PRIVATE PRACTICE SECTION, APTA

American Physical Therapy Association

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Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services Attention: CMS-6082-NC
Room 445-G
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Submitted electronically

RE: Request for Information; Reducing Administrative Burden to Put Patients over Paperwork [CMS-6082-NC]

Dear Administrator Verma:

On behalf of the over 4,000 members of the Private Practice Section (PPS) of the 100,000 member American Physical Therapy Association (APTA), I write to provide input and feedback on the Department of Health and Human Services request for information (RFI) regarding the Reducing Administrative Burden to Put Patients over Paperwork.

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.

PPS appreciates that CMS is cognizant of the undue and unnecessary administrative burdens that providers and suppliers must bear when they provide care to Medicare and Medicaid patients. Representing independent small business owners we are interested in policies that will reduce administrative burdens so that our members can focus on providing affordable, high-quality, and clinically appropriate outpatient physical therapy to patients who are Medicare beneficiaries. Our members are proud of the quality of care they provide, but as small business owners are also keenly aware when an administrative task is burdensome and duplicative. The time they spend on redundant paperwork is time they are not able to be caring for their patients.

PPS strongly urges the CMS to consider the following recommendations when evaluating how to use its regulatory authority to modernize and reduce administrative burdens for Medicare-enrolled providers and suppliers. Below please find suggestions based upon experiences of

private practice physical therapists who provide care to Medicare and Medicaid beneficiaries. PPS hopes that the experiences and expertise shared will be helpful.

Medicare Fee-For-Service

Streamline Plan of Care Certification Requirements

PPS strongly recommends that CMS revise the initial certification requirement for the therapy plan of care. A primary administrative burden of a private practice physical therapy clinic is the logistical and administrative obstacle course of sending out, tracking, and finally receiving physician sign-off of the therapy plan of care.

Our members report that most of the time the front office at the physician's office opens the submitted therapy plan of care, scans it into their system then shreds the original—in spite of instructions included which detail the process, explicit request for the physician's signature, and being paired with a return envelope to facilitate the return at no cost to the physician. For those therapists practicing in rural locations, it is not possible for the therapist offices to hand-deliver their plans of care or make the request in-person to ensure the instructions are followed. Regularly our members, who are both therapy providers and small business owners, have to make at least one, if not two or three follow up phone calls followed by faxing over a copy of the plan of care before receiving the physician's signature. This is very time and resource consuming, especially when about ninety percent of the time they already have written referrals from the physician/nonphysician practitioner (NPP) in the medical charts.

The unintended consequence is that care is frequently delayed while awaiting a physician signature; this delay places the beneficiary at risk. Furthermore, while the physical therapist has performed due diligence in requesting a physician/NPP signature, the financial burden falls on the physical therapist, leaving him or her unable to bill for the services rendered. Moreover, in instances of delayed certifications, the therapist must then identify and compile evidence that is necessary to justify the delay, further increasing his or her administrative burden. This is compounded by the frequent lack of physician response, which leaves the therapist with an inadequate paper trail of the interaction.

Each state has adopted some form of direct access to physical therapy which allows patients to go directly to a physical therapist for care without a referral. This direct access opportunity ranges from state to state—from wholly unrestricted to only two weeks of care before a referral is required to continue services. However, because of the current Medicare signed plan of care requirements, many therapists are not able to support this direct access flexibility for their Medicare beneficiary patients.

This administrative burden is untenable and unnecessary; therefore, PPS encourages CMS to modify the requirement to obtain a physician/NPP signature on the plan of care. PPS recommends that for therapists practicing in states with direct access that the federal signed plan of care requirements follow that state's regulations regarding signed plan of care. However, if CMS continues to require a signed plan of care for all Medicare beneficiaries, PPS strongly suggests that the written referral documentation from the physician/NPP be treated by CMS as

the equivalent of approval of the plan of care because an order/referral constitutes evidence that the patient needs therapy services and that the patient is under the care of a physician/NPP. Affording flexibility to physical therapy providers will greatly relieve them of the fiscal and administrative burdens associated with obtaining physician certification, while continuing to ensure that the patient is under the care of a physician.

