ALLIANCE FOR PHYSICAL THERAPY QUALITY AND INNOVATION

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**Via Electronic Submission**

September 13, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1751-P
7500 Security Boulevard
Baltimore, MD 21244-1850

**Re: CMS-1751-P, Medicare Program: CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements: Proposed Rule, Fed. Reg. Vol. 86, No. 139, (July 23, 2021).**

Dear Administrator Brooks-LaSure:

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 2022, published in the Federal Register on July 23rd, 2021 ("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 4,200 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 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 2022.

APTQI opposes the value redistributions for physical and occupational therapy set forth in the Proposed Rule. The redistributions, if finalized, will place further deep cuts on outpatient therapy providers. As demonstrated in the proposed rule, physical therapy (and occupational therapy) providers would see a combined impact of negative 3.5%. When combined, the previously implemented and future proposed reductions would total up to a staggering 9% from 2020 to 2024 for therapy services.

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. The full 9% reduction is 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 2022 reduction would come after a more than 3% reduction in 2021, a multiple procedure payment reduction (MPPR) in 2011 which was further deepened 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 2022, 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. Further, CMS has not provided any analysis of the impact of their proposal on patient access or the total cost of care.

### A. Proposed Increases to Evaluation and Management Services Redistributes Money Away from Lower Cost Therapy Services.

The 2021 Medicare Physician Fee Schedule Rule provided for substantial increases in payments for Evaluation and Management Services and introduced an add-on code for complex

[1] http://medpac.gov/docs/default-source/reports/jun18_medpacreporttocongress_rev_nov2019_note_sec.pdf?sfvrsn=0, accessed September 8, 2021.

care associated with evaluations. These changes provided the greatest benefit to primary care specialists who have a median compensation of $241,687.[2] However, due to budget-neutrality, the effect was substantial cuts to specialists who are not authorized to use Evaluation and Management codes. CMS estimates the full cut to therapy services to be 9% despite the fact that the median annual compensation for a physical therapist is only $91,010.[3] In other words, CMS' proposal is to cut physical therapists by 9% in order to pay for an increase to primary care physicians who are already paid 170% more than therapists. These cuts were so significant that Congress took it upon itself to phase in the cuts through H.R. 133. CMS has not provided any analysis on the effect these large reductions will have on patient access to therapy services, especially in rural and underserved areas, once the full 9% is phased in. APTQI believes no further cuts to therapy services should occur until such analysis is completed.

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 has worsened during the COVID-19 pandemic.[4]

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 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.

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[2] http://www.medpac.gov/docs/default-source/contractor-reports/jan19_medpac_disparities_physiciancompensationreport_cvr_contractor_sec.pdf accessed September 8, 2021.
[3] https://www.bls.gov/ooh/healthcare/physical-therapists.htm accessed September 8, 2021.
[4] https://www.dhs.wisconsin.gov/news/releases/081021.htm accessed September 8, 2021.

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.[5] 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.[6] 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 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 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 before 2024.

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, opioid use, and falls. CMS must also revisit their decision to adopt the GPC1X add-on code. **To that end, APTQI recommends that CMS pause any further changes to the conversion factor until adequate studies can be completed on the second and third order effects of these reductions can be determined**.

[5] https://www.ncoa.org/article/get-the-facts-on-falls-prevention accessed September 8, 2021.
[6] https://www.ncbi.nlm.nih.gov/pubmed/29512120, accessed September 8, 2021.

## III. APTQI Urges CMS to Allow Therapist Assistants to Practice at the Top of their License and Practice under General Supervision in Private Practice Settings.

Physical and Occupational therapist assistants are qualified providers and Medicare allows for them to provide services under the "general supervision" of a therapist in all settings except for the private practice setting, which requires "direct supervision." This inconsistency is burdensome and does nothing to improve patient care. In fact, it only serves to impair patient access, especially in rural and underserved areas. There is no sound justification for requiring a supervising therapist to be onsite to supervise in a private practice setting when one is not required in a rehab agency or other therapy setting.

It is up to each state Board to establish their requirements for therapist assistant supervision and 44 of them require only general supervision. Thus, in these states, Medicare is not allowing the therapists to practice at the top of their licenses by imposing a stricter standard than is allowed by the state. Even worse, they are arbitrarily applying that standard to one specific setting. **APTQI urges CMS to remove the direct supervision requirement for therapist assistants in private practice settings and allow general supervision if allowed by the state.** Doing so enables therapy to be delivered in a more efficient manner and will improve access to therapy in rural and underserved areas.

## IV. APTQI Proposes that CMS Exempt Rural and Underserved Areas from the 15% Payment Reduction for Services Provided in Whole or in part by Therapist Assistants.

Therapist Assistants are integral to providing therapy services to Medicare beneficiaries in rural and Health Professional Shortage Areas (HSPA). With therapy services having already been cut by over 3% in 2021 and having an additional 6% still to be phased in until 2024, the viability of many clinics in rural and underserved areas is already tenuous. The additional 15% reduction for services provided by a therapist assistant, which many of these clinics rely upon, would be disastrous for patient access.

Losing access to therapy services will mean loss of functional independence, access to post - operative care, and increased risk of falls in beneficiaries living in these areas. The increase in the total cost of care for these beneficiaries would dwarf any amount that would be saved by applying the reduction. CMS can address this by exempting therapy clinics located in rural and HPSAs from the 15% reduction.

## V. 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 – 97168, 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, with all the necessary elements, 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.

## 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 2022 and subsequent 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 2022. 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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