AMERICAN PHYSICAL THERAPY ASSOCIATION

STATEMENT TO THE PRACTICING PHYSICIANS ADVISORY COUNCIL

February 10, 2003

On behalf of our 64,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association is pleased to have the opportunity to submit this statement to the Practicing Physicians Advisory Council (the Council) concerning recommendations for changes to Medicare rules and manuals governing payment to practitioners under the physician fee schedule.

The physician fee schedule is currently the basis of payment for physical therapy services furnished by therapists in private practice. Also, the physician fee schedule amounts apply when outpatient therapy services are furnished to certain patients by hospitals, rehabilitation agencies, public health agencies, clinics, skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities. Therefore, the physician fee schedule rules have a significant and direct effect on payments to a large number of physical therapists and providers that furnish physical therapy services.

The major concerns that we urge the Council to address include the $1500 cap on therapy services, the fee schedule update formula, the practice expense methodology used to determine values for therapy services, the 30 day physician visit requirement for therapy services, locum tenens, CCI edits, and provider education. Each of these issues will be discussed in further detail in the paragraphs that follow. It is our hope that the Council makes recommendations to CMS in these areas that will ensure appropriate reimbursement for services furnished, ease regulatory burdens on practitioners, and also ensure that patients have access to high quality therapy services.

$1500 CAP ON THERAPY SERVICES

Section 4541 (c) of the Balanced Budget Act of 1997 sets two annual caps on outpatient therapy services for Medicare Part B patients. Effective January 1, 1999, occupational therapy was limited to $1500 annually, while physical and speech therapy shared the same $1500 annual cap. The cap applies to outpatient therapy services furnished in private practice physical therapist offices, physician's offices, skilled nursing facilities (Part B), home health agencies (Part B), rehabilitation agencies, and comprehensive outpatient rehabilitation facilities (CORFs). The $1500 cap does not apply to outpatient therapy services furnished in hospitals. Outpatient rehabilitation services are subject to a 20% coinsurance amount. Therefore, the maximum amount payable by the Medicare program will be $1200, or 80% of $1500.

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 suspended the cap for 2 years effective January 1, 2000. The Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 extended the moratorium on the therapy caps for another year, through calendar year 2002. Because the moratorium expired and

Congress did not pass any legislation placing further delays on the cap, the $1500 cap went back in place January 1, 2003. CMS will be issuing a program memorandum detailing the implementation of the cap.

The cap will have a serious negative impact on certain Medicare beneficiaries needing rehabilitation services, and on providers of therapy services. It will deny Medicare beneficiaries access to necessary physical therapy treatment. Senior citizens with medical conditions common to the elderly, such as stroke, hip fracture, and coronary disease, will not be able to obtain the full amount of rehabilitation care they require to resume normal activities of daily living.

In enacting the legislation, Congress presumed that the impact would not be significant because patients would be able to continue to receive their therapy services in the outpatient hospital departments, which are not subject to the $1500 limitation. But this is not necessarily the case. Patients residing in SNFs may not receive services from an outpatient hospital department because of consolidated billing requirements under Medicare. The consolidated billing rules require that SNFs bill for all services provided to their residents. In addition, it will be difficult for patients living in rural areas to get to a hospital that may be a long distance from their home.

Patients who exceed the $1500 cap will have the option of either paying the provider out of pocket for the service, having the provider absorb the costs of the service, or discontinuing the service. If they discontinue their therapy, ultimately there may be a higher cost associated with the fact that they would not be able to function independently in the future. Medicaid and other similar programs may eventually absorb the costs associated with the patient's care.

Several studies have shown the impact that the therapy cap will have on beneficiaries. The Urban Institute conducted a study on behalf of CMS and issued the results in September 2001. In that study they examined the number of Part B therapy patients that would exceed $1200 of annual therapy, which equals the Medicare program's 80% payment responsibility toward the $1500 limits. The study found that among all Part B therapy patients, 13% exceeded $1200 of annual PT/SLP or $1200 of annual OT in 1998; 5% exceeded either one or both of the annual thresholds in 1999; and 12% did so in 2000.

The Medicare Payment Advisory Commission (MedPAC) analyzed the impact of the coverage limits and presented the results of this analysis in its June 1998 report to Congress. Specifically, MedPAC examined the 1996 claims of patients treated in rehabilitation agencies and CORFs who incurred payments that exceeded the $1500 coverage limit. The Commission found that about one-third of patients in rehabilitation agencies and CORFs exceeded either $1500 of outpatient physical and speech therapy or $1500 of occupational therapy. MedPAC found that some types of patients were more likely to exceed the dollar limit than others. For example, half of the stroke patients served in these settings exceeded the cap.

