



September 27, 2019

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Attn: CMS-1715-P

Submitted electronically

RE: Medicare Program; CY 2020 Revisions to 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; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations [CMS-1715-P]

Dear Administrator Verma:

PPS is an organization of physical therapists in private practice who use their expertise to restore function, improve mobility, relieve pain, and prevent or limit permanent physical disabilities in patients with injury or disease. The rehabilitative and habilitative care they provide restores, maintains, and promotes overall fitness and health to a range of patient types. On behalf of the over 4,100 members of the Private Practice Section (PPS) of the 100,000 member American Physical Therapy Association, I write to provide feedback on the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2020 Revisions to Payment Policies under the Physician Fee Schedule (PFS) and Other Revisions to Medicare Part B proposed rule.

Representing independent small business owners, PPS encourages and supports policies that enable our members to focus on providing high-quality and clinically appropriate outpatient physical therapy. Our members are proud of the quality of care they provide, but as small business owners are quick to realize the impact of drastic and unfounded reductions to the payment they would receive for providing clinically appropriate care. They are also keenly

aware of burdensome and duplicative administrative tasks; the time they spend on these unnecessary tasks is time they are not able to be caring for their patients.

Below please find suggestions and feedback to the proposed policies based upon experiences of private practice physical therapists. PPS strongly urges the CMS to consider the following recommendations:

PHYSICIAN FEE SCHEDULE

- **Recommend substantive changes to CMS' proposed protocol for the application of the PTA/OTA payment differential for outpatient therapy and services furnished by PTAs and OTAs**
 - **Proposed protocol extends beyond agency's statutory authority**
 - **Inappropriate to discount physical therapist services when in their clinical judgment quality care cannot be provided without the assistance of a physical therapist assistant**
 - **Suggest the *de minimus* standard only apply to services furnished independently by a PTA**
 - **Requesting clarification for how to calculate 10% *de minimus* standard when using untimed codes**
 - **Recommend no reduction in reimbursement for private practice physical therapists who must be onsite to supervise a PTA**
 - **Revise proposed policy to align with CY2019 PFS final rule**
 - **Recommend retraction of unnecessary administrative burden**
 - **Warn of impact of proposed policy on rural and underserved areas**
 - **Urge consideration of interaction between proposed therapist assistant policy and other Medicare payment policies**
- **Reconsider the suggested 8% reduction to E/M coding and payment for physical therapists in 2021**
 - **Support advancement of reimbursement models which promote access to non-pharmacological pain management treatment options**
 - **Request transparency and rationale for reduced reimbursement rates**
 - **PE values should align with current physical therapist practice expense**

QUALITY PAYMENT PROGRAM

- **Appreciate the continued inclusion of physical therapists in the Merit-Based Incentive Payment Program**
- **Support the Continuance of Exemptions for Low-Volume Threshold Providers**
- **Support the Continued Exemption for Physical Therapists from the Promoting Inoperability and Cost Categories and the Related Reweighing of the Quality Category**

PHYSICIAN FEE SCHEDULE

Recommend Substantive Changes to CMS' Proposed Protocol for the Application of the PTA/OTA Payment Differential for Outpatient Physical Therapy and Occupational Therapy Services Furnished by PTAs and OTAs

Proposed Protocol Extends Beyond Agency's Statutory Authority

CMS is charged with implementing the Bipartisan Budget Act (BBA) of 2018 which requires that in 2022, payment for outpatient therapy services furnished in whole or in part by a PTA or OTA will be reimbursed at 85% of the fee schedule. Furthermore, beginning on January 1, 2020, outpatient therapy providers are to use a modifier (CQ or CO) to denote when outpatient therapy services are furnished in whole or in part by a PTA or OTA. In the CY 2019 PFS final rule, CMS clarified that the CQ/CO modifiers are required to be used on the claim line of the service alongside the respective GP or GO therapy modifier to identify services furnished under a physical therapy or occupational therapy plan of care. At that time, CMS also finalized a *de minimis* standard under which a service is considered to be furnished in whole or in part by a PTA or OTA when that PTA or OTA furnishes more than 10% of the service. Also in the 2019 final rule, CMS clarified that the same procedure code can be reported on 2 different claim lines if there is a different modifier used that would uniquely identify the service and thus would prevent the service from being considered a duplicate.

