

September 2, 2014

Marilyn Tavenner, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
9500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1612-P

Dear Ms. Tavenner:

On behalf of the Private Practice Section (PPS) of the American Physical Therapy Association (APTA), which represents over 4200 members nationwide, I write to offer comments on the proposed rule (CMS-1612-P) regarding payment policies under the Medicare Physician Fee Schedule (PFS) and other revisions to Medicare Part B for calendar year 2015.

In July, 2014 the Centers for Medicare and Medicaid Services (CMS) released the proposed 2015 Medicare physician fee schedule rule that updates payment amounts and revises other payment policies. CMS is expected to publish a final rule by November 1, which will become effective January 1, 2015, for services furnished during the 2015 calendar year.

In this publication, the Agency proposes RVUs for CY 2015 and other Medicare Part B payment policies to update payment systems to reflect changes in clinical practice and the relative value of services. In addition, the rule proposes potentially misvalued codes, updates related to the Physician Compare Website, the Physician Quality Reporting System, the Medicare Shared Savings Program, the Value-Based Payment Modifier and the Physician Feedback Program.

In addition to the SGR update and the arbitrary per beneficiary therapy cap issues, PPS appreciates the opportunity to share our views and comments with CMS on the following general topics:

- Physician Quality Reporting System
- Qualified Clinical Data Registry
- Value-Based Payment Modifier
- Physician Compare Website
- Medicare Payment Changes, Increases for 2015
- Functional Limitation Reporting
- Payment Policy for Substitute Physician Billing Arrangements

SGR Update and Other Changes Impacting Payment

The rule indicates that therapists and physicians will see no change in payment for the first three months of 2015 due to the latest sustainable growth rate (SGR) patch. However, the SGR will take effect April 1, 2015, unless Congress once again intervenes. At that time therapists and physicians would face a 20.9 percent cut as a result of the legally mandated SGR.

PPS Comment: A 20.9 percent decrease would result in a payment rate insufficient to reimburse physical therapists for even the costs associated with providing therapy to a Medicare beneficiary. Over the last thirteen years Congress has taken action numerous times to avert these cuts prior to their effective date. But due to the cumulative nature of this dysfunctional formula, short-term patches only delay, and make more costly, the ultimate solution which is permanent repeal.

PPS realizes the sustainable growth rate formula is statutory and thus requires Congressional intervention to prevent this scheduled cut. For years, PPS has urged Congress to stop these disruptive payment cuts. CMS should be aware of the impact such a profound payment decrease would have on Medicare beneficiaries and the professionals who serve them. And to that end, **we urge CMS to work with Congress in repealing and replacing the arcane SGR formula by the beginning of the second quarter of 2015.**

Therapy Caps

The therapy cap exceptions process will no longer be in effect after March 31, 2015, unless Congress acts to statutorily extend the exceptions process.

PPS Comment: PPS continues to urge Congress to repeal this arbitrary limit on the most frail and needy Medicare beneficiaries and would **encourage CMS to collaborate with the legislative branch in finding an acceptable replacement for the payment methodology that spawned these arbitrary and hurtful caps.** Meanwhile, PPS continues to support the Agency's initiative which requires the collection and submission of quality information (e.g., functional status data) to be used to describe the patient's functional limitations and the type and amount of care that is needed by specified patients or groups of patients. The collection and utilization of such data is instrumental in replacing this arbitrary and discriminatory limitation.

Physician Quality Reporting System

The Physician Quality Reporting System (PQRS) was initially implemented in 2007 as a result of section 101 of Division B of the Tax Relief and Health Care Act of 2006. Private practice physical therapists are currently participating providers in PQRS and can report individual measures and measure groups. PPS's concerns regarding the proposed changes to the PQRS program are shared below.

Physician Compare Website

Section 10331(a)(1) of the Affordable Care Act (42 U.S.C. 1395w-5 note) required CMS to, by no later than January 1, 2011, develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program under section 1866(j) of the Act as well as information on other eligible professionals who participate in the PQRS under section 1848 of the Act (42 U.S.C. 1395w-4). In addition, section 10331(a)(2) of the Affordable Care Act (ACA) also requires that, no later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, CMS implement a plan for making information on physician performance publicly available through the Physician Compare Website (PCW). CMS did meet the initial requirements and now proposes to expand the data on the PCW for 2015 and for 2016.

