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Via Electronic Submission

September 2, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1612-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CMS-1612-P, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule, Fed. Reg. Vol. 79, No. 133, (July 11, 2014).

Dear Ms. Tavenner:

This letter represents the collective comments of the Alliance for Physical Therapy Quality and Innovation (the "APTQI") to the Centers for Medicare and Medicaid Services (CMS) regarding the above referenced Proposed Rule to Payment Policies Under the Physician Fee Schedule for calendar year 2015, published in the Federal Register on July 11, 2014 ("Proposed Rule").

By way of introduction, 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. The following is a brief description of each of our APTQI members, which in aggregate currently operate and represent nearly 2,600 outpatient rehabilitation clinics:

- **Athletico Physical Therapy** currently operates approximately 90 outpatient rehabilitation clinics in 3 states;

- **Benchmark Rehab Partners** currently operates approximately 175 outpatient rehabilitation clinics in 8 states;

- **Drayer Physical Therapy Institute** currently operates approximately 110 outpatient rehabilitation clinics in 14 states;

- **Physical Therapy Business Alliance** is a not for profit professional organization representing approximately 200 entities that operate 710 independent physical therapy practices in 27 states;

- **Select Medical Corporation** currently operates approximately 1019 outpatient rehabilitation and/or occupational therapy clinics in 32 states and the District of Columbia; and

- **U.S. Physical Therapy, Inc**. currently operates approximately 491 outpatient rehabilitation and/or occupational therapy clinics in 43 states.

I. Preliminary Statement

We appreciate the opportunity to comment on the Proposed Rule. Many of the areas where feedback is sought regarding Medicare Outpatient Part B therapy services are important to the APTQI's core mission: "*Ensuring patient access to value driven physical therapy care*." 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 patient outcomes at a lower cost for Medicare beneficiaries. The APTQI 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.

II. Valuing New, Revised and Potentially Misvalued Codes

The Social Security Act requires CMS to identify and review potentially misvalued codes and make appropriate adjustments to the relative values of those services identified as being potentially misvalued. The Protecting Access to Medicare Act of 2014 (PAMA) amended the law to expand the categories of services that CMS is directed to examine for the purpose of identifying potentially misvalued codes to 9 categories, in addition to the 7 categories that already existed. The legislation also establishes an annual target from 2017-2020 for reductions

in physician fee schedule expenditures resulting from adjustments to relative values of misvalued services.

In the Proposed Rule, CMS includes a list of 65 CPT codes for review that fall into the category of "High Expenditure across Specialties with Medicare Allowed Charges of $10,000,000 or more." CMS states its belief that a review of the codes (included in Table 10 of the Proposed Rule) is warranted to assess changes in physician work and to update direct practice expense inputs since these codes have not been reviewed since CY 2009 or earlier. It should be noted that several of these codes related to therapeutic exercise (marked with * in the table below) are the very essence of rehabilitation interventions common to virtually every diagnostic category such as developmental delay, brain injury and sports injury. Therefore, utilization alone should not be an automatic justification for change. This list includes the following CPT codes reported commonly by physical therapists.

97032	**Electrical stimulation**
97035	**Ultrasound therapy**
97110*	**Therapeutic exercises**
97112*	**Neuromuscular reeducation**
97113	**Aquatic therapy/exercises**
97116	**Gait training therapy**
97140	**Manual therapy 1/> regions**
97530*	**Therapeutic activities**
G0283	**Elec stim other than wound**

The APTQI agrees with the importance of ensuring that services are appropriately valued. However, the evidence is that these codes are appropriately valued as demonstrated by the continuous on-going reviews of the American Medical Association CPT Editorial Panel, RVS Update Committee (AMA RUC), and the RVS Update Committee / Health Care Professional Advisory Committee Review Board (RUC HCPAC). CMS should allow this AMA coding process to continue without interruption and with more transparency as set forth in the Proposed Rule. Over the past several years, given the scrutiny involving therapy payments and caps (including the application of the MPPR policy to therapy payments), CMS and the AMA RUC have taken increasingly significant steps to address potentially misvalued therapy codes. The APTQI supports the role of the AMA RUC in refining and enhancing the accuracy of therapy services, including the "rolling" five year review process. However, the conclusion that the above therapy coding with charges greater than $10 million should automatically result in a code being potentially misvalued is unwarranted. In addition, CMS should provide the AMA RUC, trade groups and the public with any data used that would explain why charges of greater than $10 million would automatically translate into misvalued codes.

This valuation policy, if done in isolation, is also inconsistent with other parts of the Patient Protection and Affordable Care Act (PPACA). The PPACA features provisions that encourage the use and development of less costly interventions such as physical therapy services. One of the goals of health care reform is to minimize the use of high-cost interventions when there is a clinically comparable, but better value alternative. There is a plethora of research that supports the implementation of high quality care by a physical therapist earlier in the course of treatment is more cost-effective by promoting recovery and reducing the need for comparatively more invasive and costly interventions. For example, instead of undergoing surgery for back pain, therapy is generally seen as a less costly, less invasive option. This over emphasis on actuarial science in isolated parts of patient care fails to consider the clinical science regarding the total episode of care of beneficiaries across the health care system. In the past, this has led to the unintended consequence of increasing program health care costs due to more costly invasive procedures, whether diagnostic and/or surgical.

