September 27, 2019

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-1715-P
Room 445-G
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Submitted electronically

RE: Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations [CMS-1715-P]

Dear Administrator Verma:

We are writing in response to the request for comments on the Centers for Medicare and Medicaid Services (CMS) recently proposed 2020 revisions to payment policies under the physician fee schedule and other revisions to Medicare Part B (CMS-1715-P). The National Association of Rehabilitation Providers and Agencies (NARA) represents over 80,000 physical therapists, occupational therapists, and speech language pathologists through our member organizations who provide therapy across the United States to Medicare beneficiaries. They provide therapy in all settings across the health care continuum such as outpatient clinics, skilled nursing facilities, assisted living facilities, home health agencies, hospital outpatient and inpatient departments, in beneficiary homes, and in retirement communities. NARA's membership demographics give us a unique insight into payment and quality programs applicable for therapy providers and beneficiaries this proposed rule impacts. We appreciate the opportunity to share our feedback related to the above proposed rule with CMS.

Medicare Physician Fee Schedule

NARA understands that due to budget neutrality, when increases are made to some codes, reductions must be made in others. However, the proposed fee schedule changes result in an average 8% decrease to codes commonly used by therapy providers. This dramatic payment revision, coupled with the other cuts therapy services have taken in recent years and will continue to take with the therapy assistant payment reduction in 2022 would be highly detrimental to the professions of physical and occupational therapy and, more importantly, to the patients who need rehabilitative services. Since therapists cannot bill E/M services, physical and occupational therapy providers and speech-language pathologists will not receive any of the proposed increases of some codes to balance out the cuts to their professional services. The cumulative nature of MPPR, sequestration, inability for most therapy providers to participate in MIPS to qualify for any additional reimbursement for quality reporting, and the pending 15% payment reduction for services provided by physical or occupational therapy assistants create an untenable and harmful financial situation for therapy providers.

The continued reduction in payment for vital therapy services is substantial and hard felt, particularly by practitioners in rural and underserved areas and will almost certainly result in decreased access to care for Medicare beneficiaries. If implemented, the proposed payment reduction would cause some practices and providers to reduce operations or close their businesses altogether. The proposed changes are unsustainable and entirely inconsistent with the move toward value-based health care. Additionally, physical, occupational and speech therapy should be considered an alternative to more costly interventions including a far safer alternative to opioids for many populations. At the same time, the aging population is in greater need of therapy practitioners now more than ever before and access to these services is essential. However, the proposed rule will diminish access to care with fewer providers able to sustain operations. We respectfully urge CMS to reconsider the distribution of payment reductions for budget neutrality that is not unfairly targeted toward the therapy professions.

Proposed Payment for Outpatient PT and OT Services Provided by Assistants

NARA recognizes that pursuant to the Bipartisan Budget Act of 2018 (BBA) Section 53107, beginning on January 1, 2020, outpatient therapy providers are required to use modifiers (CQ or CO) to indicate when outpatient therapy services are furnished in whole or in part by a physical therapy assistant (PTA) or occupational therapy assistant (OTA). In the proposed rule, CMS proposes to make the 10% calculation based on the respective therapeutic minutes of time spent by the therapist and the PTA/OTA, rounded to the nearest whole minute. At times, the minutes of time spent by a PTA/OTA furnishing a therapeutic service can overlap partially or completely with the time spent by a physical or occupational therapist furnishing service. The total time for a service would be the total time spent by the therapist (whether independent of, or concurrent with, a PTA/OTA) plus any additional time spent by the PTA/OTA independently furnishing the therapeutic service. CMS also proposes to add a requirement that the treatment notes explain

why the modifier was or was not applied to the claim for each service furnished that day. NARA strongly opposes CMS' application of the 10% *de minimis* standard. Under Medicare policy, the physical or occupational therapist is responsible for the patient's plan of care and the assistant furnishes services under the direction and supervision of the therapist. When a therapist and assistant are jointly furnishing services to a patient at the same time and the therapist is fully engaged in the service during that time, the intervention during that time period should be identified as a therapist's services and not subject to a 15% reduction solely because a PTA/OTA was present. The Congressional intent of the PTA/OTA provisions in Section 1834(v) of the Social Security Act was not to change established standards of care or to extend into state license requirements for supervision of assistants. NARA believes the intent was to better align payments with the cost of delivering therapy services since assistant wages are typically lower than therapist wages. In other words, the discount should apply only to services, or parts of services, furnished independently by the therapist assistant and not to the services provided by the therapist.