Reduce wait-time for Credentialing

Physical therapists in private practice frequently experience significant delays with Medicare credentialing, ranging anywhere from 3 months up to a year. Additionally, current policy requires a licensed physical therapist to be credentialed for each practice location in which they provide and bill for a Medicare service. Some of our members own and operate a number of clinics. In these cases, they as well as each physical therapist they hire must be credentialed separately for each location. Not only is this redundant, but keeping up with all the credentialing at multiple locations—often in the same city—is a significantly expensive administrative burden.

The unpredictable and drawn-out wait time imposed upon private practice physical therapists to move through the Medicare credentialing process for each location hinders every practice's ability to quickly onboard staff which are needed to meet its community's demand for care. With the increasing number of Medicare beneficiaries, coupled with the realities of opioid epidemic, there is a critical need for access physical therapists. Delays in credentialing can result limited access for Medicare beneficiaries and disruptions in care delivery. To ensure access to physical therapy, particularly in rural and medically underserved areas, it is imperative that CMS improve the credentialing process.

PPS suggests that CMS include physical therapists within the list of practitioners for whom CMS has established an effective date of Medicare billing privileges; this would reduce credentialing delays and better ensuring beneficiary access to medically necessary physical therapist services. This could be achieved by modifying 42 CFR §424.520(d) and revising the Medicare Program Integrity Manual, Chapter 15, Section 15.17 to include physical therapists within the list of individuals and organizations for whom CMS has established an effective date for billing privileges.

Finalize proposed changes to the Common Working File

It is not uncommon for Medicare beneficiaries who are admitted to a home health Part A stay to also seek outpatient physical therapy. However, it is common for home health agencies (HHAs) to delay submitting the Request for Anticipated Payment to CMS. As a result, the beneficiaries' status in the beneficiary eligibility database is often out-of-date. As a result, outpatient physical therapy providers may unknowingly furnish therapy services to Medicare beneficiaries who are under a home health plan of care—despite their best efforts to check the Common Working File before providing care. Consequently, claims for such services have been denied and/or overpayments have been recovered.

PPS was very pleased when the CY2020 Home Health proposed rule stated that "beginning in CY 2021…all HHAs submit a one-time submission of a Notice of Admission (NOA) within 5 calendar days of the start of care to establish that the beneficiary is under a Medicare home

health period of care. The NOA would be used to trigger home health (HH) consolidated billing edits, required by law under section 1842(b)(6)(F) of the Act, and would allow for other providers and the CMS claims processing systems to know that the beneficiary is in a HH period of care." PPS is further pleased that if there is any beneficiary discharge from home health services and subsequent readmission, a new NOA would need to be submitted within 5 calendar days of an initial 30-day period of care. These changes will streamline patient transition from HH to outpatient physical therapy as well as improve the accuracy of beneficiary eligibility status.

Medicare Advantage

Require Medicare Advantage payers to Provide Accrued Amount of Therapy Services

When Medicare Advantage (MA) payers do not furnish providers with information related to each MA enrollee's therapy utilization toward outpatient therapy threshold—yet still require therapy providers affix the KX modifier for services above the outpatient therapy threshold to indicate medical necessity—it places an unnecessary and unreasonable tabulation burden on the therapy providers.

In the Medicare fee-for-service (FFS) program, outpatient therapy providers are generally able to access tabulations of the accrued amount of therapy services a beneficiary has received. However, many MA plans do not update the accrued amount of therapy services, requiring therapy providers furnishing care to MA enrollees to internally track total claim amounts for enrollees and apply the required KX modifier to claims exceeding the threshold ($2,040 for PT, SLP combined in 2019) when appropriate. By refusing to update the accrued amount of outpatient therapy services, MA plans render it extremely difficult, if not impossible, for therapists to determine when to affix the KX modifier to the claim to indicate that services over the threshold are medically necessary. This is especially the case when patients have received both physical therapy and speech language therapy, usually in two different settings.

Physical therapists in private practice have not received federal financial support to invest in robust, certified electronic health record technology. While many utilize some sort of electronic health record (EHR), others located in rural areas deal with very unreliable internet service where using an EHR is not feasible. In those situations, potential EHR businesses have no solution beyond suggesting that the providers keep off-line or hard copies of everything for the days they have no internet service—functionally requiring a redundant manual system. In these cases, office managers manually track their Medicare patients' charges on a spreadsheet so the office can know when the patient is approaching the threshold for applying the KX modifier.

