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The Honorable Chiquita Brooks-LaSure
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-1751-P

Submitted electronically

RE: Medicare Program: CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements (CMS-1751-P)

Dear Administrator Brooks-LaSure:

On behalf of the almost 4,000 members of the Private Practice Section (PPS) of the 100,000+ member American Physical Therapy Association (APTA), I write to provide feedback on the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2022 Payment Policies under the Medicare Physician Fee Schedule (MPFS) and Other Changes to Part B Payment Policies proposed rule. 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 across the age span to a range of patient types.

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 drastic 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; time they spend on these unnecessary tasks is time they are not able to be caring for their patients—which improves overall health and prevents the need for avoidable health care services.

In response to the 2022 MPFS proposed rule, PPS strongly urges CMS to consider the following recommendations and feedback informed by experiences of private practice physical therapists:

PHYSICIAN FEE SCHEDULE

Urge complete reassessment of the conversion factor and 3.75% reduction to payment

In this 2022 MPFS proposed rule, CMS proposed a conversion factor (CF) of \$33.58 which is a 3.75% reduction from the current rate and over three dollars less than the CF of 1998 which was \$36.6873. PPS strenuously objects to this additional CF reduction that follows on the heels of the drastic reduction in physical therapy payment that was just implemented in January 2021.

Physical therapists are suffering from the combined impact of the payment cuts and a drastic drop in patient volume. In the first 6 months of the pandemic, physical therapy saw a 34% reduction in Medicare Part B spending.¹ In light of the ongoing suppression of patient visits, challenges that the COVID-19 Public Health Emergency (PHE) places upon our ability to meet the needs of our patients, as well as the growing financial uncertainty within the Medicare payment system, we strongly urge CMS to utilize its administrative discretion to substantially mitigate the proposed CF reduction.

Since first proposed by CMS in 2019, PPS has stood in strong opposition to cuts to specialties that were tied to the change in Evaluation and Management (E/M) codes. Despite overwhelming and broad stakeholder along with Congressional opposition, the 2021 MPFS final rule proceeded to implement a 9% cut. Only because of Congressional intervention and enactment of the *Consolidated Appropriations Act, 2021* did physical therapists receive a 3.3% reduction this past January instead of the 9% reduction that CMS had intended. CMS' current proposal to cut reimbursement again fails to acknowledge or recognize the ongoing and extraordinary financial stress currently being felt by our nation's physicians and non-physician practitioners because of COVID-19. While inflation, staff salaries, insurance, rent, equipment, and supplies costs have increased, the conversion factor has repeatedly dropped; we remain steadfast in our position that these accumulating cuts will eviscerate the financial viability of private practice physical therapy clinics. An additional 3.75% reduction in reimbursement could jeopardize patient access to medically necessary services. Physical therapists in private practice 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 remains suppressed.

Furthermore, these proposed payment cuts cannot be viewed in isolation. If implemented, the proposed drastic reduction in payment would be in addition to the 2% sequestration reduction which had been on hold for over a year because of the PHE and is to remain on hold only through December 31, 2021. If both reimbursement cuts and sequestration are implemented on January 1, 2022, this will result in a cumulative 5.75% reduction in reimbursement for care provided to Medicare beneficiaries. Outpatient physical therapy providers who employ PTAs

¹ <https://www.ama-assn.org/system/files/2021-03/prp-covid-19-medicare-physician-spending.pdf>

will be faced with an additional 15% reimbursement reduction for services furnished in whole or in part by the physical therapist assistant (PTA) which is also planned for January 1, 2022. This cumulative payment reduction is likely to be catastrophic.

If the proposed 3.75% cut is implemented in 2022, PPS can assure CMS that many physical therapists, particularly those in rural and underserved areas, will be unable to weather these lower Medicare payments. Some will be forced to reduce essential staff or even close their practices while others may choose not to continue to treat Medicare beneficiaries and/or refuse to accept new Medicare beneficiaries. Each of these scenarios are avoidable should CMS modify its proposed payment reductions. **PPS suggests CMS use its regulatory discretion to pull back drastic cuts that would inevitably result in restricted beneficiary access to necessary physical therapy services which in turn would lead to delays of care, lack of continuity of care, and longer wait times; or in some cases cause patients to forego physical therapy care altogether.** It is similarly 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. Furthermore, research has shown that hampering access to physical therapy, via lower payment, will result in an increase in overall total physical medicine costs.²

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 allow them to continue 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 and treat—from those who have experienced shorter hospital stays and home health coverage following the onset of the medical issue to those who have delayed necessary care because of the PHE. **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 if fee schedule rates are repeatedly reduced.** CMS must recognize that an over 7% percent reduction in reimbursement over the course of 2 years for physical therapists fails to align with CMS' efforts to drive better patient access to care and management. **PPS supports the policy recommendations submitted to CMS by the APTA which include changes that could be made to the E/M code policy, cancelation of the G2211 add-on code, and revaluation of additional physical therapy codes that are analogous to E/M codes.**

