American Physical Therapy Association

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November 13, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
US Department of Health and Human Services
Attn: CMS-4174-P
PO Box 8016
Baltimore, MD 21244

Re: CMS-4174-P; Medicare Program: Changes to the Medicare Claims and Medicare Prescription Drug Coverage Determination Appeals Procedures

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Medicare Program: Changes to the Medicare Claims and Medicare Prescription Drug Coverage Determination Appeals Procedures proposed rule. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles may 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.

Physical therapy is an integral part of health care, and Medicare is no exception. Medicare spending on outpatient therapy services was $7.6 billion in 2016. Payment for physical therapy accounted for 72% of all spending on therapy services.[1] Accordingly, any changes to claims or appeals procedures will directly impact APTA members and their patients. APTA supports CMS's proposed rule and appreciates the agency's dedication to continually streamlining the appeals process and reducing burden.

[1] Medicare Payment Advisory Commission: Outpatient Therapy Services Payment System. http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_18_opt_final_sec.pdf?sfvrsn=0. Accessed October 30, 2018.

APTA supports the rule in its entirely, including elimination of the appellant signature on appeal requests, clarifying the timeframe for adjudicators to vacate a dismissal of an appeal request, referencing Medicare number instead of Medicare health insurance claim number, and the removal of duplicate provisions and the correction of incorrect cross-references. Please find below our more detailed comments.

APTA supports the removal of the requirement that appellants sign appeal requests for Parts A and B claims appeal requests at the first, second, and fourth levels of appeal, and for Part D coverage determinations at the council level. There is little risk to removing this requirement, as it is unlikely that a Medicare appeal will be submitted without the appellant's knowledge. Additionally, removing this requirement will better allow beneficiaries and providers to efficiently and timely file appeals at all levels. Further, as CMS acknowledged within the proposed rule, eliminating the signature requirement will better allow adjudicators to focus their attention "on the merits of the appeal, rather than having to dismiss potentially meritorious appeals for a lack of a signature."

Additionally, APTA supports the proposal to clarify the timeframe for allowing adjudicators to vacate a dismissal of an appeal request for a Medicare Part A or B claim or Medicare Part D coverage determination. APTA supports CMS's assertion that the timeframe for vacating a dismissal, while currently acceptable, is better expressed in calendar days than in months. Establishing a timeframe of 180 days is more precise and will result in less confusion in applying the regulation.

APTA supports CMS's proposal to modify the reference of "Medicare health insurance claim number" to "Medicare number." We appreciate that CMS will allow appellants to include either the Social Security number-based Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI) on the appointment of representative documentation and appeal requests. As CMS continues to implement Section 501 of the Medicare Access and CHIP Reauthorization Act of 2015 by removing Social Security numbers from Medicare cards and transitioning to MBIs rather than HICNs, it is appropriate that both numbers be acceptable identifiers on appeal forms during this transition. Accordingly, APTA supports the proposal to reference Medicare Number and remove the words "health insurance claim" from the regulations.

Finally, APTA supports CMS's proposals to remove various redundant provisions and correct incorrect cross-references. APTA appreciates CMS's efforts to reduce redundancies, eliminate administrative burden, and increase efficiency within the Medicare appeals process.

Conclusion

APTA thanks CMS for the opportunity to provide comments on the proposed rule and applauds the agency for continuing to take steps to reduce administrative burden and streamline the Medicare appeals process. Should you have any questions regarding our comments, please contact Kate Gilliard, senior regulatory affairs specialist, at kategilliard@apta.org or 703/706-8549.

Thank you for your consideration.

Sincerely,

Sharon L. Dunn, PT, PhD
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy
President

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