

**American Physical Therapy Association Comments to
Ways and Means Health Subcommittee on the Reduction of Regulatory Burden**

August 23, 2017

Therapy Cap

Created in 1997 through the Balanced Budget Act, the Medicare therapy cap imposes an annual financial limit on outpatient physical therapy and speech-language pathology services and a separate cap on occupational therapy services. The rationale for creating an arbitrary cap on these types of services was not based on data, quality-of-care concerns, or clinical judgment; instead it was based solely on the desire to balance the federal budget. Since 1997, Congress has acted 16 times to prevent implementation of the cap, including the 2006 creation of the exceptions process allowing patients to receive necessary services exceeding the annual cap amount.

The American Physical Therapy Association (APTA) asserts that the therapy cap presents a barrier to accessing medically necessary services for seniors and individuals with disabilities. APTA continues to work with the House Energy & Commerce Committee, Ways & Means Committee, and Senate Finance Committee to advance our legislation, The Medicare Access to Rehabilitative Services Act (H.R. 807/S. 253), which would repeal the therapy cap.

When considering ways to “cut through the red tape” in the Medicare program, please consider replacing the current exceptions process with a more permanent fix that would ensure the delivery of care to vulnerable patients, streamline the ability of providers to deliver needed care, and ensure the long-term viability of Medicare.

Plan of Care 30-Day Initial Certification and 90-Day Recertification

Initial certification

In many instances, Medicare beneficiaries may seek therapy services without first being evaluated by a physician or obtaining a referral. However, once a therapist determines that therapy is medically necessary, Medicare requires that the patient be under the active care of a physician or non-physician practitioner.

As outlined in Section 1861(r) of the Social Security Act, as well as 42 CFR 424.24(c) and 42 CFR 410.61(e), outpatient therapy services must be furnished under a plan of care. Certification of the plan by the physician or non-physician practitioner satisfies all certification requirements for the duration of the plan of care or for 90 calendar days from the date of the initial treatment, whichever is less. The provider or supplier should obtain certification as soon as possible after the plan of care is established and must obtain it within 30 days of the initial therapy treatment. Payment may be denied if the physician does not certify the plan of care. Timely certification of the initial plan is met when the certification is documented, by signature or verbal order, and dated within the 30 days following the first day of treatment. If the order to certify is verbal, it must be followed within 14 days by a signature.

Recertification

Pursuant to 42 CFR 424.24(c) and 42 CFR 410.61(e), recertifications that document the need for continued or modified therapy should be signed whenever the need for a significant modification of the plan becomes evident, or at least every 90 days after initial treatment under that plan, unless they are delayed.

The American Physical Therapy Association (APTA) strongly recommends that the Centers for Medicare and Medicaid Services (CMS) modify or eliminate the 30-day initial certification and 90-day recertification requirements.

Compliance with the physician signature requirement is a logistical and administrative burden on therapy providers, taking valuable time and resources away from delivering patient care. In many instances, the plan of care is incomplete, and it may take up to several weeks for the physician to furnish a complete plan of care. Unsigned plans of care result in therapy providers having to delay treatment in order to obtain a physician signature, thus placing the beneficiary at risk and/or being unable to bill for the services rendered. Although the medical record may illustrate the medical necessity of therapy services, CMS will deny payment or seek recoupment if the plan of care is missing a signature, if the signature was not obtained within the required timeframe, or if the signature is of marginal or questionable legibility. The administrative burden of this regulation is untenable, and we strongly encourage Congress to work with CMS to modify or eliminate these requirements.

Functional Limitation Reporting

Section 3005(g) of the Middle Class Tax Relief and Job Creation Act of 2012 required the Centers for Medicare and Medicaid Services (CMS) to implement, beginning January 1, 2013, a claims-based data-collection strategy to collect data on patient function during the course of therapy services, in order to better understand patient condition and outcomes. CMS finalized the data collection strategy to meet the above requirement in the final physician fee schedule rule of CY 2013. (*See* 42 CFR 410.61).

