

November 12, 2013

Senate Finance Committee  
United States Senate  
House Ways and Means Committee  
U.S. House of Representatives  
Washington, DC  
Via: [sgrcomments@finance.senate.gov](mailto:sgrcomments@finance.senate.gov)

Dear Senate Finance and House Ways and Means Committees:

On behalf of the Private Practice Section (PPS) of the American Physical Therapy Association (APTA), which represents over 4200 members nationwide, I write to offer comments on the “discussion draft” concept paper released by the House Ways and Means and Senate Finance Committees October 31. PPS is pleased to submit these comments and suggestions in response to your request for feedback as the committees plan to develop legislation that would enact an alternative to the SGR that will provide stability for therapist/physician reimbursement and lay the necessary foundation for a performance-based system. PPS endeavors to foster the growth, economic viability, and business success of physical therapist-owned physical therapy services provided for the benefit of the public.

PPS members provide a valuable service to communities in all fifty states and they do so in a convenient cost-effective manner. But as is typical for small businesses, narrow margins are jeopardized when a significant sector of its market cuts reimbursement without regard to the value of the services provided. The Medicare reimbursement rate for the past twelve years has not kept pace with the cost of providing high-quality, effective physical therapy and this has had a significant impact on PPS members’ ability to survive and be competitive.

### **SGR Reform**

The Sustainable Growth Rate (SGR) formula has proven to be flawed policy both from a reimbursement standpoint and a legislative perspective. The so-called accumulated debt that this formula has produced is entirely artificial and not a reflection of any real economic development.

The SGR continues to create uncertainty in the Medicare program for health professionals and beneficiaries. Because so many private insurers use the physician fee schedule as a guide for reimbursement decisions, such unpredictable economic activity taken by Medicare casts a pall over the small business environment in which independent physical therapists must function. In addition to the difficulty this causes providers, the Medicare beneficiaries are left in a very vulnerable position, unable to depend on the access to convenient, cost-effective, high-quality care to which they have become accustomed.

For over a decade Congress has recognized the folly of this formula and should delay no longer in its pursuit of repealing this statute. We commend you for the steps you have outlined in your October 31 paper. PPS believes the replacement for the SGR should be contemporary, clinically relevant and patient-centered. Moreover, the reimbursement should reflect the actual practice costs that therapists and physicians experience in running their small businesses.

### **Payment**

The proposal would repeal the SGR and freeze payment rates for ten years. PPS agrees that the SGR must be replaced and that stability and predictability are a critical element of revision. However, given that Medicare reimbursement rates over the past 12 years have lagged considerably behind the cost of operating a practice and providing good care, **we strongly urge you to build modest annual increases into the base reimbursement rate over the next ten years or at least until the incentive payments (rewards) become available for physical therapists.**

### **Value-Based Performance Payment Program**

A Value-Based Performance (VBP) composite score and associated payment incentive would incorporate the current law emphasis on quality, resource use, and use of electronic health records (EHRs) in a cohesive manner. But the Physician Quality Reporting System (PQRS), the Value-Based Modifier (VBM), and Meaningful use of certified EHR technology would sunset at the end of 2016.

The VBP program would assess eligible professionals' performance in the following categories: 1) Quality; 2) Resource Use; 3) Clinical Practice Improvement Activities; and 4) EHR Meaningful Use.

Under the proposal, Medicare payments to professionals would be adjusted based on performance on a single budget-neutral incentive payment program. Payments would be adjusted beginning in 2017 based on professionals' performance "in a prior period." **The precise prior period is not identified but should be specified.** PPS notes that in the current PQRS program, performance in 2013 is being used as the basis of an assessed penalty in 2015. Moreover, the PQRS only applies to physical therapists in private practice leaving rehabilitation agencies, hospitals, outpatient skilled nursing facilities and other therapy providers ineligible for incentive payments.

