Absent removal by CMS, the PTA payment reduction will continue to exacerbate the growing problem of limited access to medical care in rural and underserved areas.**

To redress the harms in rural areas resulting from the payment reduction for physical therapy services furnished by PTAs, CMS could use its RVU data collection incentive payment authority to effect an indirect payment adjustment. Section 1848(c)(2)(M)(vi) of the Act gives CMS authority to make incentive payments to "eligible professionals" (including physical therapists) who "submit such solicited information [for the calculation of RVUs] under this subparagraph as [CMS] determines appropriate in order to compensate such eligible professional for such submission. Such payments shall be provided in a form and manner specified by [CMS]."

CMS could exercise this authority by soliciting information from rural physical therapists to enable the agency to better calculate RVUs. CMS then would make incentive payments for providing this information that offsets (or otherwise mitigates) the 15% PTA payment reduction for these rural physical therapists. As part of the 2019 Medicare physician fee schedule rulemaking cycle, CMS received stakeholder feedback highlighting the shortages of physical therapist assistants in rural areas, and the ways that the 15% PTA payment reduction will restrict access to care for Medicare beneficiaries because payment in rural areas will not be adequate to maintain current PTA workforce levels. Given the stakeholder feedback that CMS has received, the agency could reasonably conclude that it needs greater information about RVU inputs from physical therapists located in rural areas to determine if RVUs must be adjusted given the costs of furnishing care in these areas.

These options are gaining support in Congress but are within CMS' current authority. Ultimately, patients in these locations will be disproportionately harmed by this policy, and Medicare will bear the cost of their inability to access care. Therefore, **we urge CMS provide an exemption to the PTA payment differential in designated rural, medically underserved, and health professional shortage areas.**

Valuation of Specific Codes

Caregiver Behavior Management Training (CPT Codes 96X70 and 96X71)

CMS has determined that CPT codes 96X70 and 96X71 are not payable under the PFS. Under section 1862(a)(1)(A) of the Act, Medicare payment is generally limited to items and services that are reasonable and necessary for the diagnosis or treatment of illness or injury or that improve the functioning of a malformed body member. CMS has concluded that because the codes for caregiver behavior

management training describe services furnished exclusively to caregivers rather than to the individual Medicare beneficiary, these codes will not be covered. However, CMS is seeking comment on the ways in which a patient may benefit when a caregiver learns strategies to modify the patient's behavior and understand how caregiver training services my impact Medicare beneficiary health.

APTA appreciates that CMS is continuing to consider these codes and has posed thoughtful questions that are sensitive to ensuring equitable care for all Medicare beneficiaries. Not all persons are able to care for themselves. Informal caregivers are an essential component of the health care system in the United States. This includes both long-term and episodic care givers. Informal caregivers are often expected to quickly acquire skills that can be challenging and overwhelming. The successful acquisition of those skills may be an essential element of a patient's recovery and/or management of a patient's risk factors for adverse events and preventable decline. Although in most cases the patient is an active participant in their care and the work of caregiver training is included in the work of patient treatment, as they occur simultaneously, this is not always the case. When a patient is not an active participant in their care because of cognitive limitations, such as level of consciousness or significant system compromise, the caregiver may be the focus of skilled care by serving as an extension of the patient. The time spent by a qualified health care professional to ensure skill acquisition by the caregiver will directly impact the Medicare beneficiary's health and function.

Failure to cover services such as those under 96X70 and 96X71 will result in inequitable treatment for Medicare beneficiaries and ensure that only persons who are able enough to participate in their own care are able to receive training for their caregivers.

Chronic Pain Management and Treatment Bundles (HCPCS GYYY1, and GYYY2)

APTA commends CMS for considering the development of codes GYYY1 and GYYY2 to reflect care provided for patients with chronic pain. Although CMS refers to these codes as a bundling, APTA believes the codes represent the aggregate services provided by a single provider over the course of a month. Since bundling describes payment for the total expenditures for the continuum of a single condition or medical event, the use of the term "bundle" may lead to confusion among providers.

Although CMS indicates an understanding that people living with chronic pain have unique needs and respond to different treatment models, these codes continue to support a traditional model of physician-directed care. APTA respectfully requests that CMS consider refining the description and requirements of these codes to make the codes available to other clinicians, including physical therapists, who may function as primary coordinators of care for patients with chronic pain and who are essential providers in the interprofessional approach strongly supported by evidence for the treatment of chronic pain and chronic complexity in general.

Additionally, APTA offers that a true transformation of the care for patients with chronic pain management will require additional considerations. Chronic pain often coexists with multiple comorbidities that cannot be treated separately from the chronic pain. Many chronic health conditions have an element of pain associated with them. They are inextricably linked, and the common thread is that for people with chronic illness, their nervous, immune, endocrine, and other systems are dysregulated. Once this has happened there is often a cumulative impact of chronic illness. Pain is not a disease that can be treated separately from the state of one's nervous, immune, endocrine, and other systems. It requires interdisciplinary collaboration, not compartmentalization

Additionally, indicators of chronic pain risk are apparent as early as the initial visit, so if these codes are only available after three months, this will limit robust interventions for prevention of chronic pain. CMS might consider an alternative definition that would include pain lasting more than three months ***or*** acute pain that interferes with daily biopsychosocial function in patients with a certain number of predictive physiological, social, and psychological risk factors for developing chronic pain.

APTA also encourages CMS to consider that chronic pain management should include payment for time that interdisciplinary providers spend in consultation with each other as they try to ensure a coordinated care strategy with complex patients. This would reduce conflicting or redundant care, build trust among patients that they have a cohesive team caring for them, reassure providers that they are not alone in managing such complex cases, prevent overutilization of services as providers would not duplicate or contradict each other's care, and foster interdisciplinary learning.

As it relates to the use of a pain assessment rating scale, a single, numeric rating scale fails to capture meaningful information for individuals with chronic pain. What is most meaningful is the patient's report of their ability to manage their symptoms, understand their condition, and belief that they have been heard and are in control of their care. APTA recommends consideration of the use of outcome and quality-of-life measures for a higher degree of validity. A list of tools would be especially helpful if it were comprehensive and holistic, and not reductionistic (e.g., PROMIS 29 instead of VAS).

CMS proposes to include health literacy counseling as an element of the CPT codes. APTA recommends use of the term self-care management, which would be a broader term inclusive of health literacy counseling. APTA also proposes that self-care management is less about adherence and more about a patient being actively engaged and empowered to discuss barriers to prescribed strategies and to collaborate with providers to address the barriers or find alternative strategies. When addressing chronic pain management, success is more dependent on an empowering patient-centered strategy and should include things such as the ability to convey to providers preferences and personal goals, the ability to discuss barriers to care and self-care, and the ability to hold providers accountable for providing a treatment plan that is doable for the patient given their resources, constraints, and overall context.

