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Via Electronic Submission

October 3, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-6082-NC
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1734-P, Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug Under a Prescription Drug Plan or an MA-PD Plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy: Proposed Rule, Fed. Reg. Vol. 85, No. 159, (August 17, 2020).

Dear Administrator Verma:

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 et al." for calendar year 2021, published in the Federal Register on August 17, 2020 ("Proposed Rule").

By way of introduction, we are among the nation's leading providers of outpatient rehabilitation care, and collectively employ or represent over 15,000 physical and occupational therapists, and furnish physical and occupational therapy services on an annual basis to Medicare beneficiaries throughout the United States. APTQI membership consists of affiliate and board member entities of varying size and geographic scope, which in aggregate provide patient care services in approximately 4,000 outpatient rehabilitation clinical sites.

I. Preliminary Statement

We appreciate the opportunity to comment on the Proposed Rule. Many of the areas where CMS seeks feedback regarding Medicare Outpatient Part B therapy services are important to the APTQI's core mission: "*Ensuring patient access to value driven physical therapy care.*" We support CMS' commitment 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. APTQI shares the core belief that any coding, documentation and payment proposals related to physical therapy services should (a) drive payment in line
with the value physical therapy services deliver to the patient and other providers in the continuum of care; (b) reduce unnecessary regulatory and administrative burdens unrelated to improving the quality of patient care; and (c) be transparent to patients and all stakeholders.

II. APTQI Opposes CMS' Proposed Work and Practice Expense RVU Changes for Physical/Occupational Therapy for CY 2021.

APTQI opposes the value redistributions for physical and occupational therapy set forth in the Proposed Rule. The redistributions, if finalized, will place deep cuts on outpatient therapy providers. As demonstrated in Table 90 in the proposed rule, physical therapy (and occupational therapy) providers would see a combined impact of negative 9% in 2021.

APTQI recognizes that CMS must implement any increase in work values for the office/outpatient E/M codes with budget neutrality. However, the magnitude of potential impact to physical and occupational therapy providers is staggering when history and other factors are taken into account. These cuts are much more severe than the reductions projected by MedPAC in their June 2018 report to Congress regarding the rebalancing of the Medicare Physician Fee Schedule to accommodate the changes to the E/M code set.[1]

This proposed cut is the latest in a history of cuts to physical therapy services over the past decade. If implemented, the proposed 2021 reduction would come after a 2011 multiple procedure payment reduction (MPPR); a further deepening of the MPPR in 2013; and reductions to two of the most common procedural codes used by physical therapists, Therapeutic Exercise (97110) and Manual Therapy (97140), which were instituted in 2018 after they went through the misvalued code initiative. In addition, the 15% reduction applied to services provided by therapist assistants mandated by Congress will take effect in 2022. Considering the magnitude of the redistribution proposed in this rule for 2021, it is essential for CMS to ensure that the process it uses to develop policies is transparent and that decisions are based on accurate information. The information provided in the rule is very limited and does not provide enough information regarding the data and analysis used to determine the cuts to specialty providers. CMS is proposing these cuts to specialty providers, including physical therapists, without seeking the input of any health care professionals and providers who furnish outpatient therapy services. Further, CMS has not provided any analysis of the impact of their proposal on patient access or the total cost of care.

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[1] http://medpac.gov/docs/default-source/reports/jun18_medpacreporttocongress_rev_nov2019_note_sec.pdf?sfvrsn=0, accessed September 28, **2020**.

APTQI urges CMS to be transparent and provide stakeholders with adequate information on how the redistributions were calculated.

A. **Implementing the Proposed Redistributions during a Health Emergency Will Have an Effect on Patient Access to Therapy Services and Drive Patients to Higher Cost of Care Settings.**

CMS is proposing one of the most significant redistributions of the Medicare Physician Fee Schedule ever while the nation is still in the grips of the COVID-19 public health emergency. The effect of these reductions at a time when many therapy practices have not fully recovered from the business impact of the pandemic is that access to outpatient physical therapy will be compromised. This is especially true to for patients living in rural and underserved areas.

