

# ALLIANCE FOR PHYSICAL THERAPY QUALITY AND INNOVATION

January 24, 2014

## **Via E-Mail PDF and Overnight Mail**

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American Medical Association  
AMA Plaza  
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Chicago, IL 60611-5885

**Re: Comments to the PM&R Workgroup Proposed Model for Physical Therapy Classification and Payment System; Agenda Item Tab # 92 (Physical Medicine and Rehabilitation Evaluations) and Agenda Item Tab # 93 (Physical Medicine and Rehabilitation Interventions)**

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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 items scheduled to be discussed on February 6-8, 2014 at the upcoming AMA Current Procedural Terminology (CPT) meeting in Phoenix, AZ. The Alliance requests your assistance in distributing this comment letter to Peter A. Hollmann, M.D., Chair of the CPT Editorial Panel, and the other panel members. 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 Alliance members, which in aggregate currently operate and represent approximately 2,539 outpatient rehabilitation clinics:

- **Athletico Physical Therapy** currently operates approximately 90 outpatient rehabilitation clinics in 3 states;
- **Benchmark Rehab Partners** currently operates approximately 160 outpatient rehabilitation clinics in 7 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 997 outpatient rehabilitation and/or occupational therapy clinics in 32 states and the District of Columbia; and
- **U.S. Physical Therapy, Inc.** currently operates approximately 472 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.

## **I. Preliminary Statement**

The Alliance is very appreciative of the deliberative work performed by the AMA every year, including the work of the CPT Editorial Panel, RVS Update Committee (RUC), and the RVS Update Committee / Health Care Professionals Advisory Committee Review Board (RUC HCPAC). The past effort of the various AMA panels and committees has had a positive impact on the physical therapist profession and the care provided to our patients. The Alliance acknowledges the significant steps that the AMA and CMS have taken to address potentially misvalued therapy codes and other coding issues. We also appreciate the leadership role of the American Physical Therapy Association (APTA) in the development of an alternative coding and payment system that is based on the complexity of the patient condition, the clinical judgment of the therapist, 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 delay or postpone approval of the proposed new coding structure for physical therapy services that will be presented by the PM&R Workgroup at the upcoming February 2014 CPT meeting in Phoenix.**

## **II. Issues and Concerns**

The Alliance requests that the CPT Editorial Panel delay or postpone approval of the proposed model for the following reasons:

**A. The proposed Physical Therapy Classification and Payment System (“PT Classification and Payment System”) model presented to the Alliance and shared with the provider community by the APTA should be subject to more formal clinical modeling, data analytics, and piloting before approval by the CPT Editorial Panel.** The PT Classification and Payment System model recommends the adoption of a new coding system that bases payment on a patient severity/intensity framework in lieu of the current fee-for-service system based predominantly on the use of CPT codes. The proposed model involves more than revising a few CPT codes. The presentation and approval of an entirely new coding system should be further tested, evaluated, piloted, and analyzed before its approval by the CPT Editorial Panel, subsequent RUC HCPAC review, 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 normally provided through the AMA CPT Editorial Panel approval process.

The Alliance is unsure or unclear on how past research efforts or projects by CMS will influence, or be integrated with, the PT Classification and Payment System. 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 addition to this mandatory reporting, we feel it is important to point out the participation of our members in many prior efforts conducted by CMS contractors working toward a solution for reporting functional limitations and outcomes measures en route to an alternate payment methodology. Many of our Alliance members have 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 believes it would be prudent to again engage the provider community in the clinical modeling and piloting of the PT Classification and Payment System. While there has been some engagement with the provider community on the PT Classification and Payment System, 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.

**B. 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 massive changes to existing computer documentation 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. 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. 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 PT Classification and Payment System 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 new coding system that is not in the best interest of all Medicare beneficiaries.

**C. 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); 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.

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 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 risks 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 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 PT Classification and Payment 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 physical therapy classification and 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](mailto:JDuggan@SelectMedical.com).

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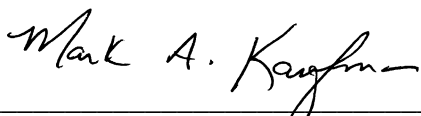
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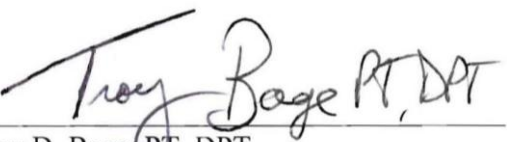
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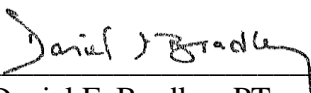
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