The Agency proposes to expand public reporting of group-level measures by making all 2015 PRQS Group- Practice Reporting Option (GPRO) measures across all reporting mechanisms available for public reporting on the PCW in CY2016 for groups of 2 or more eligible professionals (EPs). CMS also proposes to make all individual EP- level PQRS measures collected via registry, EHR, or claims available for public reporting via the PCW collected next year (2015) to be publicly reported in late CY2016 if feasible. Moreover, CMS proposes to make available on the PCW, 2015 Qualified Clinical Data Registry (QCDR) measure data collected at the individual level or aggregated to a higher level of the QCDR's choosing, such as the group practice level, if technically feasible. CMS is proposing a minimum 20 patient sample for public reporting.

PPS Comment: This is a most ambitious timetable, particularly when one considers that data submitted by non-physician providers have not been considered for public reporting to date. In fact, numerous sites of service including rehabilitation agencies are not currently allowed to participate in PQRS. Simply applying the methods employed for physician reporting to the physical community is not appropriate. Therefore, PPS urges CMS to work with non-physician stakeholders to develop the most appropriate metrics for the care they deliver. Moreover, once enacted, we urge CMS to provide health care professionals the opportunity to preview data and measures in confidential formats and provide methods for feedback prior to posting the information on the Physician Compare site. We are skeptical that the Agency will be successful in overcoming the significant challenges associated with providing timely feedback reports to all providers to view, prior to the public release of data on the PCW with the expansion of public reporting for all EPs and groups across all reporting formats. Regardless, EPs should be allowed a reasonable period of time for review in order to access and gather supporting information to correct errors, discrepancies, and other concerns. In the release of data to the public, accuracy must not be sacrificed for speed.

In addition, given that the Compare Website will include data from other EPs beyond the physician community, including physical therapists, it would be prudent and timely for the Agency to develop a more accurate moniker for the Physician Compare Website.

Satisfactory Reporting Requirements

CMS proposes to retain the claims-based, registry-based and EHR based reporting options. The

Agency is also proposing to increase the number of measures from 3 to 9 in CY2015 in order for EPs to avoid the CY2017 penalty. CMS proposes that eligible professionals, including physical therapists, who report on individual measures via the claims-based reporting option or registry option in 2015 must report on at least 9 measures covering at least 3 of the National Quality Strategy domains, at least 50 percent of the time. If less than 9 measures apply to the eligible professional, they must report 1-8 measures.

PPS Comment: We support CMS's decision to retain multiple reporting options as we believe that this will encourage broader participation in the program. It is important to keep several options open so as not to require providers to incur additional costs when they may not be in a position to incur these costs.

However, the increase from 3 to 9 measures for successful reporting is significant. PPS believes CMS should consider a lower number of measures for successful reporting in CY2015. The proposed change in the number of measures will significantly increase provider burden in reporting.

Anecdotally, we are aware that many of our providers have opted to report 3 measures in CY2014, as many of our provider still report via claims, they have elected to report at the lower threshold in CY2014 citing the reporting burden as the main reason behind this decision.

As this program is expanded, many specialty professions will struggle to achieve these new thresholds resulting in a higher number of practitioners will be found to be out of compliance and subject to the penalty. Lowering the number of measures required for the reporting threshold will substantially increase the proportion of physical therapists and other health care professionals who will successfully participate and avoid the penalty. This translates to the delivery of higher quality of care which is the overarching goal of PQRS.

Additionally, given the proposed expansion of the value-based modifier (VBM) program in 2017, setting the PQRS reporting requirements for CY2015 in the ranged of 4- 6 measures we believe will facilitate a successful transition to reporting 9 measures in later program years.

