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Via E-Mail PDF

Marie L. Mindeman
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Re: Comments to the Physical Medicine and Rehabilitation Workgroup Proposal to Revise the Evaluation and Intervention Codes in the Physical Medicine Rehabilitation Section; Agenda Item Tab # 88 (Physical Medicine and Rehabilitation Evaluations and Interventions)

Dear Ms. Mindeman:

This letter represents the collective comments of the Alliance for Physical Therapy Quality and Innovation (the "Alliance") related to the above referenced agenda item scheduled to be discussed on February 5-7, 2015 at the upcoming AMA Current Procedural Terminology (CPT) meeting in San Diego, CA. We are among the nation's leading providers of outpatient rehabilitation care, and collectively employ or represent several thousand physical and occupational therapists, and furnish physical therapy services on an annual basis to hundreds of thousands of Medicare beneficiaries. Our membership categories consist of Board and Affiliate Members, representing a diverse mix of small, medium, and large multi-state physical therapy providers. The following is a brief description of each of our Alliance Board Members, which in aggregate currently operate and represent over 3,200 outpatient rehabilitation clinics:

- **Athletico Physical Therapy** currently operates approximately 350 outpatient rehabilitation clinics in 8 states;

- **ATI Physical Therapy** currently operates approximately 373 outpatient rehabilitation clinics in 12 states;

- **Drayer Physical Therapy Institute** currently operates approximately 120 outpatient rehabilitation clinics in 15 states;

- **Physiotherapy Associates** currently operates approximately 575 outpatient rehabilitation clinics in 34 states;

- **Select Medical** currently operates approximately 1023 outpatient rehabilitation and/or occupational therapy clinics in 33 states and the District of Columbia;

- **Upstream Rehabilitation** currently operates approximately 305 outpatient rehabilitation and/or occupational therapy clinics in 22 states; and

- **U.S. Physical Therapy, Inc**. currently operates approximately 489 outpatient rehabilitation and/or occupational therapy clinics in 43 states.

The Centers for Medicare and Medicaid Services (CMS) recently published the "CMS Quality Strategy 2013 – Beyond", in which the agency adopted quality improvement as a core function. The vision of the CMS Quality Strategy is to optimize health outcomes by improving clinical quality and transforming the health system. This commitment by CMS was designed to enhance its partnerships with a delivery system in which providers are supported in achieving better outcomes in healthcare at a lower cost for Medicare beneficiaries. The Alliance shares the core belief that any coding and payment reform related to physical therapy services should drive payment in line with the value physical therapy services deliver to the patient and other providers in the continuum of care; reduce unnecessary regulatory and administration burdens unrelated to improving the quality of patient care; and be transparent to all parties. The Alliance strongly urges the CPT Editorial Panel to consider these core factors along with the standard AMA criteria for evaluating the proposed evaluation and intervention codes.

I. Preliminary Statement

The Alliance is very appreciative of the deliberative work performed every year by the CPT Editorial Panel and the CPT/HCPAC Advisory Committee. The past work of these and the other AMA committees has had a positive impact on the physical therapist profession and the care provided to our patients. We also appreciate the work of the Physical Medicine and Rehabilitation Workgroup (PM&R Workgroup) in the development of an alternative coding and payment system that is based on the complexity of the patient condition, the therapist's clinical judgment, and intensity of therapist involvement in the provision of physical therapy services. To be clear, the Alliance is in agreement that a more comprehensive coding and payment solution should be created to accurately document and value therapy services. **However, given the issues and concerns set forth below, we are requesting that the CPT Editorial Panel reject the proposed evaluation and intervention codes for therapy services that will be presented by the PM&R Workgroup at the upcoming February 2015 CPT Editorial Panel meeting.**

II. Issues and Concerns

The Alliance requests that the CPT Editorial Panel delay or postpone approval of the proposed evaluation and intervention codes (the "proposed CPT codes") for the following reasons:

A. The proposed evaluation and intervention codes should be rejected by the CPT Editorial Panel unless it can be shown that the proposed new codes have been properly vetted in a transparent methodology and are statistically valid, reliable, and accurate. The proposed coding model recommends the adoption of a new coding system that bases payment on a patient severity and complexity and treatment intensity framework in lieu of the current fee-for-service system based predominantly on the use of CPT time based codes. Last year, the Alliance suggested to the CPT Editorial Panel that the proposed coding should be subject to more formal clinical modeling, piloting, and data analytics. APTA, in partnership with AOTA, publicly announced that it would test the reliability and validity of the proposed codes.[1] The Alliance is aware that previously developed vignettes were refined and tested at four different locations across the country. It was reported to us by the APTA that the sample sizes at each location were small and involved more senior experienced clinicians. We do not believe this four city pilot, which was followed by live testing at two health healthcare systems, is capable of yielding a statistically reliable and valid result. This limited live testing is especially important since it allows for testing the extent to which the proposed CPT codes could be operationalized based on current charting practices.

