Private Practice Section, APTA
1421 Prince Street
Suite 300
Alexandria, VA 22314
(800) 517-1167
www.ppsapta.org
APTA American Physical Therapy Association

October 5, 2020

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-1734-P

Submitted electronically

RE: Medicare Program; CY 2021 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; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug Under a Prescription Drug Plan or an MA-PD Plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy [CMS-1734-P][1]

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 4,000 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) 2021 Revisions to Payment Policies under the Physician Fee Schedule (PFS) and Other Revisions to Medicare Part B proposed rule.

Representing physical therapists who are also independent small business owners, PPS encourages and supports policies that enable our members to focus on providing high-quality, cost-effective, 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

[1] https://www.govinfo.gov/content/pkg/FR-2020-08-17/pdf/2020-17127.pdf (CMS-1734-P)

drastic, unfounded, and unreasonable 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 and feedback:

PHYSICIAN FEE SCHEDULE

- **Urge complete reassessment of the 9% reduction to payment for physical therapists in 2021**
    - **It is crucial that during and immediately following a public health emergency, CMS not move forward with drastic cuts to specialists such as physical therapists**
    - **The impact of COVID-19 will increase the need for physical therapy services and is wrecking economic havoc on the business model of providers, putting many on the verge of closure**
    - **Consider likelihood of drastic reduction in patient access to physical therapy**
        - **Cost-effective outpatient physical therapy clinics will be forced out of business**
        - **Providers who cannot afford to care for Medicare patients may disenroll from Medicare entirely**
- **Challenge the untenable reduction of the conversion factor to below 1994 amount**
- **Enthusiastic support for CMS proposing to allow PTAs to provide maintenance therapy in all Part B settings.**
- **Strongly support enabling physical therapists to use telehealth methods to provide care**
    - **Support the continuation of the use of technology to keep engaging with established patients**
    - **Recommend CMS permanently add physical therapy services to the Medicare telehealth services list**
        - **Documented clinical benefit to providing physical therapy care via telehealth**
        - **Suggest CMS support Congress' efforts to legislate Medicare coverage of physical therapy care provided using telehealth**
- **Strong appreciation of focus on reducing administrative burdens**
    - **Support allowing physical therapists to be included in the list of practitioners who can review and verify documentation in the medical record instead of re-documenting**
    - **Recommend deletion of NCCI edits that were reinstated on October 1, 2020**
    - **Recommend that CMS update the supervision requirements for a Physical Therapist Assistant from direct to general supervision**

- **Suggest a waiver of the Plan of Care signature requirement**

QUALITY PAYMENT PROGRAM

- **Appreciate the continued inclusion of physical therapists in the Merit-Based Incentive Payment Program**
- **Support the continued exemption 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**
- **Recommend using performance period data for benchmarking**
- **Support changes to PT/OT measure set**
- **Suggest involving physical therapists in MVP program design discussions in order to ensure that it is of value and accessible for rehabilitation therapist participation**

PHYSICIAN FEE SCHEDULE

Urge complete reassessment of the conversion factor and 9% reduction to payment for physical therapists in 2021

PPS strenuously objects to the untenable conversion factor (CF) reduction proposed by CMS in the 2021 PFS proposed rule. It is unacceptable for the 2021 conversion factor to be below the 1994 conversion factor of $32.9050—which is worth approximately $58.02 today when adjusted for inflation.[2] While we support the CPT coding revisions and revaluations of office and outpatient evaluation and management (E/M) services recommended by the AMA/Specialty Society RVS Update Committee (RUC), we strongly oppose the proposed steep CF reduction to $32.2605.

In light of the ongoing impact of the pandemic upon our ability to meet the needs of our patients, we strongly urge CMS to exercise its administrative discretion to eliminate or substantially mitigate the proposed CF reduction. We expressed our strong opposition to cuts to specialties in the original 220 PFS proposed rule, and because of the additional one percent added—resulting in a projected nine percent cut—our concerns are now even greater than before. In last year's PFS final rule, CMS provided repeated assurances that the medical community's concerns about the potential budgetary impact of the E/M changes and the community's suggestions for mitigating that impact would be taken into account once the budgetary impact of all proposed 2021 changes was calculated. Despite these assurances, the 2021 PFS proposed rule fails to acknowledge the devastating impact of the proposed CF reduction, particularly in light of the obvious and extraordinary financial stress currently being felt by our nation's physicians and non-physician practitioners because of COVID-19.