PPS remains concerned with the lack of awareness of the reporting program given that in CY 2012 only 46.6 percent of MD/DOs and 25.7 percent of other eligible providers, including physical therapists, participated in PQRS. Many providers are oblivious to the impending change from a positive payment incentive to a penalty. Evidently, the efforts employed by the Agency to date have been insufficient to adequately increase the awareness in the provider community. We urge CMS to reassess the tools used to increase awareness about the program and, until a satisfactory level of awareness is achieved, **the Agency should delay or at least mitigate the implementation of the penalties associated with the program.**

Proposed Measures Individual & Group and Measure Specification Changes

CMS proposes to eliminate the Back Pain measures group (#148-151) from the PQRS program in CY2015. The reason given for this proposal is that the measure steward is not intending on

bringing this measures forward for re-endorsement and the measures “reflect clinical concepts that do not add clinical value to PQRS.”

PPS Comment: PPS supports the proposed change as it is consistent with our commitment to evidence-based practice.

Feedback Reports

Section 1848(m)(5)(H) of the Act requires the Secretary to provide timely feedback to eligible professionals on their performance with respect to satisfactorily submitting PQRS data. In the past, these provider level reports have been issued annually and distributed about seven months after the reporting period has ended. Additionally, CMS is providing interim dashboard reports to eligible providers quarterly through QualityNet.

PPS Comment: It is our understanding that significant delay in the distribution of these reports has made it difficult for clinicians to make any changes to improve their reporting under the program. Since a majority of PPS members still report in PQRS via claims based reporting they rely solely on QualityNet for feedback on their performance in the PQRS program. We believe that performance feedback is an essential component of successful performance improvement, and increasing the prompt availability of these reports is essential to assist EPs in improving care quality. More importantly, prompt, accurate provider feedback will become more critical as non-physicians, including physical therapists, are included in the VBM program but will simultaneously saddle the Agency with considerable additional burden.

Value-Based Payment Modifier

The requirement that CMS implement a value-based payment modifier (VBM) for some physicians by January 1, 2015, and for all physicians by January 1, 2017 was established by section 1848(p) of the Social Security Act, as added by Section 3007 of the ACA. The proposed rule seeks to apply the VBM to all physicians and groups of physicians and also non-physician eligible professionals and to increase the amount of payment at risk.

PPS Comment: PPS believes that applying the VBM to all physicians and groups of physicians and also non-physician eligible professionals and **increasing the amount of payment at risk will have a significant and abrupt impact on non-physician providers including physical therapists to whom this program has not yet been applied.**

Timing of Implementation of Value-Based Modifier

In the rule, CMS proposes to apply the VBM to all physicians and non-physician eligible professionals in groups with 2 or more eligible professionals and to solo practitioners starting in CY 2017. Under section 1848(p) of the Act, as added by Section 3007 of the ACA, CMS was required to add all physicians to the program by CY2017, but had discretion to add non-physicians to the program.

PPS Comment: As proposed, the inclusion of eligible non-physician professionals would result in full and sudden implementation of the program for non-physician providers which is a very different approach compared to previous years in which CMS slowly phased in the VBM program for physician groups.

PPS urges CMS to phase in the applicability of the VBM for non-physician providers similar to the approach that was used for physicians. Such an approach would give non-physician provider groups needed time to prepare for the VBM program while also allowing CMS to time to prepare and create Resource Utilization Reports (RUR) for these groups. Non-physician groups are insufficiently familiar with the history of the VBM and the Agency's activities to date, including RURs and will need more time to adapt to these consequential policies. Non-physician providers should be afforded the same time and consideration physicians received with respect to the VBM. In that instance, CMS phased in the program over three years applying the VBM to groups of 100 or more physicians in year one, groups of 99-10 physicians in year two, and to solo practitioners and groups of two or more physicians in year three.

Penalty and Value Matrix for the Value-Based Modifier

CMS proposes to make quality–tiering mandatory for groups and solo practitioners within Category 1 for the CY 2017 VBM. Category 1 includes: (1) groups that meet the criteria for satisfactory reporting of data on PQRS quality measures via the group practice reporting option (GPRO) for the CY 2017 PQRS payment adjustment; (2) groups that do not register to participate in the PQRS as a group practice participating in the PQRS GPRO in CY 2015 and that have at least 50 percent of the group’s eligible professionals meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the CY 2017 PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS-qualified clinical data registry (QCDR) for the CY 2017 PQRS payment adjustment; and (3) solo practitioners that meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the CY 2017 PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS QCDR for the CY 2017 PQRS payment adjustment. However, groups with between 2 and 9 eligible professionals and solo practitioners would be subject only to any upward or neutral adjustment determined under the quality-tiering methodology, and groups with 10 or more eligible professionals would be subject to upward, neutral, or downward adjustments determined under the quality-tiering methodology.

