PRIVATE PRACTICE SECTION, APTA

American Physical Therapy Association

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Marilyn Tavenner, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS–1600–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-1600-P) regarding payment policies under the Medicare Physician Fee Schedule (PFS) and other revisions to Medicare Part B for calendar year 2014. The Centers for Medicare and Medicaid Services (CMS) published the proposed rule in the *Federal Register* in July 2013, and invited comments on various issues. Our comments on issues of relevance to the proposed rulemaking address:

- SGR Update and Other Changes Impacting Payment
- Therapy Caps
- "Incident to" Billing Provisions
- Physician Quality Reporting System
- Multiple Procedure Payment Reduction
- Transitional Care Management Services

SGR Update and Other Changes Impacting Payment

Due to the flawed SGR formula, CMS announces in the proposed rule the physician fee schedule update for CY 2013 is projected to decrease by 24.4 percent. Over the last twelve 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 Comment on SGR:
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 providers who serve them. And to that end, we urge CMS to work with Congress in repealing and replacing the arcane SGR formula.

Therapy Caps

The therapy cap exceptions process will no longer be in effect after December 31, 2013, unless Congress acts to statutorily extend the exceptions process.

PPS Comment on Therapy Caps:
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 Congress to promptly find an acceptable replacement for the payment methodology responsible for these arbitrary and harmful caps. Meanwhile, PPS is encouraged that CMS is proposing to prepare for replacement of the therapy caps with "an alternative payment method" which was envisioned by the Balanced Budget Act of 1997.

PPS applauds the Agency's actions which are designed to arrange for the collection and submission of functional status data which could 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. These data, along with the alternative payment system under development by the rehabilitation therapy associations (led by APTA) should be instrumental in developing a patient-centric replacement for the therapy caps.

"Incident to Billing Provisions"

The Agency proposes to make modifications to the "incident to" billing provisions include in the Social Security Act (section 1861(s)(2)(A) that allows physicians to furnish and bill for "incident to" services under Medicare. The regulations setting forth the specific requirements are located at 42 CFR Section 410.26. CMS states that there have been situations where Medicare was billed for "incident to" services that were provided by auxiliary personnel who did not meet the state standards for those services in the state in which the services were furnished. CMS acknowledges that its regulations do not make compliance with state law a condition for payment for "incident to" services, and therefore proposes to revise its regulations to require that the individual performing "incident to" services meets any applicable state requirements to provide the services, including licensure. This would enable the federal government to recover funds paid when services are not furnished in accordance with state law.

PPS Comment on "Incident to" Billing Provisions:
PPS applauds this proposal and urges its finalization which will contribute to ensuring quality of care to Medicare beneficiaries. Interventions should be represented and reimbursed as physical therapy only when performed by individuals who are qualified under state law to provide those services.

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 (eligible professionals) in PQRS and can report individual, group and registry measures. PPS members are committed to providing high-quality, timely care and to the promotion of evidence-based practice and patient-centered practice.

PPS Comment:
CMS proposes to retain the claims-based, registry-based and EHR based reporting options. PPS supports this decision to retain multiple reporting options as we believe that this will encourage participation in the program which is warranted by the reported low participation rates. Providing several options will increase convenience and decrease the cost of participation.

Number of Measures
CMS will provide eligible professionals with the opportunity to earn the PQRS incentive payment in 2014 by reporting either individual measures or measures groups. CMS proposes that eligible professionals, including physical therapists, who report on individual measures via the claims-based reporting option or registry option in 2014 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 from 1-8 measures.

PPS Comment:
PPS believes the proposal to increase the number of measures for successful reporting from 3 to 9 to be unnecessary and, in fact, inconsistent with the goal of encouraging and achieving broader participation in PQRS as such a change in the number of measures will increase provider burden of reporting.

Maintaining the claims based reporting threshold, and lowering the registry reporting threshold to 50 percent will substantially increase the proportion of physical therapists, physicians and other health care professionals who will qualify for the PQRS incentive and will therefore encourage broader participation.

