ALLIANCE FOR PHYSICAL THERAPY QUALITY AND INNOVATION

Ensuring Patient Access to Value Driven Physical Therapy Care

APTQI
20 F Street, NW
Suite #700
Washington, DC 20001
Phone: 202-507-6354

April 14, 2015

Via E-Mail PDF and Overnight Mail

Paul Rockar Jr., PT, MS, DPT
President
American Physical Therapy Association (APTA)
1111 North Fairfax Street
Alexandria, VA 22314-1488

Re: Comments to the Physical Medicine and Rehabilitation AMA Workgroup Proposal to Revise the Evaluation and Intervention Codes in the Physical Medicine Rehabilitation CPT Code Section (Physical Medicine and Rehabilitation Evaluations and Interventions)

Dear Mr. Rockar:

This letter represents the collective comments of the Alliance for Physical Therapy Quality and Innovation (the "Alliance") related to the above referenced payment reform agenda item scheduled to be discussed on April 15, 2015 at the upcoming APTA Board of Directors Meeting in Alexandria, VA. Thank you for the invitation to the meeting and allowing us to provide input on the most significant issue facing the physical therapy provider industry in the past forty (40) plus years – i.e., the proposed transformational therapy classification and payment system reform currently under consideration at the American Medical Association (AMA).

Initially, it may be helpful to provide you and the APTA Board with some background information on the Alliance. We are among the nation's leading providers of outpatient rehabilitation care, and collectively employ or represent several thousand physical and occupational therapists, and furnish physical therapy services on an annual basis to hundreds of thousands of Medicare beneficiaries. Our membership categories consist of Board and Affiliate Members, representing a diverse mix of small, medium, and large multi-state physical therapy providers. The following is a brief description of each of our Alliance Board Members, which in aggregate currently operate and represent over 3,000 outpatient rehabilitation clinics:

- **Athletico Physical Therapy** currently operates approximately 350 outpatient rehabilitation clinics in 8 states;
- **ATI Physical Therapy** currently operates approximately 310 outpatient rehabilitation clinics in 12 states;
- **Drayer Physical Therapy Institute** currently operates approximately 125 outpatient rehabilitation clinics in 16 states;
- **Physiotherapy Associates** currently operates approximately 575 outpatient rehabilitation clinics in 34 states;
- **Select Medical** currently operates approximately 1023 outpatient rehabilitation and/or occupational therapy clinics in 33 states and the District of Columbia;
- **Upstream Rehabilitation** currently operates approximately 305 outpatient rehabilitation and/or occupational therapy clinics in 22 states; and
- **U.S. Physical Therapy** currently operates approximately 494 outpatient rehabilitation and/or occupational therapy clinics in 42 states.

I. Preliminary Statement

The Centers for Medicare and Medicaid Services (CMS) recently published the "CMS Quality Strategy 2013 – Beyond", in which the agency adopted quality improvement as a core function. The vision of the CMS Quality Strategy is to *optimize health outcomes by improving clinical quality* and transforming the health system. This commitment by CMS was designed to enhance its partnerships with a delivery system in which providers are supported in achieving better outcomes in healthcare at a lower cost for Medicare beneficiaries. The Alliance shares the core belief that any coding and payment reform related to physical therapy services should drive payment in line with the value physical therapy services deliver to the patient and other providers in the continuum of care; reduce unnecessary regulatory and administration burdens unrelated to improving the quality of patient care; and be transparent to all parties. The Alliance strongly urges the APTA Board to consider these core factors when evaluating the proposed evaluation and intervention codes.

We appreciate the hard work of the AMA Physical Medicine and Rehabilitation Workgroup (PM&R Workgroup) in the development of an alternative coding and payment system that is based on the complexity of the patient condition, the therapist's clinical judgment, and intensity of therapist involvement in the provision of physical therapy services. To be clear, the Alliance is in agreement that any coding reform and payment solution should be created to accurately document and value therapy services. **However, we do not believe that the current CPT coding proposal satisfies the core principles associated with value based reform. Therefore, given the substantial issues and concerns set forth below, the Alliance requests**

that the APTA Board reject and discontinue its support of the proposed evaluation and intervention codes (the "Proposed CPT Codes").