Finally, APTA requests that CMS consider that these codes may be billed by more than one provider in each month, as according to best evidence there frequently should be more than one provider who is providing the extensive work of coordinating the care of a patient with chronic pain.

<u>Request for Information: Medicare Potentially Underutilized Services</u>

APTA applauds CMS for inquiring about potentially underutilized high-value services that could improve health care outcomes for Medicare enrollees and that may also, in some cases, reduce unnecessary spending within the health care system by decreasing the need for more expensive forms of care. As the population continues to age, it is imperative that CMS continually evaluate covered and noncovered services to determine what benefits are of the highest value to patients. As movement experts, physical therapists understand the value of their services across a range of settings for many different patient populations. The following comments describe the role of PTs across the lifespan, laying out underutilized services that PTs and PTAs provide that are valuable to Medicare enrollees. This list of services and conditions is by no means exhaustive, but it should illustrate the broad range of ways physical therapy can positively impact not only patient health but also Medicare's bottom line.

Because the overarching goal of physical therapy is to enhance the capacity of individuals to do what is important to them in their daily lives, it can be effective for almost any condition or patient. However, in

most clinical settings, PTs require referrals or some form of oversight from other practitioners; this referral process limits physical therapy to a secondary point of care and creates barriers to the high-value services that PTs offer. Medicare, while not requiring a referral, imposes a burdensome prerequisite that requires the PT to obtain a physician's signature on their plan of care in order to be paid for services. CMS must consider the detrimental impact that substantial hurdles to physical therapy services have within underserved populations. Likewise, APTA understands that to effectively remove these barriers, CMS needs to be aware of the breadth and value of services that PTs provide. Of the services CMS expressly mentions in the RFI, the following can be provided by PTs: preventive services, diabetes screening and management, education and referral services, cardiac rehabilitation, opioid treatment and prevention, chronic care management, and cognitive assessment and care. In addition, physical therapists and physical therapist assistants provide lesser-known rehabilitation services and nonsurgical forms of treatment covered by Medicare but infrequently utilized by specific populations or types of patient. Below APTA has detailed an evidence-based review of these services and why they are of high value to Medicare enrollees.

Preventive Services

Physical therapists have the education, experience, and expertise necessary to provide a broad health screening that assesses the patient's health status and identifies health risks within communities over time. Benefits of routine physical therapy visits include optimized movement and better health; slower progression of impairments of bodily functions and structures; fewer activity limitations; and an overall higher level of physical fitness. Regular examinations also promote overall population health by preventing injury and disease before they occur and educating patients on how to reach their physical goals and obtain a lifestyle they desire.

Regular visits with a PT can also improve a patient's behavioral health. We know that physical, behavioral, and mental health are interconnected, so it should come as no surprise that exercise prescribed by a physical therapist demonstrates numerous health benefits for Medicare enrollees, including improved sleep; stress relief; improved mood; increased energy; reduced tiredness; an overall reduction in anxiety, depression, negative mood, and social isolation; improved cognitive function; and higher quality of life. And, since many Medicare enrollees who have mental illness frequently report co-occurring physical conditions that worsen both their mental and physical health outcomes, PTs could alleviate physical conditions that would improve both mental and physical health.

If an annual physical therapy evaluation was encouraged as routine, high-value care, beneficiaries would have greater access to general medical services that strengthen both their physical and mental well-being.

As people age, they often experience decreases in strength, a loss of flexibility and endurance, and changes in vision, putting them at a higher risk for falls and fall-related injuries. These limitations of mobility make falls the leading cause of injury and injury-related deaths for those 65 and older. Nationwide, this results in 3 million emergency department visits and 800,000 hospitalizations annually. Total medical costs for falls in 2015 amounted to more than $50 billion, with Medicare footing 75% of the bill.

Falls not only prevent older adults from living autonomously by causing their health to deteriorate, they also represent a high-cost health problem that has a simple, low-cost solution. Physical therapists can reduce an individual's risk of injury by implementing evidence-based intervention programs that increase strength and balance.

Acknowledging that falls are caused by a combination of risk factors, many of which are preventable, PTs provide clinical interventions such as exercise, balance, strength, and gait training to reduce potential risk and improve patient mobility. The U.S. Preventive Services Task Force highly recommends exercise and physical therapy interventions to prevent falls. PTs also implement home-based modifications that reduce environmental hazards and work within communities to implement multimodal community-based falls prevention programs that target community-wide fall risks. Lastly, PTs can also screen and assess patients for previous falls and future risk factors. Using these intervention techniques, PTs reduce the risk of injuries and lower the rate of fall-related deaths.

The following are examples of falls-reducing interventions PTs provide:

- Multimodal community-based fall prevention programs:
    - Otageo Exercise Programs: evidence-based falls prevention program that reduces falls and falls-related injuries in the community-dwelling elderly.
    - Matter of Balance: one of the top three falls risk programs; an evidence-based program the reduces fear of falling and increases physical activity levels.
    - Tai Ji Quan: a multi-week program focusing on gentle movements to target balance, strength, and stability.
    - Stepping On: workshops focusing on increasing older adult self-efficacy.
    - Move with Balance: physical and mental exercise program that promotes the improvement of balance and the prevention of falls.
- Screenings and complete assessments that inquire about previous falls and risk factors for future falls.

Based on a peer-reviewed literature review, seven specific falls interventions delivered by U.S. providers, such as PTs, could avoid what would be between 9,563 to 45,164 medically treated falls, thereby averting $94 million to $442 million in Medicare costs. While this study used a number of interventions to prevent falls risk factors, treating mobility problems and improving poor balance alone demonstrated cost savings of $228 million and $135 million respectively. Both of these interventions are administered by a physical therapist using multimodal intervention programs, ultimately contributing to the direct savings of Medicare dollars.

As falls prevention is a top public health priority, CMS must examine the role of PTs in preventive services and programs, making it easier for underserved populations to access their services. CMS can increase access to physical therapy for beneficiaries at risk of falls by requiring functional ability and a falls screen during every annual wellness visit for individuals covered under Medicare. CMS can also encourage beneficiaries to seek out a physical therapist evaluation annually to ensure patients at risk are receiving care and not being identified only after a fall occurs. Relief from plan of care certification requirements, described in detail below, especially for evaluations with no subsequent treatment, would encourage more physical therapists to engage in and advertise these services to reach the maximum number of beneficiaries.