MPFS rates set by CMS also impact the fee schedules of private payors. PPS would like to remind CMS that any decision to cut Medicare reimbursement will inevitably result in decreased payment rates when our members provide care for Veterans, TRICARE enrollees, Medicare Advantage beneficiaries, and commercially insured patients. It is unreasonable and irresponsible for CMS to create an environment where private practice physical therapists—who are both small business owners and providers—are asked to deliver high-quality, cost-effective care without being afforded sufficient payment. PPS takes this opportunity to remind policy makers that because physical therapists are not currently a provider type who may opt out of Medicare, a

² [Health Serv Res.](https://www.ncbi.nlm.nih.gov/pubmed/29790166) 2018 Dec;53(6):4629-4646. doi: 10.1111/1475-6773.12984. Epub 2018 May 23, <https://www.ncbi.nlm.nih.gov/pubmed/29790166>

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, ***PPS suggests that the Agency provide Congress the necessary technical assistance and support for adding 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.

Enable Essential Healthcare Providers to Provide Accessible and Optimized Care

As PHE-designated essential healthcare providers, physical therapists are caring for COVID-19 survivors who need rehabilitative care as well as the patients who have delayed accessing therapy due to the pandemic. Most private practice physical therapists have been challenged repeatedly for over 18 months by delays of elective surgeries as well as the impact of following federal guidelines such as social distancing which have aimed at mitigating the transmission of COVID-19. As referenced earlier, the American Medical Association (AMA) found that physical therapy had the sharpest drop in Medicare revenue of all medical specialties—suffering a 34% reduction in Medicare Part B spending from January to June 2020.³ Private practice physical therapists are trying to manage this significant disruption, and in some cases collapse, of their business model; they are struggling to meet short-term obligations such as payroll and rent, in many cases also making painful decisions to furlough staff. 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 also being forced to consider whether to close their doors forever or hover on the brink of insolvency.

PPS' recommendations below contain 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 for physical therapists in private practice who are focused on meeting the clinical needs of their patients.

Physical Therapist Assistants

Modify Physical Therapist Assistant Differential

In our private practice clinics, physical therapist assistants (PTAs) implement components of patient care, obtain treatment-related data, and collaborate with their supervising physical therapist to modify care as necessary. They are an integral part of our care team—enabling us to provide physical therapy services that meet the needs of our community. The *Balanced Budget Act of 2018* requires that on January 1, 2022, some form of the PTA differential go into effect. Under normal circumstances a drastic reduction in payment would be a challenge. However, the PHE is ongoing and the 15% payment differential will be added on to the 3.75% reduction in Medicare reimbursement, the existing 7% (on average) cut to payment due to multiple procedure payment reduction, as well as the return of the 2% Medicare sequester. This cumulative 27.75% reduction in payment for care provided in whole or in part by PTAs is indefensible.

³ <https://www.ama-assn.org/system/files/2021-03/prp-covid-19-medicare-physician-spending.pdf>

PPS urges CMS to use its regulatory authority to mitigate the impact that these cuts will have on independent practices who employ PTAs. To that end, ***PPS implores CMS to delay implementation of the payment differential until January 1, 2023, in order to give providers additional time to recover from the pandemic while also granting the Agency additional time to provide education and technical assistance on implementation to enable both therapy providers and MACs to accurately code for proper CQ/CO modifier application*** instead of providing as little as six weeks between when the final rule is released and when the finalized changes must be implemented in clinical settings and billing systems.

If a one-year delay is not possible, at the very least ***PPS suggests CMS delay implementation of the therapist assistant differential for those providers working in small practices*** (as defined in the 2022 MPFS proposed rule, practices with 15 or fewer eligible clinicians under a TIN) and ***delay imposing the differential on those PTAs and OTAs who are providing care in rural and underserved areas***. Americans living in rural, medically underserved, and health professional shortage areas face hurdles when attempting to access health care services. In many of these settings, it is challenging for clinics to be able to recruit or afford to pay the salary of enough physical therapists to meet their patient volume, therefore access to physical therapy in these areas often depends on employing PTAs in community-based clinics such as those owned and operated by PPS members. These two changes will protect patients' ability to access physical therapy care in these geographic locations. In addition, those who seek care from small practices—as well as the PTAs who play crucial roles in the care team—will be protected from becoming the collateral damage of cut upon cut in reimbursement. It must be re-emphasized that these practices will be operating under the combined impact of the reduction of the conversion factor, the reinstatement of the Medicare sequester, and the implementation of the PTA/OTA payment reduction—all while the country is still in the midst of the COVID-19 PHE. Our member providers are struggling to remain economically viable in the face of each of these successive reimbursement cuts. Regulatory action from CMS could help alleviate this crisis.