PPS Comment: The inclusion of all non-physician providers in the VBM program immediately in CY2017 will subject to some groups to full quality-tiering in year one if the group is composed of 10 or more eligible non-physician providers. Given the complex methodologies of the VBM program and its measures, a phased-in approach, as described above, would allow non-physicians providers to sufficient time to adequately familiarize themselves with the program. This reasonable approach is essential, especially considering the proposed increase in the penalty associated with the VBM.

CMS proposes to increase the VBM penalty to 4 percent. Doubling of the penalty while simultaneously including all non-physician providers in the VBM, is an astoundingly abrupt and significant change for non-physician providers and one with potentially

devastating impacts on the viability of their small business operations. The 25.7 percent participation rate in PQRS as evidenced by the 2012 PQRS data must be substantially increased before such a significant policy change is enacted. The magnitude of the impact of this proposed policy change should not be underestimated.

Value-Based Payment Modifier Quality Measures

CMS proposes to utilize a comprehensive group of quality measures in the VBM program to ensure that payment is reflective of both the quality and the cost of care. The conditions specific and readmissions quality measures as well as the cost measures included in the VBM program are specific to physician practice. CMS policy codified in §414.1270(b)(5) states that a group of physicians subject to the value-based payment modifier will receive a cost composite score that is classified as “average” under §414.1275(b)(2) if such group does not have at least one cost measure with at least 20 cases. CMS proposes in this rule to apply this policy to solo practitioners under the VBM program as well. Based on this policy, almost all groups comprised of eligible physical therapists in the VBM program will be scored as “average” for the specific quality measures and cost measures. Thus, performance in PQRS measures will be the primary determination of the VBM score.

PPS Comment: We appreciate the intent to integrate disparate quality initiatives, but this above-described consequence reveals yet another reason why the phased-in approach we propose for non-physician providers is even more critical. **In addition to the three-year transition, non-physician stakeholder groups should be engaged to develop specific quality and cost measures that are meaningful to non-physicians providers.**

Functional Limitation Reporting

Section 3005(g) of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) required CMS to implement, beginning on January 1, 2013, a claims-based data collection strategy that would be designed to collect data on patient function during the course of therapy services in order to better understand patient characteristics and outcomes. CMS finalized the data collection strategy to meet the above requirement and initiated the program effective January 1, 2014.

To implement this policy, claim forms are to include nonpayable G-codes and modifiers that describe the beneficiary’s functional limitations (a) at the outset of the therapy episode; (b) at specified points during treatment; and (c) at discharge. In addition, the therapist’s projected goal for functional status at the end of treatment is to be reported on the first claim for services and periodically throughout the episode. Modifiers indicate the severity of the functional limitation. Submission of functional limitation data on the claim form is a condition of payment for therapy services provided under Medicare Part B.

PPS Comment: CMS has not included any planned changes to the data collection regulations in the CY2015 proposed Physician Fee Schedule rule. Nevertheless, as the Agency is aware, therapy providers have faced numerous challenges with the implementation of the Functional

Limitation Reporting (FLR) requirements. Because of the problems with Medicare's claims processing systems, many providers were not paid for therapy services. As a result, physical therapy providers, especially those operating as small businesses, experienced significant financial hardship.

CMS implemented new system edits in early May 2014 which appears to have somewhat improved many of the claims processing issues related to FLR. Unfortunately, therapists are still experiencing claims processing and reimbursement issues. The payment problems associated with this seemingly benign policy change were not anticipated but have thrust considerable financial burden on therapists. Consequently, this vivid illustration underscores the need to slow down the implementation of the VBM for non-physician providers. PPS urges CMS to continue to work rapidly to resolve the payment problems associated with FLR to ease the financial difficulty experienced by private physical therapy practices doing their best to comply with the requirement.

Currently the FLR requirement is resulting in a wide variety of data being submitted to CMS and it is not known how the Agency will attempt to analyze, understand and make use of these data. The utility of these data are in doubt as it may not be possible to organize them in such a way that renders an accurate description of a physical therapy patient and the effect of treatment.

