PRIVATE PRACTICE SECTION, APTA

American Physical Therapy Association

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September 6, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05 Attention: CMS–1654–P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code-CMS-1654-P; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Proposed Rule

Dear Acting Administrator Slavitt:

On behalf of the over 4200 members of the Private Practice Section (PPS) of the 90,000 member American Physical Therapy Association (APTA), I write to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule regarding "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for 2017" (CMS-1654-P), published in the July 15, 2016 *Federal Register*.

In this publication, CMS the proposes revisions to payment policies, updates quality provisions, and establishes 2017 payment rates for Medicare-billed services that take place in hospital and ambulatory surgery center settings. CMS is expected to publish a final rule by November 1, which will become effective January 1, 2017, for services furnished during calendar year 2017. The physician fee schedule is the basis of payment for outpatient therapy services furnished by therapists in private practice as well as outpatient therapy services furnished by hospitals, outpatient rehabilitation facilities, public health agencies, clinics, skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities (CORFs). Therefore, any changes to payments under the physician fee schedule for outpatient therapy services have a significant and direct effect on Medicare payments across the entire spectrum of the therapy delivery system.

PPS will share views and comments with CMS on the following topics that our relevant to our membership:

- Evaluation Codes
- Medicare Advantage Provider Enrollment
- Expansion of the Diabetes Prevention Program
- Physician Self-Referral Updates
- Telehealth

- Implementation of the Merit-Based Incentive Payment System (MIPS)

With the release of the 2017 proposed physician fee schedule on July 15th, CMS is introducing physical therapists to a new current procedural terminology (CPT) coding system that acknowledges varying levels of complexity in evaluations. However, at this point the Agency is not proposing any payment changes from 2016 rates, nor will the payment reflect the complexity of care. Instead, CMS is calling for educational efforts to train physical therapists on how to appropriately use the new system before it will implement tiered payment rates. CMS also continues its review of potentially misvalued codes, including 10 commonly used physical therapy codes. The proposed rule refines Medicare Advantage provider enrollment as well as physician-self referral prohibitions for per-click compensation agreements. Furthermore it reiterates that CMS does not have the regulatory authority to extend telehealth services to care provided by physical therapists.

Valuation of Specific Codes (Physical Therapy Evaluation and Reevaluation)
In the proposed rule, CMS adopts new CPT code descriptors for physical therapy evaluations and reevaluations created by the CPT Code Editorial Panel effective January 1, 2017. The new code descriptors differentiate therapy evaluations by complexity thus creating three new evaluation codes and one new reevaluation code. CMS proposes to price the three new therapy evaluation codes the same rather than individually as recommended by the American Medical Association's (AMA) Relative Update Committee (RUC) Health Care Professionals Advisory Committee (HCPAC). Therefore, CMS proposes to retain the longstanding Relative Value Unit (RVU) of 1.20 for the new group of therapy evaluation codes. Additionally, CMS proposes a RVU of .60 for the new reevaluation code.

The Agency states that it is concerned that the new coding structure differentiating complexity of the evaluation may result in upcoding especially as therapists become familiar with the new required components. CMS is especially concerned that there will be an inherent incentive to upcode to a higher complexity level than was actually furnished in order to receive a higher payment.

PPS Comment:
PPS is extremely concerned that CMS is planning not to adopt the proposal of the RUC HCPAC in its entirety. Consequently, we strongly urge the Agency to reconsider this proposal and adopt payment levels associated with the detailed complexity of each code descriptor. The new physical therapy evaluation codes essentially split the current physical therapy evaluation code (97001) into three levels, low-complexity (97X61), moderate-complexity (97X62), and high-complexity (97X63). As articulated in the proposed rule, we assert that prospective utilization for the three levels will breakdown as follows: 25 percent utilization for the low-complexity evaluation code, 50 percent for the moderate-complexity evaluation code, and 25 percent for the high-complexity evaluation code.