Inappropriate to discount physical therapist services when in their clinical judgment quality care cannot be provided without the assistance of a physical therapist assistant

PPS understands Congress' intent for the application of the PTA/OTA payment differential was to better align payments with the cost of delivering therapy services since assistant wages are typically lower than therapist wages. In other words, the discount would apply only to services, or parts of services, furnished *independently* by the therapist assistant. PPS does not believe the congressional intent was to extend the application of the adjustment to therapy services furnished when the therapist assistant was providing a "second set of hands" to the therapist for safety or effectiveness reasons. Furthermore, PPS suggests that Congress intended that in circumstances which require a physical therapist and PTA to jointly furnish services to a patient at the same time, and when the physical therapist is fully engaged in the service during that time, that the *service* during that time period should be identified as a physical therapist's services and be allocated to the physical therapist. In short, when the physical therapist is providing care, that care should not be reimbursed at a discounted rate.

The example scenarios published in the CY 2020 PFS proposed rule illustrate a very different version of how to apply the "in whole or in part" standard. PPS was shocked to learn that CMS seeks to apply the reduced payment rate when a physical therapist is furnishing care that requires the help of a PTA as a "second set of hands" for safety or effectiveness purposes. Under this scenario, CMS proposes that if a therapist spent the entire 60-minute *service* providing direct care to a patient, but during that session they required the side-by-side assistance of a therapist assistant for 7 minutes or more, then the entire hour of service would be subject to the 15% therapist assistant adjustment. PPS struggles to accept that for payment purposes in this scenario

the therapist's time is ignored, and this treatment time is instead attributed wholly to the PTA 15% payment adjustment policy.

When a physical therapist uses his or her clinical judgement and decides that they need a PTA's assistance in order to furnish quality care to a patient, that is because it requires a second set of hands in order to provide the highest quality of care. There are a number of scenarios where the skills of both a physical therapist and PTA are necessary which PPS fears CMS does not fully appreciate. In 2014 alone, older Americans experienced 29 million falls, causing 7 million injuries and costing an estimated \$31 billion in annual Medicare costs.¹ Physical therapists routinely provide interventions to reduce fall risk; in doing so a PTA may walk with an unsteady patient to allow the physical therapist to stand behind the patient and assess the patient's gait. Another clear example is when a physical therapist is treating a stroke patient or someone with mobility issues, they require PTA assistance in order to help the patient to maintain the upright position and perform weight shifting so that patient may take a step; while the PTA is assisting in stabilizing measures, the physical therapist is providing neuromuscular re-education by assisting the patient with foot placement and verbal cues as well as preventing the knee from buckling when weight is put on the weak leg. In both of these examples, the quality and value of the intervention is markedly increased by having both types of providers present.

PPS hopes that the above examples have illustrated that in these types of scenarios there is no feasible or medically responsible way for the treatment to be performed by a physical therapist without the assistance of another therapist or PTA. When seeking to reduce the payment rate for PTAs and OTAs, Congress did not intend to also change established standards of care or to alter state license requirements for supervision of therapy assistants. Accordingly, it is inappropriate to diminish reimbursement for services when safety precautions are implemented, and the overall value of the care is increased. CMS' purposeful attempt to pay less for highly skilled and technical services is incongruent with CMS' goals to promote the delivery of high-quality, value-based care within a patient-centered health care delivery system.

Suggest the *De Minimus* Standard Only Apply to Services Furnished Independently by a PTA
Under Medicare policy, the physical therapist is responsible for the patient's plan of care, and the PTA furnishes services under the direction and supervision of the therapist. Accordingly, PPS and our members were very surprised when within the 2020 PFS proposed rule, CMS instead proposes to calculate the 10% threshold based on the total therapeutic minutes of time spent by both the therapist and the PTA/OTA, rounded to the nearest whole minute. The total time for a service would be the total time spent by the therapist (whether independent of, in succession, or simultaneously with a PTA/OTA) plus any additional time spent by the PTA/OTA independently furnishing the therapeutic service. It is important for CMS to take into consideration that in some private practice settings, the minutes of time spent by a PTA/OTA furnishing a therapeutic service can overlap partially or completely with the time spent by the therapist furnishing the service. PPS strongly opposes CMS' proposed approach to reimburse only at the PTA rate when team-based care is delivered.