[2] Using the U.S. Bureau of Labor Statistics inflation calculator, the conversion factor in 1994, $32.9050, is worth approximately $58.02 today. This means that the proposed CY 2021 cut of the conversion factor to $32.2605 is an even steeper cut when adjusted for inflation and is by far the lowest conversion factor since its inception in 1992. https://www.bls.gov/data/inflation_calculator.htm.

The 2021 PFS proposed rule fails to consider, address, or discuss any of the numerous suggestions already offered by commenters, stakeholders, and Members of Congress that could be implemented in order to mitigate the budgetary impact of these proposed changes; instead this proposed rule has reiterated CMS' plan to implement drastic reductions in payment for physical therapists and other specialists on January 1, 2021. These cuts could jeopardize patient access to medically necessary services. The reductions are primarily driven by new Medicare payment policies for evaluation and management (E/M) codes for office and outpatient visits. Severe cuts caused by changes to these visit codes will further strain a healthcare system that is already stressed by the COVID-19 pandemic. It is shortsighted for CMS to not consider that primary care providers and referring physicians will have fewer choices when referring patients to physical therapy if physical therapists are forced to close or limit their practices as a result of these cuts.

While CMS has presented these cuts as the means to achieve budget neutrality for these and other PFS changes proposed for 2021, we remain steadfast in our position that these cuts will eviscerate the financial viability of a private practice physical therapy clinic. Furthermore, as our nation struggles with the impact of the COVID-19 Public Health Emergency (PHE), the concerns we expressed in 2019 have been magnified. If adopted as proposed, the 2021 Medicare PFS payment rates will surely jeopardize the recovery of the nation's healthcare system by exacerbating revenue shortfalls that are already threatening the financial viability of physician and non-physician providers across the country. Private practice physical therapists will be hard-pressed to overcome the significant reduction in Medicare payment for services provided in outpatient therapy clinics at a time when the spread of COVID-19 remains unchecked and patient volume is down. Data collected by our parent association, the American Physical Therapy Association (APTA) found that 38% of physical therapy owners/partners reported that revenue had decreased 76% to 100% in the early phases of the pandemic, with another 34% reporting declines of 51% to 75%.[3] Sixty-four percent saw fewer patients via direct access visits, and 88% reported a drop-off in physician referrals.

Furthermore, if implemented, the proposed drastic reduction in payment would be in addition to the 2% sequestration reduction, thereby amounting to a 11% cut in reimbursement. This 11% 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 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 9% 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

[3] Impact of COVID-19 on the Physical Therapy Profession Report: A Report from the American Physical Therapy Profession (June 2020). https://www.apta.org/contentassets/15ad5dc898a14d02b8257ab1cdb67f46/impact-of-covid-19-on-physical-therapy-profession.pdf

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.[4]

PPS would like to remind CMS that it has significant administrative discretion in administering the budget neutrality provision, and that under the unique circumstances of the PHE currently in effect, the Administration has the power to lessen the impact of this provision by utilizing funds outside of the PFS. In this context, we urge CMS to consider mitigating the impact of the BN provision by taking at least one of the following actions. CMS could exercise its PHE authority to eliminate or reduce the impact of the proposed CF reduction. It could also eliminate the new E/M add-on code (GPC1X) because the premature adoption of GPC1X for payment purposes will not only create open-ended liability for the Medicare Trust Fund but also will increase aggregate beneficiary copayments at a time when many Americans are facing their own financial crisis. If CMS is unwilling to delay implementation of the GPC1X code, PPS requests that it be implemented on a "no-pay" basis in 2021, so that reliable utilization data can be collected for use in future budget neutrality calculations. Another option would be for CMS to exercise its considerable statutory discretion to either reduce the overall projected utilization of E/M services by at least 8 percent to reflect the drop in visits resulting from the continuing pandemic or utilize a base period that reflects the reduced utilization of physicians' services resulting from COVID-19 which would be in line with CMS' own rationale regarding the need to consider using 2020 data for QPP benchmarking.[5]