Chronic Disease Management

Physical therapists and physical therapist assistants have the knowledge, skill, and ability to guide people toward optimal health and well-being by supporting and facilitating behavior change for enhanced quality of life. PTs serve as movement experts who teach people how to safely incorporate physical activity into their lifestyles by providing detailed plans of care that are tailored to each individual. Using these modifiable plans, PTs can prevent, treat, and manage chronic diseases.

Physical therapists encourage patients to take control of their cardiovascular health by developing a plan of care that supplements or replaces medication for other activities that help patients lose weight, increase physical activity, and improve levels of healthy eating. These nonpharmacological interventions are proven to reduce rates of hypertension, improve overall patient health, and delay or reduce the need for medication in early stages of hypertension. Knowing that physical activity has numerous benefits for adults who are at-risk for heart disease, PTs use monitored exercise regimes to improve a patient's exercise tolerance, endurance, and quality of life. To reduce the rate of injuries from performing exercises incorrectly, PTs meticulously monitor patients to make sure they increase their tolerance safely and are using exercises that are best for their situation. While physical activity and other nonpharmacological interventions are proven effective, a blend of both pharmacological and nonpharmacological treatments is recommended for higher-risk patients. This gives PTs the opportunity to work collaboratively on a primary care team to develop the correct combination of exercise and medicine that treats the patient's condition.

PTs can also play a vital role in the prevention and treatment of diabetes by screening patients for prediabetes and showing them how to safely add physical activity to their lives in effective and enjoyable ways. For older diabetics who commonly report issues with balance, PTs provide exercises that improve their stability, guarding them against injuries from falls or overexertion in daily activities. And, by managing diabetes, PTs also treat co-occurring diseases such as peripheral neuropathy, a disease that leads to weakness, numbness, and pain from nerve damage in patients with diabetes.

Even with all of the therapeutic benefits PTs provide, only 2% of referrals to outpatient PTs in the U.S. noted diabetes as the primary health condition being treated. While many patients seen in outpatient physical therapy have diabetes or are at risk for it, these patients are referred to PTs for other disease limitations. This demonstrates the failure of providers to see diabetes as an underlying contributor to a multitude of conditions that PTs examine and treat. **CMS should see PTs as part of the diabetes management team by integrating their services into the Medicare Diabetes Prevention Program to ensure that patient populations are receiving maximum health benefits for the most high-value, low-cost care.**

For Medicare enrollees, managing cognitive decline is crucial to providing a high quality of life. Accordingly, PTs encourage lifestyle changes and implement exercise interventions that can prevent or slow the progression of neuromuscular and neurodegenerative disorders such as Parkinson disease, multiple sclerosis, and Alzheimer's disease.

Clinical evidence supports a PT's ability to ease the risk factors of neurological diseases and reduce disability progression through exercise. Even before a patient is diagnosed, common clinical tests allow PTs to identify functional markers of disease, and detect diseases and disorders in their earlier stages before providing treatment. After diagnosis, therapeutic exercise — the most common course of physical therapy for patients with neuromuscular diseases — can reduce cognitive decline, serving as a therapeutic approach for people who demonstrate early cognitive impairment. Physical therapists also work directly with patients and their caregivers to keep patients mobile and adept in their daily routines. Specifically, exercise programs and instructions in ADL provided by PTs give autonomy to patients with neuromuscular disorders and lead to a decreased utilization of health care services.

Physical therapists also play a vital role in controlling lymphedema, the swelling of ligaments due to disruptions in flow throughout the lymphatic system after a lymph node removal. PTs treat lymphedema by reducing swelling using compression-based physical therapy, and results have been promising. In lower limb lymphedema for women who had gynecological cancer treatments, compression therapy demonstrated improvements in lower limb circumference. Similarly, after breast cancer surgery leading to

upper extremity lymphedema, women reported 14-day improvements in quality of life, as well as the anxiety and depression brought on by lymphedema after complex decongestive therapy and compression treatments.

In total, PTs reduce downstream health care costs using innovative therapeutic techniques that reduce rates of chronic disease and help patients manage their symptoms effectively.

Education and Referral Services

Education and prehabilitation from a physical therapist before surgery can reduce costs and improve outcomes. Research has indicated that preoperative education is effective at improving long-term function, increasing range of motion, and decreasing pain post-surgery. A randomized controlled trial compared patients who did and did not have preop education before a surgery to relieve low back pain; those that received education viewed their surgical experience more favorably and used fewer health care services postop. In another study examining the impact of preoperative physical therapy on patients undergoing elective cardiac surgery, therapeutic exercises correlated with reduced postoperative complications and shortened lengths of stay. For consumers in need of surgical interventions, education and manual physical therapy before a necessary surgery can increase functional capacity, decrease recovery time, and lead to overall better outcomes.

Nonsurgical Treatment

While surgical interventions are necessary for many patients, some patients arrive with nonurgent clinical presentations that can be resolved with noninvasive treatment options. CMS should examine the rate of unnecessary surgeries it provides and seek to disincentivize treatment options that are not indicated based on the patient's presentation. Using Medicare claims data, BMJ investigated the top eight unnecessary surgeries that were performed during the COVID-19 pandemic. In total, 106,474 low-value surgeries were completed from March to December 2020. Ultimately, these surgeries provided little value to the patient and cost CMS hundreds of millions of dollars in medical care. Specific procedures during the height of the pandemic that could have been avoided or delayed using physical therapy include 13,541 spinal fusions for back pain and 1,596 knee arthroscopies; PTs are trained to provide care that reduces complications from these surgeries or prevents their need altogether. To combat poor health outcomes and downstream costs, CMS must incentivize noninvasive alternatives to surgery that are often overlooked for a quicker, high-risk procedure.

If PTs are able to educate patients about nonsurgical interventions and then provide that conservative care to a degree where patients begin to see results, they could prevent unnecessary surgeries leading to less complications and reduced downstream costs. Likewise, if physical therapy services were more commonly understood by patients and providers, medically appropriate patients could avoid unnecessary, high-risk surgeries in lieu of more affordable therapeutic options.

If equally effective, low-risk care is available, CMS should reduce the harm of overtreatment and increased hospitalization by encouraging providers to refer surgical patients to physical therapy before surgical intervention. Likewise, as PTs develop new strategies to help patients understand and manage their surgical recovery, CMS must be willing to approve payment for and create policies around these new modes of care.

Nonpharmacological Pain Management

Chronic pain affects over 50 million individuals annually and costs the health care system an estimated $560 million each year in medical costs, lost productivity, and disability programs. If CMS were to introduce low-cost pain management techniques, PTs could effectively target and mitigate the root cause of the pain, which would prevent further unwarranted use of high-cost health care services.