APTQI recognizes that CMS is attempting to stay within the budget neutrality provisions under Section 1848 of the Social Security Act which aims to keep spending within the Medicare Physician Fee Schedule budget neutral to itself. However, history has shown time and again that this approach ignores the effects of the sustained cuts to office-based specialists stemming from the policy. **When office-based specialists, such as physical therapists, are forced to close their centers, such care moves to higher cost sites-of-service. The outcome is higher costs to the Medicare program and its beneficiaries.** This situation is only exacerbated by the ongoing COVID-19 pandemic. At a time when CMS has stated that many interventions should not be postponed[2] and, in the case of physical therapy, are keeping patients out of the hospital, such proposed cuts are simply unconscionable.

B. **Implementation of the Redistribution Will Have a Negative Impact on Opioid Misuse and Falls.**

If CMS wants to reach the stated goal of decreasing opioid use, access to physical therapy should be expanded– not cut. In its Guideline for Prescribing Opioids for Chronic Pain, the Centers for Disease Control and Prevention (CDC) recommends physical therapy as an alternative to opioids for the treatment of chronic pain. The CDC notes physical therapy is especially effective at reducing pain and improving function in cases of low back pain, fibromyalgia, and hip and knee osteoarthritis. Providing this type of nonpharmacological therapy is only possible if we are able to keep our doors open and continue seeing Medicare patients. This is even more crucial now as there are reports that the opioid crisis is worsening during the COVID-19 pandemic.[3]

Moving forward, it is imperative that CMS acknowledge the important role physical therapists play in the prevention and treatment of acute and chronic pain. The solution requires more than limiting access to drugs. Rather, Medicare payment policies should incentivize collaboration, assessment, and care coordination with foundational care team partners, particularly physical therapists. CMS and Congressional policies to reduce reimbursement for physical therapy services is misguided (i.e., through MPPR, misvalued codes, PTA/OTA proposal, PT/OT value

[2] https://www.cms.gov/files/document/covid-elective-surgery-recommendations.pdf, accessed September 28, 2020.
[3] https://www.wsj.com/articles/the-opioid-crisis-already-serious-has-intensified-during-coronavirus-pandemic-11599557401, accessed September 28, 2020.

redistributions, etc.) at a time when benefit design and reimbursement models should support early access to nonpharmacological interventions -- including physical therapy for the primary care of pain conditions. The continuing payment reduction policies for physical therapy services impose greater challenges on physical therapy clinics to keep their doors open, thus placing at risk Medicare beneficiary access to nonpharmacological treatments for pain. It is critical that CMS, in conjunction with other state and federal agencies, examine how to reduce barriers to nonpharmacological treatment options such as physical therapy that serve as an alternative to opioids. If CMS, policymakers, and other stakeholders remain silent on the benefit of nonpharmacological treatments, this will only reinforce the idea that pharmaceuticals are the only option—an option with significant risk of harm.

The availability of physical therapy should be encouraged among older Americans because of the critical role it plays in preventing harmful senior falls. Accounting for roughly 300,000 hip fractures, 800,000 hospitalizations, and 27,000 deaths every year, falls are the leading cause of injury-related emergency room visits for older Americans.[4] It is estimated that medical expenditures attributable to fatal and nonfatal falls are roughly $50 billion annually, underscoring the need to support fall prevention strategies and treatments.[5] With fall deaths increasing every year, undermining beneficiary access to fall prevention treatments offered by physical therapy is both short sighted and financially ill-advised. As aforementioned, the costs that falls incur on America's healthcare system are exorbitant and unsustainable. Siphoning resources away from physical therapy services as the fall epidemic increases in size and scope will only result in more injury-related costs further down the line. Diminishing access to physical therapy services that save lives and reduce downstream medical costs is counterproductive, plain and simple. APTQI urges CMS to alter their recently Proposed Rule to ensure beneficiary access to physical therapy is preserved well into the future.