The VBP program would apply to: physicians beginning with payment year 2017; physician assistants, nurse practitioners, and clinical nurse specialists beginning with payment year 2018; and all others paid under the physician fee schedule (as the Secretary determines appropriate) beginning with payment year 2019.

**PPS would like to emphasize that neither the Value-Based Modifier (VBM) nor the EHR MU currently apply to therapists. The VBM is still in development and will not apply to physical therapists until 2017 at the earliest. The EHR MU does not apply to PTs since our profession was not included from that authorizing legislation.**

Thus, there is considerable disparity between the performance incentive described for physicians and that which the concept paper implies for "all other professionals." **The incongruence and incompleteness places the "other professionals" including physical therapists in a uniquely disadvantaged position.**

Under the proposal, quality measures used in the current law such as PQRS and other incentive programs would be used for the quality category. In addition, the Secretary would solicit recommended measures for inclusion annually, and funding would be provided to develop additional measures. Professionals would be given credit for attainment and achievement, with higher overall weight given to outcomes measures. **PPS strongly supports greater overall weight being given to outcomes measures.**

The proposal mentions that professionals who report quality measures through certified EHR systems would meet the meaningful use clinical quality measure component. But **it does not mention reporting through a registry in the description of this section. We urge this inclusion.**

The paper indicates the monies associated with penalties that would have been assessed under PQRS, VBM, and EHR MU would remain in the physician payment pool which would result in a significant increase in total physician payments as compared to the current law baseline. The proposal suggests that the amount available for total physician payments could increase in the neighborhood of \$10 billion over the period 2017-2023. **There is little evidence available to conclude that this amount of money is sufficient to bring about desired clinical behaviors.**

According to the concept paper, therapists will receive a flat (zero percent) update until they are eligible for the performance bonus in 2019 under the new VBP program. However, this reimbursement rate will only be flat if therapists are able to avoid penalties by successfully participating in PQRS.

Physical therapists at all sites are currently submitting functional limitation data on every patient. But because only a small percentage of therapists are eligible for PQRS, basing the composite score for therapists on outcomes, using functional limitation reporting as the model is a much more comprehensive and equitable model. In this case, all therapists in all settings would be eligible for the incentive programs and such a program would facilitate the desired quality of care and patient results that should prove to be the hallmark of a value-based purchasing program.

The paper specifies that therapists are eligible for no incentive payments until 2019. Thus, therapists have no alternatives during 2017 and 2018. Unless this is modified, the best reimbursement available to therapists from 2014 – 2018 would be a flat update. **We urge the committees to remedy this concept and make therapists eligible for the incentive payments the same time as physicians.**

**Resource use, clinical practice improvement activities and EHR MU do not currently apply to PTs. In responding to the Centers for Medicare and Medicaid Services (CMS) we have argued in the past that the VBM program is designed for physicians and cannot be applied to PTs without substantial modification. How the VBM would affect PTs in the new system remains unclear since the program is still in the design stage. We are similarly skeptical of the clinical practice improvement activities as most of the examples delineated in the concept paper are not applicable or clinically relevant to physical therapists.**

PPS can support the concept of excluding professionals who treat few Medicare patients, as well as professionals who receive a significant portion of their revenues from an advanced APM(s) from the VBP program. But **the threshold for this exception must be reasonable and specified.**

### **Payment Accuracy**

The proposal also calls for improving the accuracy of the physician fee schedule by setting a target for correcting “misvalued” services and allow for the collection of information on resources used in furnishing services. The proposal would involve the health care professional community in furthering the measurement of resource use.

PPS commends the committees for including this provision because the indiscriminant and arbitrary adjustments that have been made to the values of codes by CMS and Congress have created more inaccuracy. A prime example is the Multiple Procedure Payment Reduction.

At the beginning of this year, Congress passed and President Obama signed the American Taxpayer Relief Act (ATRA) which saved the nation from the so-called fiscal cliff by postponing sequestration for two months. ATRA contained a provision which negatively impacts Medicare beneficiaries with complex conditions requiring extensive physical therapy and other rehabilitative services.