When APTA developed its recommendations for the AMA RUC, it solicited input from the physical therapy community, including providers in skilled nursing facilities (SNFs), hospital

outpatient settings, and independent physical therapy practices. According to expert physical therapists, the work and practice expense values submitted are reflective of the typical physical therapist practice today. We are informed that the minutes presented and accepted by the AMA RUC are representative of typical practice.

Therefore, we believe the adoption of the new values of: .75 for the PT Low Complexity Evaluation, 1.18 for the PT Medium Complexity Evaluation and 1.50 for the High Complexity Evaluation and .75 for the PT Reevaluation are wholly appropriate and should be adopted in the final rule. There is a CMS precedent to afford stakeholders the opportunity to implement proposals that have been approved and vetted by the AMA RUC HCPAC and then apply the appropriate payment adjustments once it has been determined that the value construct is not adequate to meet CMS budget neutrality requirements. PPS is dismayed that CMS is not granting that long-standing opportunity to the new physical therapy evaluation and reevaluation codes and their associated values, as recommended by the AMA. Furthermore, PPS believes that accepting one part of the AMA recommendation (CPT coding revisions) while ignoring the other (RUC HCPAC values) is detrimental to both patient care and physical therapy practice. We know that APTA worked in good faith through the AMA process to better align coding with the direction that both CMS and private payers are heading in—seeking additional information about patient condition. We are deeply concerned that CMS is fragmenting the thoughtful AMA proposal. APTA discussed the prospect of delaying publication of the new evaluation and reevaluation codes with AMA in late July. AMA did not believe a delay was necessary and instead decided to proceed with printing of the 2017 AMA manual. Nevertheless, if a viable option exists to delay implementation of the new codes for CY 2017 that does not further disrupt patient care of physical therapy practice, PPS would be very interested in exploring this with CMS.

As articulated in APTA's compelling evidence presented to the AMA RUC, PPS concurs with APTA in the belief that the clinical staff time for physical therapy evaluation and reevaluation services have changed since the previous AMA Practice Expense Advisory Committee (PEAC) review in 2001 due to the types of patients that are being seen, earlier access to physical therapy services, use of technology, and an increase in documentation requirements. In addition, while the PEAC review in 2001 was related to the physical therapist work, the physical therapist work itself has not been directly reviewed since 1997.

The work related to physical therapy evaluation and reevaluation has increased due to the mandatory requirements regarding performance and outcome measurement, quality reporting, as well as a more diverse and active Medicare patient population who are living with more chronic comorbidities and also accessing services earlier. New technology has also created an opportunity for additional types of treatment approaches. Most significantly, there are increased documentation requirements, (over and above the justification requirements inherent in the codes as written) reflecting the emphasis on quality of care and outcomes focused management with increased accountability. All of these factors have increased the work for both the physical therapist and their clinical staff.

The 2015 Medicare Benefit Policy Manual, Chapter 15, describes (in detail) the documentation that is a necessary part of a physical therapy evaluation or reevaluation (please see attached excerpt from Section 220.3 of the manual). These extensive documentation requirements were implemented in 2005 and subsequently amended in 2008. Additionally, in 2013 the functional reporting requirement was added as a result of The Middle Class Tax Relief and Job Creation Act of 2012 and included a provision that mandated the collection of information regarding the beneficiaries function and condition, therapy services furnished, and outcomes achieved on the claim forms, at the initial evaluation, at the time of any re-evaluation or by the 10th visit and at discharge. The goal was to be able to the use the data in the future to reform payment policies. If implemented with the values as suggested, data from the reporting of these evaluation codes could supplement this data collection as reform of payment policies is still to be achieved.

In this post-ACA[1] era physical therapists and their clinical staff, like other health care providers, are adjusting how they communicate with their patients in order to meet expectations of timely access to health information. Well-informed patients/families are, and should be, actively involved in decision-making about their care and are more prepared and engaged when accessing their choice of health care provider; patients have high expectations of what the therapists and their clinical staff will provide during an episode of care. As a result, physical therapists and their clinical staff have increasingly complex responsibilities. The physical therapy evaluation today, in contrast to 18 years ago, requires more time both in the preparation and in the execution of the key elements of the evaluation. In order to meet the challenges and responsibilities of being a practitioner today, the therapist must be able to effectively examine the patient, evaluate the findings and communicate the best plan for managing the patient's complaints, functional impairments, access to resources, and return to function to multiple parties (patient, caregiver and payer) as well as report the predicted and actual outcomes to the patient, caregiver, payer, and other healthcare providers.