We also do not believe that Congressional intent was to apply an adjustment to therapy services furnished when the therapist assistant was providing a "second set of hands" to the therapist for safety or effectiveness reasons. However, as part of the *de minimis* standard information and examples in the proposed rule, CMS proposes that when a therapist is furnishing care and requires the help of a therapist assistant as a "second set of hands" for any reason, then for payment of those services is subject to the 15% reduction. In this case, the therapist's skilled time and clinical judgment capabilities are ignored solely because a therapy assistant is present. For example, if a therapist spends 60-minute service providing direct care to a patient, but during a therapy session the side-by-side assistance of a therapy assistant for 7 minutes was required, the entire hour of service would be subject to the 15% therapy assistant adjustment under the proposed rule. NARA believes the therapy documentation should support the clinical judgment and services provided by the qualified therapist versus individual therapy services provided by a therapy assistant and therefore does not support 100% of the services provided to be billed by the therapy assistant rather than the therapist. NARA strongly encourages CMS to revisit their application of the 10% *de minimis* standard and only services provided in part or in whole independently by the therapy assistant be attributed to the *de minimis* standard and billed with the assistant modifier.

As highlighted above, the implementation of the fee schedule reduction in the proposed rule along with CMS' application of the *de minimis* standard would result in significant payment reductions in the common CPT codes billed by therapy providers. Nearly two-thirds of therapy providers are unable to participate in MIPS because of billing methodologies offering no possible changes in reimbursement for continuing to provide appropriate, results-driven and innovative services. These reductions may force providers, currently operating on very thin margins for therapy service to Medicare Part B beneficiaries, to stop delivering certain services and/or stop utilizing therapy assistance to avoid facing a financial "penalty". The result will be reduced patient access and lower overall efficiency of therapy services. If implemented as proposed, these

changes are likely to have a serious adverse impact on the therapy profession as a whole and, consequently, on patients. Medicare payment and coverage policies should afford flexibility to therapists and other therapy professionals to develop an individualized care plan tailored to the needs of each Medicare beneficiary.

NARA recommends that CMS implement a mid-point policy, similar to AMA's and APTA's CPT mid-point rule. That is, if the physical therapist furnishes the service for more than half of the time, regardless of the assistant's involvement, the code would be affixed with the GP modifier.

Additionally, NARA is concerned about the burden of additional documentation CMS is proposing to be associated with the new CQ/CO modifiers and conflicts with CMS' Patients Over Paperwork Initiative. Specifically, the proposed rule states "…we propose to add a requirement that the treatment notes explain, via a short phrase or statement, the application or non-application of the CQ/CO modifier for each service furnished that day." In other words, in addition to existing documentation requirements, CMS is proposing the outpatient therapy provider be required to add a statement in the medical record for *each* line of *every* claim to explain why the CQ/CO modifier was *used or not used*. We believe if a provider has a mechanism to provide evidence whether a specific service was furnished *independently* by a therapist or a therapy assistant, or was furnished "in part" by an assistant in sufficient detail to allow a medical record reviewer to determine whether the *de minimis* threshold was met then no further documentation should be required. This requirement not only adds significant burden, but also is *not* statutorily required.

We further disagree with CMS' inference in the proposed rule that the CQ/CO modifier policy explanation in the treatment note might address the "possible additional burden associated with a contractor's medical review process conducted for these services." Rather, it serves merely as one more mechanism for reviewers to issue a technical denial even though the medical record may otherwise contain sufficient documentation to justify the use or non-use of the CQ/CO modifier. Medicare Benefit Policy Manual (MBPM) Chapter 15 Section 220 already includes extensive documentation requirements, and Medicare Claims Processing Manual Chapter 5 Section 20.2 contains detailed guidance on how to count minutes. Included in those sections are phrases such as the following from the MBPM, Chapter 15, Section, 220.3.B: "A separate statement is not required if the record justifies treatment without further explanation." Additionally, some outpatient therapy providers do not employ therapist assistants. Thus, requiring such providers to document the application or non-application of the CQ/CO modifier for each service is unnecessary and creates substantial administrative burden for providers—a regulatory burden which CMS should be working to reduce.

Finally, NARA believes requiring therapists or therapy assistants to document why the CQ/CO was applied or not applied is inconsistent with the practice governing other professions. For example, physicians or physician assistants (PAs) and nurse practitioners (NPs) are not

required to explain via a short statement that the physician provided services or that the PA and NP did or did not bill under their own NPIs (and are accordingly paid at 85% of the PFS) for each service delivered to each patient seen each day. NARA strongly opposes this unnecessary documentation requirement which demonstrably does not contribute to the delivery of high quality, cost effective care.