PPS appreciates CMS' additional clarifications to the “midpoint rule” policy and “two remaining unit” scenarios. The examples provided make it clear that CMS recognizes the importance of enabling physical therapists to be fully compensated for their time when care was provided jointly by a therapist and a therapy assistant. While not discussed by CMS in this proposed rule, PPS recommends that the Agency apply a similar philosophical approach to non-timed code scenarios. For example, on untimed CPT codes, ***PPS recommends that if the therapist provided any minutes of the untimed service, that CPT code would be billed without the CQ/CO modifier*** since it is an untimed code.

Verify that PTA/OTA Differential does not impact Medicare beneficiary copays

In the proposed rule CMS states: “Under sections 1834(k) and 1848 of the Act, payment is made for outpatient therapy services at 80 percent of the lesser of the actual charge or applicable fee schedule amount (the allowed charge). The remaining 20 percent is the beneficiary copayment. For therapy services to which the new discount applies, payment will be made at 85 percent of the 80 percent of allowed charges. Therefore, the volume discount factor for therapy services to which the CQ and CO modifiers apply is: $(0.20 + (0.80 * 0.85))$, which equals 88 percent.”

APTA sought feedback from CMS on stakeholder calls following publication of the proposed rule and received confirmation that the 15% reduction in payment does not impact the 20% of the fee schedule amount attributable to beneficiary copayment, and that providers should charge patients a copay based on the allowed amount before application of the modifier and the differential. We agree with this protocol but request verification and that CMS include this important clarification in the MPFS final rule so that providers can confidently and accurately charge the correct copayment amount.

Permanently implement general supervision for Physical Therapist Assistants in private practice
PTAs provide physical therapist services under the direction and supervision of a physical therapist. As a result of the flexibilities granted for the duration of the PHE, supervisors of PTAs continue to be able to “meet the immediate availability requirement for direct supervision through the use of real-time, audio/video technology” and do so “when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider.” The prompt issue of supervision flexibility in 2020 has supported uninterrupted care for Medicare beneficiaries during the PHE. In this proposed rule, CMS indicates that it is willing to make this flexibility permanent so that moving forward “direct supervision” could “include immediate availability through the virtual presence of the supervising physician or practitioner using real time, interactive audio/video communications technology without limitation.” ***PPS requests confirmation that CMS intends this proposed permanent change to not be restricted to instances “when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider.”***

CMS’ modified direct supervision proposal would require either in-person availability or the use of real-time, audio/video technology to satisfy the direct supervision requirement when a PTA is treating Medicare beneficiaries. Under this proposal, the practice is severely limited if the supervising physical therapist is unable to be in the clinic or unable to use both the audio and visual components of telecommunication. In contrast, current CMS general supervision policy only requires the use of “telecommunications”. This disparity increases administrative burden and could also impact patient care—especially for those patients who are located in rural areas where broadband or cellular infrastructure is lacking or limited. Through no fault of their own, patients in rural areas would not have as many choices as their suburban or urban counterparts who have better access to the infrastructure necessary to utilize combined audio and visual technologies. While PPS appreciates that CMS is willing to modify PTA supervision standards for private practice settings, ***instead of this incremental change, PPS strongly recommends that CMS use its authority to wholly modify the supervision requirements from direct to general supervision for physical therapist assistants in private practice settings as outlined in 42 CFR 410.60(a)(3)(ii) and (c)(2).***

Physical therapists are licensed (and PTAs are either licensed or certified) in all states, the District of Columbia, and the U.S. Virgin Islands. Under Medicare, the level and frequency of PTA supervision differs by setting and by state or local law; if state or local practice requirements are more stringent, the physical therapist and PTA must comply with their state

practice act. The current direct supervision requirement as well as the proposed regulation-- which both arbitrarily apply only to private practice settings—are more burdensome than the general supervision requirements in 44 states.⁴ Adjusting this Medicare policy would have an immediate impact in those 44 states because at this time the only obstacle to using general supervision is Medicare’s direct supervision requirement. Furthermore, making the supervision requirement consistent across outpatient settings will decrease administrative burden and confusion as well as ease compliance on the part of providers who work and manage staff in more than one type of outpatient setting. Therefore, ***PPS recommends that CMS permanently allow general—not direct—supervision of physical therapist assistants in private practice, without limitation, that could be satisfied through audio-only communication.***