With respect to the complexity issue and the health status of patients needing services, the entire spectrum of complexity is seen in the Medicare population seeking physical therapy care. According to the CDC, in 1994, **almost all states** had prevalence of obesity **less than** 18%. Nationally, in 2013 **more than one-third** of the US population was overweight and 28% of the US population was obese. These alarming statistics related to the incidence of obesity creates a host of other concerns in regards to patient's comorbidities (e.g., Type II diabetes, COPD, hypertension, heart failure, and joint and spine degeneration). In 2010, more than two-thirds of Medicare beneficiaries had two or more chronic conditions, such as hypertension, heart disease, arthritis, diabetes, heart failure, chronic kidney disease, and depression. According to census data, 98.2% of all people in their 90s who lived in a nursing home had a disability and/or condition that prevented them from taking care of themselves, and 80.8% of people in their 90s who did not live in a nursing home also had one or more disabilities. These older patients present a special challenge because, in addition to physical disabilities, there is also often concurrent cognitive decline, polypharmacy, and complex psychosocial issues, all of which take additional effort and time. Patients with these comorbidities require more time and physical effort during therapy evaluation and reevaluation. However, it is important to point out that a full range of patients, with varying degrees of complexity, seek physical therapy care. Physical therapists in

private practice treat many younger and more active Medicare patients who due to their active lifestyle and other factors do not present with a long list of co-morbidities. These patients generally represent lower complexity, fewer visits, and better outcomes due to their own health promotion diligence.

Therefore, PPS strongly urges CMS to reverse its current proposal and adopt the original proposal submitted by the AMA RUC HCPAC. Short of that, we reiterate our willingness to explore a delay of implementation of the new codes for CY 2017 provided such action does not further disrupt patient care provided by a physical therapist in private practice.

In order to ensure coding accuracy when differentiating physical therapy evaluations by complexity, we are aware that APTA has established an educational plan for physical therapists and its stakeholders both internal and external. The plan is two-fold, first understanding the new evaluation codes and complexity levels. Second is adequately documenting to support their choice of complexity level. Successful implementation of the educational plan will require commitment and broad participation by all stakeholders involved. Following the release of the AMA CPT language, APTA is planning a release of numerous educational resources to be made available to its members as well as non-members. Educational resources will include complimentary webinars, interactive self-pace online course, frequently asked questions, train-the-trainer slide deck, documentation resources, and articles through APTA publications.

The resources will allow therapist to learn about the new codes and practice codifying patient vignettes into the appropriate complexity levels. APTA has dedicated web space and an interactive list serve for members to ask clarifying questions regarding the codes. Realizing that communication of their clinical decision-making represents the therapist's biggest challenge in terms of documentation, APTA will focus its educational resources and other efforts in this area of training.

It is our strong belief that this education effort can take place in a rapid fashion and can continue as necessary throughout the implementation of the new codes with the values adopted by the AMA RUC.

CMS specifically requests more information about how the physical therapist differentiates the number of personal factors that actually affect the plan of care. In addition, CMS is interested in understanding more about how the physical therapist selects the number of elements from any of the body structures and functions, activity limitations, and/or participation restrictions to make sure there is no duplication during the physical therapist's examination of body systems.

PPS Comment:
The mere fact that CMS is requesting this clarifying information should be sufficient reason for the Agency to consider delaying adoption of the new evaluation codes. To that end, we reiterate our willingness to explore a delay of implementation of the new codes for CY 2017 provided such action does not further disrupt patient care by a physical therapist in private practice.