2020 MIPS Program

NARA appreciates CMS's modifications to the low-volume threshold and the creation of an opt-in policy for the MIPS program. We also appreciate the inclusion of eligible physical, occupational and speech therapists in the MIPS in the payment 2021 year. However, NARA strongly encourages CMS to determine avenues to ensure that all eligible rehabilitation providers regardless of setting, billing methodology, or size are able to participate in this program.

- Facility-Based (Institutional) Providers vs Private Practice Providers: Currently therapists who bill through rehabilitation agencies, SNF part B, and hospital outpatient are unable to participate as a group in MIPS because they bill on the UB04 Institutional Claim Form (CMS 1450) and CMS is unable to attribute services to a specific treating individual NPI. Therapists in private practice, either as individuals or groups, are able to report on the CMS 1500 form. Pursuant to the MedPAC Analysis of Part B outpatient therapy claims in 2015[1], 62% of providers bill on the UB04 (CMS 1450) form and therefore, are unable to participate in the current MIPS program. This MIPS initiative in its current format applies to less than 38% of Part B therapy claims. NARA recommends modifications to the UB04 (CMS1450) in order to accommodate a provider NPI so the 62% of providers who cannot currently participate in the program solely due to the billing methodology will have the opportunity to provide patient outcome data and share in the opportunity for higher reimbursement for obtaining quality metrics. NARA welcomes the opportunity to work with CMS to provide feedback on how to make these changes;
- NARA recommends that CMS extend claims-based reporting to accommodate greater provider ability to report as either individuals or as a group;
- Small physical, occupational, and speech therapy practices indicate the financial burden of registry reporting is prohibitive and may cause more of these small practices to not accept Medicare beneficiaries. NARA strongly encourages CMS to not eliminate claims reporting until CMS has had sufficient time to explore and implement a system allowing providers to upload data directly to CMS via a portal or establish other low-cost reporting options.

NARA encourages CMS to explore ways that all eligible clinicians can participate in the evolution of the value-based payment systems. Facility-based therapists could participate in MIPS under the group reporting option. However, due to current billing practices, this may pose

[1] MedPAC analysis of 100 percent Medicare Part B outpatient therapy claims, 2015

a challenge for tracking the individual therapist. One potential solution is to allow facility-based groups with rehabilitation providers to report in MIPS as a group using the revenue code to identify services and track the group as a whole rather than the individual therapists. Another potential solution would be to modify the UB04 (CMS1450) to include a box on each service line for the treating therapist's NPI. One consideration is that this would require more therapists to apply for provider NPIs which could cause a strain on the NPPES system for a brief time. However, CMS would be able to continue tracking the outcomes based on the individual therapist as they do with other eligible providers.

Should CMS make accommodations so that facility-based therapists are able to participate in the program in the future, we encourage CMS to consider allowing providers in facilities to report measures relevant to their respective settings, similar to their physician colleagues. For example, therapists billing for services for a Medicare Part B beneficiary in skilled nursing facilities (SNFs) may wish to report the same functional measures they report under the SNF Quality Reporting Program. This would enable CMS to begin to align the new improving Medicare Post-Acute Care Transformation (IMPACT) Act measures with the MIPS program. Again, NARA welcomes the opportunity to work with CMS to determine how to add facility-based providers to the MIPS program and other future programs such as additional alternative payment models (APM).

Therapy Limitation Threshold

NARA appreciates CMS' acknowledgment of the permanently extended exceptions process instituted for outpatient therapy services. We recommend CMS issue additional clarification and guidance on the appropriate use of the KX modifier for outpatient therapy claims and any applicable definitions. We also recommend CMS stress both to providers and beneficiaries the $3,000 threshold is not a "cap" but rather a point at which the claims may be targeted for a medical necessity review. NARA also recommends CMS set the threshold for the application of the KX modifier at the same threshold as the medical review threshold to decrease the administrative burden for providers. Finally, NARA requests CMS to require Noridian Healthcare Solutions to create a website specifically for offering instructions to providers on the targeted medical review process. We further request CMS to provide the data on the results of these reviews that have been conducted since 2016—the results would be a valuable educational tool for providers.