Telehealth

Permanently add physical therapy codes to Medicare telehealth services list

Current law does not include physical therapists in the list of eligible distant site practitioners identified in section 1842(b)(18)(C) of the Social Security Act. However, there is no statutory restriction against CMS adding Therapy Procedures, CPT codes 97110, 97112, 97116, 97150, and 97530; Physical Therapy Evaluations, CPT codes 97161 – 97164; Therapeutic Procedures, CPT codes 97535, 97537, and 97542; and Therapy Tests and Measurements services, CPT codes 97750, 97755, and 97763 to the list of Medicare telehealth services which would be permanently covered. In the 2021 MPFS, CMS requested input about which CPT codes should be permanently included in the list of Medicare telehealth services. PPS is disappointed that, despite strong stakeholder support and the rationales submitted to the Agency by providers as well as telehealth organizations, CMS continues to omit these physical therapy services codes from the list of permanently covered telehealth services. APTA’s 2022 MPFS comment letter reiterates the evidence it provided in 2021 to support CMS’ inclusion of these codes in the Category 2 list; PPS suggests CMS take this evidence into consideration once again. ***PPS recommends that the Agency proactively add physical therapy CPT codes to the list of Medicare telehealth services*** in response to the widespread acknowledgement of the value of providing care via telehealth and in anticipation of the likelihood of legislative change.

As a result of the *CARES Act* waiver, physical therapists have been providing physical therapy services via telehealth, resulting in ample evidence of the clinical benefit of physical therapy services provided to patients via telehealth. Focus on Therapeutic Outcomes (FOTO) studied patients whose care was provided via telehealth by comparing outcomes data collected during the first six months of the PHE with its historical outcomes data. FOTO found that physical therapy provided to rehabilitation patients in-person and physical therapy provided via telehealth methods (videoconference, phone, and email) were equally as effective for improving patients' functional status.⁵ The study also found that patients receiving care via telehealth methods were

⁴ Forty-four states require 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. Federation of State Boards of Physical Therapy Jurisdiction Licensure Reference Guide <https://www.fsbpt.net/lrg/Home/SupervisionRequirementLevelsBySetting>.

⁵ 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/>

just as satisfied as patients receiving exclusively face-to-face therapeutic care; furthermore, the research suggested that utilizing 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.⁶ Even if payment is currently restricted to instances where the care is provided “incident to” a physician’s care, ***PPS continues to encourage CMS to permanently extend Medicare coverage and payment to physical therapy services.*** While the physical therapy services provided independently by a physical therapist in private practice would not be “incident to”, we take this position because it is our mission as physical therapists to facilitate the improved function of patients in need of physical therapy.

While PPS hears CMS’ concerns that coding confusion may arise, PPS is committed to educate our members so that they understand that by statute (outside of the PHE-related waivers implemented on April 30, 2020) 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 as distant site providers to bill telehealth.

Enable physical therapists to use Remote Therapeutic Monitoring codes

Remote therapeutic monitoring (RTM) is an important and valuable component of physical therapist practice; it also has the potential to improve patient care, enhance the effectiveness of home exercise and self-management programs, accelerate recovery, and promote patient and/or caregiver self-efficacy. Physical therapists routinely prescribe home exercises, physical activity plans, and self-management plans that are a critical component of the overall physical therapy plan of care. Absent the use of remote monitoring technologies, physical therapists must rely on the patient’s self-report and observed performance during an in-person treatment session to assess the patient’s proficiency with these assigned programs. In contrast, remote monitoring technologies provide physical therapists with the ability to determine in actual (or close to) real-time if a patient is engaged in these prescribed activities as well as the frequency with which the programs are being done. In some cases, therapists are also able to monitor the quality of the patient’s performance. Additionally, important patient-reported feedback such as pain level, level of confidence, and rating of perceived exertion responses to home exercise and self-management programs can be gathered in real-time and therefore more accurately.

Putting aside the current disagreement between the AMA and CMS about whether or not RTM codes were designed to be used by physical therapists and other providers who cannot bill E/M codes (and are thereby unable to use remote patient monitoring codes), PPS remains frustrated with CMS’ position that despite the proven value of obtaining health information via technology and providing physical therapy care via telehealth that physical therapists are not permitted to bill RTM codes. Compounding the problem is that physical therapists are currently permitted to furnish and bill for their services both independently as well as incident-to a physician. PPS members do not practice incident-to a physician. Instead, they operate solo practices or run their own clinics. Should CMS’ reasoning regarding the RTM codes be applied to existing physical therapy codes, physical therapists would only be permitted to practice incident-to a physician—

⁶ <https://www.prnewswire.com/news-releases/ground-breaking-net-health-study-compares-telehealth-rehab-therapy-with-in-clinic-visits-301135101.html>

thereby eliminating the private practice physical therapy business model. PPS sincerely doubts that this is the intent of the Agency; therefore, ***PPS requests that CMS create G codes that will support the use of RTM by physical therapists as part of a physical therapy plan of care.*** Any G codes that would be developed would need to reflect the following work and expense aspects of a physical therapist delivering these services:

- Time spent instructing the patient in the use of a remote therapeutic monitoring technology
- Time spent analyzing the data and using the information to make decisions regarding the patient's plan for care, as well as follow-on decisions when care is ongoing
- Cost of the remote therapeutic monitoring technology

PPS suggests CMS consider the examples of the use of remote therapeutic monitoring by physical therapists submitted by American Physical Therapy Association.