PPS is shocked and dismayed that CMS has proceeded to put forth drastic reductions to reimbursement at a time when policy makers in Congress and at HHS are focused on patient access to quality, integrated, team-based care, in pursuit of life- and money-saving chronic disease management and reducing hospital admission/readmission rates for beneficiaries residing in the community. Private practice physical therapists provide care that meets all of these goals. 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 co-morbidities if fee schedule rates are drastically reduced. CMS must recognize that a 9 percent reduction in reimbursement for physical therapists fails to align with CMS' efforts to drive better patient access to care and management.

[4] 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

[5] CMS-1734-P, pp 50307

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

Policies Implemented during the Public Health Emergency that should be made Permanent

Categorized as essential early in the COVID-19 pandemic, physical therapists have served critical roles on the front lines helping stricken patients regain mobility and recover while also safely providing care to their existing patient population. At the same time, many have had to deal with the complete disruption, and in some cases collapse, of their business model. Most outpatient physical therapists have been challenged by the moratorium on elective surgeries as well as the impact of following federal guidelines aimed at mitigating the transmission of COVID-19 such as social distancing; as a result, private practice physical therapists are seeing fewer patients and thus are struggling to meet short-term obligations such as payroll and rent, in many cases also making painful decisions to furlough staff for an unknown duration. Simultaneously, physical therapy providers are preparing for COVID-19 survivors who need rehabilitative care as well as the surge of patients who have delayed non-COVID-19 related care due to the pandemic. Easy access to critical physical therapy care after hospitalization is essential for patients to regain their health and independence, but many community-based outpatient physical therapy clinics, who are barely hanging on through the joint impact of the public health emergency and economic crisis, are being forced to consider whether to close their doors forever or hover on the brink of insolvency. Therefore, PPS' recommendations below contain both a response to CMS' proposed policies as well as suggestions for how to increase patient access to cost-effective and necessary care while reducing administrative burdens to physical therapists in private practice who are focused on meeting the clinical needs of their patients.

Enthusiastically support plan to permanently authorize Physical Therapist Assistants to perform maintenance therapy

Currently, physical therapist assistants (PTAs) are allowed to furnish maintenance therapy in the SNF and home health settings under Medicare Part A. PPS appreciate CMS' proposal to permanently allow PTAs to perform maintenance therapy under Part B. Apart from the expected outcomes and goals of treatment, skilled maintenance therapy is not different from skilled restorative therapy. The physical therapist is professionally trained to oversee and direct a patient's course of care, and to assign responsibilities to the assistant as clinically appropriate. Moreover, the qualified therapist determines whether it is clinically appropriate for the therapist assistant to perform maintenance therapy. Allowing PTAs to perform maintenance therapy

across settings would promote regulatory alignment and afford providers more latitude in resource utilization.

Strongly support the continued use of technology to prevent disconnect from patients
PPS appreciates that CMS is planning to allow physical therapists to be paid for providing e-visits, virtual check-ins, and remote assessments of recorded content or images for an established patient. Therefore, PPS supports CMS' development of Healthcare Common Procedure Coding System (HCPCS) codes that are identical to existing virtual therapy codes G2010 and G2012 but designated as "sometimes therapy" codes.

Recommend permanently add physical therapy services to Medicare telehealth services list
Current law does not authorize physical therapists to bill for telehealth. Only as a result of the *CARES Act* waiver are physical therapists currently being paid (on a temporary basis) when providing physical therapy services via telehealth. CMS has stated that it is seeking comment on whether or not to make its initial, PHE-specific, policy of paying for physical therapy care provided via telehealth permanent.[6] Should CMS provide Medicare coverage for physical therapy provided via telehealth *to the fullest extent of their regulatory authority* (emphasis added) that would mean that physicians and other practitioners who can bill telehealth would be paid for providing physical therapy through telehealth—but that regulatory policy could not extend to physical therapists themselves. PPS is frustrated that CMS' regulatory authority is limited in this way. Therefore, PPS is committed to pursuing legislation that will resolve this discrepancy in coverage and result in requiring CMS to pay for physical therapy care provided by physical therapists—regardless of whether that care is provided face-to-face or utilizing telehealth methods.