The law more than doubled a cut passed by Congress two years ago. This provision, known as the Multiple Procedure Payment Reduction (MPPR) reduces payment for the practice expense portion of codes when therapeutic services are delivered in multiples or combinations, which is typical in physical therapy.

In 2011, physical therapists received a 20-25 percent (20% for private practices, 25% to facilities) MPPR on outpatient therapy services delivered on the same day. This means that when a treatment involves more than one procedure or a patient requires more than one therapy service in a single day, the code with the highest practice expense value that day will be reimbursed at 100 percent and the practice expense component of the second and subsequent codes will be reduced by 20-25 percent.

Under ATRA, this percentage was increased to a 50 percent reduction of the practice expense value for both private practice and facilities beginning April 1, 2013.

The MPPR congressional actions were used in both 2011 and 2013 as a means of paying for an extension of the Medicare Physician payment rate which was scheduled to be cut due to the flawed sustainable growth rate formula. Thus, these MPPR provisions represent bad policy employed to offset the cost of legislation to patch another flawed policy, the SGR. More importantly, this negative adjustment to the payment codes for the therapies has done nothing to enhance the accuracy of the payment system. In fact, it can be argued and demonstrated that these congressional manipulations have done just the opposite; i.e., reduced payment accuracy.

Therapy services are typically delivered in combinations and multiples in order to achieve the most positive outcomes. This fact is expressly recognized when the codes for therapeutic services are initially valued by the American Medical Association’s Relative Value Update

Committee (RUC). In other words, the practice expense component of physical therapy codes is already valued in accordance with the MPPR concept which means that the congressional actions of 2011 and 2013 are second and third insults to therapists and their patients. Moreover, this represents congressional micromanagement of the resource-based relative value scale (RVRVS), the system used to reimburse health care services for several decades.

Congressional manipulation of the intricacies of the Medicare Physician Fee Schedule (MPFS) is further evidence of the flawed system we are currently enduring. And this has been recognized by several witnesses testifying before the Finance Committee over the years. PPS concurs with this advice and urges Congress to prevent the implementation of this MPPR adjustment as it renders the FFS system less accurate rather than the more balanced system recommended during congressional hearings featuring Medicare Payment Advisory Commission chairman Glenn Hackbarth, Dr. Bob Berenson of the Urban Institute and others.

Accuracy of code values for payment should be relegated to the AMA RUC. If additional proscription or direction is necessary, Congress should so advise the RUC or even consider adjusting the composition or methodology of the committee. But congress should refrain from involving itself in the intricacies of payment code valuation as this is an exercise that has repeatedly fallen short of the stated desire of the Senate Finance Committee to increase payment accuracy.

**In developing the legislation to reform the SGR, PPS urges the committees to rescind this latest MPPR provision that took effect on April 1, 2013.** This policy is short-sighted, misdirected and restricts patient access to vital therapy services, especially impacting patients with multiple chronic conditions, most in need of intensive therapy treatment programs and treatment from more than one discipline (e.g., PT, OT, SLP). **Moreover, CMS recognized in 2011 that a 50 percent practice expense MPPR policy is not supportable by reliable data.**

**To create a more accurate payment system that is clinically relevant and patient-centric, PPS believes Congress should direct CMS to convert as soon as possible to a physical therapy reimbursement system based on severity of patient condition and appropriate intensity necessary to produce in optimal functional outcome.** This system should gradually evolve to per diem reimbursement and eventually to payment for an episode of care. When the fully mature severity-intensity payment model is realized, complete repeal of the arbitrary and discriminatory annual beneficiary therapy caps can be accomplished.

### **Alternative Payment Methods**

The committee proposal continues to encourage coordinated care and would exempt professionals who receive a significant portion of their revenue from an alternative payment method (APM) that involves two-sided financial risk and a quality measurement component (referred to as an "advanced APM") such as an accountable care organization (ACO). These professionals would instead receive a bonus payment starting in 2016.