On a daily basis, PTs are helping individuals restore health and alleviate pain using prevention, promotion, and wellness practices to treat and manage chronic pain. PTs design individualized treatment plans that combine the most current techniques to control a patient's pain. Examples of pain management techniques that PTs use to treat acute and chronic pain include: therapeutic exercises that maintain motion gains achieved by manual therapy and strengthen and coordinate muscle function to enhance and complete the rehabilitative process; manual therapy, such as mobilization, manipulation, dry needling, and massage, that restores normal mobility to body parts that have been injured; stress management that can help patients reduce pain and improve their functional capacities; sleep management that increases appropriate sleep techniques to help combat the vicious cycle of persistent pain; and pain neuroscience education that highlights the processes involved in pain, which empowers patients in their journey to overcome pain using nonpharmacological courses of treatment.

While physical therapy is already acknowledged as the foundation of chronic back and musculoskeletal pain treatment, PTs are effective at alleviating all kinds of pain, including autoimmune diseases such as arthritis and Crone's disease, connective tissue disorders such as Ehlers-Danlos syndrome, and lupus. These techniques serve as alternatives to pharmacological medications that mask a full recovery and often lead to far worse health care outcomes than what the patient initially presented with.

Prevention of Opioid Misuse

The nationwide opioid crisis showcases the need for healthy pain management in the United States. In the past 20 years, opioid misuse, particularly synthetic opioids, has led to nearly 500,000 deaths, with the annual overdose death rate in 2019 quadruple the rate it was in 1999, even with a downturn in opioid prescribing. For years, our country has chosen to control pain using pharmacological methods, rather than treating the actual causes of pain. Since the alarming growth of opioid use over the past decade, prescribing practitioners now know that opioids do not have a lasting effect on pain, they only provide brief, early relief. As a country, we need to reexamine how we treat pain and how we can align our practices with the goals and needs of the patient population we are working with. APTA has published and continues to update a white paper that addresses the opioid epidemic and the impact it has had on patients across the nation. It also reaffirms that physical therapists are an essential component of the multidisciplinary team that will be required to improve patient outcomes and alter the trajectory of this public health crisis.

Evidence has demonstrated that nonpharmacological options are safer, more effective, and longer lasting than opioids. Researchers have examined claims data to assess whether there is a link between early physical therapy and decreases in long-term opioid use. The results suggest that early physical therapy is associated with an approximate 10% reduction in the probability of any long-term opioid use for patients with shoulder, neck, knee, and low back pain. Correspondingly, initial visits with physical therapists associated with substantially decreased early and long-term use of opioids; therefore, CMS should incentivize the early use of PTs in the pain management process to reduce medical costs and opioid addiction.

In particular, managing chronic pain in older adults is complex because of psychological change, the presence of other comorbidities, increases in pain thresholds, decreases in pain tolerance, and the numerous side effects of pharmacological treatment. There are special considerations to know and common pain presentations to understand within this population that informs how treatment is administered. The 2019 Pain Management Best Practice Inter-Agency Task Force recommends: "… a multidisciplinary approach with nonpharmacologic emphasis, given the increased risk of medication side effects in this population." While pain medication should not be completely removed from the older population, it should instead be used alongside other modalities such as physical therapy.

Accordingly, CMS must continue to address access barriers to physical therapy services for treatment of acute or chronic pain. In addition to rural populations, uninsured and under-insured individuals of low socioeconomic status have particularly limited access to multimodal treatment. **It is critical that future policy reforms result in fewer obstacles — in terms of copays, referral requirements, and insufficient coverage — to nonpharmacological pain interventions for acute and chronic pain.**

Pelvic Floor Dysfunction

Physical therapists work with both men and women to diagnosis and treat abnormal function of the pelvic floor. Conditions that can cause dysfunction include urinary incontinence, pelvic organ prolapse, sexual dysfunction, and chronic pelvic pain. To treat pelvic floor dysfunction, PTs will use exercises (such as Pilates), EMG biofeedback, pelvic muscle electric stimulation, and electrical stimulation, all of which help patients better control their bladder and stop unwarranted contractions of the muscles. These treatment strategies increase patient knowledge of bladder re-training techniques, decrease postural asymmetries, reduce pain, normalize tone, increase strength, reduce myofascial restrictions, and improve neuromuscular coordination.

One of the goals of pelvic floor rehabilitation is improved continence. Common in older adults, urinary incontinence is an important health problem that inhibits a patient's daily activities by impairing their quality of life and reducing their independence. Studies have shown the benefits of physical therapy in the prevention of worsening of symptoms of urinary incontinence, using electrostimulation to increase muscle strength and reduce urine leakage. Routine pelvic floor rehabilitation as a treatment for urinary incontinence allows Medicare enrollees to have full control of bladder, leading to decreased pain with daily activities such as sitting, walking, prolonged standing, and sexual function.

For men, pelvic floor rehabilitation is much more taboo, and men often are misdiagnosed and are unable to get the care they need because there is a lack of education and awareness around the topic. Similarly, even when men are correctly diagnosed, there are little to no accessible providers who are able to treat men. To stop the undertreatment of chronic pelvic floor pain and dysfunction, CMS needs to consider pelvic floor rehabilitation as a high-value, low-cost service with numerous benefits to Medicare enrollees, both women and men.

Respiratory Conditions

Physical therapists play a crucial role in the multidisciplinary rehabilitation of individuals with impaired physical, cardiovascular, and respiratory function, as well as fatigue. As more patients experience what is commonly referred to as "long COVID" or still have these and other symptoms after recovering from an initial COVID-19 infection, there is an increasing need for physical therapy treatment of these individuals. Post-COVID-19 conditions or long COVID can start as early as four weeks after the initial infection. In these instances, a wide range of symptoms include fatigue, post-exertional malaise, fever, difficulty

breathing, cough, chest pain, fast-beating heart, difficulty thinking, headache, sleep problems, dizziness, changes in smell and taste, depression, gastrointestinal pains, and joint and muscle pains. PTs can relieve shortness of breath, halt psychological distress, and improve physical function and quality of life following COVID-19. PTs are also uniquely placed to monitor COVID-19 patients and diagnose post-COVID-19 syndrome if symptoms continue for at least 12 weeks.

Using respiratory rehabilitation, PTs increase respiratory endurance to improve respiratory symptoms, preserve function, and reduce complications and disability in patients suffering from long COVID. Specifically for those experiencing post-exertion symptom exacerbation, physical therapists can complete exercise tolerance screening and testing, activity response monitoring, and future activity modifications to improve quality of life. Similarly, for patients experiencing cardiac complications after a COVID-19 diagnosis, PTs use exercise training to monitor and improve their symptoms, capacity, and function. For those experiencing persistent shortness of breath after hospitalization due to COVID-19, PTs use cardiopulmonary rehabilitation to recondition muscles and retrain breathing. Ultimately, rehabilitation is crucial in helping post-COVID-19 patients recover from fatigue and improve their physical function in activities of daily living. For long COVID patients, it is essential that rehabilitation is part of the multidisciplinary services used to effectively assess and rehabilitate them.