II. Issues and Concerns

The proposed coding model recommends the adoption of a new coding system that bases payment on a patient severity/intensity framework in lieu of the current fee-for-service system based predominantly on the use of procedure codes. Last year, given our concerns based on preliminary information, the Alliance suggested to the APTA and PM&R Workgroup that the proposed coding should be subject to more formal clinical modeling, data analytics, and piloting. Subsequently, the APTA publicly announced that it would test the reliability and validity of the proposed codes.[1] The Alliance is aware that previously developed vignettes were refined and tested at four different locations across the country. **The Alliance strongly urges that the APTA Board reject and discontinue its support of the Proposed CPT Codes for the following reasons:**

A. The research report provided by the Post-Acute Care Research Center (PACCR) clearly demonstrates that that the Proposed CPT Codes

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[1] The Alliance has signed a Confidentiality Agreement with the APTA in order to review the preliminary report on the reliability and validity of the proposed CPT codes. However, our comments also take into consideration what has been publicly announced in other industry settings, disclosed to us by an independent third party, or was otherwise disclosed to us in prior meetings and communications with APTA staff.

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We do not believe this four city pilot study, which was followed by live testing at two healthcare systems, is capable of yielding a statistically reliable and valid result. In fact, no study is capable of validating this flawed CPT coding proposal. This limited live testing is especially compelling since it allowed for testing the extent to which the Proposed CPT Codes could be operationalized

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this is the case, and the Proposed CPT Codes (evaluations and interventions) move forward to the AMA RUC HCPAC evaluation phase, it would cause more harm than good to an entire industry already under regulatory and payment pressure. Our respective companies at the Board level and those hundreds (and growing) private practice locations at our "affiliate membership level" believe this system will be seriously damaging to their ability to bill and code reliably, and given the rather complete coding overhaul, result in massive unnecessary and unproductive upheaval and distress at the private practice level.

B. The Alliance is unsure or unclear on how past research efforts or projects by CMS will influence, or be integrated with, the Proposed CPT Codes. We have been advised that the PM&R Workgroup was formed to address concerns expressed by CMS in past Medicare Physician Fee Schedule Rules. CMS has already spent considerable resources in an effort to find an alternative therapy payment system for physical therapy services. Most recently, The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA), enacted by Congress, mandated the implementation of such an alternative payment system. As a result of this legislation, CMS created a "claims-based data collection strategy" designed to assist in reforming the Medicare payment system for outpatient therapy services through the creation of non-payable G codes and severity modifiers that is currently being used to gather information on beneficiary function and condition, therapy services furnished, and outcomes achieved. In the past, several of our

Alliance members have also actively participated in both the *Development of Outpatient Therapy Payment Alternatives* (DOTPA) and *Short Term Alternatives for Therapy Services* (STATS) projects. Several clinical and technical experts involved with our Alliance provided critical feedback and guidance on both of these projects utilizing our extensive experience collecting patient reported outcomes data for the Medicare population in the outpatient setting. We actively sought to facilitate a collaborative process and assist in providing guidance in a proactive manner across all provider types and disciplines. The Alliance does not believe the proposed CPT coding model takes into consideration the key factors considered in these past and current efforts by CMS to reform the Medicare payment system for outpatient therapy services.

C. The Proposed CPT Codes that categorize patients based on the severity of their condition and intensity of intervention is largely subjective without specific quantifiable and objective criteria. Establishing new codes that physical therapists report for their services would be a significant change that would require therapists to learn the new code sets and update billing systems. This would involve massive and expensive changes to existing computer documentation and billing systems. The Alliance, through its members, has considerable experience of how the coding and payment system works at the "*individual practitioner level*." If the Proposed CPT Codes are "pushed" through AMA and approved by CMS, it will be subject to the subjective clinical reasoning and decision-making of the therapist that will vary depending on experience, background and training. For example, a classification of "high severity" by one may be perceived as "low severity" by another. If "high severity/complexity" patients received a higher bundled evaluation, the system could easily be subject to abuse and/or the inability of providers to defend their coding choices that will vary considerably as evidenced by the PACCR study. We believe that a review of the results of the PACCR pilot study will provide further proof of this concern. This subjectivity will, in our view, be a step backwards from the current coding system and lead to further significant coding and audit concerns. In a meeting with CMS regarding the CPT coding proposal, one senior CMS (Part B payment) official stated: "*If this coding system goes through, the folks in audit recovery will be very busy.*"