Despite the fact that it would not benefit private practice physical therapists or their patients, PPS encourages CMS to permanently extend Medicare coverage and payment to physical therapy services. We take this position because it is our mission as physical therapists to facilitate the improved function of patients in need of physical therapy; we also see ample evidence of the clinical benefit of physical therapy services provided to patients via telehealth. A recent study[7] from Focus on Therapeutic Outcomes (FOTO) analyzed outcomes of patients whose care was provided via telehealth; the study compared outcomes data collected since the beginning of the PHE with its historical outcomes data. While there are many physical therapy treatments which cannot be rendered via telehealth, FOTO found that the physical therapy which was provided to rehabilitation patients in-person and provided via telehealth methods (videoconference, phone and email) were equally as effective for improving patients' functional status. The study also found that patients receiving care via telehealth methods are just as satisfied as patients receiving exclusively face-to-face care therapeutic care; furthermore, the research suggests that utilizing

[6] CMS 1734-P, pp 50109
[7] Overview of Telehealth and Outcomes in Rehabilitation," Mark Werneke, PT, MS, Dip. MDT, Daniel Deutscher, PT, PhD, Deanna Hayes, PT, DPT, MS; https://www.nethealth.com/2020-study-shows-telehealth-is-as-effective-in-rehab-therapy-as-in-person-care/

telehealth may provide additional benefits, including cost-savings and the ability to reach more patients, particularly those in remote areas or with limited access to transportation.[8]

While PPS hears CMS' concerns regarding confusion that may arise, PPS is committed to educate our members so that they understand that by law, CMS is currently only able to provide coverage and payment for physical therapy provided via telehealth to physicians and other practitioners who are authorized by law to bill telehealth.

PPS hopes that because CMS recognizes the value of covering physical therapy provided via telehealth the Agency will provide robust and supportive technical assistance to Members of Congress who are working to achieve legislation that will empower CMS to pay for physical therapists for physical therapy services provided via telehealth. Furthermore, if CMS decides to add physical therapy services to the Medicare telehealth services list, PPS encourages other payers to similarly recognize the clinical benefit associated with physical therapy provided via telehealth.

Appreciate the reiteration of review and verify privileges previously granted to physical therapists

The proposed rule clarifies and verifies that as of the 2020 MPFS final rule physical or occupational therapists, speech-language pathologists, and other clinicians "who is authorized under Medicare law to furnish and bill for their professional services…may review and verify (sign and date) the medical record for the services they bill, rather than re-document, notes in the medical record made by physicians, residents, nurses, and students (including students in therapy or other clinical disciplines), or other members of the medical team."[9] CMS states, "This will help ensure that therapists are able to spend more time furnishing therapy services, including pain management therapies to patients that may minimize the use of opioids and other medications, rather than spending time documenting in the medical record. We emphasize that, while any member of the medical team may enter information into the medical record, only the reporting clinician may review and verify notes made in the record by others for the services the reporting clinician furnishes and bills. We also emphasize that information entered into the medical record should document that the furnished services are reasonable and necessary."[10] PPS appreciates the Agency's recognition of physical therapists as a member of the medical team whose time is valuable and better spent focused on patient care instead of redocumenting medical information.

Delete the NCCI edits which were reinstated on October 1, 2020

To ensure Medicare beneficiaries are able to lead productive lives and regain physical function, CMS must promote policies that improve access to physical therapy, not limit it. On October 1, 2020, CMS reinstated National Correct Coding Initiative (NCCI) edits which had been removed in April 2020. These edits impose a significant penalty on code combinations that represent

[8] https://www.prnewswire.com/news-releases/ground-breaking-net-health-study-compares-telehealth-rehab-therapy-with-in-clinic-visits-301135101.html
[9] CMS 1734-P, pp 50148
[10] CMS 1734-P, pp 50148

standard and necessary care, fail to align with current practice of care, and impose undue hardship upon Medicare providers and beneficiaries.