This report indicates that the ability of Medicare beneficiaries to receive the necessary physical therapy services under the $1500 limit is further exacerbated if speech therapy

and physical therapy are grouped together under one $1500 cap. In its report to Congress, MedPAC stated that in 1996 *"Physical therapy accounted for 70% of outpatient therapy payments. Occupational therapy and speech pathology made up 21% and 9% of payments, respectively."*[1]

Other recent studies indicate that the application of the fee schedule payment methodology to institutional providers beginning in 1999, not the $1500 caps, drove payment reductions. Specifically, CMS recently released a report in which their contractor, AdvanceMed (formerly Dyncorps), analyzed claims data during 1998-2000 from the entire universe of more than 15 million outpatient therapy claims per calendar year. The report concludes that residual lower payments after the therapy caps were suspended in 2000 "clearly indicated that it was the application of the fee schedule...and not the therapy caps that principally drove payment reductions."

During 2003, legislation will be introduced in Congress to repeal the cap. We recommend that the Council strongly urge CMS to support the cap repeal legislation.

PHYSICIAN FEE SCHEDULE UPDATE

As the Council is well aware, in 2002 Medicare payment for all services provided by physicians and nonphysicians, including physical therapists, were cut by 5.4%. In the 2003 physician fee schedule rule, an additional 4.4% was proposed. Unless the formula by which updates are calculated is revised, additional significant cuts will occur in the next few years.

APTA is concerned that the negative payment updates to the RBRVS fee schedule will hinder the ability of physical therapists to care for Medicare beneficiaries needing rehabilitation services. It is important that these individuals continue to receive the rehabilitation and other services that they need in order to achieve their maximum level of functional independence. Because rehabilitation enables beneficiaries to function more independently, rehabilitation will save the Medicare program dollars in the long run.

The impact of these Medicare payment cuts needs to be viewed in the context of significant legislative and regulatory changes affecting physical therapists that have occurred over the past few years. Since 1992, physical therapists in private practice have been reimbursed under the RBRVS fee schedule. Prior to 1999, all other outpatient therapy settings were reimbursed under a cost-based system. The 1997 Balanced Budget Act (BBA) required that outpatient therapy services in all settings be reimbursed under the RBRVS fee schedule, beginning in January 1999. Thus, in addition to impacting physical therapists who own and operate private physical therapy practices, the cuts in payment and the flawed update methodology also impacts the provision of outpatient therapy services in outpatient hospital departments, skilled nursing facilities (Part B),

[1]Report to the Congress: Context for a Changing Medicare Program, Medicare Payment Advisory Commission, June 1998, p. 82.

home health agencies (Part B), rehabilitation agencies, and comprehensive outpatient rehabilitation facilities (CORF).

As discussed in the previous section of this document, the BBA also imposed a $1500 cap on outpatient therapy services in all settings except for hospitals. In 1999 and again in 2000, due to concerns raised by beneficiaries, Congress placed a moratorium on enforcement of the $1500 cap. The present moratorium expired in January 2003. The $1500 cap will further compound the Medicare payment cuts.

In addition to the cap, physical therapists continue to deal with increasing documentation requirements, conflicting Medicare rules, non-uniform application of Medicare requirements among Medicare contractors, and impending privacy requirements under HIPAA. When combined with the current and impending cuts, the Council can begin to understand how difficult it is and will be for health professionals to continue providing services within the Medicare program.

The majority of physical therapists in private practice are small businesses. As small businesses, their ability to operate is in jeopardy when they lose necessary revenue or cannot forecast revenue accurately from year to year. As a result, maintaining access to providers like these, who play such an important role in health care delivery, cannot be sustained without immediate reform of the payment update formula.

It is critical for the Council to urge CMS to support legislation that would prevent the Medicare payment cuts immediately and revise the update formula in future years.

"CROSSWALK UTILIZATION" PRACTICE EXPENSE METHODOLOGY

APTA believes that CMS used a flawed methodology in determining practice expense values for the physical medicine and rehabilitation codes in the 97000 series. CMS crosswalked all utilization for therapy services in the CPT 97000 series to the physical and occupational therapy practice expense pool based on the Agency's belief that most physical therapy services furnished in physicians' offices are performed by physical therapists.

Although physical therapists in private practice account for approximately 53 percent of all claims for therapy services, more than 50 physician specialties - particularly orthopedic surgeons, physical medicine and rehabilitation physicians and internists - also provide therapy services in the CPT 97000 series. These physicians have much higher practice expenses than physical therapists.

The Agency's decision to shift all the utilization data from the physician specialties to the physical and occupational therapy practice expense pool is totally inconsistent with the "top down" methodology used by CMS to calculate practice expense relative value units. As a result, it fails to account for the actual practice expenses incurred by those physician specialties that provide physical therapy services in their offices and it penalizes everyone who provides the services.