D. APTA has not clarified with CMS how existing regulations would be eliminated or applied under the Proposed CPT Codes. Any transformational modification to the coding and payment system for therapy services should preserve the ability of outpatient physical therapy providers to deliver the necessary treatment required by Medicare beneficiaries. The current Medicare Part B outpatient therapy policy is made up of a cumbersome collection of rules and regulations that have unintended consequences that are not always in the best interest of the patient. Providers and Medicare program beneficiaries are already confused and, in some cases, financially burdened by the existing rules and reimbursement policies. Eliminating the therapy cap and developing a replacement system remains a major goal for CMS, MedPAC, APTA, other professional associations, and the provider community. However, there are other CMS regulatory requirements that should be considered now before final approval of an alternative coding payment system. We believe there should be formal collaboration with CMS

on whether and, to what extent, the layers of Medicare rules and regulations applicable to Part B therapy services will be applied under a new coding system including: therapy caps and the exceptions process; manual medical review (MMR) process; multiple procedure payment reduction (MPPR); Physician Quality Reporting System (PQRS); total time rule; group and concurrent therapy rules. If this is not addressed now, the Proposed CPT Codes will be further burdened with superimposed rules and regulations that add significant unexplained variation and unnecessary cost as well as complexity. As this new payment model is tested, these rules and regulations should not be ignored or the APTA Board and AMA RUC HCPAC risk approving a therapy coding system of "practice patterns" that do not optimize efficiency.

III. A "Fee for Value" Alternative to the Proposed CPT Codes

There are other better alternatives to physical therapy payment reform that meet the triple aim of healthcare – improve the health of the population, improve the patient experience, and improve affordability as measured by the total cost of care. One primary argument has been put forth by the APTA is that "*change is coming to the fee-for-service reimbursement system and if we do not press forward with alternative coding system we will have no say in payment reform*." This panic to implement a payment reform system that fails to resolve many of the issues commented on by MedPAC and CMS is misguided and creates a myriad of unintended consequences. This offensive strategy also ignores the reality of what is actually being proposed here. The Proposed CPT Codes are still based on a model of fee-for-service reimbursement. The proposed consolidation of these fee-for-service codes in a "budget neutral manner" does little, if anything, to advance therapy payment reform towards a true value-based reimbursement model. In fact, arguably, it simply consolidates so called "misvalued fee for service codes" into an unproven system that fails to comprehensively address functional outcomes, quality and accountability.

The Department of Health and Human Services announced in January that it plans to shift thirty (30) percent of Medicare provide payments to alternative models by 2016 and half of all payments by 2018, as well as the subsequent formation of a provider-payer alliance known as the Health Care Transformation Task Force. This, of course, begs the question: "*How exactly does one measure that?*" Value can be illustrated by using the simple equation of value equals outcomes divided by costs. For several decades, the CMS payment system has attempted to increase value by cutting the denominator in this equation – costs. Most would agree that we've reached a point where further cost reductions create a risk of declining outcomes. No value is realized when the outcomes numerator decreases in parallel with a reduction in the costs denominator. In addition to the cost of the care, true value should measure quality combined with customer service or patient experience and convenient access.[3]

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[3] This approach to value is also consistent with other parts of the Patient Protection and Affordable Care Act (PPACA). The PPACA features provisions that encourage the use and development of less costly interventions such as physical therapy services. One of the goals of health care reform is to minimize the use of high-cost interventions when there is a clinically comparable, but better value alternative. There is a plethora of research that supports the implementation of physical therapy earlier in the course of treatment as more cost-effective by promoting recovery and reducing the need for comparatively more invasive and costly interventions. For example, instead of undergoing surgery for back pain, physical