Additionally, these penalties are piled atop numerous existing payment policies which result in multiple cuts to physical therapy rates. For example, in 2011 Congress adopted the multiple procedure payment reduction, then in 2013 the reduction was increased to 50% for Medicare therapy providers across all settings. Also in 2013, Congress implemented sequestration which required an across-the-board reduction in Medicare fee-for service reimbursement of 2%. In 2018, physical therapy codes were revalued which resulted in sizeable and unsupported cuts to the work and practice expense relative value units of physical therapy services. While Congress has placed sequestration on a temporary hold due to the COVID-19 crisis, that 2% will be withheld again starting January 1, 2021. Given that physical therapy providers are also facing an estimated 9% payment reduction also effective January 1, 2021, these CCI edits have been added to a looming 11% reduction in payment at the beginning of 2021—when the PHE is still in effect and providers will have yet to see their patient volume rebound and will still be trying to recover from the economic devastation of the COVID-19 pandemic. Furthermore, beginning in 2022 Medicare payment for services provided by physical therapist assistants will be further reduced to 85% of the otherwise applicable fee schedule amount.

Therefore, PPS implores CMS to permanently delete the NCCI edits applicable to the following codes pairs billed by physical therapy providers:

- **97140 with 97530**: This code pair has a modifier indicator of "1." However, the edit for this code pair can restrict access to care and ultimately reduces the opportunity for patients to achieve the best outcomes. It would be clinically impossible to have overlapping minutes of therapeutic activities and manual therapy. There is no procedure that could be performed at the same time as manual therapy. CPT code 97530 (therapeutic activities) is not inclusive of CPT code 97140 (manual therapy), as each of these procedures are separate and distinct.

- **97161-97163 with 97140**: These code pairs have a modifier indicator of "1." This edit means that a patient who presents with MSK pain may not be able to receive manual therapy on the day of their evaluation. This makes no clinical sense, hampers access to care, and could actually delay recovery. Evidence clearly indicates that for patients with MSK pain early intervention is critical and delaying necessary care on the day of an evaluation is contrary to this evidence.

- **97150 with 97110; 97112; 97116; and 97164**: These code pairs have a modifier indicator of "1." 97150 is a group therapy code, whereas 97110, 97112, and 97116 are one-on-one direct care codes. The manner of practice should clearly distinguish between direct care and therapy provided simultaneously to two or more patients; moreover, these procedures also are separate and distinct. Per CMS: "When direct one-on-one patient contact is provided, the therapist bills for individual therapy, and counts the total minutes of service to each patient in order to determine how many units

of service to bill each patient for the timed codes. These direct one-on-one minutes may occur continuously (15 minutes straight), or in notable episodes (for example, 10 minutes now, 5 minutes later). Each direct one-on-one episode, however, should be of a sufficient length of time to provide the appropriate skilled treatment in accordance with each patient's plan of care. Also, the manner of practice should clearly distinguish it from care provided simultaneously to two or more patients. Group therapy consists of simultaneous treatment to two or more patients who may or may not be doing the same activities. If the therapist is dividing attention among the patients, providing only brief, intermittent personal contact, or giving the same instructions to two or more patients at the same time, it is appropriate to bill each patient one unit of group therapy, 97150 (untimed)."

Moreover, CPT 97164 is a re-evaluation that is focused on the evaluation of progress and modifying goals/treatment; it does not encompass group therapy (97150). Per CMS: "A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services. Indications for a re-evaluation include new clinical findings, a significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care."

As stated above, PPS respectfully requests that CMS permanently delete these NCCI edits applicable to the codes billed by physical therapy providers. At the very least, PPS encourages CMS to—in light of the COVID-19 PHE which has been extended once again for at least 90 days, effective October 23, 2020, and the resulting economic challenges that exist for providers—reverse course and remove such edits until the COVID-19 PHE has been lifted.