Avoiding Payment Adjustments in 2016
The Agency indicates that eligible professionals will have the opportunity to avoid 2016 payment adjustments by successfully participating in the PQRS program in 2014. Additionally, CMS has proposed that eligible professionals, who report 3 individual measures at least 50 percent of the time, will be exempt from payment adjustments in 2016. The fact that in CY 2011 only 32 percent of MD/DO's and 17.9 percent of other

eligible providers, including physical therapists, participated in PQRS, suggests that many providers are still unaware of the impending changes to the structure from a payment incentive to a payment adjustment program.

PPS Comment:
We urge CMS to continue to disseminate information about the PQRS program to increase awareness about the program and to recognize the efforts of providers who attempt to participate in the program even if they are unsuccessful. We caution CMS against making changes that increase the complexity of the program and the burden of reporting until such a time that the participation rate exceeds 60 percent.

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. This delay in distribution of these reports has made it difficult for providers to make any changes to improve their reporting under the program.

PPS Comment:
PPS believes that increasing the availability and timeliness of these reports is essential in order to achieve the public policy potential of the PQRS program which includes assisting providers in improving the quality of care they deliver. PPS urges CMS to set a date certain by which quarterly feedback reports will be incorporated into the PQRS program.

Multiple Procedure Payment Reduction (MPPR)

In the proposed rule, CMS discusses the application of the Multiple Procedure Payment Reduction to therapy services and references Section 633 of the American Tax Relief Act (ATRA), which revised the MPPR reduction from 20/25 percent to 50 percent effective April 1, 2013.

PPS Comment on MPPR:
Due to implementation of MPPR, Medicare payments for outpatient therapy services under Medicare have been cut by approximately 14 percent since 2010. These are arbitrary across the board cuts that also impact those beneficiaries who are most in need of rehabilitation therapy. Because of these cuts, therapists are not being adequately compensated for the resources needed to provide medically necessary therapy services. The MPPR reduction is based on an incorrect assumption that duplicate clinical labor and supplies are included in the practice expense (PE) relative value units (RVUs) when multiple services are furnished to the same patient in a single session. This assumption is incorrect because these efficiencies were already taken into account during the original development of the treatment codes and PE RVUs for therapy services, PPS believes that cuts of this magnitude could restrict Medicare beneficiary's access to physical therapy services. This cut would be further compounded by the projected reductions in the SGR and the annual per beneficiary therapy cap.

PPS recognizes that it will take congressional action to prevent the 50 percent MPPR reduction and we continue to urge Congress to take timely action to pass legislation that would delay or stop these large cuts until an alternative payment methodology is implemented. In the interim, we urge CMS to take steps that would mitigate the negative impact of these cuts. One such step within the Agency's authority would be to amend the MPPR policy so that it no longer applies across multiple therapy disciplines. Application of the policy on a per day basis and across disciplines mistakenly assumes that there is duplication in such circumstances. In certain settings, such as skilled nursing facilities, it is common for a patient to receive services from one discipline, such as physical therapy in the morning, and another discipline, such as speech-language pathology in the afternoon. Clearly, there is no duplication and no economies of scale when services are provided at two separate times during the course of the day. Moreover, there is no duplication of practice expenses when distinct and separate professions are providing services.

Transitional Care Management Services

In the proposed rule, CMS proposes that complex chronic care management services include transitional care management services (CPT 99495, 99496), home health care supervision (HCPCS G0181), and hospice care supervision (HCPCS G0182). If furnished, in order to avoid duplicate payment, the Agency would prohibit these services from being billed separately during the 90 days for which either GXXX1 or GXXX2 are billed.

PPS Comment on Transitional Care Management Services:
We suggest that CMS require the treating physician or other entity responsible for the complex chronic care management to notify any other practitioner who may become involved in or asked to participate in the treatment of the patient that their services may not be billed separately.

PPS thanks the Agency for the opportunity to provide these comments on the proposed rule for the 2014 Medicare Physician Fee Schedule. PPS is committed to continue its cooperation and collaboration with CMS as needed. We look forward to more opportunities to partner with CMS in pursuit of meaningful and effective innovation in the Medicare program.

Sincerely,

Tom DiAngelis, PT, DPT
President