To date there is evidence that physical therapists in independent practice are being excluded from the collaborative arrangements promoted through ACOs. This is no surprise as ACOs tend to be under the influence and control of physicians and institutions that view independent therapists as competition. Bonusing such alternative payment methods in 2016 could disadvantage therapists even more since the concept paper does not allow therapists to be eligible for performance incentives until 2019.

### **Therapy Caps**

The proposal does not include “extenders and additional policy priorities” such as the therapy caps but the paper indicates discussions continue to determine how bipartisan, bicameral agreement can be reached on those policies.

**PPS strongly urges the committee to include repeal of the therapy caps in legislation that repeals the SGR.**

**This year is an opportune time to seek a long-term strategy that would alleviate the pattern of yearly extensions that put patient access to medically necessary therapy services at risk.** Some 931,000 Medicare beneficiaries per year require the therapy cap exceptions process to ensure timely access to outpatient physical services. While passage of the therapy cap exceptions process has helped to reduce the risk of these services being discontinued it does not provide a permanent solution for policy makers or those who utilize outpatient therapy to remain functional in their daily lives. Including a long-term therapy cap solution in the larger SGR package will ensure that Medicare beneficiaries will continue to have access to **these vital services.**

**We urge you to include a long-term solution for the therapy cap in the SGR package.** By transitioning to a payment system for physical therapy based on the severity of the patient’s condition and the corresponding intensity of services required to achieve optimal outcome, the arbitrary and clinically irrelevant therapy caps can be repealed. Efforts to address the therapy cap must encompass reforms to a number of existing flawed policies, including the manual medical review process.

The American Taxpayer Relief Act (ATRA) extended a provision from previous legislation that established a manual medical review (MMR) process for outpatient therapy services exceeding \$3700. Unfortunately, providers, patients and consumers are encountering numerous challenges with regard to implementation of the MMR. When Medicare patients exceed \$3700 in outpatient therapy services, providers are experiencing major delays in the MMR process, overly burdensome additional documentation requests (ADRs), loss by the contractors of medical records submitted by providers, insufficient rationale for denials, and backlogs in the appeals process. As a result, patient access to medically necessary outpatient therapy is being increasingly threatened, potentially resulting in more complications and creating uncertainty about whether to proceed with patient care.

**PPS recommends the following policy revisions to MMR in order to better manage this process for the providers and the Medicare beneficiaries needing therapy services:**

- Develop an electronic mechanism for the submission, confirmation of receipt, and tracking of MMR requests;
- Require CMS to standardize, simplify, and make uniform forms, documentation requests, and determination letters;
- Establish an enforcement mechanism for compliance with the required 10 business day turnaround of MMR requests (e.g. financial penalties for contractors not performing the review in the required timeframe) and automatic approval of claims if 10 days is exceeded;

- Require a GAO or similar report to monitor the process. This should include metrics such as cases approved or denied, number of reviews when the 10 day turnaround was exceeded and number of successful appeals;
- Place a time limit on Medicare contractor issuance of ADRs (e.g. within one business day of receipt of claims exceeding \$3700); and
- CMS should review MMR data to determine if targeted medical reviews of outliers above \$3,700 is more appropriate than broad, burdensome, blanket review
- Outlier factor selection shall be data driven, transparent, and involve stakeholder input to assure appropriate access to patient populations with more extensive therapy needs.

**Performance Assessment**

Professionals would be assessed and receive payment adjustments based on a composite score that encompasses all of the applicable composite categories and associated measures. A professional would get a score in each category, which would add up to a single composite score. These scores would reflect the differences in professionals’ performance and would be tied to VBP incentive payments. Because it is a budget neutral program, payment increases provided to professionals with high performance scores would be offset by payment reductions to poor performing professionals. **PPS believes the creation of “winners and losers” is neither necessary nor appropriate to incorporate into a payment system for physical therapy services provided to our nation’s elderly.**