¹ CDC Press Release 2016 <https://www.cdc.gov/media/releases/2016/p0922-older-adult-falls.html>

Instead, PPS urges CMS to finalize regulations that would only apply the 10% *de minimus* standard to services furnished in whole or in part independently by the PTA. This would mean that CMS would refine its definition of “in whole or in part” to mean skilled therapy services furnished by a therapist assistant under the supervision of a therapist, but independent of any time the therapist is furnishing the service. This is because services furnished jointly by a therapist and assistant team, where the assistant is supplementing the therapist’s services, are fundamentally therapist services and therefore should not be attributed to the PTA’s time when calculating the CQ/CO modifier *de minimis* standard.

PPS appreciates the opportunity to illustrate the real-world implications of CMS’ proposed evaluation of PTA involvement and how patient care and access to community-based care is likely to be negatively impacted. As such, PPS strongly believes that unless the payment differential is only applied to the time when a PTA is independently providing services, the 15% payment adjustments would extend beyond congressional intent and would improperly apply a payment cut to a therapist’s services. Furthermore, such a cut would result in unintended consequences that could harm Medicare beneficiaries and incentivize unsafe clinical practices as therapists may opt to provide care without the second set of skilled hands in order to receive full reimbursement.

Requesting clarification for how to calculate 10% *de minimus* standard when using untimed codes

CPT codes 97010-97028 are service-based interventions and are untimed. PPS requests CMS clarify how it will determine the *de minimis* standard when a physical therapist and a PTA are involved at separate and distinct times providing a supervised modality to a Medicare beneficiary. For example, consider the following scenario: a PTA spends 2 minutes asking a Medicare beneficiary about the location of their pain and a description of that pain which is then followed by a physical therapist spending 8 minutes determining what type of unattended electrical stimulation (G0283) to provide, placing the electrodes, determining the parameters of the electrical stimulation, answering patient questions and pushing start, which is followed by unattended electrical stimulation on the Medicare beneficiary for 15 minutes. PPS suggests that CMS recognize the total time of service (which in this example includes the 15 minutes that the Medicare beneficiary is receiving the unattended electrical stimulation for a total time of 25 minutes); thereby with the application of the *de minimis* standard, 10% of 25 minutes is 2.5 minutes and would be rounded up to 3 minutes and since the PTA only provided 2 minutes, the CQ modifier would not be required. Should CMS only incorporate the 10 minutes (2 minutes of PTA and 8 minutes of PT) that were taken to determine the need for the unattended electrical stimulation, placement of the electrodes, parameters of the electrical stimulation, answering patient questions and pushing start, then 10% of 10 minutes is 1 minute and the CQ modifier would be required. It is crucial that our members receive clarity on this issue.

Recommend No Reduction in Reimbursement for Private Practice Physical Therapists Who Must be Onsite to Supervise a PTA

In order for a PTA to provide care to a Medicare beneficiary in a private practice setting, a licensed physical therapist must be on-site, supervising that PTA. Because of this requirement that is unique to outpatient therapy settings, CMS’ proposal to reduce the overall reimbursement

for care if the fully-supervised PTA provides more than 10% of the care is not only unworkable, but also simply unreasonable. PPS thereby suggests that there be no reduction in the reimbursement rate for care provided by physical therapists in a private practice setting when that care is provided jointly or in succession with a PTA that they are required to supervise.

Revise Proposed Policy to Align with CY2019 PFS Final Rule

Additionally, PPS believes that CMS' proposed application of the 10% standard when the PTA and the physical therapist each separately furnish portions of the same service is in direct conflict with what CMS outlined in the 2019 PFS final rule (83 FR 59452) regarding the application of the modifier when the therapist and therapist assistant furnished portions of the same service. CMS specified that its "claims processing systems already allow, when not constrained by other policies such as Medically Unlikely Edits (MUEs), the same procedure code to be reported on two different claim lines as long as there is a different modifier used to uniquely identify the service and prevent the service from being considered a duplicate. For example, if a therapy assistant furnished one unit (15 minutes) and the therapist furnished 2 units (30 minutes) of the same procedure code that is defined to be billable in 15-minute increments, one unit of the procedure code would be billed on the claim line with the modifier for the therapy assistant's services and two units of the procedure code would be billed on another claim line without the assistant modifier."²

While the differentiation was made clear in 2019, with the CY2020 PFS proposed rule, the agency is contradicting itself and ignoring its ability to discern the role and involvement of each type of provider by instead proposing to require that the CQ/CO modifier apply when the minutes furnished by the assistant are greater than 10% of the sum of the minutes spent by the therapist and therapist assistant for that service. Doing so does not utilize the ability for the same procedure code to be reported on 2 different claim lines and the result is in direct conflict with the policy finalized in 2018.