We strongly urge the CPT Editorial Panel to review the entire report (not just an edited summary of the quantitative and qualitative results) from both phases of the pilot survey testing. The CPT Editorial Panel should assess and answer, among other inquiries, the following: (1) in terms of reliability, how confident it is that the proposed CPT codes accurately and consistently assess the performance of therapists providing the care assessed in the measure; (2) in terms of inter-rater reliability, the extent to which the coding practices of two or more therapists are congruent with each other; and (3) in terms of validity, whether the studies have actually measured what is intended to be measure, and not other variables. We believe a review of the results will not meet the level of statistical reliability necessary for CMS to ultimately adopt these proposed CPT codes. If this is the case, and the proposed CPT codes (evaluations and interventions) move forward to the AMA RUC HCPAC evaluation phase , it would cause more harm than good to an entire industry already under regulatory and payment pressure.

The proposed model involves more than revising a few CPT codes. The presentation and approval of an entire new coding system should be further tested, evaluated, piloted, and analyzed before its approval by the CPT Editorial Panel/RUC HCPAC and submission to CMS. This type of transformational change should receive further analytical analysis to make sure it does not harm beneficiary access to needed therapy services and cause provider confusion. This will require a stronger and more representative input, review and testing advisory function than what is being provided to the CPT Editorial Panel by the PM&R Workgroup.

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[1] The Alliance has signed a Confidentiality Agreement with the APTA in order to review a preliminary report on the reliability and validity of the proposed CPT codes. Therefore, our comments will be limited to what has been publicly announced in other industry settings, disclosed to us by an independent third party, or was otherwise disclosed to us prior to the execution of this agreement.

B. The Alliance is unsure or unclear on how past research efforts or projects by CMS will influence, or be integrated with, the proposed CPT codes. We have been advised that the PM&R Workgroup was formed to address concerns expressed by CMS in past Medicare Physician Fee Schedule Rules. CMS has already spent considerable resources in an effort to find an alternative therapy payment system for physical therapy services. Most recently, The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA), enacted by Congress, mandated the implementation of such an alternative payment system. As a result of this legislation, CMS created a "claims-based data collection strategy" designed to assist in reforming the Medicare payment system for outpatient therapy services through the creation of non-payable G codes and severity modifiers that is currently being used to gather information on beneficiary function and condition, therapy services furnished, and outcomes achieved. In the past, several of our Alliance members have also actively participated in both the *Development of Outpatient Therapy Payment Alternatives* (DOTPA) and *Short Term Alternatives for Therapy Services* (STATS) projects. Several clinical and technical experts involved with our Alliance provided critical feedback and guidance on both of these projects utilizing our extensive experience collecting patient reported outcomes data for the Medicare population in the outpatient setting. We actively sought to facilitate a collaborative process and assist in providing guidance in a proactive manner across all provider types and disciplines. The Alliance does not believe the proposed CPT coding model takes into consideration the factors considered in these past and current efforts by CMS to reform the Medicare payment system for outpatient therapy services.

The Alliance believes it would be prudent to again engage the provider community in the live clinical modeling and piloting of the proposed CPT codes. While there has been some limited engagement with the provider community, we believe there should be more collaboration to ensure reporting accuracy, promote quality of care, and minimize potential coding errors. The clinical science involved must be right before the actuarial science (i.e., valuation) takes hold. In summary, any approach to implement an entirely new coding and payment system should be extensively modeled and piloted prior to its application on a nationwide basis.

C. The proposed CPT codes that categorize patients based on the severity of their condition and intensity of intervention is largely subjective without specific quantifiable and objective criteria. Establishing new codes that physical therapists report for their services would be a significant change that would require therapists to learn the new code sets and update billing systems. This would involve massive changes to existing electronic medical record and billing systems. The Alliance, through its members, has considerable experience of how the coding and payment system works at the "*individual practitioner level*." If there is no additional clinical modeling and analytics to test this proposed system, it will be subject to the subjective clinical reasoning and decision-making of the therapist that may vary depending on experience, background and training. For example, a classification of "high severity" by one may be perceived as "low severity" by another. If "high severity" patients received a higher bundled evaluation, the system could easily be subject to abuse. We believe that a review of the results of the pilot study will provide further proof of this concern. Again, this subjectivity could be significantly reduced if more advanced clinical modeling and testing was performed to ensure that the coding system adopted identifies progression of the patients' status and outcome measures.

