PRIVATE PRACTICE SECTION, APTA

American Physical Therapy Association

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October 10, 2012

Mr. Glenn Hackbarth, JD, Chairman
Medicare Payment Advisory Commission
425 Eye St., N.W. Suite 701
Washington, DC 20001

Re: Outpatient Therapy Mandated Report

Submitted via Web

Dear Chairman Hackbarth:

Please accept these written comments offered on behalf of the American Physical Therapy Association Private Practice Section (PPS/APTA) which represents over 4200 members nationwide. PPS/APTA members own and operate private practices that operate as small businesses providing rehabilitative therapy to patients across the spectrum of impairments and functional limitations secondary to neurologic and/or musculoskeletal conditions. The PPS/APTA endeavors to foster the growth, economic viability, and business success, of physical therapist-owned physical therapy services provided for the benefit of the public.

On October 5, the Medicare Payment Advisory Commission (MedPAC) devoted considerable time to discussing outpatient therapy services in preparation for a mandated report to Congress due June 15, 2013. It was observed that the Commission continued to struggle to adequately comprehend the therapy benefit. This was evident by fact that the time devoted to clarifying questions was nearly twice as much as to substantive discussion.

Admittedly, the therapy benefit and corresponding issues such as the outpatient payment system and eight different settings where care is provided are complex and not easily understood. But the number and type of questions asked by commissioners leads PPS/APTA to conclude that a majority of the commissioners still have less than a clear understanding of the therapy benefit, the issue of medical necessity, determination of effectiveness of care, and how, where and by whom outpatient therapy is received.

If the commission acts without a sufficient understanding of the therapies, it runs a substantial risk of making recommendations that could, if implemented, be harmful to beneficiaries. Consequently, PPS/APTA urges the commission to verify with Congress that body's preference that MedPAC take the time that is needed and commensurate with the complexity if these issues. The Commission should use the time allotted by Congress, study the therapy benefit, delivery system and payment methods more thoroughly and deliver a complete and comprehensive report to Congress in June of 2013.

Using all the allotted time provides a number of benefits:

1. All commissioners can gain a better understanding of the benefit, the professions, the effects on beneficiaries;
2. Data and experiences from 4th quarter of 2012, including the application of the therapy caps to hospital outpatient departments, can be considered and incorporated into the report.
3. Rulemaking which is pending will affect the delivery of outpatient therapy and the effects on beneficiaries including initiation of a requirement to report functional status data via claims;
4. CMS experience with manual medical review (MMR) which commenced in Q4 will also be informative to the commission which clearly desires to use MMR on a larger scale.

Manual medical review (MMR) was initiated in Q4 and needs to be evaluated before risking making a recommendation that could adversely impact beneficiaries. Even though it is early in the process, patients report receiving letters with respect to the therapy cap that they find confusing and intimidating; some even to the point that the chose not to pursue the necessary and indicated therapy.

PPS/APTA urges MedPAC reconsider and rescind the draft recommendation that would apply a 50 percent multiple procedure payment reduction (MPPR) to the practice expense (PE) component of outpatient therapy services provided to the same patient on the same day. Implementing a 50 percent MPPR reduction would result in arbitrary across the board cuts and as a result providers will not be adequately compensated for the resources needed to provide medically necessary therapy services. Currently, physical therapists, occupational therapists, speech-language pathologists and the facilities in which they provide patient care have very small margins between the cost of delivering their care and the payments they receive under Medicare. Such a policy is not supported by data or evidence and appears simply to be an attempt to derive budgetary offsets. This errant recommendation is likely to result in impeded access to outpatient therapy services and further exacerbate the current workforce shortage for therapy services. This cut would be further compounded by the projected reductions in the sustainable growth rate and the annual per beneficiary therapy cap.

CMS modified its original proposal not because of strenuous objection from stakeholders, but because the agency realized the rulemaking was significantly flawed and not supportable by reliable data. Therefore, PPS/APTA urges MedPAC not to mimic the actions of CMS unless and until the Commission is able to thoroughly review the formulae for code determination and valuation and the data with respect to combinations of therapeutic procedures typically employed by therapists.

MedPAC may recall the useful information that we included in our letter of March 13 with respect to mandating collection and reporting of functional status data. PPS/APTA urged MedPAC to recommend to Congress that CMS be required to collect functional status data across all outpatient therapy settings in order to increase quality, ensure applicability and appropriateness of the therapy benefit and prepare to transition to an alternative payment method based on severity and intensity.

However, the October draft recommendation that would have CMS undertake the development of a streamlined standardized assessment instrument using the DOTPA study methodology as a starting point is severely misdirected.

Reporting functional status information via claims is required by recent legislation and is now being formulated by CMS which is still in rulemaking for 2013. This provides another important reason MedPAC should use all the time allocated by Congress to develop its report on improving therapy. Several important developments are taking place in the fourth quarter of this year that the Commission will not be able to evaluate or consider thus rendering its report to Congress less than complete or useful.