Implement a general supervision requirement of Physical Therapist Assistants in private practice

While PPS is in complete agreement with the above policy to allow PTAs to provide maintenance therapy, we suggest CMS remove additional barriers to care provided by PTAs by modifying the supervision requirement in private practice settings.

For the duration of the PHE, CMS has allowed direct supervision of PTAs, including virtual presence through audio/video real-time communications when using such technology is indicated to reduce exposure risks for the beneficiary or healthcare provider. PPS greatly appreciates this flexibility which has supported uninterrupted care for Medicare beneficiaries while enabling healthcare providers and patients to comply with the Centers for Disease Control and Prevention's social distancing and other recommendations to reduce the spread of COVID-19.

Physical therapists are responsible for providing safe, accessible, cost-effective, and evidence-based services. Services are rendered directly by the physical therapist and with responsible utilization of PTAs under the direction and supervision of the physical therapist. The physical therapist's practice responsibility for patient and client management includes examination, evaluation, diagnosis, prognosis, intervention, and outcomes. Physical therapists may use PTAs in components of intervention and in collection of selected examination and outcomes data.

Under Medicare, the level and frequency of PTA supervision differs by setting and by state or local law. Physical therapists are licensed (and physical therapist assistants are either licensed or certified) in all states, the District of Columbia, and the USVI. Medicare currently allows for general supervision for PTAs *in all settings except for private practice* (emphasis added), which requires direct supervision. However, if state or local practice requirements are more stringent, the physical therapist and PTA must comply with their state practice act. Currently, 44 states call for general supervision; in six states, supervision level differs by settings; the District of Columbia requires onsite supervision; and in both Puerto Rico and the USVI, the supervision level is undetermined.[11] PPS encourages CMS to recognize the value and benefit of permanently modifying the supervision requirement from direct to general for PTAs in private practice settings as such modification would better promote unrestricted, non-delayed access to therapy interventions.

Adjusting this Medicare policy would have an immediate impact in those 44 states which permit general supervision, because the only obstacle at this time is Medicare's direct supervision requirement. When treating Medicare beneficiaries, a PTA may only provide care to Medicare beneficiaries during the hours the physical therapist works. As a result, the practice is severely limited if the supervising physical therapist is ill or unable to be in the clinic. Delays in care may be harmful to long-term functional outcomes and quality of life. Modifying the supervision requirement would better align with state law. Therefore, PPS recommends that CMS permanently allow general, not direct, supervision of physical therapist assistants in private practice.

<u>Recommend modification of therapy Plan of Care Certification requirement</u>
Pursuant to Medicare Benefit Policy Manual Chapter 15 Section 220, a plan of care must contain diagnoses, long-term treatment goals, and type, amount, duration, and frequency of therapy services. CMS requires physicians or nonphysician practitioners to certify a patient's therapy plan of care, with a dated signature on the plan of care or with another document that indicates approval of the plan of care. The manual states that it is not appropriate for a physician or NPP to certify a plan of care if the patient was not under the care of some physician or NPP at the time of the treatment, or if the patient did not need the treatment. By certifying an outpatient plan of care for physical therapy, a physician or NPP is certifying that: services are or were required because the individual needed therapy; a plan for furnishing therapy has either been established by a physician or NPP or by the therapist providing such services and is periodically reviewed by a physician; and services are or were furnished while the individual was under the care of a physician. Chapter 15 further states that there is no Medicare requirement for an order. However, "when documented in the medical record, an order provides evidence that the patient both needs therapy services and is under the care of a physician." The manual also states that *if the signed order includes a plan of care, no further certification of the plan is required* (emphasis added). Compliance with the requirement for a physician signature on therapist-developed plan of care imposes a significant logistical and administrative burden for both therapy providers and physicians, taking valuable time and resources away from delivering patient care. Although an

[11] Federation of State Boards of Physical Therapy Jurisdiction Licensure Reference Guide https://www.fsbpt.net/lrg/Home/SupervisionRequirementLevelsBySetting.