Recommend Retraction of Unnecessary Administrative Burden

Regulations previously finalized by CMS will require providers to use a CQ or CO modifier to denote when outpatient therapy services are furnished in whole or in part by a PTA or OTA beginning January 1, 2020. CMS is now proposing that an outpatient therapy provider be required to add a statement in the medical record for each line of every claim to explain why the CQ/CO modifier was used or why it was not used. Through the act of appending the CQ/CO modifier to a CPT code on the claim form, it is indicated that service was provided in whole or in part by a PTA or an OTA. By extension, when the CQ/CO to a CPT code is not included on the claim form, this would indicate that the service was provided in whole by a PT or OT or if a PTA or OTA was involved in that service, the time was 10% or less. PPS struggles to see the value of adding an additional layer of documentation to the medical record. For example, when rehabilitation therapists append the KX modifier to CPT codes on the claim form, the application of the KX modifier attests that the therapist testifies that therapy is still medically necessary and requires the unique skills of a therapist to provide; no additional documentation is required in the medical record. The same rationale should apply to the application or non-application of the

² CY 2019 PFS Final Rule p. 59659 <https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf>

CQ/CO modifier—if the CQ/CO modifier was applied, the therapist would be attesting that the PTA or OTA provided that service in whole or in part according to the finalized standard. If the CQ/CO is not applied to a CPT code on the claim form, the therapist would be attesting that the service was done in whole by the physical or occupational therapist and/or the PTA or OTA provided 10% or less of the minutes associated with that service (CPT code).

Additionally, PPS disagrees with CMS' inference in the proposed rule that the CQ/CO modifier policy explanation in the treatment note might address the “possible additional burden associated with a contractor's medical review process conducted for these services.” Instead, this additional requirement would serve as one more mechanism for reviewers to use against providers to justify a technical denial even though the medical record may otherwise contain sufficient documentation to justify the use or non-use of the CQ/CO modifier. Instead, PPS recommends that CMS refer to the Medicare Benefit Policy Manual (MBPM) Chapter 15 Section 220.3.B which clearly states that “A separate statement is not required if the record justifies treatment without further explanation.”

Finally, this proposed documentation requirement is extremely burdensome and conflict with CMS' Patients Over Paperwork Initiative. Furthermore, as many of our members do not employ PTAs in their clinics, this proposal would require them state for every line of every Medicare claim that no CQ modifier was used because they did not receive care from a type of provider who was not even employed at that site. PPS struggles to see the value in this additional and unnecessary administrative burden. Therefore, PPS recommends that the presence of a CQ or CO modifier on the claim line for each service be sufficient documentation as it already provides full disclosure of the type of therapist providing care.

Warn of Impact of Proposed Policy on Rural and Underserved Areas

Many of our PPS members provide access to outpatient physical therapy in their private practice clinics located in rural and underserved areas. These practices are part of the economic engine of the communities in which they are located. As an employer, our members provide good paying jobs to not only therapists but administrative and support staff as well. As providers of rehabilitation and habilitation therapy, our members are able to improve their patients' quality of life and ability to work or meaningfully volunteer in their community, not to mention reduce the burden on those who would otherwise be in the role of caregiver.

Access to physical therapist services in rural, medically underserved, and health professional shortage areas can be challenging as there are often insufficient numbers of physical therapists and PTAs in those areas. Our members in these areas are proud to be able to provide care to Medicare beneficiaries living in rural America because while access to medical care is fast dwindling in rural localities, physical therapists and PTAs often work as a team to ensure early and uninterrupted access and thereby play an increasing and crucial role in bridging gaps in care. It is also important for CMS to understand that while demand for care is high, it can be a real challenge to recruit physical therapists to work in rural or underserved areas. It is not uncommon for clinics owned by PPS members to have attempted to recruit an additional physical therapist for a number of years but eventually have had to employ a PTA in order to meet the patient demand. CMS' proposed PTA payment reduction puts the financial viability of physical therapy

practices at risk. Many of our members have simply stated that they will have to close if the policy as proposed were to be finalized. Fundamentally, payment policies that will functionally limit the provision of services by PTAs are even more detrimental to rural health care. Absent a significant revision of the proposed policy, the therapist assistant payment reduction will exacerbate the growing problem of limited access to medical care throughout much of rural America.