Therapy and Telehealth Services

NARA strongly encourages CMS, through the Center for Medicare and Medicaid Innovation, to conduct a pilot or demonstration program to evaluate the clinical benefit of physical therapists, occupational therapists, and speech-language pathologists furnishing telehealth services to Medicare beneficiaries in all settings— where such services are permitted by the state. NARA encourages CMS to consider and assess how to engage providers to

participate in these more non-traditional alternative delivery models and the role of telehealth. The results of this demonstration would provide valuable feedback to policymakers as they consider adding physical therapists, occupational therapists, and speech-language pathologists as authorized providers of telehealth.

Opioid Management

NARA recognizes the devastation that opioid addiction has caused in communities throughout the United States and is committed to helping fight this public health crisis in any way possible. NARA proffers the following recommendations to CMS:

- Institute provisions to promote payment models and integrated team approaches that support early access to nonpharmacological interventions, including physical and occupational therapy, for the primary care of pain conditions;
- Continue limiting access to certain drugs but develop and promote policies to increase access to nonpharmacological alternatives;
- Remove barriers to effective care by reducing or eliminating copays that prevent beneficiaries from accessing person-centered, nonpharmacological pain management and treatments interventions
- Support broader access to interdisciplinary, comprehensive pain management models that evaluate and treat the different factors influencing the presence of pain;
- Additional training and educational resources for prescribers and other health care professionals to convey the value of nonpharmacological treatments and offer guidance on how to recognize when they are the safer, more effective option for the patient's condition;
- CMS, in a joint effort with other federal agencies, expand its public awareness campaign on nonpharmacological treatment options for pain.

Additional Concerns

NARA would like to take this opportunity to address some additional concerns of our members who provide Medicare services:

- Administrative Burden: To better align with CMS' Patients over Paperwork initiative, we urge CMS to take action toward reducing unnecessary burden, increasing efficiencies, and improving the patient experience by eliminating administratively burdensome requirements for therapy providers.
- Administrative Burden with Medicare Advantage Plans: NARA urges Medicare to review the requirements and expectations of MA plans to ensure beneficiary care is not denied without just cause or free from restrictions to ensure better access to timely, high-quality

care that is appropriate for their condition; avoids preventable adverse events; and saves patients, plans, and providers from expending resources on unnecessary services.

- Many Medicare Advantage plans prior authorization processes have caused significant delays in beneficiaries receiving treatment. While NARA understands the desire of these payers to ensure the appropriate level of care is provided to its subscribers, our members have experienced some unnecessarily long and unpredictable delays in care while awaiting authorization. NARA recommends creating a standard requiring all Medicare Advantage payers communicate authorization decisions with two (2) business days;
- Credentialing of Rehab Agencies: CMS allows therapy providers to be certified as a Rehabilitation Agency or provide service as a Private Practice. There are advantages to being credentialed as a Rehab Agency over a Private Practice including billing as an institutional provider (on a CMS-UB-04 claim form) and not having to individually credential each physical, occupational or speech language pathologist therapist providing care to its beneficiaries. However, many commercial payers with Medicare Advantage plans frequently process claims from Rehabilitation Agencies incorrectly or deny payment which requires the provider to dedicate unnecessary resources to appeal a denial or complete a reconsideration process for incorrectly processed claims. NARA members have found that these commercial payers do not recognize the Rehabilitation Agency as an institutional provider and subject them to private practice requirements including individual credentialing of therapist and billing claims on a CMS-1500 claim form instead of the institutional provider practices established by Medicare. NARA recommends that CMS standardize the process and require commercial payers offering a Medicare Advantage plan to follow established CMS practices for claims, credentialing and reimbursement for all Medicare approved providers.

- Bundled Payments RFI: NARA appreciates the opportunity to provide feedback on concepts and principles associated with bundled payment models—particularly the idea of per-beneficiary payments for multiple services or condition-specific episodes of care—being applied to the Physician Fee Schedule. While NARA believes bundled payments could be an interesting opportunity there are several important questions regarding how it would work for therapy—e.g. How would different settings be impacted i.e. professional billing vs facility/institutional billing? Who would own/direct the bundle? What would the qualifications be? NARA welcomes the opportunity to work more with CMS on this type of initiative.

Conclusion

NARA thanks you for this opportunity to share some of our insight and recommendations related to the CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies. We applaud CMS's effort to seek feedback to provide high

quality, cost effective care for Medicare beneficiaries. Should you have any questions concerning these comments or if NARA can be of further assistance to CMS, please contact George G. Olsen, Esq. of Williams & Jensen, PLLC at ggolsen@wms-jen.com.

Respectfully submitted,

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