Furthermore, the success of health care reform will not only involve looking at the total cost of care, but will also depend on whether there are enough providers to deliver care for the millions of new covered lives. Drastically reducing payment for qualified therapists may hinder both their ability to provide high-value, cost effective care as well as further increase patient access barriers. An arbitrary misvalued codes policy reviewed in isolation will, in the long term, exacerbate the current shortage of physical therapists, occupational therapists, and speech language pathologists, and increase the risk of reduced access to therapists when more providers are needed as the baby boomers enter the Medicare program.

Finally, in the Proposed Rule, CMS also projects that due to the SGR formula there would be a 20.9 percent reduction in the Medicare physician fee schedule conversion factor beginning April 1, 2015. While APTQI appreciates that such a sizable cut in Medicare payments is currently required by federal statute, we urge CMS to continue to work with Congress to prevent this drastic cut from occurring next year. APTQI believes that a cut of such magnitude would seriously hinder the Medicare beneficiary's access to physical therapy by making it virtually impossible for physical therapists in any Part B setting to be able to provide care to Medicare beneficiaries. The continuing reimbursement cuts in therapy payments, including the recent application of the multiple procedure payment reduction (MPPR) policy to therapy services during a period of escalating costs for providers, will have the effect of causing some providers to exit the Medicare provider system altogether thereby diminishing access to these valuable health restoring services.

III. Proposals to the Timeline for Valuing New, Revised and Potentially Misvalued Codes

In the Proposed Rule, CMS has asked stakeholders for feedback on the existing timeline regarding the process for reviewing new, revised and potentially misvalued codes. In order to accommodate the publication of proposed valuation of new, revised, and potentially misvalued services, CMS discusses three alternatives including a proposal to require that all AMA RUC recommendations be submitted by January 15 of each preceding year. **The APTQI supports**

transparency and collaboration in a revised process that would allow stakeholders the opportunity to respond to any RUC action and recommendations in a proposed rule before CMS adopts interim final values. This process will also add support to the recently announced CPT editorial process improvements that included, among other initiatives, the willingness of the AMA to consider the input of the provider community to ensure a fair, open and transparent process for all stakeholders. However, the AMA CPT Editorial and RUC process today is still not completely transparent based on its current operating procedures including: meetings that do not easily permit public comment; individual voting records are not made public; members cannot share information or recommendations because of confidentiality agreements; and transcripts of meetings are not made public.

Although we support the CMS proposal on the "change in timeline process" to allow public comment, we are concerned about CMS' recommendation that it still adopt coding policies and payment rates, to the extent possible, when it does not receive AMA RUC recommendations before January 15th of the preceding year. CMS proposes to create G-codes for predecessor codes that were revised or deleted as part of the annual CPT coding change but still require agency review and approval of the relevant RUC recommendations. The creation and adoption of a few temporary G-codes, unrelated to a formal clinical coding pilot, would unnecessarily add to the confusion and administrative burden of providers who would be tasked with the implementation of new codes within a relatively short period of time after approval of any coding changes in the MPFS Final rule. Moreover, this may create a situation of parallel but distinct coding between Medicare and private payers, as private payers are likely to implement new CPT codes as soon as they are published. We understand that the AMA has offered a detailed and reasonable proposal to expedite the review processes for new, revised and potentially misvalued services so they may be timely submitted to CMS. We strongly urge that CMS continue to coordinate closely with the AMA CPT Editorial and RUC committees. If CMS works closely with the AMA, it would eliminate, in most cases, the need to create G-codes and ensure timely adoption of CPT coding and valuation changes.

IV. AMA CPT Editorial Panel and the Proposed Physical Therapy Classification and Payment System

APTQI strongly believes that the proposed Physical Therapy Classification and Payment System ("PT Classification and Payment System") model working its way through the AMA CPT Editorial Panel and RUC process should be subject to more formal clinical modeling, data analytics, and piloting before approval by CMS. The APTQI has previously expressed its concerns to the AMA CPT Editorial Panel and CMS about the current iteration of the PT Classification and Payment System model that recommends the adoption of a new coding system that bases payment on a patient severity/intensity framework. The current CPT Editorial panel "paper survey process" involving small groups of 50-60 therapists in different regions of the country will be of limited reliability without (a) more advanced pilot testing in clinics and at CMS, and (b) ensuring there is a representative sample of adequate size from all Part B settings providing therapy services. The proposed model involves more than revising a few CPT codes based on updated clinical work and practice expense inputs. The presentation and approval of an

entire new coding system should be further tested, evaluated, piloted, and analyzed before final CMS approval. This type of transformational change should receive further analytical analysis to make sure it does not harm beneficiary access to needed therapy services, cause provider confusion, or inadvertently increase costs throughout the continuum of care. This will require a stronger and more representative input, review and testing advisory function using scientifically validated criteria than what is normally provided through the CPT Editorial Panel and RUC HCPAC survey process.