HHS/CMS has acknowledged that alternative payment reform includes offering rewards for achieving cost or quality goals such as the Physician Quality reporting System (PQRS). For calendar year 2014, providers who satisfactorily reported data on PQRS quality measures will earn a 0.5% incentive payment on their total allowed charges during the reporting period. In addition, penalties for failing to successfully participate in PQRS began this year. While we commend CMS for its attempts at quality reporting, admittedly, many in the industry remain disappointed with CMS's implementation of the Physician Quality Reporting System (PQRS), as it has excluded eligible professionals providing covered therapy services to Medicare Part B beneficiaries in institutional settings (SNFs, Rehab Agencies, outpatient HH). The Tax Relief and Health Care Act of 2006, which established PQRS, specifically defined physical therapists, occupational therapists and qualified speech-language pathologists as eligible professionals. We believe that CMS is willing to consider updating and enhancing a PQRS therapy quality reporting program that involves all eligible professionals and settings.

The Alliance believes that APTA and the industry should focus on creating a comprehensive quality reporting program. The Alliance believes that a comprehensive quality reporting program for therapy services provided across all settings is a better "valued based" payment reform approach than the AMA PM&R Workgroup Proposed CPT Codes. The Alliance is in favor of a value based payment program that includes quality measures to demonstrate the outcome and value of therapy. Moving from a purely volume to value based payment system can and should involve benchmarks and metrics to measure progress and hold ourselves accountable to each other. We feel that the use of the aforementioned existing PQRS tools, as well as expansion of the functional limitation categories to allow for more granularity, would be more effective to obtain the end goal on determining functional improvement and thus value.

IV. Conclusion

We urge the APTA Board to consider the concerns and recommendation of the Alliance as set forth above. The implementation of the Proposed CPT Codes will lead to unintended harmful consequences for physical therapy beneficiaries and providers alike. As the Medicare Shared Savings Program and Pioneer ACO programs have demonstrated, models on paper do not work precisely as predicted if we ignore inherent complexity without the predictability of pre-testing and modeling. **Therefore, if necessary, we will have no other alternative that to use all of our available resources to counter implementation of the Proposed CPT Codes at the AMA Committee level, CMS, and with other trade groups and associations.**

We appreciate the willingness of the APTA to solicit the input of the provider community to ensure a fair, open and transparent process for all stakeholders. We recognize the many

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therapy is generally seen as less costly, less invasive option. The failure to consider the total episode of care of beneficiaries across the health care system has led to the unintended consequence of increasing program health care costs due to more costly invasive procedures, whether diagnostic and/or surgical.

nuances inherent in any coding and payment reform initiative.[4] The Alliance is willing to contribute time and resources to a proposed alternative coding and payment system for therapy services that is truly value driven and based on: **Best Quality. Best Service. Best Price**. As you consider solutions to improve the proposed physical therapy coding system, please know that we too will continue to work diligently to increase the quality and value of physical therapy services provided to our patients. We would much prefer to engage with the APTA to develop a new, triple-aim focused, alternative payment system which utilizes the existing code set while rewarding providers for exceptional outcomes and high quality care at a reasonable cost.

We appreciate the opportunity to comment on the PM&R Workgroup's proposed new coding structure for physical therapy services, and would be pleased to discuss our concerns with you further. If you have any questions, or would be interested in further collaboration, please feel free to contact John F. Duggan, J.D., M.B.A., Senior Vice President and Senior Counsel – Select Medical Corporation, at 717-975-4534 or **JDuggan@SelectMedical.com**, or any of the Board level members listed below.

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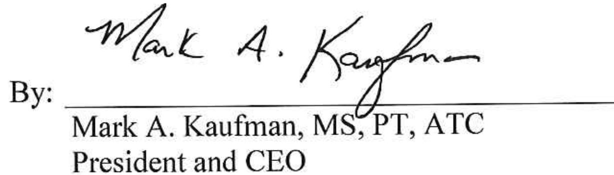
[4] It has been argued by some that the current CPT therapy coding system also lacks statistical reliability and validity. There may be some issues with the current therapy coding system, but we are not aware of any study that substantiates the degree of variability noted with the Proposed CPT Codes in the PACCR study. In any case, transforming the current CPT therapy coding system with an unreliable one that does not consider quality and outcomes is strategically flawed.