Using data collection to achieve the goal of improving the payment system for outpatient therapy services is possible only if it is meaningful information that can compare providers, compare patients, and account for variables. In lieu of developing a single standardized data collection tool, which could take years, CMS should require and accept only FLR data that are collected with valid, reliable and responsive measures. Requiring data to be collected using instruments with strong psychometric properties will foster the growth of evidence-based practice while simultaneously respecting the clinical preferences of therapists. Moreover, such an approach will more promptly enable CMS to describe the characteristics of physical therapy patients and the effects of that therapy despite this being included in the Balanced Budget Act of 1997, the Congressional action that carried the temporary therapy caps.

In 2006, CMS recognized four patient assessment instruments for the purpose of documenting patient function, the need for therapy and justification for continuation or discontinuation of care. Transmittal 63 listed:

- National Outcomes Measurement System (NOMS) by the American Speech-Language Hearing Association
- Patient Inquiry ® by Focus On Therapeutic Outcomes, Inc. (FOTO)
- Activity Measure – Post Acute Care (AM-PAC)
- OPTIMAL by Cedaron through the American Physical Therapy Association

The above represents a sound and appropriate starting place for data collection and submission requirements for functional limitation reporting.

Presently, CMS requires submission of the functional limitation data via the claims-based mechanism. But outpatient private practice physical therapists are required to report in quality programs, such as PQRS, under Medicare and may comply by submitting data to CMS via claims, a registry, a qualified clinical data registry, or an electronic health record. In the interest of easing the compliance burden associated with the various reporting requirements, we would urge CMS to explore accepting FLR data submitted by any of the methods identified above.

Comments on the Payment Policy for Substitute Physician Billing Arrangements.

In the proposed rule, the Agency expresses concern about operational and program integrity issues that result from the use of substitute physicians to fill staffing needs or to replace a physician who has permanently left a medical group or employer—that both the departed physician and the departed physicians' formal medical group might bill Medicare under the departed physician's NPI for furnished services due to processing delays or miscommunication regarding which party would report the change to Medicare.

CMS also indicates a desire to require that a substitute physician be enrolled in the Medicare program because having a NPI does not necessarily mean that the substitute physician is enrolled in Medicare. CMS is seeking comment regarding how to achieve transparency in the context of substitute billing arrangements for the identity of the individual actually furnishing the service to a beneficiary.

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

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

- the regular physician is unavailable to provide the visit services,
- the Medicare beneficiary has arranged or seeks to receive the visit services from the regular physician,
- the regular physician pays the locum tenens for his/her services on a per diem or similar fee-for-time basis,
- the substitute physician does not provide the visit services to Medicare patients over a continuous period of more than 60 days, and
- the regular physician identifies the services as substitute physician services by entering the HCPCS modifier Q6 (service furnished by a locum tenens physician) after the procedure code in Item 24d on the CMS-1500 claim form or electronic equivalent.

The patient's regular physician must keep on file a record of each service provided by the substitute physician, along with the substitute physician's UPIN/NPI. This record should be available to Medicare on request. It is not necessary to provide this information on the claim form. The group should enter the modifier Q6 after the procedure code.

In the proposed rule, the Agency expresses concern about operational and program integrity issues that result from the use of substitute physicians to fill staffing needs or to replace a physician who has permanently left a medical group or employer—that both the departed physician and the departed physicians' formal medical group might bill Medicare under the departed physician's NPI for furnished services due to processing delays or miscommunication regarding which party would report the change to Medicare.

PPS Comment: Physical therapists do not currently utilize the locum tenens provision as they were not included in the very narrow statute when it was originally enacted. However, **physical therapists should be added to the locum tenens provision as Medicare beneficiaries are considerably disadvantaged when PTs in private practice are unable to appropriately arrange for a substitute PT to treat their patients when they must be away from the clinic for a short period of time.**

PPS supports the reduction of fraud, abuse, and waste in the health care industry and increased transparency. At the same time, it is imperative that senior citizens and people with disabilities have timely access to medically necessary health care services. If a physician, physical therapist, or health care professional will be absent from their practice due to illness, pregnancy, continuing medical education or other issues, it is important for their patients to continue to receive the care that they need. Locum tenens has been a long-standing mechanism for enabling coverage for physicians in these circumstances on a temporary basis. It is particularly beneficial in rural areas where patients have no other options close by to receive their care. The inability of physical therapists to bill under locum tenens has limited patient access to physical therapy services, particularly in rural areas.