The lack of disclosure on the part of the large, commercial MA plans places a significant and unnecessary administrative and financial burden on private practice outpatient therapy providers. If the CMS truly wants to focus on patients over paperwork and reduce burdens for therapy providers while improving the quality of care, decreasing costs, and ensuring that patients and their therapy providers are making the best health care choices possible, the Agency would require MA plans provide data on enrollee utilization of therapy services in real-time instead of

forcing the providers to expend time, effort, and resources calling MA plans and inquire as to the enrollee's eligibility.

Limit Prior Authorization and Third-Party Utilization Management

PPS contends that current prior authorization/UM programs used by Medicare Advantage (MA) plans and Medicaid Managed Care Organizations (MCOs) fail to strike the balance of encouraging quality care and efficiency. Instead these tools, as currently used by MA plans and MCOs, increase administrative burden while simultaneously adversely impacting patient access to medically necessary services. When beneficiaries choose their MA plans, they purchase coverage that offers, for example 30 physical therapy visits per year. As a result, those patients expect to be able to be treated by a physical therapist 30 times if therapy is prescribed by a physician and a physical therapist determines that therapy is medically necessary—instead that decision is made by their MA plan and not in a straight-forward way.

When care is rationed solely based upon the volume of services, the possibility of inadvertent error can become a reality. Prolonged, burdensome processes to obtain treatment authorizations result in delayed access to care. In many cases, the patient understands that delaying care may severely hinder their recovery, but is wholly unaware of the presence of prior authorization and UM hurdles that result in physical therapists and other providers being forced to decide between furnishing an uncovered service at their own expense or risk the patient's health and well-being by waiting for a plan to authorize medically necessary care. Furthermore, in some cases therapists following all required guidelines from the MA plan and still receive rejections.

PPS members have experienced MA plans limiting the amount of therapy covered in a number of ways. Some MA plans will authorize care using algorithms based on the diagnosis codes, procedure codes, and outcome measure used, without consideration given to the therapy prescribed by the patient's physician or the evaluation done by a licensed physical therapist. Some major MA plans give authorization for a number of units instead of a number of visits; tracking the units approved versus the units billed by the therapists requires a significant amount of paperwork. One therapist describes the burden this way, "each claim date has to be opened and edited on our electronic software program and then manually written on a spreadsheet to track the units authorized versus billed."

Disturbingly, the care authorized by the health plan often disagrees with the health care professional's recommendations. Effectively, MA plans are questioning the professional judgement and expertise of the therapists (and possibly the referring providers as well). In essence, using UM protocols, MA plans are treating therapists as if they don't have the knowledge necessary to make medical assessments for their clients. It is vital that future approaches that allow for prior authorization recognize a clinician's ability to render patient-centered care using evidence-based guidelines, clinical judgment and decision-making, and full scope of licensure. This would help ensure timely patient access to medically necessary services and streamlined administrative processes.

Unfortunately, current prior-authorization programs are not consistent with these objectives. Further, each MA plan's instructions for obtaining prior approval for current and ongoing

patients are unclear. Therefore, to reduce clinician burden and promote standardized data collection, PPS recommends that CMS incorporate standard language within its contracts that requires all MA plans to adopt a prior-authorization process wherein all prior authorizations, whether submitted directly to the MA insurer or to a subcontractor, are submitted through an electronic portal (consistent portal framework) using the same standardized form that was developed by CMS utilizing stakeholder input and reflecting public comments. Employing the standard prior-authorization process, the MA insurer or subcontractor would be required to approve or "deny" an authorization within 24 or 48 hours, then allow 72 hours for the provider to appeal through a similar, standardized electronic portal; if the insurer or subcontractor failed to do implement this protocol, it would be at risk of being in violation of its contract with CMS. Furthermore, if the insurer or subcontractor failed to reply within the 24 or 48 hour timeframe, the authorization would be granted. This type of process would allow the payer to use algorithms—that had been reviewed by stakeholders including professional associations—to identify the most blatant instances of abuse while also allowing for proper, timely care to beneficiaries being treated by licensed and reputable physical therapists.

Streamlining processes to ensure patients continue to receive high-quality care and avoid stinting on medically necessary services while reducing administrative burden to all parties involved would align well with CMS's Patients over Paperwork initiative. Therefore, PPS recommends CMS consider exempting from prior authorization patient populations with certain conditions and clinicians who participate in standardized data collection systems and are willing to share outcomes (requiring the use of specific performance-based outcome measures and/or requiring the collection of patient-reported outcome measures) which have clinical utility and importance that are meaningful to a diverse set of provider types.