Furthermore, the 15% Medicare PFS payment reduction for services furnished “in whole or in part” by the PTA coupled with application of the geographic indices will unfairly penalize providers in rural, medically underserved, and health professional shortage areas. Moreover, the 15% reduction will be on top of payment reductions in rural areas resulting from the fee schedule’s geographic indices in addition to the reduction imposed as a result of the multiple procedure payment reduction (MPPR), which reduces the practice expense RVUs for physical therapist services.

Therefore, PPS strongly recommends that CMS use its regulatory authority to mitigate the harm to patients in rural and underserved communities that would otherwise result from the 15% reduction for physical and occupational therapy services furnished in whole or part by PTAs and OTAs. This could be achieved by either creating a class-specific geographic index for physical and occupational therapy services furnished by PTAs and OTAs to offset the payment reduction in rural areas or by establishing incentive payments for RVU data collected from rural physical and occupational therapists to offset the PTA and OTA payment reduction in rural areas.

Urge Consideration of Interaction Between Proposed Therapist Assistant Policy and Other Medicare Payment Policies

PPS also has serious concerns that reconciliation of the modifier and payment differential policy with other Medicare payment policies will create significant confusion among providers and patients. Therefore, PPS seeks clarification from CMS regarding how the 15% reimbursement cut will impact or be impacted by other Medicare payment policies. For example, how will the MPPR be applied; is the 15% deducted from the fee schedule amount prior or subsequent to application of MPPR? How will this policy impact calculation of the RVU? PPS also requests clarification on how the beneficiary coinsurance will be calculated if the service is wholly or partially furnished by the therapist assistant, as well as how the proposed new modifier and differential policy will interact with the National Correct Coding Initiative edits, sequestration, the KX modifier exceptions process which was permanently extended by BBA, the 59 modifier, as well as any other applicable modifiers.

Reconsider the Suggested 8% Reduction to E/M coding and payment for physical therapists in 2021

For 2021, CMS proposes to impose an 8% reimbursement reduction for physical/occupational therapy, whereas, for example, general practice and family practice physician specialties will experience an 8% and 12% increase in reimbursement, respectively. While PPS recognizes the important role general practice and family practice physicians play in providing care to Medicare beneficiaries, we would like to point out that Medicare margins for physical therapy providers are already low and the sustainability of practices is in question. The arbitrary and severe reimbursement reductions proposed by CMS will create challenging and likely unsustainable

financial circumstances that would adversely impact patients' access to care and the ability of physical therapy providers to continue to furnish care to beneficiaries.

Furthermore, if implemented, the proposed drastic reduction in payment would be in addition to the 2% sequestration reduction, thereby amounting to a 10% cut in reimbursement. This 10% reduction is in addition to the 50% multiple procedure payment reduction (MPPR) policy for the practice expense (PE) relative value units (RVUs) for “always therapy” services and NCCI edits that impose a significant penalty on code combinations that represent standard and necessary care, which have decimated reimbursement for skilled physical therapy services. PPS urges CMS to also consider the compounding impact upon outpatient physical therapy providers who will be faced with a 15% reimbursement reduction for services furnished in whole or in part by the physical therapist assistant (PTA) beginning in 2022. If the proposed 8% cut is implemented in 2021, PPS can assure CMS that many physical therapists, particularly those in rural and underserved areas, will be unable to weather these lower Medicare payments and will be forced to reduce essential staff or even close their practices, while others may choose not to continue to treat Medicare beneficiaries and/or refuse to accept new Medicare beneficiaries—each of these inevitable scenarios will result in restricted beneficiary access to necessary physical therapy services. Research has shown that impeding access to physical therapy, via lower payment, will have an overall negative impact on total physical medicine costs.³

Therefore, PPS strongly opposes CMS' proposal to impose a combined negative 8% reimbursement reduction for physical therapy services in 2021 and urges CMS to reconsider its proposal. PPS acknowledges that CMS must maintain budget neutrality with the fee schedule; however, in order to ensure that community-based providers will be available to meet patient demand, it is crucial that CMS reimburse outpatient physical therapy providers at a level that will continue to allow them to deliver high-quality care to their patients. This is especially the case because patients in need of physical therapy are increasingly complex, to evaluate as well as to treat, in part because they have experienced shorter hospital stays and home health coverage following the onset of the medical issue. When determining reimbursement rates, it is crucial that CMS recognize the tremendous value of physical therapy in the outpatient setting while also understanding that those providers cannot continue to deliver care to patients with increasing comorbidities if fee schedule rates are drastically reduced.