With respect to how the physical therapist addresses personal factors that may affect the plan of care as well as selects the number of elements from any of the body structures and functions, activity limitations, and/or participation restrictions and how the clinician differentiates between the two, we offer the following;

Personal factors include gender, age, coping styles, social background, education, profession, past and current experience, overall behavior pattern, and other factors that influence how disability is experienced by the individual. The physical therapists takes a patient's history–a systematic gathering of data from both the past and the present–related to why the individual is seeking the services of the physical therapist, their history of function, and their medical history. The data that are obtained include personal factors (e.g., demographic information, social history, employment and work history, growth and development, living environment, general health status, social and health habits, family history), medical and surgical history, current conditions or chief complaints, functional status and activity level, medications, and other clinical tests. While taking the history, the physical therapist also identifies health restoration and prevention needs as well as coexisting health problems and co-morbidities that may have implications for intervention. This history typically is obtained through the gathering of data from the individual, family, significant others, caregivers, and other interested parties (e.g., rehabilitation counselor, teacher, workers' compensation case manager, and employer); through consultation with other members of the team; and through review of the individual's record.

The physical therapist identifies the existence and origin of impairments in body functions and structures, activity limitations, and participation restrictions commonly related to medical conditions, sociodemographic factors, or personal characteristics first by way of taking the patient history; however, during the course of the physical examination, physical therapists are able to further evaluate the patient and determine the implications of these factors.

Physical therapists then utilize tests and measures to pinpoint causes of impairment in body structures and functions, activity limitations, and participation restrictions. The tests and measures are performed as part of an initial examination to (1) confirm or reject a hypothesis about the factors that contribute to making the individual's current level of function less than optimal and (2) support the physical therapist's clinical judgments about the diagnosis, prognosis, and plan of care. Before, during, and after administering the tests and measures, physical therapists gauge responses, assess physical status, and obtain a more specific understanding of the condition and the diagnostic and therapeutic requirements.

Finally, at the point the codes are adopted by CMS we strongly urge the Agency to delay the development of any payment adjustments as a result of analyzed claims data during CY 2017 after the implementation of the tiered code descriptors. It is imperative that CMS work closely with PPS, APTA, and other stakeholders to make payment decisions that are in the best interest of patient care. In order to fully derive the best data to make sound future payment policies, CMS must have a comprehensive picture of all of the factors facing the payment environment. Thus, it is critical that CMS work with APTA, other clinicians, and stakeholders as we all seek to ensure proper use and coding accuracy. APTA plans to initiate its own payment research efforts over the

next year, and we know the Association looks forward to sharing more information with the Agency in CY 2018.

Potentially Misvalued Services under the Physician Fee Schedule
In the proposed rule, CMS has identified 10 physical therapy codes as part of its continued efforts to update payment accuracy through the potentially misvalued codes initiative. They are 97032 Electrical stimulation, 97035 Ultrasound therapy, 97110 Therapeutic exercises, 97112 Neuromuscular reeducation, 97113 Aquatic therapy/exercises, 97116 Gait training therapy, 97140 Manual therapy 1/regions, 97530 Therapeutic activities, 97535 Self-care management training, and G0283 Electrical stimulation other than wound. CMS acknowledges that APTA and other specialty societies are working on coding changes through the CPT process for these modality and procedures services and therefore requests input on valuation of the above listed codes.

PPS Comment:
PPS is convinced APTA is committed to providing CMS the requisite information to appropriately value the above referenced codes and will be working diligently over the next several months to do so. As CMS is aware, APTA along with other stakeholders, through an AMA-convened workgroup, made a concerted effort to refine the physical medicine and rehabilitation (PM&R) code family over the last few years that would weave complexity of the patient's condition into its codes as well as reflect contemporary practice. Unfortunately, the PM&R work group was disbanded and instructed to go through the CPT process for any code changes. In April 2016, APTA along with other stakeholders presented an action plan to the AMA Relativity Assessment Workgroup (RAW) regarding its plan to survey or submit CPT code changes of the physical medicine and rehabilitation code family. APTA will work with AMA and stakeholders in surveying the 10 physical medicine and rehabilitation codes identified in the proposed rule. PPS believes APTA is committed to this work and will finalize the sequence and timeline for the survey process following additional discussion with the AMA and CMS in the coming weeks. We are of the understanding that APTA has already initiated the process of developing the necessary information and should be prepared by October to survey the codes that are included on the misvalued list previously mentioned.