In the proposed rule, CMS asks for comment on whether the Agency should require enrollment in the Medicare program of all physicians under locum tenens. PPS firmly believes that enrollment is an approach that is NOT workable in the context of substitute or locum tenens billing. The current Medicare enrollment process is inefficient, time consuming and burdensome, resulting in significant wait times before enrollment is finalized. PPS members consistently and repeatedly report instances in which the enrollment process takes three months and sometimes even a year before completion. For physical therapists, delays in the enrollment process are further exacerbated by the requirement for a site visit prior to enrollment even when a therapist is added to an existing, previously surveyed practice. Until CMS can expedite the enrollment process by increasing timeliness, efficiency, and reducing burden, requiring enrollment for temporary substitutes is not a feasible option. Such a requirement would jeopardize care to Medicare beneficiaries due to delays in access to timely, medically necessary care. Moreover, a likely unintended consequence is the potential increase of the cost to care for these Medicare beneficiaries.

Enrolling in Medicare is a time-consuming and burdensome process, especially for a substitute therapist who may only work in a given clinic for one or two weeks and may work for several different clinics over the course of a year. It is profoundly unworkable for the Agency to require substitute physicians or therapists to be enrolled in the Medicare program and registered, credentialed or assigned to every private practice for which they are employed temporarily.

With respect to the Agency's concern about operational and program integrity issues that result from the use of substitute physicians to fill staffing needs or to replace a physician who has permanently left a medical group or employer—that both the departed physician and the departed physicians' formal medical group might bill Medicare under the departed physician's NPI for furnished services due to processing delays or miscommunication regarding which party would report the change to Medicare, **PPS would observe that this possibility exists whenever a physician permanently leaves a medical group or employer. It is not an issue that exists because of locum tenens. But rather it exists as a result of the processing delays.**

The enhanced transparency the Agency seeks can be accomplished through a better tracking of the NPI and of the Q6 modifier that indicates the service was furnished by a locum tenens physician. Requiring physicians and therapists to endure an even more time-consuming enrollment process is not the solution to Medicare's processing delays or miscommunication regarding which party would report the change to Medicare.

The practice billing the care that was provided is ultimately responsible for the care delivered. No separate billing criteria or procedures are necessary nor should they be imposed. The practice engaged in caring for these Medicare beneficiaries, has as their primary mission to provide timely, high-quality, effective care to the patient. They should not be required to identify, develop or adhere to any arbitrary criteria to determine if they need a substitute physician or therapist. Other than the restriction of 60 calendar days, there should be no additional limitations or prohibitions on using substitute physician or physical therapist. **More robust tracking of the Q6 modifier and expanded use of the NPI number to identify the treating practitioner on claims should be sufficient data to enable CMS to rigorously enforce the prohibition of physician self-referral.**

PPS would strongly discourage CMS from creating any additional qualifications for substitute physicians or therapists. These professionals are qualified and duly licensed as should be evidenced by the issuance of an NPI. Moreover, **we urge CMS to work with Congress to add physical therapists to the list of providers authorized to use locum tenens.**

Lastly, PPS recommends that CMS require every therapist who treats Medicare beneficiaries, regardless of setting, to have an NPI. Further, PPS urges that the Agency adopt the policy that Medicare enrollment not be required for physical therapists who provide temporary, short term services (i.e., less than 60 calendar days) in the private practice setting in order for the practice to be allowed to bill Medicare for treatment under the practice group enrollment number.

PPS thanks the Agency for the opportunity to provide these comments on the proposed rule for the 2015 Medicare Physician Fee Schedule. PPS is committed to continue its cooperation and collaboration with CMS and we look forward to more opportunities to partner with the agency in pursuit of meaningful and effective innovation in the Medicare program.

Sincerely,

A handwritten signature in black ink that reads "Tom DiAngelis". The signature is written in a cursive style with a large, stylized 'T' and 'D'.

Tom DiAngelis, PT, DPT
President, PPS/APTA