C. APTQI Urges CMS to Consider that Other Payers Base Their Fee Schedules Upon the Medicare Physician Fee Schedule.

Reductions to the Physician Fee Schedule have far reaching ramifications for therapy providers. This is because commercial payers and state workers' compensation programs adopt, directly or indirectly, changes to Physician Fee Schedule into their own rates. This also extends to other federal plans such as Medicaid and Tricare. APTQI has seen no indication that CMS has acknowledged this fact or performed any analysis on the impact of their proposal on a therapist's entire payer mix.

D. APTQI Urges CMS to Eliminate the GPC1X Add-on Code.

CMS adopted the GPC1X add-on code as a way to capture the complexity of certain office visits. APTQI has grave concerns on the lack of specificity provided by CMS on the appropriate utilization of the add-on code. This stems from CMS' own assumptions that the code

[4] https://www.ncoa.org/news/resources-for-reporters/get-the-facts/falls-prevention-facts/, accessed September 28, 2020.
[5] https://www.ncbi.nlm.nih.gov/pubmed/29512120, accessed September 28, 2020.

would be used by specialists who "would bill HCPCS code GPC1X with 100 percent of their office/outpatient E/M visit codes" (84 FR 63157). This is clear evidence that the add-on code does not have clear criteria for application and is not intended for a small subset of highly complex patients. Due to the that fact that $3.3 billion of the $10.2 billion of additional spending is due to the add-on code, CMS must recognize that it is not reasonable to require other providers to offset such a large sum of money on a code that is so ill-defined. For this reason, APTQI urges CMS to eliminate the GPC1X add-on code.

In summary, the proposed redistribution will have a massive effect on patient access and affordability of care, especially as the nation is still in a public health emergency. APTQI has serious concerns about the consequences of adopting the rule as proposed. Due to the large scale of the proposed cuts, APTQI urges CMS to perform a transparent analysis on the consequences of their proposed rule. CMS should study the effect of the cuts on patient access, migration to higher cost site-of-service settings, opioid use, and falls. CMS must also revisit their decision to adopt the GPC1X add-on code. **To that end, APTQI recommends that CMS waive budget neutrality under the physician fee schedule for 2021 to preserve patient access to essential services and prevent migration of services to higher cost site-of-service**. While we understand that fundamental changes to budget neutrality may require Congressional action to allow for long-term reform, APTQI urges in the strongest possible terms that CMS utilize its authority under the Public Health Emergency to waive budget neutrality requirements when implementing the proposed increases to the E/M codes.

III. APTQI Urges CMS to Permanently Include Therapy Service Procedures in the List of Covered Telehealth Services.

In the proposed rule, CMS seeks comment on whether certain codes should be listed as covered telehealth services. APTQI recommends that the following CPT codes be added: 97161 – 98168, 97110, 97112, 97116, 97530, 97535, 97750, 97755, 97760, 97761, and 97763. While it is true that physical therapists are not currently eligible by statute to furnish and bill for telehealth services under Medicare, these services have safely and effectively been provided to Medicare beneficiaries via telehealth since they were authorized under the Public Health Emergency. By including these services in the list of covered telehealth services now, it would obviate the need to add them in the future if therapists become eligible telehealth providers under the Medicare program.

IV. APTQI Supports the Proposal to Allow Therapists Assistants to Furnish Maintenance Therapy in Part B Settings.

Physical therapist assistants are qualified providers in the Medicare program who work under the supervision of physical therapists. They have the training and oversight to furnish maintenance therapy to patients in a safe and effective manner. APTQI supports the proposal to remove the restriction and urges the Agency to finalize the rule as proposed.

V. APTQI Requests that CMS Classify CPT Codes 20560 and 20561 as Covered Services Eligible to be Furnished by Physical Therapists.

APTQI supports CPT codes 20560 and 20561 being updated to active payment status, however CMS states in the proposed rule that dry needling services are non-covered by Medicare unless otherwise specified through a national coverage determination (NCD). APTQI urges CMS to classify dry needling as a covered service and allow for Medicare Administrative Contractors to provide coverage for these services.