Ultimately, PPS urges CMS to take action toward a goal of reducing unnecessary burden, increasing efficiencies, and improving the customer experience by eliminating prior authorization or, at a minimum, penalizing MA plans that fail to furnish visit-based authorizations within a limited timeframe listed in the policy. By protecting MA and/or Medicaid enrollees from arbitrary care denials and restrictions, CMS would help to better ensure patient access to timely, high-quality care that is appropriate for the patient's condition, and avoid preventable adverse events, while saving plans, providers, and patients from expending resources on unnecessary services.

Standardize Application of Medical Necessity Definition between Medicare and MA plans
Unfortunately, the definition of medical necessity used by MA plans commonly echoes the definition used in their commercial products and not the Medicare definition. Therefore, PPS recommends that CMS require that MA plans use the same definition of medical necessity that exists under Medicare Part B. PPS further recommends that CMS standardize the Medicare coverage, coding, and billing guidelines that an MA plan may adopt. MA plans often state that they follow Medicare guidelines but then have interpretations of these guidelines regarding the use of Correct Coding Initiative edits, the multiple procedure payment reduction, and the 8-minute billing rule that are inconsistent with Medicare itself. Standardization of guidelines between Medicare and MA would reduce confusion among providers, improve documentation

integrity, care coordination, and collaboration among health care providers while significantly reducing increasing provider burden and improving the quality of care.

Standardize CMS and MA Plans' Submission Processes for Medical Review

CMS and MA plans' requirements for submitting documents in response to a medical review vary significantly. For example, when submitting documentation in response to an Additional Documentation Request, providers must use one process for Original Medicare, a second process for MA insurer #1, and a third different process for MA insurer #2, and so on. Furthermore, in order to use a website for electronic submission, for each payer the provider must log into a portal, familiarize themselves with the website map, and use a separate submission protocol.

To decrease burden and substantially increase interoperability, PPS recommends that CMS require each MA plan, as well as each CMS contractor (Medicare Administrative Contractor, Recovery Audit Contractor, Supplemental Medical Review Contractor, etc.) to use the same format, structure, and website and webpage layout, and opportunity to submit records or correspond electronically. Administrative burden is sure to be reduced if providers are able to submit to all payers using the same layout, file structure, and transport method, and with a similar webpage layout.

Health Information Technology

Eliminate Financial and Technical Barriers Preventing Physical Therapists from Adopting Certified EHR Technology

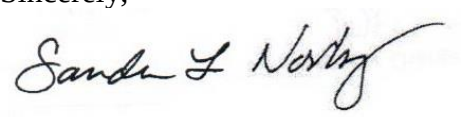
PPS supports rehabilitation providers being able to fully participate in the Quality Payment Program. While at this point physical therapists are not scored on their utilization of certified electronic health record technology (CEHRT), it is important to point out that physical therapists in private practice were ineligible to participate in the Meaningful Use EHR Incentive Program and have received little to no direction or resources, to adopt and implement comprehensive, interoperable EHR systems that promote care coordination and improved patient outcomes. This is stark contrast to physicians and hospitals who were afforded EHR incentive funding and multiple opportunities to adopt EHRs and learn how to successfully exchange patient information using CEHRT.

To ensure that the future health care system is patient-centric and dedicated to improving care quality and increasing patients' access to their information, all relevant parties across the continuum need and deserve financial and administrative support to help them implement CEHRT and adopt measures that give patients the ability to manage their health information. It is critical that patient information can flow between various sectors of the care continuum, including physicians, hospitals, physical therapists in private practice, post-acute care and long-term care providers, and other health care providers. Therefore, PPS recommends that CMS provide administrative and financial support to help providers—including physical therapists in private practice who did not receive financial or technical assistance associated with Meaningful Use—adopt and implement CEHRT.

Conclusion

PPS appreciates the opportunity to respond to CMS's RFI to Reduce Administrative Burden to Put Patients over Paperwork. We hope our insight and perspective will be helpful as CMS considers making changes which will reduce administrative burden, allowing providers and suppliers to focus on improving patient outcomes.

Sincerely,



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