Dry Needling

Dry needling is a minimally discomforting technique performed by trained physical therapist. It is a distinctive and clinically effective skilled intervention that uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, and muscular and connective tissues for management of neuromusculoskeletal pain and movement impairments. It is used to treat dysfunctions in skeletal muscle, fascia, and connective tissue; diminish persistent peripheral nociceptive input; and reduce or restore impairments of body structure and function, leading to improved activity and participation.

Dry needling has been highly studied as an appropriate course of treatment for muscle and tissue dysfunction, postsurgical pain, and bodily impairments. Moreover, dry needling is not a type of acupuncture; it is an intervention separate and apart from acupuncture.

Medicare provides limited coverage of dry needling codes (20560 and 20561). These codes now have an “A” indicator, indicating active status, but only within the context of the National Coverage Determination for Acupuncture for Chronic Low Back Pain. Unfortunately, this NCD arbitrarily limits coverage to patients with low back pain and allows only acupuncturists to provide the service. We urge CMS to increase access to this valuable service by allowing physical therapists, where allowed by state law, to perform and bill for dry needling services.

Barriers to Care

Most patients suffering from conditions described above are not accessing physical therapy for the simple reason that they are not aware it is an effective option. CMS could increase access to these services by improving both patient and provider awareness. Most patients rely on their physician to determine when physical therapy is appropriate, even though Medicare regulations do not require a referral. Increasing physician understanding of these services would therefore increase patient access and awareness.

CMS could also take steps to reduce administrative burden around performing these services, thereby incentivizing physical therapists to offer them. Currently, CMS does not require a referral or order for a Medicare patient to see a physical therapist. However, CMS does require a physician sign the patient’s plan of care in order for the physical therapist to be paid for the services.

A physician's signature on the plan of care is not required by statute. In fact, the statute indicates that the "plan for furnishing such services has been established by a physician or by the qualified physical therapist or qualified occupational therapist, respectively, providing such services and is periodically reviewed by a physician." 42 U.S.C. 1395n (a)(C).

APTA does not take issue with the requirement to collaborate with physicians. We support interdisciplinary care and welcome the input of primary care providers on physical therapy plans of care. However, the specific requirement of obtaining a signature does more damage than good and is preventing patients from accessing necessary services. Although a signature on a plan of care may seem like a small burden, physicians — primary care providers especially — are already overwhelmed with paperwork. Our members have reported spending months trying to obtain signatures from physicians' offices, contacting them via phone, email, and fax more than 30 times, just to obtain one signature. Failure to obtain the signature means the physical therapist will not be paid for any services they deliver. So while CMS allows treatment to begin before the signature is obtained, physical therapists are doing so at their own risk, knowing that whether or not the physician's office sends back the signed plan of care will determine if they will be paid. Accordingly, care is frequently delayed while awaiting a physician signature — often after multiple requests — placing the beneficiary's health at risk due to the delay.

Payment for physical therapy services should be determined by the medical necessity of the service and whether the physical therapist has completed their statutory and regulatory requirements. Physical therapists have no control over whether a physician will or will not sign a document and it should therefore not be a factor in payment.

APTA has held meetings with CMS suggesting ways this administrative burden can be relieved without sacrificing the physician's role in physical therapy. For instance, when the patient has an order or referral on file, the statutory requirement that the patient be under the care of a physician is not only satisfied but also documented. CMS should in these situations require only that the physical therapist deliver the plan of care to the physician and remove the requirement that a signature be returned. APTA would even be supportive of CMS requiring proof the plan was delivered, such as via a fax receipt or other confirmation of delivery. This way, physicians have the opportunity to provide input on the plan of care, but physical therapists won't be penalized if they are unable to sign and return it. Physical therapists are already permitted to begin treatment before obtaining the signature, so timing is not of a concern in this situation. Further, because these patients have an order or referral on file, any specific instructions the physician needs to communicate will have already been delivered. Similarly, if a patient has an order or referral, or if the original plan of care has been signed, then the same requirements should apply to recertification of the plan of care.

APTA had asked CMS to include a request for comments on this proposal in this years' fee schedule proposed rule, and we are disappointed it was not included. However, this type of simple regulatory change can significantly increase access to the services described above and ultimately save Medicare from spending more in the long run. Multiple studies, cited above, show that delay in access to physical therapy is directly correlated to poorer outcomes and increased need for services. Allowing PTs to treat patients immediately without risking their payment would benefit Medicare patients and Medicare as a whole.

We also encourage CMS to allow screenings and evaluations to be performed and reimbursed without requiring a physician signature. Currently, when an evaluation is performed and the PT does not believe the patient needs further skilled therapy, the PT still must get the evaluation signed by the physician to be reimbursed (Medicare Benefit Policy Manual Chapter 15 Section 220.3 C). There is no statutory basis for

this requirement. Physical therapists often screen patients and recommend home exercise, community services, and other lifestyle changes without developing a plan of care and continuing treatment. However, PTs seldom offer these types of services to Medicare beneficiaries due to the immense administrative burden relative to the payment for a single evaluation. Removing these requirements for evaluations without treatment would allow Medicare beneficiaries to benefit from screenings. Patients with acute needs or high risk could receive necessary care to prevent expensive events such as falls, while lower-acuity patients can be given one-time advice that could ultimately prevent the need for Medicare to cover myriad future services.

By alleviating barriers to low-cost, high-value care, the Medicare program could improve the overall health of enrollees, avoid harmful or wasteful practices, and reach disproportionately underserved communities. APTA looks forward to working with CMS to operationalize policies and programs that achieve these goals.

Non-Face-to-Face/Remote Therapeutic Monitoring Services

Practice Expense

APTA appreciates that CMS continues to work to improve and refine the remote therapeutic monitoring codes. These services can have a profound impact on patient well-being, outcomes, and ultimately the total cost of care. In the proposed rule, CMS expressed concern about the inclusion of clinical labor in codes that could be billed by qualified nonphysician health care professionals, because Medicare Part B does not include a benefit for services furnished ‘‘incident to’’ the services of some types of qualified nonphysician health care professionals, including physical therapists.