PPS believes that the AMA RUC process is the appropriate venue in which to survey and valuate the codes, and we are committed to working through that process in an expeditious manner starting this fall. Also, we would appreciate the opportunity to discuss our progress with CMS at the beginning of next year prior to the publication of the 2018 Fee Schedule proposed rule.

Medicare Advantage Provider Enrollment
The proposed rule would require that all providers and suppliers enroll in Medicare in an approved status before being reimbursed for providing health care services to someone who receives his or her Medicare benefit through a Medicare Advantage (MA) organization.[8] As all private practice physical therapists must be in approved status in order provide care in their own

clinics, this would not add an additional burden to PPS members. The proposed effective date of these requirements is the end of 2018.[9]

PPS Comment:
Since all private practice physical therapists must be in approved status in order to provide care in their own clinics, this would not add an additional burden to PPS members. Therefore, PPS can support this proposal.

PPS commends CMS for requiring that all providers and suppliers be enrolled in Medicare before they can be reimbursed for care provided to Medicare beneficiaries whose benefits are managed by an MA organization. PPS members who provide care to Medicare beneficiaries must already be enrolled Medicare in approved status. Therefore, the extension of this requirement to beneficiaries using their MA plan benefits will not hinder access to care provided in a private practice setting. In addition, PPS urges CMS to make it clear in the final rule the benefits of increased opportunities for private practice physical therapists to become in-network providers under MA plans.

Expansion of the Diabetes Prevention Program
Citing that Type 2 diabetes is typically preventable with appropriate lifestyle changes, CMS is seeking to expand the diabetes prevention program to Medicare beneficiaries. This program, called Medicare Diabetes Prevention Program (MDPP) would become effective on January 1, 2018.[10]

CMS is reportedly considering requiring existing Medicare providers and suppliers to submit a separate enrollment application. But the proposed rule would allow existing Medicare providers and suppliers who wish to become MDPP coaches and bill for MDPP services to simply inform CMS of their intention to do so and satisfy the other enrollment requirements.[11] MDPP coaches would be required to use their National Provider Identifier (NPI).

PPS Comment:
PPS supports the proposal that would allow existing Medicare providers and suppliers who wish to become MDPP coaches and bill for MDPP services to simply inform CMS of their intention to do so and satisfy the other enrollment requirements. The national Provider identifier would be used to identify the provider and services.

Physician Self-Referral Updates
Many studies have shown that physicians who had financial relationships with entities to which they refer patients ordered more services than those without such financial arrangements. CMS continues to express concern that despite the Stark Law, incentives remain in place that "create an incentive for physicians to narrow their choice of treatment options to those for which they will realize a profit" as well as the risk that "physicians refer to the lessee instead of referring to another entities that utilizes the same or different (and perhaps more efficacious) [interventions] to treat the patient's condition".[12] Furthermore CMS recognizes that "the medical marketplace suffers if new competitors cannot win business with superior quality, service, or price".[13]

Following a favorable decision by the D.C. Circuit Court in Urological Interests v. Burwell,[14] CMS is using this proposed rule to reiterate their previous rulemaking[15] that while office space and equipment rental is allowed under the physician self-referral statute, in order to prevent abuse of the program, it is prohibited to use per-unit of service (aka "per-click") compensation formulas in order to determine office space and equipment rental charges.[16]

PPS Comment:
PPS thanks CMS for continuing to recognize the perverse incentives created by compensation arrangements between physicians and other providers that are based on volume. Moreover, we commend CMS for keeping the integrity of the Medicare program in mind through reiterating its position that per-unit of service (aka "per-click") compensation formulas in order to determine office space and equipment rental charges are prohibited. It is important to recognize, as CMS apparently does, that financial arrangements not only risk wasting funds but could also limit access to more appropriate treatment options because "the medical marketplace suffers if new competitors cannot win business with superior quality, service, or price".[17]