unintended consequence, care is frequently delayed while awaiting a physician signature — often after multiple requests — placing the beneficiary's health at risk due to the delay. While signing plans of care may not be a priority for a busy physician, this results in avoidable and perhaps harmful delays to receiving physical therapy care. Forcing physical therapists to develop the plan of care and then to send it to the physician for signature is a burdensome and unnecessary process that during normal circumstances often takes weeks. Moreover, in some instances, physicians ask beneficiaries to come to their office for a visit before they will sign the plan of care. This visit typically results in checking of vital signs, medication review, and a request for a referral. Beneficiaries have voiced frustration that this requested visit results in out-of-pocket costs for the beneficiary and a cost to Medicare– but provides no clinical benefit— instead it is for the sole purpose of obtaining an approval to activate their right to receive therapy services.

During normal circumstances, delays and a lack of physician response are common. In cases where the physical therapist has performed due diligence in requesting a physician signature on the plan of care, but has not received a physician response, the therapist is left with an inadequate paper trail of the interaction. Moreover, the financial burden unfairly falls on the physical therapist if a signature is not obtained. Furthermore, in instances of delayed certifications, the therapist must identify and compile evidence necessary to justify the delay, further increasing his or her administrative burden. Frustratingly, while the medical record may illustrate the medical necessity of therapy services, CMS contractors will deny payment or seek recoupment if the plan of care is missing a signature, if the signature was not obtained within the required timeframe, or even if the signature is of marginal or questionable legibility. The administrative burden of this regulation is untenable. A physician's inaction should not result in patients suffering a delay in care and a shifted burden where physical therapists are held responsible and possibly subject to medical review simply because they were unable to compel a response. Moreover, the plan of care signature requirement is at odds with contemporary physical therapist practice. Every state, the District of Columbia, and the U.S. Virgin Islands have removed from their statutes all or some of the referral requirements or order provisions for physical therapist evaluation and treatment; physical therapists can provide evaluation and treatment services within their respective disciplines without the need for an order or referral from any other health care professional in accordance with state law.

State laws have recognized that physical therapists are highly educated healthcare professionals who can provide evaluation and treatment services within their respective disciplines without the need for an order or referral from any other healthcare professional. PPS recommends that CMS eliminate the plan of care certification requirement if there is evidence in the record that the patient is under the care of a physician. Should this change be made, in cases where there is evidence in the record of the patient being under the care of a physician or NPP, such as the presence of a referral, the therapist would not be required to share the plan of care with the physician or NPP. However, if there is no evidence in the record of the patient being under the care of a physician, the physical therapist would be required to share the plan of care with the physician/NPP but not be required to obtain a signature.

QUALITY PAYMENT PROGRAM

Support for QPP policies that reflect the realities of private practice physical therapists

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 (PI) 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. The score for PI should not be relevant to a physical therapist's MIPS final score until they receive federal financial support for such an investment, particularly for those providers who fall in the low-volume threshold category. Therefore, PPS appreciates that in this proposed rule, CMS has continued to exempt physical therapists from the PI category and has again reweighted the Quality portion of the score to be worth 85% of the final score.

Recommend nuanced approach to benchmarking

PPS agrees that historical benchmarking results could be skewed "because of the flexibility provided to MIPS eligible clinicians to allow for no data submission for the 2019 performance period, [CMS] may not have as representative of a sample of data as [they] would have had without the national PHE for COVID–19."[12] Therefore, it is both understandable and reasonable that CMS would propose that the "benchmarks for the CY2021 performance period are [to be] based on the actual data submitted during the CY2021 performance period,"[13] instead of using historical benchmarks to score quality measures for that performance period. While using this methodology would clearly impede clinicians' ability to be aware of and seek to achieve defined benchmarks, it is also clear that using the most current information available would capture any changes in care that have occurred as a result of the national PHE and would thereby have the potential to provide more accurate results for benchmarking purposes for the CY2021 performance period.