The AMA's Socioeconomic Monitoring System (SMS) survey provides information about practice expenses by specialty. It does not provide practice expense data at the procedure code level, and there is no evidence to suggest that the practice expenses for therapy services provided by physicians are different from the practice expenses of all other services they provide. We also note that the size of the practice expense pool for every specialty that provides therapy services has been inappropriately reduced by CMS' decision to crosswalk all utilization for therapy services in the CPT 97000 series to the physical and occupational therapy practice expense pool.

This crosswalk methodology has a significant negative financial impact upon payment for the CPT codes in the 97000 series. CMS representatives informed APTA that the total allowed charges for physical and occupational therapy would be as much as 18 % higher if CMS did not employ this flawed methodology. It is obvious that, for the past 4 years, physical therapists and others providing therapy services have been underpaid to a significant degree. Clearly, payments would be more consistent with the costs of providing the services if CMS did not use the "utilization crosswalk" and instead left the therapy services that are performed by each specialty in each specialty's practice expense pool.

In the December 31, 2002 final physician fee schedule rule, CMS discusses comments they received on this issue and states that they welcome further public comments on this issue.

We urge the Council to recommend that CMS immediately discontinue the use of this utilization crosswalk methodology. It is arbitrary and inequitable, and it was not opened to public comment and review before it went into effect. Its impact on payments is significant. Instead, the Council should call on CMS to use the standard and accepted "top down" methodology when computing the practice expense values for the 97000 CPT code series.

30 DAY VISIT

Existing Medicare regulations require that outpatient physical therapy services be furnished while the individual is "under the care of a physician**,** nurse practitioner, clinical nurse specialist, or physician assistant." (See 42 CFR §424.24(c)(1)(ii)). They also require that a plan of care be established and that a physician, nurse practitioner, clinical nurse specialist or physician assistant review the plan of care and recertify the beneficiary's continued need for outpatient physical therapy services every 30 days. [See: 42 C.F.R. §410.61(e), 42 C.F.R. §424.24(c)(4)(i),]. For comprehensive outpatient rehabilitation facilities (CORFs), the physician is required to review the plan of care and recertify the need for care every 60 days.

In its program manuals, CMS has further interpreted the requirement that the individual be "under the care of a physician" to require that there be evidence in the patient's clinical record that a physician has seen the patient at least every 30 days. According to the program manuals, this 30 day physician visit requirement applies to patients receiving

therapy services in the following settings: outpatient hospital, skilled nursing facility (Part B), home health agency (Part B), rehabilitation agency, and private practice. (SNF manual, §271.2, Hospital Manual §242.2, Outpatient Physical Therapy/CORF Manual, §270.2, Home Health Agency Manual, §219.4(D), Carriers Manual §2206.2). The requirement that the patient be physically seen by the physician does not exist in the Medicare regulations; it is only stated in the Medicare program manuals.

The need for a physician visit every 30 days is arbitrary and problematic. In many instances, it takes a week or two before the patient is able to see the physical therapist after seeing the physician. After receiving two weeks of treatment, the 30 days expires, and the patient then needs to see the physician again in order to continue treatment. Returning to the physician's office in this time frame is an inconvenience to the patient and the physician. It is particularly problematic in rural areas, where the patient may have to travel a long distance to get to a physician's office. Eliminating the 30-day physician visit requirement would save the Medicare program the cost of unnecessary physician office visits and reduce co-payment costs for beneficiaries.

We urge the Council to recommend that CMS revise its Manuals to eliminate the 30 day visit requirement. Safeguards exist within the current regulations, which require the physical therapist to promptly notify the physician of any change in the patient's condition or in the plan of care during the course of treatment, and to review and recertify the plan of care every 30 days. This is sufficient to ensure that the patient is receiving care that is reasonable and necessary.

PHYSICIAN SIGNATURE ON PLAN OF TREATMENT

Medicare requires that the physician recertify the need for therapy services every 30 days. Because this policy is not written clearly in CMS's manuals, there is considerable confusion with respect to when the 30 day time frame begins and at what point the physician signature has to be on the plan of care. It is not clear whether the 30 day time frame begins after the physical therapist conducts an evaluation, after the initial physician visit, or when the physical therapy treatment actually begins. It is also unclear whether the physician signature has to be on the plan of treatment before therapy begins, before the claim is submitted to Medicare, or shortly after therapy begins. Because the language in the manuals is unclear, carriers and fiscal intermediaries throughout the country are interpreting this provision differently.

We urge the Council to recommend to CMS that the 30 day time frame begin when the therapist sees the patient, and that the physician signature be on the plan before the claim is submitted to Medicare. Because it can often be difficult to obtain the physician's signature, requiring the signature before treatment begins would result in delayed patient care.