It is unreasonable for CMS to expect physical therapist private practices to deliver high-quality, efficient, and cost-effective care without affording them sufficient payment. PPS takes this opportunity to remind policy makers that because physical therapists in private practice are not currently a provider type that may opt out of Medicare, a significant number of physical therapists may simply choose to stop treating Medicare beneficiaries all-together. While not their preference, therapists may need to do so in order to maintain a viable business. Should CMS share our concern, we suggest that the agency work with Congress to add physical therapists to the list of providers that may opt out of Medicare, ideally on a case-by-case basis in order to truly protect patient access in communities across America while enabling physical

³ [Health Serv Res. 2018 Dec;53\(6\):4629-4646. doi: 10.1111/1475-6773.12984. Epub 2018 May 23, https://www.ncbi.nlm.nih.gov/pubmed/29790166](https://www.ncbi.nlm.nih.gov/pubmed/29790166)

therapists to make decisions regarding their business and participation in Medicare that would be more amenable to the changing environment.

Support Advancement of Reimbursement Models Which Promote Access to Non-pharmacological Pain Management Treatment Options

The presence of pain is one of the most common reasons people seek health care. The CDC in its Guideline for Prescribing Opioids for Chronic Pain states that “Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain.” The CDC concluded that there is insufficient evidence that opioid usage alone improves functional outcomes for those in pain but found that “many non-pharmacologic therapies, including physical therapy...can ameliorate chronic pain.” In its final report, the President’s Commission on Combating Drug Addiction and the Opioid Crisis recommended that “CMS review and modify rate-setting policies that discourage the use of non-opioid treatments for pain, such as certain bundled payments that make alternative treatment options cost prohibitive for hospitals and doctors, particularly those options for treating immediate post-surgical pain.”⁴ PPS is perplexed that in the face of this sophisticated understanding of the value of physical therapy—both for the general population as well as those struggling with opioid addiction—that CMS would proposing an 8% cut to physical/occupational therapy services for 2021, while other pain management specialties, such as Interventional Pain Management, will experience a reimbursement increase of 8%. In the face of the opioid crisis and the overwhelming research proving the efficacy of nonpharmacological therapies,^{5 6} PPS requests that CMS reassess its proposed 8% payment reduction as well as explain in its final rulemaking how an 8% payment reduction for physical therapy supports the use of nonpharmacological physical therapist services for preventing, treating, and managing Medicare beneficiaries’ acute and chronic pain.

Moving forward, it is imperative that CMS understand and embrace the important role physical therapists play in the prevention and treatment of acute and chronic pain. To really make strides in this arena, physical therapists should be included within the primary care team to increase access to best practice pain management care. PPS recommends that rather than significantly cut reimbursement for physical therapists, CMS should instead promote coverage and payment models that eliminate access barriers to physical therapy and other nonpharmacological therapies that have proven to be effective for the prevention or treatment of pain. Until such barriers are addressed, access to nonpharmacological therapies will continue to be limited, and opioids will remain a tempting quick fix for pain despite their known and dangerous side effects and, in some instances, long-term ineffectiveness.

⁴ The President’s Commission on Combating Drug Addiction and the Opioid Crisis. Final Report. https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.

⁵ Association of Early Physical Therapy With Long-Term Opioid Use Among Opioid-Naïve Patients with Musculoskeletal Pain <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2718095>.

⁶ Physical Therapy as the First Point of Care to Treat Low Back Pain: An Instrumental Variables Approach to Estimate Impact on Opioid Prescription, Health Care Utilization, and Costs <https://www.ncbi.nlm.nih.gov/pubmed/29790166>.