Support statutory change to extend telehealth coverage to physical therapists

Recognizing some statutory limitations that CMS faces, PPS is committed to pursuing legislation that will remove disparities in coverage and empower CMS to pay for physical therapy care provided by physical therapists utilizing telehealth methods. ***PPS recommends that the Agency provide robust and supportive technical assistance to Members of Congress working on legislation that will allow for payment for physical therapy services provided by physical therapists or PTAs via telehealth.***

Modify therapy Plan of Care Certification requirement

In light of the mounting Medicare reimbursement cuts proposed by CMS, PPS recommends the Agency utilize its regulatory authority to reduce administrative burdens on those same providers. One such opportunity would be to modify the requirement that a therapy plan of care be certified by a physician or nonphysician practitioner (NPP). 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 NPPs 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 also 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."

Compliance with the requirement for a physician signature on a therapist-developed plan of care imposes a significant logistical and administrative burden for both therapy providers and physicians/NPPs—taking valuable time and resources away from delivering patient care.

Forcing physical therapists to develop and then send the plan of care to the physician for signature is a burdensome and unnecessary process that often takes weeks, even during normal circumstances. The average wait time has grown significantly during the COVID-19 PHE. Because signing plans of care may not be a priority for a physician, care (despite multiple requests) is frequently delayed while awaiting a physician signature. Although an unintended consequence, this avoidable delay places the beneficiary's health at risk. 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 superficial visit results in out-of-pocket costs for the beneficiary and a cost to Medicare, but provides no clinical benefit; instead, the visit is for the sole purpose of obtaining an approval to activate their right to receive therapy services.

It is unique in the Medicare program that in order for physical therapists to be compliant with Medicare policy and be paid for patient care, they must rely on another providers' administrative efficiencies and timeliness. During normal circumstances, delays and a lack of physician response are common. Additionally, in situations 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. Furthermore, in instances of delayed certifications, the therapist must identify and compile evidence necessary to justify the delay, when often they have no way of knowing nor control over why the physician/NPP has not certified a submitted plan of care. If a provider does not have the documentation to support the delayed certification or recertification, this leads to denials by Medicare Administrative Contractors and other CMS contractors when they are performing a pre-payment or post-payment medical record review. Frustratingly, while the medical record may clearly illustrate the medical necessity of therapy services, CMS contractors 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 (as stamped signatures are not allowed). The administrative burden of this regulation is indefensible, anti-patient, and unnecessary. It also reflects the fact that Medicare has not updated key portions of its' benefit policy manual (chapter 15, sections 220-230) well over 25 years. Fundamentally, 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 elicit a response.

In further support of our request that CMS review of this policy, PPS would like to point out that 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. So that Medicare beneficiaries have equal access to care, CMS policy should align with state laws which 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 health care professional.

PPS suggests that 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 an order for physical therapy care, the therapist would not be required to share the plan of care with the physician/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 dated signature. As such *PPS recommends that CMS eliminate the plan of care certification requirement.*

Physical therapy services should trigger In-Office Ancillary Services Exception Referral Options Disclosure Requirement

Current law bars physicians from referring Medicare patients for certain designated health services (DHS) in which they have a financial interest. Section 1877(b)(2) of the Social Security Act, entitled “IOAS,” sets forth an exception that permits a physician in a solo or group practice to order and provide DHS in the office, provided that certain criteria are met. The IOAS exception was originally created so that physicians could—within their offices, at the same time as the patient’s visit—render non-complex services like X-Rays and simple blood tests which are useful for purposes of timely diagnosis and treatment. Allowing physicians to self-refer to physical therapy services was intended to reduce burden on patients but has instead led to inappropriate utilization of such services. Physical therapy services while important to achieve positive outcomes, are not integral to the physician’s initial diagnosis and there is no prevailing quality of care need nor is an added patient convenience realized because patients must receive physical therapy treatments over the course of many days or weeks. According to a 2010 MedPAC report, only 3 percent of outpatient physical therapy services were provided on the same day as an office visit, only 9 percent within 7 days of an office visit, and only 14 percent within 14 days of an office visit.

Section 6003 of the Affordable Care Act (ACA) amended Section 1877(b)(2) of the Social Security Act to create a new disclosure requirement for the IOAS exception with respect to referrals for magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), and any other DHS specified under Section 1877(h)(6)(D) of the Act⁷ that the Secretary determines appropriate. Section 6003 also requires the referring physician inform a patient in writing at the time of the referral that the patient may obtain the service from a person other than the referring physician or someone in the physician’s group practice as well as provide the patient with a list of suppliers who furnish the service in the area in which the patient resides; we will call this the “referral options disclosure requirement”.