APTA seeks clarification related to CMS’ determination of the direct practice expense inputs for CPT codes 98980 and 98981 as “incident to” services. The clinical staff time identified for these CPT codes includes “communications with the patient” and “perform procedure/service not related to physician work time.” These activities are included in the practice expense of codes frequently billed by physical therapists and are performed by physical therapist assistants as part of the direct practice expense. Although physical therapist assistants would not update and modify a care plan, physical therapist assistants do assist the physical therapist in communications with the patient and gathering and reviewing the data. Accordingly, removal of these inputs is not only unnecessary but also inappropriate, as this type of labor still must be performed in order to complete the services described by these codes.

Should CMS maintain the position that the services described fall under the definition of “incident to,” APTA urges CMS to reconsider deletion of all PE inputs for HCPCS codes GRTM2 and GRTM3. Whether performed by a physician or by a physical therapist, the service is the same and the practice expense resources required to perform the service do not change. The fact that these tasks are completed by a PTA rather than an RN/LPN/MTA does not negate the need for the tasks to be performed as part of the delivery of the service. Eliminating the practice expense from GRTM2 and GRTM3 would have a significantly negative impact on the ability of physical therapists to perform this service. **Accordingly, APTA recommends that CMS include all practice expense inputs of 98980 and 98981 in GRTM3 and GRTM4 given that the same resources are required to perform the services whether performed by a physician or a qualified health care professional even if the resources are delivered by other clinical staff or the QHP themselves.**

Billing Requirements

APTA also requests that CMS remove the requirement that CPT codes 98975 and 98976 or 98977 be billed before billing GRTM3 or GRTM4. The requirement for billing these codes creates a scenario where a provider may meet all of the requirements for billing remote therapeutic monitoring treatment assessment services but are prohibited from doing so because the criteria for billing 98975 and 98976 or 98977 cannot yet be met.

RTM rules allow the education codes to be billed once per episode of care and device codes to be billed once during a 30-day period, while the treatment management services codes are billed on a calendar month basis. Should a patient whose plan of care includes remote therapeutic monitoring begin care in the latter half of the month, the services provided would not be eligible for billing even when the RTM treatment assessment services requirements are met, simply because 16 days of data would be impossible to achieve before the end of the calendar month. Currently, billing 98980 and 98981 is appropriately allowed even if 98975 and 98976 or 98977 have not yet been billed.

It is important to note that the effective use of remote therapeutic monitoring treatment assessment in physical therapy is often achieved prior to the transmission of 16 days of data. RTM is different from remote patient monitoring given that the nature of RPM often means a patient will be monitored for the long-term management of chronic disease. In the case of RTM, especially when provided by physical therapists, the monitoring is expected to enable a patient to achieves self-management and not as a long-term provider management strategy. We find the 16-day requirement to be arbitrary and a barrier to effective, efficient care.

Accordingly, we ask CMS to delete the provisions requiring CPT codes 98975 and 98976 or 98977 to be billed prior to reporting GRTM 1, GRTM 2, GRTM 3, and GRTM 4, and that at least 16 days of data must be reported.

Finally, we request CMS exempt RTM services from counting toward therapy thresholds. Many providers are still analyzing whether or not to offer these services and the risk of increased scrutiny associated with therapy thresholds may dissuade some providers from adopting them. Additionally, due to the nature of billing requirements, wherein a provider must accumulate 16 days of data before billing, it may not be possible to know when a patient has cross the therapy threshold. This is especially true for SLPs and PTs who are counted together toward the threshold, yet an SLP and/or PT may have little information on the exact types of services the other is providing. Accordingly, in order to ensure these services are utilized and are not disrupting the billing processes of other providers, we encourage CMS to exempt them from counting towards therapy thresholds.

Payment for Skin Substitutes

APTA has several concerns with the 2023 proposals addressing new nomenclature, coding, and payment for items currently known as “skin substitute products” and “cellular, synthetic and/or tissue-based products”, which CMS is proposing to redefine as “wound care management” or “wound care management products”, based loosely on the FDA category of the same name. In its companion coding and payment proposals, all WCM products would receive A code assignment, including products for which a HCPCS Level II code is requested for the first time, as well as wound care management products to which were previously assigned a Q code. Additionally, CMS would require that these products would need to submit additional information to CMS within 12 months of effective date (existing Q codes with FDA Sec. 361 HCT/P designations), and would require a recommendation letter from the FDA’s Tissue Reference Group to be submitted as part of the HCPCS Level II application for all wound care

management products described by the applicant as a Sec. 361 HCT/P. CMS plans to reevaluate the applications for all Sec. 361 HCT/P wound care management products through biannual coding cycles for non-drugs and non-biological products, rather than on a quarterly basis, beginning January 1, 2024.

Physical therapists apply therapeutic methods and techniques to enhance wound perfusion and establish optimal environments for wound healing. They have significant expertise in wound care, and are necessary members in clinical wound care treatment and rehabilitation for patients across settings. For this reason, these broad changes to payment for WCM have significant direct and downstream impacts on PTs treating wounds, compounding the access and payment issues for wound patients, described more generally elsewhere in this comment letter. As a member of the Alliance of Wound Care Stakeholders, APTA supports the more detailed and specific comments on these proposals in the Alliance's separate comment letter. **However, given the unknown and potentially significant impact of these sweeping proposals on both patients and providers, APTA independently urges CMS to delay finalizing the proposals related to WCM products. Doing so would enable the Agency to meaningfully engage key wound care stakeholders, provide additional explanation of CMS' proposed changes, and develop a more precise understanding of the impact of these changes on beneficiary access.**

Rebasing and Revising the Medicare Economic Index

In the proposed rule, CMS considers rebasing and revising the Medicare Economic Index based on a methodology that uses publicly available data sources for input costs that represent all types of physician practice ownership. The agency also considers moving the base year from 2006 to 2017. The most considerable impact of this proposal is that the relative weight of each RVU component will shift, with practice expense becoming the largest component, at 51.3%, whereas physician work now is the largest, at 50.9%.

The shifting of RVU component weight has significant implications for payment under the PFS. Table 148 illustrates that some specialties will see as much as a 16% increase in payment while others will see a 12% cut. APTA has in this letter previously expressed the frustration of our members in PFS payment and is concerned that this proposal will only further destabilize providers who rely on Medicare payments. It would appear that this policy will go into effect just as the PFS should be regaining some predictability after the turbulence caused by the E/M code policy.

With regard to physical therapy specifically, CMS predicts a positive 2% adjustment to payment as a result of this policy. However, given that the key impact of the policy is to increase the relative weight of practice expense, we question whether CMS has taken into account the impacts of multiple procedure payment reduction when calculating its impact. MPPR reduces the value of practice expense by 50% for codes deemed "always therapy" when multiple codes are billed on the same day. The policy is intended to account for the fact that certain practice expenses should only be incurred once per visit, not per billable code. This reduction is applied to every code billed on a given day after the primary code regardless of the discipline of therapy being provided (PT/OT/SLP) or the diagnosis. APTA estimates that MPPR reduces payment approximately 15% per visit.