Medicare Part B outpatient therapy services are furnished in a variety of settings, including hospitals; skilled nursing facilities (SNFs); comprehensive outpatient therapy facilities (CORFs); outpatient rehabilitation facilities (ORFs); and home health agencies (HHAs). Medicare outpatient therapy services are also provided through individual specialties in professional offices, including physical therapists in private practice (PTPP); occupational therapists in private practice (OTPP); Speech-language pathologists in private practice (SLPP); physicians; and non-physician practitioners. In order to ensure consistency in the categorization of patients across all provider facilities and professional offices, data analysis for outpatient physical therapy services needs to be supplemented with clinical expertise, clinical and outcomes research, and expert opinion. We have not been presented with any statistically valid evidence to support the proposed CPT codes across all settings. The trade associations that represent the different settings and individual specialties should be involved more extensively at this stage in the process to make sure the proposed CPT codes will continue to increase the quality and value of physical therapy services in all practice settings. In summary, a more comprehensive clinical model to address what services should be bundled together will enhance the delivery of services across all settings and avoid implementation of a coding system that is not in the best interest of all Medicare beneficiaries.

D. The PM&R Workgroup should verify with CMS how existing regulations would be eliminated or applied under the proposed PT Classification and Payment System. Any transformational modification to the coding and payment system for therapy services should preserve the ability of outpatient physical therapy providers to deliver the necessary treatment required by Medicare beneficiaries. The current Medicare Part B outpatient therapy policy is made up of a cumbersome collection of rules and regulations that have unintended consequences that are not always in the best interest of the patient. Providers and Medicare program beneficiaries are already confused and, in some cases, financially burdened by the existing rules and reimbursement policies. Eliminating the therapy cap and developing a replacement system remains a major goal for CMS, MEDPAC, professional associations and the provider community. However, there are other CMS regulatory requirements that should be considered now before final approval of an alternative coding payment system. We believe there should be formal collaboration with CMS on whether and, to what extent, the layers of Medicare rules and regulations applicable to Part B therapy services will be applied under a new coding system including: therapy caps and the exceptions process; manual medical review (MMR) process; multiple procedure payment reduction (MPPR); Physician Quality Reporting System (PQRS); total time; group and concurrent therapy rules. If this is not addressed now, the proposed CPT codes will be further burdened with superimposed rules and regulations that add significant unexplained variation and unnecessary cost as well as complexity.

A properly modeled, tested and piloted coding and payment system will enable CMS to focus on whether existing rules primarily add value to the beneficiary or whether they add costs to the provider without value, and apply only those rules that protect and approve the care provided to the patient. At the same time, depending on the clinical modeling, CMS may want to consider modifiers and payment adjustments to deal with highly rehabilitation complex patients (i.e., possible outliers). As the Medicare Shared Savings Program and Pioneer ACO programs have demonstrated, models on paper do not work precisely as predicted if we ignore inherent complexity without the predictability of pre-testing and modeling. As this new payment model is tested, these rules and regulations should not be ignored or the CPT Editorial Panel and RUC

HCPAC risk approving a therapy coding system of "practice patterns" that do not optimize efficiency.

III. Conclusion

We urge the CPT Editorial Panel to consider the concerns and recommendation of the Alliance as set forth above. We appreciate the recently announced CPT Editorial Panel process improvements that included, among other initiatives, the willingness of the AMA to solicit the input of the provider community to ensure a fair, open and transparent process for all stakeholders. The Alliance is willing to contribute time and resources to the modeling and piloting of a proposed alternative coding and payment system for therapy services that is **value driven**. The implementation of an entirely new evaluation and intervention coding system, without appropriate review and testing, could lead to unintended harmful consequences for physical therapy beneficiaries and providers alike. As you consider solutions to improve the proposed physical therapy coding system, please know that we too will continue to work diligently to increase the quality and value of physical therapy services provided to our patients.

We look forward to working with the AMA, CMS, CMMI, MEDPAC, APTA and other trade associations to find meaningful physical therapy coding and payment solutions that will not only maintain but improve Medicare beneficiary access and quality of care. We appreciate the opportunity to comment on the PM&R Workgroup's proposed new coding structure for physical therapy services, and would be pleased to discuss our concerns with you further. If you have any questions, or would be interested in further collaboration, please feel free to contact John F. Duggan, J.D., M.B.A., Senior Vice President and Senior Counsel – Select Medical Corporation, at 717-975-4534 or JDuggan@SelectMedical.com.

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Very truly yours,

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