Despite input in 2010 from the APTA which pointed out the increasing number of “referral for profit” physical therapy service models appearing nationwide and recommending that CMS expand the application of the disclosure requirements to additional services like physical therapy, in the CY 2011 MPFS final rule⁸ CMS took the position that “Section 6003 of the ACA does not grant the Secretary the authority to expand application of this disclosure requirement to DHS

⁷ https://www.ssa.gov/OP_Home/ssact/title18/1877.htm

⁸ 75 FR 73616, finalized regulations at 42 CFR § 411.355(b)(7)

other than those in Section 1877(h)(6)(D). The requested expansion to other DHS is beyond the Secretary’s authority and cannot be accomplished via rulemaking.”

PPS disagrees with CMS’ rationale from 2011 and believes that Section 1877(b)(2) of the ACA does not limit the referral options disclosure requirement to only those DHS listed in Section 1877(h)(6)(D). Instead, PPS believes that Section 1877(b)(2) of the ACA grants the Agency the authority to expand the referral options disclosure requirement to any of the DHS exempted from the IOAS.

The GAO has found that the IOAS exception has resulted in increased financial gain for physician-owned practices while creating higher costs for patients by limiting patient choice⁹; the consumer often is unable to recognize this loss of choice, as no other option is offered nor required to be disclosed. Further, there is evidence that beneficiaries may receive higher-quality care—and therefore better outcomes—when able to choose their therapy provider. A 2015 study¹⁰ on low back pain episodes of care found that non-self-referred episodes of care were far more likely to provide “active,” or hands-on, services than self-referral episodes—52% compared with 36%. This, according to the study’s authors, suggests the care delivered by physical therapists in non-self-referred episodes is more tailored to promote patient independence and a return to performing routine activities without pain. It is important to note that “passive” treatments, which are more likely found in self-referring episodes, can be performed by a person who is not a licensed physical therapist. The authors of this study also cite evidence that these passive physical therapy modalities are “ineffective” in treating low back pain when not combined with active services.

Adding physical therapy services to the list of DHS subject to the referral options disclosure requirement would empower patients to choose their providers, increase awareness of a potential conflict of interest, and aid CMS’ efforts to ensure patients can make well-informed decisions about their care. Accordingly, ***PPS recommends that CMS use their Section 6003 authority to require a referring physician to inform a patient in writing at the time of the referral that the patient may obtain the service from a person other than the referring physician or someone in the physician’s group practice as well as provide the patient with a list of suppliers who furnish the service in the area in which the patient resides.***

⁹ US Government Accountability Office (2014, April). Medicare Physical Therapy: Self-Referring Providers Generally Referred More Beneficiaries by Fewer Services per Beneficiary (Publication No. GAO 14-270). <https://www.gao.gov/assets/670/662860.pdf>. Accessed August 31, 2021.

¹⁰ Jean Mitchell, PhD, Georgetown University, *Forum for Health Economics and Policies*, July 2015. Of note, this study highlights the difference in overall expenditures for episodes of care between self-referring and non-self-referring physicians. The study examines the total insurer-allowed amounts for low back pain episodes of care and parses out expenditures on physical therapy only. On average, spending for services by self-referring providers was \$144 as opposed to only \$73 for services by non-self-referring providers. This is a significant difference for a very common episode of care.

QUALITY PAYMENT PROGRAM

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

Approve of maintaining low-volume threshold and continued reweighting policies

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 and scoring 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. As such, it would be inappropriate to score physical therapists on their use of an electronic health record and 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. PPS appreciates that in this proposed rule, CMS has continued to exempt physical therapists from both the PI and Cost categories and has again reweighted the values of Quality (at 85%) and Improvement Activities (at 15%) for the final score.

Support Flexibility for Small Practices

For the first time in this proposed rule, CMS notes that “given infrastructure and resource limitations within small practices, we believe it is appropriate to place more emphasis on a performance category that poses a reduced reporting burden such as the Improvement Activities performance category.” As a result, CMS has proposed that for MIPS eligible clinicians in small practices when both the Cost and the Promoting Interoperability performance categories are reweighted to zero (as would be the case for physical therapists), that Quality will be weighted at 50% and Improvement Activities will be weighted at 50%. PPS commends CMS for recognizing the challenges of small practices. Many of our members would find this option appealing. However, as each small practice is different, *PPS suggests that CMS score small practices using both options (reweighting of Quality and Improvement Activities categories to 50% each and the standard reweighting option of Quality (85%) and Improvement Activities (15%), then use the better of the two scores for that small practice’s final score. Additionally, PPS suggests that CMS to include both scores in the feedback reports shared with participating small practices.*

Request Detailed Feedback on High-Priority Measures and Complex Patient Bonus

The feedback reports from CMS are appreciated, but it can be a challenge for providers to identify all of the factors that go into their final score. *PPS suggests that CMS provide sufficient information about which other types of providers were involved in the care of the patient or patient types who triggered the complex patient bonus*—within the limitations of patient confidentiality. PPS would also *suggest that feedback reports include detailed information about which and how many bonus points were earned as a result using high priority measures*. These details not only support the ongoing engagement of those who are participating in MIPS, but could also encourage the participation of others who are able to opt-in.