**Weights for Performance Categories**

The Weights for Performance Categories are described in the following table. However, **since at least two of the above identified categories do not apply to PTs, it needs to be determined what effect that will have on the weighting and subsequent performance score and monetary incentives. At minimum, a separate weighting table for physical therapists should be created and disseminated.**

Category	PY 2017 Weight	PY 2018 Weight	PY 2019 Weight
Quality	60% total with neither category less than 15%		30%
Resource use			30%
Clinical practice improvement activities	15%	15%	15%
EHR meaningful use	25%	25%	25%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

**Performance Pool Funding**

For 2017, the funding available for VBP incentive payments would be equal to eight percent of the total estimated spending for VBP eligible professionals. Eight percent is the projected 2017 amount tied to performance under the current law incentive programs. The entire funding pool for a year would be paid out to eligible professionals based on their VBP composite score for a

specified performance period, with those achieving the highest scores receiving the greatest incentive payment. The funding pool would be increased to nine percent in 2018 and ten percent in 2019. Starting 2020, the Secretary would have the authority to increase, but not lower, the funding pool.

**PPS believes that limiting VBP incentive payments to an aggregate of eight, nine or even ten percent of total estimated spending is a flawed theoretical construct. Presently, there is no definitive way to know if this size of a funding pool is sufficient to bring about the desired behavior.** What is known is that participation in the PQRS program has been disappointingly low leading to the reasonable conclusion that the program, including the incentive amount, is flawed. In addition, the VBM program is in its infancy and the EHR MU program does not apply to nonphysician professionals. This leaves us doubting that there is sufficient data to support a decision to set the size of the incentive payment pool at 10 percent of total spending. Moreover, due to the “winners and losers” construct described, if 50 percent of professionals earned a composite score that warranted even some incentive payment, this would mean that half of the participating providers would be penalized. We believe this construct needs further vetting as well as statistical analysis.

#### **Feedback for Performance Improvement**

The proposal calls for the Secretary to provide confidential feedback on performance in the quality and resource use categories to professionals *on a timely basis*, such as quarterly. Feedback may be provided using multiple mechanisms, such as a web-based portal or qualified clinical data registries. This system of timely and actionable feedback would replace the current confidential quality and resource use reports, thus avoiding the potential for redundant feedback mechanisms. **PPS is concerned about the Secretary’s capability of meeting this tenet, given that presently in the PQRS program, feedback is provided 18-24 months in arrears.** In addition to timely, feedback must be prompt; meaning that quarterly reports, for example, should be based on what took place in the immediate transpiring quarter and not several time periods in the past.

#### **Assistance to Small Practices**

The Secretary, through Quality Improvement Organization (QIOs) or other entities, would provide assistance to practices of ten or fewer eligible professionals located in HPSAs or rural areas to help them improve performance and to facilitate participation in advanced APMs. Ten million dollars would be available each year from 2014 to 2018 to provide such technical assistance.

**Providing assistance to “small practices” is prudent and supportable. But how assistance is prioritized and awarded will need to be specified and reviewed. Insufficient information is currently available to determine if \$10 million annually for five years is likely to bring about the desired results.**

#### **Encouraging Alternative Payment Model Participation**

The concept paper describes at least two options by which successful APM participation could be rewarded. Professionals who have a significant share of their revenues in an APM(s) that involves two-sided financial risk and a quality measurement component would be excluded from the VBP composite assessment and the EHR meaningful use information exchange and quality reporting requirements, and the bonus would not be counted in any assessment of an APM’s expenditures. This means that any professionals electing to start or join an accountable care

organization that embraces only a *one-sided risk*, would not be eligible for this consideration despite their attempts to practice in a model promoting efficiency and effectiveness.