The PT Classification and Payment System that categorizes 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 significant changes to existing electronic documentation and billing systems. If there is no additional clinical modeling and analytics to test and further refine 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 valuation, the system could easily be subject to abuse, or miscoding due principally to difference in therapist experience. Again, this subjectivity could be significantly reduced if more advanced clinical modeling and testing was performed to ensure that the coding system adopted is objective; has high levels of inter-rater reliability across all therapy settings; and identifiably improves the progression of the patients' status and outcome measures.

CMS should work with interested stakeholders to understand and address 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); 8-minute rule and total time; group and concurrent therapy rules. If this is not addressed now, the PT Classification and Payment System could be further burdened with superimposed rules and regulations that add significant unexplained variation and unnecessary cost as well as complexity and confusion to providers and patients.

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, and apply only those rules that protect the quality and value of care provided to the patient. At the same time, depending on the clinical modeling, CMS may want to consider modifiers and payment adjustments to address highly complex rehabilitation 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 CMS risks approving a therapy coding system of "practice patterns" that do not optimize efficiency.

To be successful and satisfy the needs of beneficiaries, CMS, and providers, an alternative coding and payment system for therapy services must have the following elements: adequate pay to the provider with the flexibility to enable delivery of planned services; accountability by the provider to the patient for successfully achieving the intended outcomes; and protection from significant variation in financial risk. To satisfy these elements, the transition to an alternative physical therapy payment system approach based on quality and value should start with testing new models of care over at least a 2-year period and incorporating them into an increasing number of practices with the goal of broad adoption at the end of this transition period. The failure to do this could lead to widespread dissatisfaction among beneficiaries and providers, an unintended increase in program health care costs, and a disruption in access to high quality therapy services.

V. Physician Quality Reporting System

While we commend CMS for its attempts at quality reporting, admittedly, the APTQI is disappointed with the agency's implementation of the Physician Quality Reporting System (PQRS), as it has excluded eligible professionals providing covered therapy services to Medicare Part B beneficiaries in institutional settings (SNFs, Rehab Agencies, outpatient HH). The Tax Relief and Health Care Act of 2006, which established PQRS, specifically defined physical therapists, occupational therapists and qualified speech-language pathologists as eligible professionals. Unfortunately, therapists who provide care to hundreds of thousands of Medicare patients in an institutional setting are unable to report under PQRS. CMS has stated that institutional practice settings cannot participate in the PQRS program because they do not use the 1500 or 837-P claim form. Instead, they submit claims using the UB-04 or 837-I, and there is no place on this form to report the individual NPI of the therapist providing the service.

Although many groups have recommended ways in which quality-reporting data could be collected, the PQRS program for 2015, as outlined in the Proposed Rule, would continue the exclusion of reporting from institutional settings. We believe that the restrictive manner of collecting quality reporting information that has been adopted by CMS undermines the validity of the therapy data that are being reported in this program. Furthermore, forcing these institutional practice settings to use registries in order to participate in the PQRS program would add cost and increase the inherent administrative burden that currently exists in the program.

Nothing in the legislative history of PQRS suggests that Congress intended for a significant segment of professional Medicare Part B therapy services to be excluded. With value based purchasing taking on such a central role in CMS reimbursement policies, the continued exclusion of such a large segment of providers from PQRS undercuts the agency's efforts to promote and achieve a truly successful program.

In addition, very few measures apply to the physical therapy setting and care delivery. As a result of the above inconsistencies in collecting data and the recent addition of functional limitation reporting, we urge CMS to re-evaluate the PQRS program and its utility at actually reporting the outcome and value of therapy services. PQRS is primarily a reporting mechanism for quality indicators and does not result in demonstrating any benefit or functional improvement the Medicare beneficiary may have gained as a result of therapy. Very few measures apply to physical therapy services and care delivery so obtaining the required numbers of measures poses a significant challenge for eligible professionals. Furthermore, there is significant duplicative administrative burden placed on the provider to reporting these quality measures that in the end do not always relate to the patient presentation or condition. If and when they do correlate to the patient's presentation or condition, it is repetitive for the provider as they would already be delineated and included in the evaluation and plan of care which could include use of publically valid and reliable patient reported outcomes tools. We feel that the use of the aforementioned tools, as well as expansion of the functional limitation categories to allow for more granularity, would be more effective to obtain the end goal on determining functional improvement and thus value.

APTQI is in favor of a value based payment program and the inclusion of reliable and valid outcome and quality measures to demonstrate the outcome and value of therapy. APTQI believes that the expansion of functional limitation reporting with the addition of an outcomes measure would better serve Medicare to value therapy services over the inclusion of quality measures as structured under the current PQRS program.

VI. Conclusion

The APTQI appreciates the opportunity to provide comments on the Proposed Rule. We encourage CMS to continue to work with AMA and professional societies such as the APTQI through the rulemaking process in order to create a stable and equitable therapy coding and payment system. The APTQI looks forward to continued dialogue with CMS officials about these and other issues affecting therapy services. 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 202-507-6354 or JDuggan@SelectMedical.com.

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Very truly yours,

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