Encourage Flexibility for Group Reporting

Starting with the CY2022 MIPS performance period/2024 MIPS payment year, CMS is proposing that “small practices, excluding those participating in MIPS as part of a virtual group, must submit data as a group in any performance category to indicate that they wish to be scored as a group for Medicare Part B claims. CMS further explains that “once the group submits data to MIPS as a group, we would consider any available Medicare Part B claims measure submissions in calculating their quality performance category score.”

Is CMS proposing to remove its policy of scoring individual providers both as an individual and as a group and then giving them the best result? If so, PPS suggests that if CMS is interested in encouraging providers to opt-in to MIPS then it should *retain the policy that enables providers use the better of the two results (scoring as an individual or a group) for their final score.*

When considering this issue, it is important to keep in mind that providers who submit via a registry or QCDR are able to analyze their data prior to submission and anticipate their overall score while small practices who submit measures via Medicare Part B claims have significant challenges predicting their final MIPS scores.

Support Data Completeness and Performance Thresholds

In line with statutory requirements for the QPP, CMS is proposing to require clinicians to meet a higher performance threshold to be eligible for incentives. CMS is proposing that for the 2022 performance/2024 payment year, MIPS eligible clinicians will need to achieve a final score equal to 75 points in order to receive a neutral MIPS payment adjustment. PPS supports the 15-point increase over last year’s threshold. Furthermore, PPS fully supports the data completeness criteria threshold remaining at 70% for the 2022 performance period and increasing to 80% for 2023. In addition, because the PHE for COVID-19 is expected to remain in place through the end of the year, PPS also supports CMS’ decision to continue the extreme and uncontrollable circumstances policy for the CY 2021 performance period/CY 2023 MIPS payment year.

Propose review of the Physical Therapy and Occupational Therapy Measure Set

Quality Measure #154 Falls: Risk Assessment

PPS has some questions about the Agency’s proposal to remove Quality Measure #154 from the physical therapist/occupational therapist (PT/OT) specialty measure set. The rationale provided for removal is that it has a continued topped out status and a limited opportunity to improve clinical outcomes, yet the Agency has not suggested the removal of all other topped out measures. For example, Quality Measure #130 Documentation of Current Medications in the Medical Record is also a topped-out measure and has a 7-point cap for Medicare Part B claims, eCQM, and MIPS CQM collection types; but this measure is not being proposed for removal from the MIPS program.

Most concerning however is that upon removing Quality Measure #154, the Quality Measure #155 Falls: Plan of Care becomes impossible for physical therapists to report. This is because Measure #155 is a two-part measure which is paired with Measure #154: Falls: Risk Assessment. Functionally, the only way to report Measure #155 is if CPT II code 1100F is submitted in the numerator for Measure #154.

According to the Centers for Disease Control and Prevention, falls among adults aged 65 and older are common, costly, and preventable; yet annually about 28% of seniors report falling (equaling roughly 36 million falls each year). Falls are the leading cause of fatal and nonfatal injuries among older adults¹¹; while not all falls result in an injury, about 37% of those who fall reported an injury that required medical treatment or restricted their activity for at least one day (an estimated 8 million fall injuries)¹². Physical therapists should be incentivized to implement the necessary physical therapy services to improve the flexibility, strength, balance, posture, proprioception, and/or kinesthetic awareness of those patients in order to reduce their risk for future falls. These therapy interventions will improve the patient's quality of life while also saving the Medicare program millions of dollars in preventable costs. Separately, if physical therapists do not have the ability to report this pair of Quality Measures (#154 and #155) during the 2022 MIPS Performance Period, those physical therapists who submit quality measures via Medicare Part B Claims would only have 6 Quality Measures to report. We suggest the Agency ***retain Quality Measure #154 for the 2022 MIPS Performance Period so that physical therapists can continue to be able to identify patients who are at an increased risk for falls and continue to have 7 Quality measures to report via claims.***

Alternatively, if CMS is determined to remove Measure #154, then it must make an adjustment so that physical therapists can use the retained Quality Measure #318 Falls: Screening for Future Falls Risk. Currently Measure #318 can only be reported via eCQM; however, most physical therapists report quality measures via Medicare Part B Claims and MIPS CQM. In order for this option to be a true substitute and available to all physical therapists, it ***would be necessary for the Agency to do two things: 1. change the Collection Type for Measure #318 to allow for Medicare Part B Claims and MIPS CQM Collection Types beginning with the 2022 MIPS Performance Period and; 2. link Measure #318 to Measure #155 in order to create a new two-part measure.***