PPS/APTA believes therapists should be required to collect and report these pertinent data on their patients. But neither Congress nor MedPAC should dictate which instrument a therapist uses. Rather, policy makers should recommend that the government set standards for qualified instruments, namely rigorous psychometrics, and allow the therapists to select from among the numerous recognized instruments available.

Moreover, MedPAC should avoid urging Congress or CMS to develop a patient assessment instrument and should not encourage CMS to build on the “DOTPA” effort. That tool was developed with the intention of determining the most appropriate placement for a patient after hospitalization. DOTPA is lengthy, complex and time-consuming, lacks clinical utility and outpatient centers are reluctant to even participate in the DOTPA study. Several established instruments would be a much more appropriate starting point as they are more applicable to relevant clinical settings and do not carry the shortcomings of DOTPA methodology which lacks specificity, is directed at patients with lower level functioning, is not applicable to all outpatient settings and lacks clinical relevance. In addition, the existing tools have succeeded in incorporating rigorous risk adjustment, something DOTPA has not pursued.

As MedPAC is aware, the therapy caps have long been held by beneficiaries, CMS staff, therapists and even legislators as 'bad policy'. Moreover, therapy caps are inconsistent with spirit of the Affordable care Act (ACA) which contains insurance reforms prohibiting

annual and lifetime caps. And at times, more rather than less therapy is necessary to achieve the functional goals of the patient. As Commissioner Gradison pointed out, earlier intervention, timely intervention (i.e., without delay or gaps) and sometimes even more intervention is needed to accomplish optimal return to function. Thus, a comprehensive analysis of outpatient therapy is not complete without consideration of altering the caps, such as by separating the PT and SLP caps. Moreover, consideration should be given to repealing the caps as this is one distinct and achievable remedy that would bring immediate improvement to the outpatient therapy benefit, the charge given MedPAC by Congress.

PPS/APTA believes most of the recommendations lack substantial support and justification and the purpose of many is not readily identified.

For example,

1. The proposed elimination of the V code reporting is only applicable to facilities and will not render any visible or material improvement in outpatient therapy. Facilities use these V codes not to indicate any medical necessity but instead to indicate the reason for "admission" to the facility outpatient department (thus the V57.1 code for physical therapy). The secondary code is used to describe medical necessity. But MedPAC should be aware that the contractors are not universally requiring or utilizing the secondary code. Thus, if the V code use is deemed to be a problem that needs solving, it will require payer claims processing remedies as well as provider (facility) reporting. Simply eliminating the use of the V codes accomplishes little.

2. The benefit desired from reducing the certification of the plan of care duration from 90 to 45 days is a mystery. Currently, compliance with the plan of care certification is a paperwork exercise; it does not require the patient to see the doctor; it only requires the therapist to establish a plan and send it to the doctor for approval. The requirement of re-evaluations every 10 visits or 30 days, which provides a status of the patient, is still required no matter how long the certification timeframe is. Decreasing the maximum certification time from 90 to 45 days will only result in more provider time spent on paper work rather than on patient care. If the intent is to cause more patient visits to the physician, then reducing the period from 90 to 45 days will not only inconvenience the beneficiary but will also increase costs by resulting in more unnecessary doctor visits.

3. Imposing a temporary moratorium on enrollment of therapists and require current enrollees to re-enroll also seem of questionable merit. Since this draft recommendation was not openly discussed during the recent commission meeting, it is not possible to identify its intended purpose, nor its supposed

benefit. This proposal would create chaos in the industry, decrease access to therapy for patients, and trigger site visits by CMS or its contractors which would add costs to the Medicare program.

These MedPAC recommendations can have a profound effect on beneficiaries who, as Commissioner Naylor emphasized, highly value their independence and functional abilities and loss of these are among their highest fears. It is short-sighted and premature to issue a report with recommendations before the above information is thoroughly considered and carefully analyzed. Of particular relevance will be the information and experiences from the fourth quarter 2012 relating to manual medical review, functional outcomes reporting and the hospital outpatient departments falling under the therapy caps.

It is unclear to PPS/APTA why the commission believes it is necessary to hurry this report and issue recommendations before empirical and practical evidence become available. We urge the commission to resist the temptation to file this report and check this off your list. Instead, the commission should conduct the careful and complete analysis that Congress is expecting and deliver in June 2013 a full and comprehensive report that is consistent with the quality standards of MedPAC.

On behalf of PPS/APTA, thank you for the opportunity to provide this additional input. We would be happy to provide additional information and/or meet with the MedPAC staff to discuss these issues.

Sincerely,

Tom DiAngelis, PT, DPT
President
Private Practice Section/APTA