There has been a long history of problems relating to physician-owned physical therapy arrangements. Studies have demonstrated that physician-owned physical therapy arrangements have a significant adverse economic impact on consumers, third-party payers, and physical therapists.[18] Specifically, a 2006 report by the Department of Health and Human Services' Office of the Inspector General (OIG)[19] showed that physical therapy billed directly by physicians represents a large and growing percentage of Medicare's total expenditures for these services. The OIG found that 91% of PT billed by physicians and allowed by Medicare did not meet Medicare guidelines which resulted in a significant amount of improper payments. In addition, Medicare claims from 2002 to 2004 were analyzed and aberrant patterns of billing and unusually high volumes of claims were identified. In a report issued in August 2009, the OIG examined physician "incident to" services billed in 2007 under the Medicare program, and found that 49 percent of rehabilitation therapy services (including primarily therapeutic exercise, massage therapy, ultrasound therapy, therapeutic activities, and electrical stimulation) performed by non-physicians were furnished by staff not trained as therapists that the OlG found to be unqualified.

Telehealth
In the proposed rule, CMS makes it clear that physical therapists are not listed in statute as authorized providers of telehealth services and therefore reimbursing physical therapists for care provided via telehealth would require an act of Congress. While CMS proposes to add several codes to the list of services eligible to be provided by way of telehealth, it is not going to add any physical therapy services to that list.

PPS Comment:
PPS thanks CMS for using its authority to expand the list of services eligible to be provided using telehealth. But because the Agency is not able to add any physical therapy services to the list, we are supporting the necessary Congressional action to make that possible. When PTs are included by law in the list of eligible providers, we look forward to working with CMS to ensure

that regulations are implemented allowing for the PTs and their patients to benefit from the use of telehealth to increase access to care.

Implementation of the Merit-Based Incentive Payment System (MIPS)

PPS would also like to take the opportunity in this letter to reiterate its concerns about the implementation of the Merit-Based Incentive Payment System (MIPS) Section 1848(q) of the Act, added by section 101(c) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), requires that CMS consolidate several existing programs, including Medicare and Medicaid EHR Incentive Programs, Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier (VM) into a single, more simplified program called the Merit-Based Incentive Payment system (MIPS), applicable beginning with payments for items and services furnished on or after January 1, 2019. Through MIPS, annual payment updates will be provided based on their performance in four categories:

1. Quality (maximum 30 points)—determined by the Physician Quality Reporting System (PQRS) mandatory quality reporting requirement and the Value Based Modifier (VM) quality measures;
2. Resource use (maximum 30 points)—determined by the VM cost measures;
3. Meaningful use of an electronic health record (maximum 25 points)—for complying with Meaningful Use (MU) in the performance year; and
4. A new category of "clinical practice improvement" activities (maximum 15 points)–the criteria of which have yet to be determined. CMS is expected to post a request for information regarding the definition of clinical practice improvement before December 2015.

PPS Comment:

PPS notes that under Section 2 of MACRA the PQRS program becomes voluntarily in 2019 (based on performance in 2017) and the MIPS program begins in 2019 for physicians, physicians' assistants, nurse practitioners, clinical nurse specialists, and nurse anesthetists. Other non-physician eligible professionals to be added beginning in year 3 (2021) of the MIPS program under the discretion of the Secretary including physical therapists, occupational therapists, speech language pathologists, clinical social worker, clinical psychologist, registered dietician, nutrition professional, and audiologists. However, the factors by which additional eligible professionals will be included by CMS at a later date are not known. PPS has concerns regarding these legislative changes to the quality reporting program, specifically with the lack of inclusion of several non-physician groups including physical therapists and therefore urges CMS to include in the final rule an amplification of the criteria to include non-physician professionals such as physical and occupational therapists in the MIPS beginning in 2021.