Further, and most important, the authors of this policy failed to appreciate that during the valuation process of these codes the RUC already divides the practice expense clinical staff time to account for any duplication that might occur. In fact, in valuing therapy codes the RUC assumes that two or three codes will be billed during the same encounter and reduces the values of the codes to reflect that. For example, although the standard allocation for the task described as "clean room/equipment by clinical staff" is three minutes for CPT codes, the allocation for therapy procedure and modality codes is one minute. As

another example, although the allocation of time for the direct practice expense task described as "prepare room/equipment by clinical staff" is two minutes for CPT codes, it is one minute for therapy procedure and modality codes. These examples demonstrate that the RUC considers the provision of multiple units and/or procedures when valuing "always therapy" codes and the subsequent reduction under MPPR results in a duplicate reduction and consequent underpayment for these codes.

Despite the fact that the actual value of the codes is already reduced by the RUC to account for the nature of therapy billing as a multiple unit per visit, Medicare cuts the codes again for the same reason. To illustrate how damaging this policy is, APTA has created three typical visit scenarios to demonstrate the policy and its impact:

Visit	Payment With MPPR	Accurate Payment	Difference
Typical Visit 1	$ 109.70	$ 130.81	16%
Typical Visit 2	$ 87.90	$103.13	15%
Typical Visit 3	$ 75.10	$ 87.90	15%

Typical Visit 1: 1 unit of 97110; 1 unit of 97140; 1 unit of 971530; 1 unit of 97112.
Typical Visit 2: 1 unit of 97110; 1 unit 0f 97530; 1unit of 97112.
Typical Visit 3: 2 units of 97110; 1 unit of 97140.

This chart, based on 2022 RVUs and conversion factor, demonstrates that MPPRs significantly reduce payment for codes already accurately valued. Should CMS move forward with the MEI update, the practice expense portion of therapy codes will increase, meaning more of the code is subject to MPPR. This means CMS' estimate of a 2% increase may be inaccurate, causing qualified health care providers who bill "always therapy" codes to be disproportionately impacted by underpayment of their services.

APTA appreciates that CMS cannot rescind MPPR nor adjust the amount of the reduction due to statute. However, CMS must take this policy into account when implementing its MEI updates. APTA appreciates that CMS' goal in the MEI update is to create a more accurate payment system based on available data, but CMS must take into account disruptive and inequitable policies such as MPPR that inaccurately devalue the payments of certain specialties.

APTA therefore requests that CMS confirm that MPPR was accounted for in Table 148 and its estimated impact using rebased and revised MEI cost share weights. APTA can neither support nor oppose this policy without this information.

Updates to the Quality Payment Program

MIPS Promoting Interoperability Performance Category

The Promoting Interoperability Program and the QPP require the use of certified electronic health records technology as defined at 42 CFR 495.4 and 414.1305, respectively. Since 2019, this has generally consisted of EHR technology certified under the Office of the National Coordinator for Health Information Technology Health IT Certification Program that meets the 2015 Edition Base EHR definition (as defined at 45 CFR 170.102) and has been certified to certain other 2015 Edition health IT certification criteria as specified in the definition.

Since PTs' initial inclusion in the MIPS program, CMS has assigned them a weight of zero in the Promoting Interoperability performance category in the MIPS final score. This is largely because physical therapists were not eligible to participate in the Medicare or Medicaid Promoting Interoperability Program, and there are not sufficient measures applicable and available to them in that performance category.

However, in this year's PFS CMS proposes to continue the existing policy of reweighting the Promoting Interoperability performance category for physical therapists only for the CY 2023 performance period/2025 MIPS payment year, not extending it beyond that. CMS states as its reason that it wants to encourage MIPS-eligible clinicians to adopt and use certified electronic health record technology, which would contribute to increased interoperability and data exchange nationwide.

APTA is concerned that CMS' will require physical therapists to report on the Promoting Interoperability category in 2024. As CMS is aware, physicians and hospitals were afforded through the former Meaningful Use incentive program (now the Promoting Interoperability category in MIPS)funding and staged adoption of EHRs to enable them to learn how to successfully exchange patient information using CEHRT. Physical therapists in private practice, other nonphysician health care professionals, and long-term and post-acute care facilities were ineligible to participate in the Meaningful Use and have received little to no direction, time, or resources to adopt and implement comprehensive, interoperable EHR systems that promote care coordination and improve patient outcomes.

Moreover, while large provider groups and health systems may be on a compatible EHR system, most independent practices use EHRs that are not standardized, making it that much more imperative that these providers, and their specific needs, are front and center in health IT discussions. To ensure the future health care system is one that is patient-centric and dedicated to improving care quality and increasing patients' access to their information, all relevant parties across the continuum need and deserve financial and administrative support to help them implement CEHRT and adopt measures that give patients the ability to manage their health information. It is vitally important that patient information flow between various sectors of the care continuum, including physicians, hospitals, physical therapists in private practice, post-acute care and long-term care providers, and other health care providers.

The Office of National Coordinator for Health Information Technology certification process has established standards and other criteria for structured data that EHRs must use. However, CEHRT requirements are designed for prescribing professionals and do not capture tasks performed by nonphysician professionals using different types of EHRs. Consequently, the vast majority of EHR technology developed for use by physical therapists and other nonphysician providers cannot fully satisfy the technology requirements outlined in 42 CFR 414.1305, therefore hindering these providers' capability to participate in the Promoting Interoperability category of MIPS, in MVPs, or in Advanced Alternative Payment Models.

As is a common theme throughout our previous comments submitted to the agency, modifying and building upon the existing technological structure to satisfy future CEHRT requirements requires significant financial investment, is time-consuming, and is disruptive to workflow. To better leverage health IT functionality, as well as to incentivize physical therapist and other nonphysician provider participation in the QPP and other value-based models in the future, it is critical that CMS recognize that much of the updated 2015 Edition certification criteria may not apply to physical therapist practice, including:

CEHRT Category	CEHRT Criteria
Clinical Processes	Computerized provider order entry (CPOE) medications (prescribing) CPOE laboratory Drug-drug, drug allergy interaction checks for CPOE Drug-formulary and preferred drug list checks (CPOE) Implantable device list
Care Coordination	Electronic prescribing* (for medications)
Public Health	Transmission to immunization registries Transmission to public health agencies — syndromic surveillance Transmission to public health agencies — reportable laboratory tests and values/results Transmission to cancer registries Transmission to public health agencies — electronic case reporting Transmission to public health agencies — antimicrobial use and resistance reporting Transmission to public health agencies — health care surveys
*Electronic prescribing may be utilized for referrals and DME.	