Dry needling is within the scope of physical therapy practice in over 30 states and has been used by therapists for over 30 years. It is yet another way in which physical therapists can use nonpharmacological means to treat chronic pain in the Medicare population. By classifying dry needling as a covered service, CMS would be providing Medicare beneficiaries another safe, yet effective option to alleviate their pain while sparing them from needing to utilize potentially dangerous opioids.

VI. APTQI Proposes a Change to Allow for a Certified Plan of Care OR a referral from a Physician/NPP to Meet the Requirement for Coverage and Payment of a Therapy Claim for Outpatient Therapy Services.

APTQI appreciates that CMS is constantly searching for ways to decrease administrative burden on providers and to put patients over paperwork. One way in which this can be achieved is to change the plan of care certification requirements for outpatient therapy services. APTQI recognizes that CMS requires that therapy services must be required because the patient needed therapy services (42 CFR 424.24(c), MBPM §220.1.3), provided under a plan of care established by a physician/NPP or a therapist (42 CFR 424.24(c), MBPM §220.1.2), and furnished while the patient is or was under the care of a physician (42 CFR 424.24(c), MBPM §220.1.1). However, the regulations state that in order to meet these three conditions, they must have the physician/NPP certify the plan of care after treatment has begun. APTQI supports a change to allow for a certified plan of care **or** a referral from a physician/NPP to meet the requirement for coverage and payment of a therapy claim for outpatient therapy services.

Across the over 4,000 locations operated by APTQI members, thousands of Medicare beneficiaries seek therapy services every day. **Over 95% of these patients arrive for their first visit with a referral from a physician/NPP in hand and the therapist creates a plan of care**. The signed referral is proof that the patient is under the care of a physician/NPP and that therapy services are needed, however the therapist must send the plan of care back to the referring physician to get another signature on the same patient for the same diagnosis in order to meet the requirement for coverage and payment. APTQI recognizes the importance of regulatory requirements to ensure medically necessary services. However, in most case, the physician has already indicated the need for medical necessary services by ordering the rehabilitation therapy. In fact, the MPBM states there is no Medicare requirement for an order, however, “when documented in the medical record, an order provides evidence that the patient needs therapy services and is under the care of a physician.”

The process of sending, tracking, and ensuring physician/NPP signature on a plan of care for a patient who is in possession of a referral is burdensome, not only for the therapist, but also for the physician who has already written the referral and is now asked to duplicate their work by certifying a plan of care for the same patient and diagnosis. The time spent by providers and clinicians in faxing (and in some cases refaxing) documents, calling physician offices to follow up, documenting attempts at certification in tracking logs, and in some cases even visiting physician offices in person to gain certification is time taken away from patient care. The attached infographic illustrates the unduly burdensome and counterproductive process involved in obtaining a dated physician signature on the plan of care. Allowing a therapist to use a referral, if one was available, to meet coverage requirements would allow them to focus more of their time on improving the function and outcomes of their patients. However, if a patient did not present with a referral, or the initial duration of the first plan of care needed to be exceeded, APTQI supports the need for a certified plan of care to ensure requirements are being met.

VII. Conclusion

APTQI is in favor of value driven care and reimbursement. We ask that CMS revisit the proposed reductions for physical/occupational therapy and fully consider the impact of those cuts on two of the most important health issues of our day, opioid misuse and falls resulting in injury and hospitalization. Considering the enormity of these cuts, it is clear that physical therapy for Medicare patients is at serious risk. If CMS proceeds with the 2021 cuts as proposed, the country will undoubtedly see practice closures and providers opting out of the Medicare program, which would then stifle access to important therapy treatments.

APTQI appreciates the opportunity to provide comments to CMS on the Proposed Rule for CY 2021. We encourage CMS to continue to work with professional societies such as the APTQI through the rulemaking process. 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 Nikesh "Nick" Patel, PT, DPT Executive Director, at 713-824-6177 or npatel@aptqi.com.

Very truly yours,

ALLIANCE FOR PHYSICAL THERAPY QUALITY AND INNOVATION

By: ________________________________

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