Preferring to be evaluated against known benchmarks, PPS recommends that CMS consider using the 2020 quality measure benchmarks for CY2021. If this is not possible, PPS would support CMS' plan to use performance period (instead of historical) benchmarks to score quality measures for the CY2021 performance period that will be derived from 2021 performance data. While it is appropriate to be held to benchmarks that most accurately reflect the current standards of care, it remains unclear if it would be possible to calculate 2021 benchmarks with 2021 data in a timely manner. A likely scenario is that the benchmarks will not be available ahead of time therefore physical therapists will not know what their performance will be compared to until after they have submitted data. Does CMS have a plan to efficiently calculate and publish 2021 benchmarks before providers would be required to submit data, and if so, when would that

[12] CMS 1734-P, pp 50307
[13] CMS 1734-P, pp 50307

benchmarking be complete? The least favorable option would be to use 2018 data because of the high likelihood that practice changes may have occurred.

PPS also echoes APTA's suggestion that moving forward, CMS align all benchmarks, for all four performance categories, from data that originates from the same time period in order to ensure the harmonization of data.

Proposed change to the Physical Therapy and Occupational Therapy Measure Set

PPS supports the recommended changes to the measure set that can be used by physical therapists, including adding physical therapists as MIPS-eligible clinicians for two measures: Depression screening (#134) and Tobacco Use: Screening and Cessation intervention (#226).

APTA has recommended that CMS include physical therapy evaluation and re-evaluation codes (97161, 97162, 97163, and 97164) to quality measure #050 (Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older). PPS supports this recommendation and suggests these revisions be made for claims and CQM, as well as eCQM collection types. Adding physical therapy codes to this measure is appropriate because physical therapists have training in the anatomy, physiology, and function of the neuromuscular and fascial support structures of the lumbopelvic region. They evaluate patients and design treatment programs to improve urinary function by increasing strength and fascial mobility, instructing bladder training strategies, reducing neuromuscular incoordination, normalizing tone, and decreasing postural asymmetries. Treatment modality choices are based on the individual patient's needs and response to treatment. Pelvic floor muscle rehabilitation is employed to improve the capacity of the muscles through neuromuscular reeducation, since these muscles are an integral part of the body's postural support mechanism. The most common physical therapy treatment for women with stress urinary incontinence (SUI) is pelvic floor muscle training, which has been shown to cure or improve symptoms of SUI and all other types of urinary incontinence (UI).[14] Pelvic floor muscle training may also reduce the number of leakage episodes and symptoms on UI-specific symptom questionnaires.

MIPS Value Pathways

While CMS is not currently moving forward with implementing of the MVP program[15], as currently envisioned, the MVP program does not seem likely to increase the ability of physical therapists to participate at a level higher than the limited way in which they currently participate in the QPP. In order to create a functional program that achieves CMS' goals, PPS encourages the Agency to keep non-physician clinician types such as physical therapists in mind as they develop the MVP program. If CMS is interested in attracting a wide range of provider engagement and participation in MVPs, PPS suggests that the ensuing time be spent engaging with stakeholders such as private practice physical therapists in order to ensure that, when the program is ready to launch, it is accessible and valuable for specialty providers who presently struggle to find ways and reasons to invest in MIPS participation.

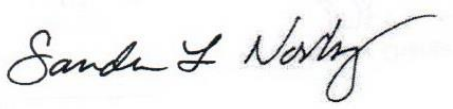
[14] https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD005654.pub4/full
[15] CMS 1734-P, pp 50276 +

As CMS is aware, physical therapists were not included in the electronic health record program from the outset and therefore have not been monetarily incentivized nor supported to invest in this vital communication link; nor were physical therapists included in the 21st Century Cures Act provisions affecting how Certified Electronic Health Record Technology (CEHRT) impacts the Quality Payment Program. Presently, attaining 2015 CEHRT EMRs that serve non-prescribing providers such as private practice physical therapists is both challenging and cost-prohibitive. Therefore, requiring the use of 2015 CEHRT EMR technology presents a significant obstacle to participation in any program. PPS suggests that the MVP program reweight the categories of Quality, Improvement Activities, Promoting Interoperability, and Cost to include only those which are appropriately applicable—similar to the reweighting policy in MIPS which only scores physical therapists on Quality and Improvement Activities.

CONCLUSION

Thank you for the opportunity to comment on the CY 2021 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 in safe, cost-effective community-based settings.

Sincerely,



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