To move to a more standardized and interoperable environment; facilitate physical therapists and other nonphysicians' participation in MIPS, MVPs, and Advanced APMs in the future; and promote increased interoperability and care coordination, it is critical that CMS work with ONC to offer financial and technical assistance to help nonphysician providers, including physical therapists, adopt and implement CEHRT. Moreover, to ensure that the CEHRT adoption process is equitable and fair for all parties, we recommend that CMS set a date by which it expects all EHRs to achieve certification. To that end, we request that CMS allow EHR vendors and health care providers a transition period of three-to-five years to develop, adopt, and integrate certified products. We also recommend that CMS work with ONC to educate providers on the certification process in a manner that clearly conveys what providers need to know, what they need to do now and in future years, and the anticipated costs associated with adopting and implementing certified technology.

CMS' proposal to require physical therapists to report the promoting interoperability category without offering appropriate incentives and guidance to help them obtain the requisite technology could have the opposite effect on physical therapy participation in MIPS and Medicare generally. As we have expressed earlier in this letter, many physical therapists are considering leaving the Medicare program due to the constant reduction in payment. Adding the financial burden of upgrading EHR to meet promoting interoperability standards will only encourage more disillusion with Medicare, especially when the MIPS program has failed to deliver its promised incentives.

While MIPS was intended to be a method by which CMS could reward high-performing providers, it has become an administrative burden without any financial upside. In a report conducted by GAO, it was determined that from 2017 through 2019, payment adjustments for providers who earned a positive adjustment ranged from 0% to 1.88%. In 2021 the maximum adjustment was reported to be 1.79%.

This adjustment is insufficient to account for the expense of participating in MIPS for physical therapists — even before adding the burden of obtaining CEHRT. **Accordingly, we recommend that CMS continue to exempt physical therapists from reporting the Promoting Interoperability category of MIPS until it has addressed the current barriers to physical therapists' acquisition of CEHRT.** We support continuing to exempt providers meeting the small business threshold, but we also ask that CMS, in the very least, allow providers voluntarily opting into MIPS to be exempt from Promoting Interoperability. This will keep providers who may be considering a trial run from being dissuaded.

MVPs and APM Participant Reporting Request for Information

CMS states that it intends MVPs to drive value and help clinicians and practices prepare to take on and manage financial risk; for example, through Advanced APMs, as they build out their quality infrastructure components and gain experience with cost measurement. CMS notes that interested parties have requested more options for meaningful specialty clinician participation within both the MVP framework and APMs, and so seeks feedback on a number of questions. The majority of questions concern better aligning MVPs with APMs.

APTA is concerned that CMS' line of questioning misses a serious flaw in both MVPs and APMs: that the majority of nonphysician providers have no way to participate meaningfully in these programs. While we support CMS' goal to use MVPs as a path toward increased participation in APMs, and appreciate the need to align the two, it appears little to no progress is being made to better incorporate physical therapy and other nonphysician providers. To date there are no cost measures in any QPP program that are applicable to physical therapists. This means physical therapy is not fully accounted for in MIPS, MVPs, or APMs. Accordingly, it is frustrating that CMS' focus remains on better aligning programs in the QPP rather than opening doors to those locked outside.

APTA appreciates that CMS is developing a cost measure on low back pain that would be applicable to PTs. In anticipation of the completion of this measure APTA convened a group of stakeholders to draft an MVP on low back pain and submitted the proposal to CMS in February 2022. We acknowledged that our proposal technically lacked a cost measure since the low back pain measure we included in the application was not yet finalized. We expressly stated in our application that we sought substantive feedback from CMS on the whole of the application in order to continue to refine the MVP on low back pain while the cost measure completed testing.

Unfortunately, CMS rejected the proposal for lack of a cost measure without providing any substantive feedback on any element of the application. APTA and its partners in the design of this MVP were seeking to proactively lay the groundwork for meaningful physical therapy participation in MVPs. The need for meaningful feedback on how to refine the model to position it for future success is critical. This episode is unfortunately only one example of many in which APTA and/or physical therapists have been unable to participate in meaningful quality-based payment at a time when continued year-over-year cuts to the fee schedule threaten the ability of PTs to continue to participate in the Medicare program.

APTA appreciates that designing and maintaining the QPP is unquestionably a monumental undertaking. However, we cannot help but question whether CMS is making a good faith effort to fully incorporate nonphysicians in its QPP programs. Currently, nonphysician providers are in limbo: expected to participate in programs such as MIPS and constantly facing increasingly burdensome requirements such as promoting interoperability, but not given the financial or regulatory support physicians have received. Further, they are navigating QPPs whose infrastructure was designed for physicians; measures are designed to work based only on E/M codes, interoperability standards are built for prescribers, etc. Add to these barriers the fact that PFS payment is constantly declining and the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 has tethered any future payment increases to participation in the QPP, and it is understandable why so many nonphysician providers are not optimistic about the future of Medicare. **Accordingly, we urge CMS to make meaningful efforts to include nonphysician providers such as physical therapists in all programs under the QPP, including working with stakeholders, measure developers, and professional associations. Absent this effort CMS should exempt these providers from any type of mandatory participation in these programs.**

MVP Development

CMS proposes to modify the MVP development process such that it would evaluate a submitted candidate MVP through the MVP development process, and if it determines it is ‘‘ready’’ for feedback, it would post a draft version of the submitted candidate MVP on the QPP website and solicit feedback for a 30-day period. CMS hopes to receive a broader set of perspectives on a draft MVP, including from patients, patient advocates, practices that serve underserved and rural areas, specialty organizations, health systems, and the general public.

APTA is supportive of this proposal. We agree that CMS must include more stakeholders in the development of MVPs in order for them to be meaningful. We also encourage CMS to do more to assist applicants in developing an MVP that is “ready” for feedback. As we expressed in the section above APTA has found the process of MVP development to be challenging, and more guidance and feedback from CMS on refinement on proposed MVPs will greatly assist the program’s success. We would appreciate better collaboration with policy makers as we seek better inclusion of physical therapists in the QPP.

Conclusion

APTA thanks CMS for the opportunity to provide feedback on the 2023 Medicare Physician Fee Schedule proposed rule. Should you have any questions regarding our comments, please contact Kate W. Gilliard, JD, director, health policy and payment, at kategilliard@apta.org or 703-706-8549; or Rachel Miller, MPH, specialist, health policy and payment at rachelmiller@apta.org or 703-706-8547.

Sincerely,

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