Physical therapists have been included in quality reporting under Medicare part B in the PQRS program since its inception in 2007. The PT/OT participation rate in PQRS in 2013 was 62.6%, which exceeded the overall eligible professional (EP) participation rate of 51.2% and the MD/DO participation rate of 59.1%. PPS has significant concerns that PT exclusion from the MIPS program in 2017 and 2018 will have a strong negative impact on the reporting rate of quality measure by physical therapists. Furthermore, PPS is concerned that PTs will struggle to return successfully into the quality reporting space in 2019 under the constructs of an entirely

new program after this two year hiatus. PPS strongly encourages CMS to continue to incentivize participation in quality reporting programs (e.g. PQRS) for PTs and the other non-physician providers that are excluded from the initial group of EPs in MIPS. One example of incentivizing PTs to continue to reporting quality measures in the 2017 and 2018 reporting year would be to give providers credit towards their MIPS performance when they join that program in 2019. We would welcome the opportunity to work with CMS on developing mechanisms to incentivize physical therapists to continue to participate in PQRS.

Another concern PPS has is the gap in the reporting of public data that will occur on the Physician Compare website as result of the exclusion form the first two years of the MIPS program. As CMS continues to launch data on the Physician Compare website, PPS is concerned about the public perception of the absence of physical therapists during the 2017 and 2018 years when they are not participating in the MIPS program. We believe that a lack of data during these years may give the public an incorrect impression that physical therapists are choosing not to participate in the MIPS program when they are legislatively excluded. Again, we encourage CMS to develop mechanisms that will incentivize PTs and the other non-physician providers to continue reporting quality measures during these interim years (2017, 2018) in order to avoid these unintended consequences.

We are hopeful that exclusion from the MIPS program in its inception years will not impact our ability to participate and advocate for physical therapists. Given the changes that are simultaneously occurring in the post-acute care space with the implementation of the IMPACT Act, PPS believes that the next several years will be a critical period for the development and implementation of measures that impact physical therapists in various quality programs across the continuum of care.

Conclusion

PPS thanks CMS for the opportunity to provide these comments on the proposed rule for the 2017 Medicare Physician Fee Schedule. PPS is committed to meaningful and effective innovation in the Medicare program and pledges to continue its cooperation and collaboration with CMS. We look forward to more opportunities to partner with CMS in pursuit of meaningful and effective innovation in the Medicare program.

Sincerely,

Terrence Brown, PT, DPT
President, Private Practice Section of APTA

End Notes

[1] https://www.gpo.gov/fdsys/pkg/FR-2016-07-15/pdf/2016-16097.pdf, pp, 46256. Also see table 19 on pp 46258.
[2] *Ibid*. Pp. 46256, 46258.
[3] *Ibid.* Pp. 46257.
[4] *Ibid.* Pp. 46256.
[5] *Ibid.* Pp. 46258.
[6] *Ibid.* Pp. 46256.
[7] *Ibid.* Pp 46259.
[8] *Ibid.* Pp 46412.
[9] *Ibid.* Pp 46412.
[10] *Ibid.* Pp 46414.
[11] *Ibid.* Pp 46415.
[12] *Ibid.* pp.46452.
[13] *Ibid.* pp. 46452.
[14] 790 F.3d 212 (D.C. Cir. 2015)
[15] In the 2009 IPPS final rule (73 FR 48716).
[16] 46450.
[17] *Ibid.* pp. 46452.
[18] Mitchell JM, Scott E. Physician ownership of physical therapy services: Effects on charges, utilization, profits, and service characteristics. JAMA. 1992; 268:19-23; Swedlow A, Johnson G, Smithline N, Milstein A. Increased costs and rates of use in the California Workers' Compensation System as a result of self-referral by physicians. N Engl J Med. 1992;327:1502-1506; Office of the Inspector General, Department of Health and Human Services. 1994.
[19] *Physical Therapy in Physician's Offices*, no. OEI-02-90-00590. Washington, DC: OIG and OIG, Physical Therapy Billed By Physicians (May 1, 2006).