Request Transparency and Rationale for Reduced Reimbursement Rates

While PPS appreciates that CMS gave providers an early indication of cuts to reimbursement that they are considering in 2021, it is essential that CMS ensure that the process it uses to develop policies is transparent and that decisions are based on accurate information. This proposed rule lacks depth and does not provide sufficient detail regarding the data and analysis used to determine the magnitude of cuts or increases to specialty providers. Moving forward, PPS insists that when proposing changes in E/M coding and payment, CMS must disclose the considerations taken, factors weighed, and evaluations upon patient access and impact on the opioid crisis that are utilized when determining the precise amount for the reduction to physical therapists.

As CMS considers how to distribute cuts across the code set, PPS recommends that the agency include the American Physical Therapy Association (APTA) in future discussions, as it could provide further clarification regarding the provision of physical therapy services and the current state of physical therapist practice so that any payment adjustments would reflect a full understanding of the implications of such cuts upon both Medicare providers and beneficiaries.

PE Values Should Align with Current Physical Therapist Practice Expense

As evidenced by proposing an 8% cut, it is clear to PPS that CMS has not given thorough consideration to the work and PE requirements for outpatient physical therapy providers. This significant reduction in reimbursement for physical therapy services will result in a decreased workforce and an inability to meet the needs of the Medicare population. Rising costs, student debt, and shrinking reimbursement provide the perfect storm for discouraging individuals from choosing to enter these professions.

The APTA is extensively involved in the establishment and valuation of most of the Current Procedural Terminology (CPT) codes billed by physical therapists through the CPT, RUC, and PE Subcommittee process and therefore could provide valuable insight to CMS as it modifies and refines its proposal for the redistribution of E/M coding and payment. The RVUs for PE are based on the expenses that providers incur when they rent office space, buy supplies and equipment, and hire nonphysician clinical and administrative staff. Starting a private physical therapy practice requires considerable thought, special skills, and a significant financial and administrative commitment. Additionally, physical therapy providers must purchase numerous types of equipment including treatment tables, body-weight-support systems, transfer slings, exercise bikes, and/or parallel bars, and treatment modalities including electric muscle stimulation and ultrasound.

Rather than taking the time to ensure that payment for individual services are based on the resources required to deliver them, CMS is calling for arbitrary across-the-board cuts that put expediency ahead of equity. Noting that the realities of PE could not have been properly considered, PPS opposes the proposed reductions to the PE value and recommends that CMS redistribute the expenses across health care providers who do not have as demonstrable costs for equipment and supplies. Furthermore, this proposal makes further reductions where duplication of PE has already been addressed, through both revaluation of the codes and application of the multi procedure payment reduction (MPPR).

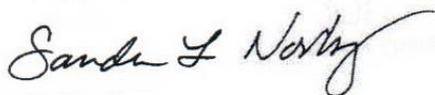
QUALITY PAYMENT PROGRAM

PPS thanks CMS for its continued inclusion of physical therapists in the Merit Based Incentive Payment System (MIPS). Further, PPS is pleased that CMS has chosen to continue the provisions of MIPS which are responsive to the realities of most private practice physical therapists—the low volume threshold exemption as well as limiting the reporting requirements of those who participate in MIPS to the Quality and Improvement Activities portions of the program. Under current law physical therapists are not required to participate in meaningful use (known as the Promoting Interoperability category in MIPS) and have not had access to the resources available to physicians and hospitals for implementing and using health information technology; therefore, it would be inappropriate to score physical therapists on their use of an electronic health record. Finally, PPS appreciates that in this proposed rule, CMS has reweighted the Quality portion of the score to be worth 85% of the final score.

CONCLUSION

Thank you for the opportunity to comment on the CY 2020 Medicare Physician Fee Schedule and QPP proposed rule. We hope our insight and perspective will prompt CMS to reconsider its proposals and remember that when access to care is diminished, beneficiaries will be forced to delay or forgo necessary care which leads to negative health outcomes and greater overall cost to the system. The federal government, as well as patients and tax payers, are better served in the long run by ensuring that the Medicare program supports providers who are able to participate in the efficient treatment of beneficiaries. The Private Practice Section of the American Physical Therapy Association welcomes the opportunity to work with CMS to identify solutions that will safeguard the financial health of the Medicare program while ensuring that beneficiaries have adequate access to high-quality physical therapy services.

Sincerely,



Sandra Norby, PT, DPT
President, Private Practice Section of APTA