The proposal also would encourage the Secretary to test APMs relevant to specialist professionals and those that align with private and state-based payer initiatives. **PPS would urge the committees to include in the concept paper and subsequent legislation, direction of the Secretary to test an alternative payment system for the physical therapies that considers the severity of the patient's condition and the intensity of services necessary to bring about an optimal functional outcome. Such a system better reflects the professional clinical reasoning and judgment of the therapist, improves patient care, and provides policymakers and payers with an accurate payment system that ensures the integrity of medically necessary services. Legislative language similar to that included in HR 574, the *Medicare Physician Payment Innovation Act of 2013* is recommended.**

**We also recommend the inclusion of the reference to outpatient therapy that incentivizes adherence to a comprehensive list of cost, quality, and outcome measures as demonstrated by participation in a certified registry, the physician quality reporting system, use of an approved patient assessment tool, current certification as a clinical specialist, or measuring and reporting the functional status of patients. (Also in HR 574)**

#### **Qualified Entities**

The proposal would expand the data available to qualified entities (QEs) for quality improvement activities as well as the information available on the Physician Compare website to help consumers make informed purchasing decisions and help professionals improve their performance. However, the concept paper does not specifically define QEs. We assume the term could refer to organizations such as the National Quality Forum (NQF) or Quality Improvement Organizations (QIOs), but would **urge the committees to be specific in the next phase of proposal development.**

#### **Expanding the Use of Medicare Data for Performance Improvement**

The proposal would allow those that currently receive Medicare data for public reporting purposes (qualified entities, "QEs") to provide or sell non-public data analyses to physicians and other professionals to assist them in their quality improvement activities. The proposal would also allow QEs to provide or sell similar analyses to health insurers and employers meeting certain criteria.

The proposal would also expand the data available to QEs to include Medicare Advantage and Medicaid/CHIP data and require the Secretary to make data available to qualified clinical data registries to support quality improvement activities. **PPS urges the committees to establish a precise definition of QEs. Therapists and other nonphysician professionals would recommend that such definition include entities (such as clinical registries) to which therapists may report.**

#### **Transparency of Physician Medicare Data**

The proposal would require HHS to publish utilization and payment data for physician and other practitioners on the Physician Compare website. In addition to the quality and resource use information that would be posted through the VBP program, this information would assist beneficiaries in selecting professionals by enabling them to search for professionals by name,

specialty, and services. Professionals would continue to have an opportunity to review and correct their information prior to its posting on the website. **PPS has long supported professionals' opportunity to review and correct their information prior to its posting on the website.**

As Congress considers ways to modernize the Medicare reimbursement methods, PPS also urges serious consideration be given to correcting a number of obstacles that, at minimum, prevent independent physical therapy practitioners from providing care in the most streamlined of manners. At least one correction would curb over-utilization and thereby generate savings. These include: locum tenens, opting out of Medicare, and the in-office ancillary exception.

### **Locum Tenens**

**PPS supports HR 3426 the *Prevent Interruptions in Physical Therapy Act*, which adds physical therapists to the statute allowing locum tenens arrangements under Medicare. We urge its inclusion in the Medicare legislative package being developed by the committees.**

Locum tenens is a longstanding and widespread practice for physicians to retain substitute physicians in their professional practices when they are absent for reasons of illness, pregnancy, vacation or continuing medical education. It is also acceptable for the regular physician to bill and receive payment for the substitute physician's services as if he, or she, performed them. The substitute physician generally has no practice of their own and moves between practices as needed.

The patient's regular physician may submit a claim and (if assignment is accepted) receive the Part B payment for covered visit of a locum tenens physician who is not an employee of the regular physician and whose services for patients of the regular physician are not restricted to the regular physician's offices, provided specific criteria are met.

However, physical therapists are not included in the locum tenens statute and this creates a hardship for independent practitioners who operate small businesses. The locum tenens provision included in section 1842(b)(6) with the enactment of Section 125(b) of the Social Security Act Amendments of 1994, only allows locum tenens for practitioners identified as "physicians" under Medicare.

HR 3426 would add physical therapists to the list of professionals allowed to obtain a temporary substitute provider. This patient-centric policy change does not carry a cost and is an essential modernization of Medicare reimbursement policy. Please include this provision in your legislation.