Under the rule, nonpayable G-codes and modifiers were to be included on the claim forms that would capture data on the beneficiary's functional limitations (a) at the outset

of the therapy episode, (b) at specified points during treatment, and (c) at discharge. In addition, the therapist's projected goal for functional status at the end of treatment would be reported on the first claim for services and periodically throughout the episode. Modifiers would indicate the extent of the severity of the functional limitation.

Therapy providers faced numerous challenges with the implementation of the functional limitation reporting (FLR) requirements. In the inception years of the program, problems with Medicare's claims-processing systems caused payment issues for many providers. Providers consistently report that FLR is one of their most burdensome reporting requirements, and they would like feedback on their performance. Given the time and effort spent collecting and reporting on FLR, providers have reached out to the American Physical Therapy Association (APTA) to inquire about the data, specifically questioning if, how, and when CMS might analyze or use the data in the future.

Due to the increasing questions from members and our desire to foster evolution of the FLR requirements, APTA purchased a sample of the 2014 data to perform an analysis. Our analysis included both facility-based and private practice Medicare B claims, revealing that although FLR data was collected 93% of the time on evaluation, only 36% of episodes had discharge data. As claim submission of a billable code is required in order to submit discharge data, we believe that some percentage of cases may be lost in follow-up for patients who do not have a formal discharge visit. Additionally, intra-episode reporting, at a minimum of every 10 visits, ranged between 12% and 16%. Based on this analysis, we recommend 3 changes to the FLR requirements in 2019 as a first phase of improvements to the program:

1. Allow FLR through clinical data registries, EHRs, facility-based submission vehicles, and other means.
2. Require FLR only upon patient intake and patient discharge from a course of outpatient therapy services. No longer require reporting at intervals.
3. Include FLR by therapy providers as a clinical practice improvement activity under MIPS.

Ultimately, we believe the FLR requirements should move toward reporting standardized measures of function. These measures may reflect global function or may be specific to a condition. We encourage CMS to focus on the development of setting-appropriate outpatient therapy quality measures that address the domains of function, cognitive function, and changes in function and cognitive function:

1. Measuring functionality. Measures developed shall reflect outcomes for the achievement of improvements in cognitive, physical, and psychosocial function for Medicare beneficiaries with recovery potential; and outcomes for successfully maintaining function or delaying decline in beneficiaries with chronic and progressive conditions.
2. Harmonization of patient assessment data and measures of functional limitation with relevant IMPACT Act measures. This directs the Secretary to take steps (as appropriate for the outpatient therapy settings and type of therapy provider involved) to ensure that any patient-assessment data and measures that may be specified by the Secretary for the collection of data on patient function during the

course of therapy services under this subsection are coordinated and aligned with patient-assessment data under the IMPACT Act.

APTA strongly supports the long-term goal of improving the payment system for outpatient therapy services, using data collection to achieve this goal. We believe that implementing the above changes to the FLR program will be a step in the direction of achieving the ultimate goal of uniform measures of function across care settings.

Skilled Nursing Facility 3-Day Inpatient Stay Requirement

When the Medicare program was enacted, Congress placed restrictions on the skilled nursing facility (SNF) benefit, including requiring that beneficiaries have at least a 3-day hospital inpatient stay within 14 days prior to a SNF admission (later extended to 30 days).

The American Physical Therapy Association (APTA) strongly recommends modification of the SNF 3-day inpatient stay requirement under Section 1861(i) of the Social Security Act (42 U.S.C. 1395x(i)) to count days spent in observation toward satisfying the 3-day inpatient hospital stay requirement for Part A coverage of SNF care. Congress has also expressed support for such a policy change, as members in both the House and Senate have introduced the Improving Access to Medicare Coverage Act of 2017 (H.R. 1421/S. 568). The legislation expands the definition of inpatient for purposes of the 3-day inpatient stay requirement, and allows time spent in observation to count toward satisfying the requirement.