"IN ROOM" SUPERVISION REQUIREMENT OF PHYSICAL THERAPIST ASSISTANTS IN PHYSICAL THERAPIST PRIVATE PRACTICE OFFICES

In the physician fee schedule rule published in the November 2, 1998 *Federal Register* (63 Fed. Reg. 58814), CMS required that a licensed physical therapist in private practice must personally supervise physical therapist assistants (PTAs). CMS defines personal supervision to mean the physical therapist must be in the room during the performance of the service. Prior to that date, the standard for supervision was "direct supervision." In our view, the "in the room" supervision requirement is too strict and unnecessary. PTAs are state regulated practitioners who can safely and effectively furnish therapy services under a less stringent supervision standard. The personal supervision requirement imposes a level of supervision higher than that required for PTAs furnishing services in all other Medicare settings.

We urge the Council to recommend that CMS revise the supervision requirement in the Private Practice Office setting to require direct supervision of physical therapist assistants.

CORRECT CODING INITIATIVE EDITS

On January 1, 1996, CMS implemented a national Medicare policy involving more than 80,000 coding edits that restricted certain coding combinations. AdminaStar Federal developed these code edits under a contract with CMS. These code pair edits are combinations of two CPT codes that cannot be billed together because either the code pair represents services that are considered mutually exclusive or one code in the pair is considered a component of a more comprehensive procedure code. The CCI edits are applied to services furnished in physical therapist private practice offices and in hospital outpatient settings.

APTA recognizes the need for CMS to create edits in coding systems to detect inappropriate billing. However, CMS has created a number of edits that do not make clinical sense and therefore are inappropriate. For example, CMS has established CCI edits which prohibit billing for a reevaluation and treatment in the same session. Furnishing an evaluation/reevaluation and treatment in the same session is common industry practice and results in more efficient and effective patient care. CMS has also established CCI edits that prohibit billing for group therapy and therapeutic procedures in the same session. It is appropriate for a physical therapist to work individually with a patient on therapeutic procedures to improve the patient's strength and endurance, prior to the patient's participation in a group exercise program. APTA has requested that CMS delete the problematic code pair edits, but is still awaiting action from the Agency.

We urge the Council to recommend that CMS eliminate inappropriate CCI edits as soon as possible. In addition, we recommend that CMS make CCI edits available through its website. CCI edit updates are currently costly to obtain and should be accessible to providers.

LOCUM TENENS

It is a widespread practice for physicians to retain substitute physicians to take over their professional practices when the regular physicians are absent due to illness or vacation, and for the regular physician to bill and receive payment for the substitute physician's services as though he or she performed them himself or herself. The substitute physician is an independent contractor and generally has no practice of his or her own. The regular physician typically pays the substitute physician, referred to as "locum tenens" physician, a fixed amount per diem. Section 125(b) of the Social Security Act Amendments of 1994 makes this procedure available on a permanent basis. This provision is described in further detail in Section 3060.7 of the Medicare Carriers Manual (CMS-Pub 14-3).

CMS has stated that this provision in the Carriers Manual is not applicable to physical therapists in private practice. Therefore, a physical therapist who goes on vacation or it out due to illness cannot have another physical therapist come to the office and substitute in his or her absence. Thus, patients have to be sent to another office to receive their physical therapy or wait until the physical therapist returns. Such a delay in treatment can be detrimental to the patient's care.

We urge the Council to recommend to CMS that the locum tenens policy currently applied to physicians also be applied to physical therapists in private practice.

PROVIDER EDUCATION

Many physical therapists have great difficulty finding the "right" answer to questions regarding Medicare requirements. Carriers and intermediaries often give incorrect information to providers. There appears to be a lack of communication of information between CMS and its carriers and fiscal intermediaries.

In addition to receiving incorrect information from carriers and fiscal intermediaries, providers find that carriers and fiscal intermediaries are interpreting CMS regulations and policies differently throughout the country. As a result, providers in different regions are subject to different standards for Medicare coverage and reimbursement. There is a need for uniformity. Physical therapists are trying to provide good patient care while complying with Medicare regulations, but because of the confusing and conflicting information they are provided, this objective has become more difficult to achieve.

There is a need for CMS to provide clear, concise guidance on its Medicare policies and interpretations to its fiscal intermediaries and carriers, to national associations, and to providers. This guidance should ensure providers receive accurate and timely information to assist them in complying with Medicare requirements.

It is our hope that the Council can emphasize to CMS the importance of carrier and provider education and training by making funding in these areas a higher priority.

CONCLUSION

We appreciate the opportunity to provide comments to the Council on these critical issues. We would be happy to work with the Council in the future to address these issues.