### **Adding Therapists to List of Professionals Allowed to Opt-out of Medicare**

Physical therapists may not collect out-of-pocket payment from a beneficiary for a Medicare covered service and PPS recommends Congress remedy this oversight by amending the statute to allow such transactions with consenting Medicare patients. By making this change in statute, Congress will require physical therapists to comply with the same private contracting (opt-out) requirements as physicians and non-physicians who already enjoy this privilege. In such an instance under current law, the physical therapist would not be reimbursed for treating Medicare patients for two years following the filing of the opt-out affidavit. Beneficiaries with means who are able and willing to pay out-of-pocket for services will not have an adverse

effect on the Medicare program. This has been amply demonstrated by the professions who are currently allowed to opt-out. **Physical Therapists simply wish to join their professional colleagues on this list in current law.**

PPS recommends that Section 1802(b)(5)(B) of the Social Security Act be amended as follows:

*Inclusion of physical therapists under private contracting authority, Section 1802(b)(5)(B) (42 U.S.C. 1395a(5)(C)) is amended by striking "the term practitioner has the meaning given such term by section 18a2ft)(18)(C)" and inserting "In this subparagraph, the term "practitioner" means an individual defined at section 18a2ft)(18)(C) or an individual who is qualified as a physical therapist."*

### **Physician Self-Referral**

Physician self-referral has been linked to increased utilization in numerous ways and by several reputable reports. Last fall, the Government Accountability Office (GAO) issued a report showing increased utilization in imaging when physicians own sophisticated imaging equipment. A GAO study with similar results in the anatomic pathology labs was published in June.

Currently under Medicare Part B there are various ways to bill for services. One policy in particular -- the Stark II in-office ancillary services exception to the self-referral law -- carries a proven propensity for overutilization. PPS believes, and evidence shows, that elimination of this exception could provide cost-savings and improve the integrity of the services delivered and paid for by the Medicare program. **The Office of the Inspector General of the United States Department of Health and Human Services has continued to identify a high rate (78 to 91 percent) of inappropriate billing of physical therapy services billed incident to a physician's professional services.** Moreover, both the President's budget and the Bowles-Simpson Commission have recommended that the in-office ancillary services exception be eliminated. Elimination of these practices must be addressed in an effort to provide a sustainable payment system for Medicare Part B and ensure we are paying for only services delivered appropriately by qualified professionals of that discipline.

At a time of fiscal austerity for the nation coincides with the search for ways to curb utilization of Medicare services, especially inappropriate utilization, **it is time to end this practice of physician self-referral by eliminating the in-office ancillary services exception. Such elimination would be accomplished by language included in the *Promoting Integrity in Medicare Act of 2013 (HR 2914)* which PPS supports. The 10-year savings rendered from enactment of such policy is between \$1.8 billion (CBO) and \$6 billion (OMB).**

### **Conclusion**

The above-discussed issues have beneficial effects for the Medicare beneficiaries, the physical providers, and the Medicare system in the following ways. Repealing the SGR and allowing private contracting have major positive impacts on the provider and secondary benefits for the patient. The therapy cap repeal (or extending the exceptions process) is primarily a Medicare beneficiary issue. Curbing overutilization through elimination of the in-office ancillary exception enhances patient protection while simultaneously benefitting the Medicare program.

The current reimbursement method is but one of a systematic series of changes needed in order to streamline the performance of clinicians and the care of patients. The other elements essential to modernizing the Medicare payment system are addressed in this letter.

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House Ways and Means Committee  
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On behalf of PPS, thank you for your continued efforts to create a more stable, predictable and effective Medicare payment system. Our organization is eager to continue to work with the Finance Committee, Congress in general, and CMS to help preserve and strengthen the Medicare program which means increasing quality, decreasing cost and improving outcomes.

Sincerely,

A handwritten signature in cursive script that reads "Tom DiAngelis".

Tom DiAngelis, PT, DPT  
President  
Private Practice Section