Very truly yours,

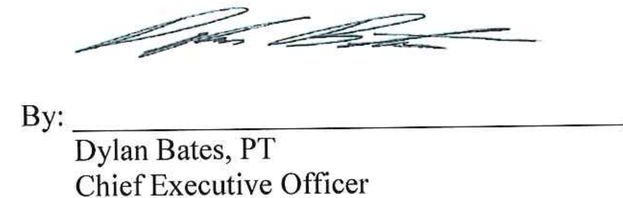
ATHLETICO PHYSICAL THERAPY



By: ______________________
Mark A. Kaufman, MS, PT, ATC
President and CEO

Very truly yours,

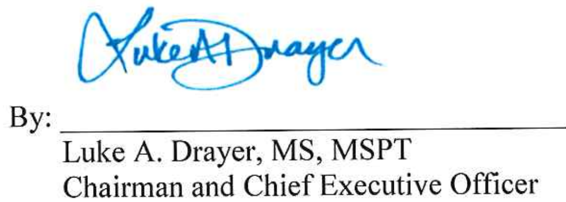
ATI PHYSICAL THERAPY



By: ______________________
Dylan Bates, PT
Chief Executive Officer

Very truly yours,

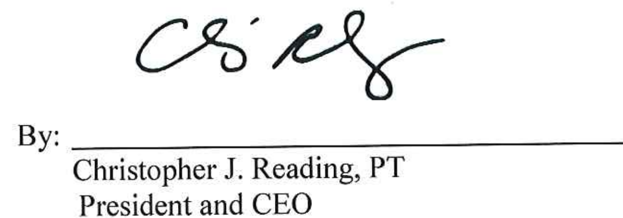
DRAYER PHYSICAL THERAPY INSTITUTE



By: ______________________
Luke A. Drayer, MS, MSPT
Chairman and Chief Executive Officer

Very truly yours,

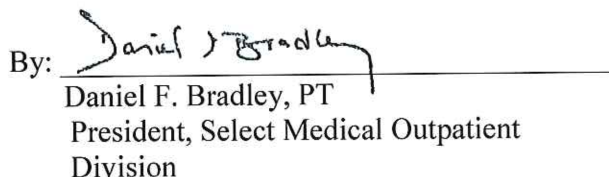
U.S. PHYSICAL THERAPY, INC.



By: ______________________
Christopher J. Reading, PT
President and CEO

Very truly yours,

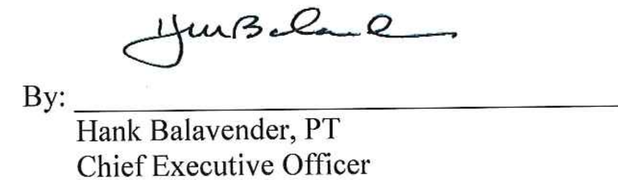
SELECT MEDICAL CORPORATION



By: ______________________
Daniel F. Bradley, PT
President, Select Medical Outpatient Division

Very truly yours,

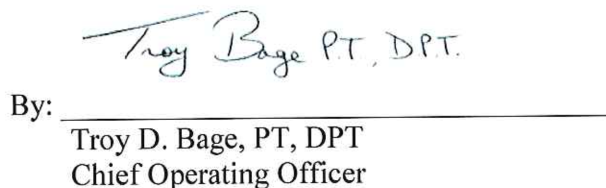
PHYSIOTHERAPY ASSOCIATES



By: ______________________
Hank Balavender, PT
Chief Executive Officer

Very truly yours,

UPSTREAM REHABILITATION



By: ______________________
Troy D. Bage, PT, DPT
Chief Operating Officer

CC: Members of the APTA Board of Directors (via e-mail delivery only)