Quality measure #50

PPS also seeks clarification regarding the proposed removal of Quality measure #50 Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older from the PT/OT measure set. The rationale for removal of measure #50 and the Agency's preference for quality measure #48 Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older as a more widely applicable measure which can achieve a similar assessment goal makes sense; however, neither measure #48 nor #50 are currently part of the PT/OT specialty measure set. At the same time, in table C.6, CMS states that should measure #50 be retained, it "would update the denominator eligible encounters to add coding for Physical Therapy MIPS eligible clinician type and add the measure to the PT/OT specialty measure set." How can a measure be removed from a specialty measure set before it is included? Should measure #50 be retained, when would it be added to the PT/OT measure set? Or is CMS' preference to add measure #48 instead of measure #50 to the PT/OT specialty set?

¹¹ <https://www.cdc.gov/injury/wisqars/>

¹² https://www.cdc.gov/mmwr/volumes/69/wr/mm6927a5.htm?s_cid=mm6927a5_w

Make MIPS Value Pathways accessible

Engage with stakeholders to produce relevant MVPs

While delaying the beginning of the MIPS Value Pathways (MVP) programs for another year to ensure more meaningful participation for clinicians and improved outcomes for patients, CMS has proposed its first seven MVPs. PPS is pleased that one of these seven MVP clinical areas—lower extremity joint repair—could be relevant to our members, however we have a number of concerns. As currently envisioned, the MVP program does not seem likely to be accessible to physical therapists in private practice nor increase the ability of physical therapists to participate beyond 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 outpatient settings and non-physician clinician types such as private practice physical therapists in mind as they develop MVPs. If CMS is interested in attracting a wide range of provider engagement and participation in MVPs, ***PPS suggests CMS engage 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 incentives to invest in MIPS participation.***

Align Cost Measure Development and MVP Approval

Physical therapists have a critical role to play in caring for the millions of Americans with low back pain (LBP). PPS appreciates steps taken by CMS to create a “Wave 4” cost measure focused on LBP, but we are concerned that the process to approve MVPs may not be aligned with the work to develop a LBP cost measure. Because LBP is such a critical part of patient care and overall Medicare spend, ***PPS encourages the Agency to coordinate efforts so that the initial work on approving a low back pain MVP is not put off until the cost measure is approved.***

Significant shared savings can result if an MVP enables early access to physical therapy care. Years ago PPS recognized that musculoskeletal rehabilitation was being targeted under alternative payment methodologies, including bundled payments, for musculoskeletal episodes of care and wanted to contribute to the effort. PPS then commissioned a study, “Impact of Physical Therapist Services on Low Back Pain Episodes of Care,” (the Milliman study)¹³ and shared the results with private payers across the country. Fundamentally, the Milliman study shows that starting physical therapy early results in lower overall costs. The conclusions of the Milliman study illustrate three main points: First, if a physician chooses to refer a patient to a physical therapist, referrals sent within the first 14 days result in lower costs and less use of invasive/higher cost procedures. Second, when accessing physical therapy for low back pain, direct access to physical therapy is the lowest cost method and results in a lower use of invasive/higher cost procedures. Third, recommended/active clinical patient care results in lower cost and quicker outcomes than with passive care. The study shows the value of restructuring payment policies to encourage better health outcomes at lower cost by allowing for early access to physical therapy or direct access. The APTA White Paper “Beyond Opioids: How Physical

¹³ Available at <https://ppsapta.org/userfiles/File/ImpactofPhysicalTherapistServicesonLowBackPainEOC.pdf>

Therapy Transforms Pain Management to Improve Health”¹⁴ also highlights important considerations that we urge CMS to include in their work.

These studies and reports emphasize the importance of addressing low back pain as an MVP. PPS looks forward to working with CMS to coordinate the activities of the Wave 4 Low Back Pain Cost Measure work group and the creation of an MVP that depends partially on what that work group creates. The work on MVPs in the context of physical therapy, low back pain, and the Wave 4 cost measure work should be closely coordinated.

Continue Reweighting Protocol in MVP

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. ***PPS suggests that at minimum 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 2022 Medicare Physician Fee Schedule and QPP proposed rule. We hope our insight and perspective will prompt CMS to reconsider some of 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 and enabling them to readily participate in the timely 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,



Mike Horsfield, PT, MBA
President, Private Practice Section of APTA

¹⁴ <https://www.apta.org/contentassets/b9421650038941469c75d06a0a191069/beyond-opioids-white-paper.pdf>, accessed September 7, 2021.