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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:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants (PTAs), and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments on the Centers for Medicare and Medicaid Services' (CMS) Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule (PFS) and Other Revisions to Part B for Calendar Year (CY) 2020; Medicare Shared Savings Program Requirements; and Updates to the Quality Payment Program (QPP) proposed rule. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for otherwise

avoidable health care services. Physical therapists' roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

APTA has serious concerns with the recently released rule, specifically the CQ/CO modifiers policy and the proposed application of the 10% *de minimis* standard to services furnished in whole or in part by PTAs and occupational therapy assistants (OTAs).

Our detailed comments specifically on the proposed application of the CQ/CO modifiers for outpatient physical and occupational therapy services furnished by PTAs and OTAs are below. APTA will submit a separate comment letter on this and other policies included within the PFS proposed rule in advance of the September 27, 2019 comment deadline.

Overview

For the reasons discussed in more detail below, the CQ/CO modifier policy as currently proposed is fundamentally flawed and will result in drastic underpayments for outpatient therapy services beginning in 2022, likely leading to severely restricted Medicare beneficiary access to vital therapy services, particularly in rural and underserved areas. Outpatient therapy providers, including therapists in private practice, skilled nursing facilities (SNFs), home health agencies (HHAs), comprehensive outpatient rehab facilities (CORFs), and hospitals have very small margins between the cost of delivering their care and the payments they receive under Medicare. There is a strong likelihood that this policy, if finalized as proposed, will create an access issue for Medicare beneficiaries—particularly patients who have conditions that require 2 qualified health care professionals to deliver treatment. As the baby boomer generation continues to retire and age, there will be an increased demand for physical therapy services. For instance, over the last several years, the number of Medicare beneficiaries accessing physical therapy through physical therapists in private practice has increased:¹

- 2013: 2,091,751
- 2014: 2,198,616
- 2015: 2,354,958
- 2016: 2,546,041
- 2017: 2,673,120

Further, there will be an increase in the number of Medicare beneficiaries suffering from multiple chronic conditions that require caregiver training; mobility and self-care; and home safety and home modification to enable “aging in place.” In short, if this proposal stands, access to vital outpatient therapy services will be at grave risk. **It is imperative that Medicare beneficiaries continue to have access to high-quality physical therapy services, given the critical role physical therapists and PTAs play in ensuring the health and vitality of this nation.** Further, imposing new documentation requirements on therapy providers, without justification, directly contradicts CMS' claim that its top priority is putting patients first under the “Patients over Paperwork” initiative.

¹ https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2017/2017_Utilization.html#Medicare%20Physician/Supplier

Pursuant to the Bipartisan Budget Act of 2018 (BBA) Section 53107, beginning on January 1, 2020, outpatient therapy providers are required to use a modifier to denote when outpatient therapy services are furnished in whole or in part by a PTA or OTA. In 2022, payment for such services will be reimbursed at 85% of the fee schedule. The reduced payment rate is applicable when payment is made under the PFS to therapists in private practice, outpatient hospitals, rehabilitation agencies, SNFs, HHAs, and CORFs. In the CY 2019 PFS final rule, CMS clarified that the CQ/CO modifiers are required when applicable for services furnished on or after January 1, 2020, on the claim line of the service alongside the respective GP or GO therapy modifier to identify services furnished under a physical therapy or occupational therapy plan of care. CMS also finalized a *de minimis* standard under which a service is considered to be furnished in whole or in part by a PTA or OTA when more than 10% of the service is furnished by the PTA or OTA. **Finally, CMS clarified that the same procedure code can be reported on 2 different claim lines as long as there is a different modifier used to uniquely identify the service and prevent the service from being considered a duplicate.**

Within the 2020 PFS proposed rule, CMS proposes to base the 10% calculation on the respective therapeutic minutes of time spent by the therapist and the PTA/OTA, rounded to the nearest whole minute. 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 the 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. If the PTA/OTA participates in a service concurrently with the therapist for only a portion of the total time that the therapist delivers the service, the CQ/CO modifiers apply when the minutes furnished by the therapist assistant are greater than 10% of the total minutes spent by the therapist furnishing the service. If the PTA/OTA and the therapist each separately furnish portions of the same service, the CQ/CO modifiers would apply when the minutes furnished by the therapist assistant are greater than 10% of the total minutes—the sum of the minutes spent by the therapist and therapist assistant—for that service. The CQ/CO modifier policies would apply to all services that would be billed with the respective GP or GO therapy modifier. 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.

Proposed Payment for Outpatient Physical Therapy and Occupational Therapy Services Furnished by Therapist Assistants

CMS' proposed application of the 10% de minimis standard exceeds statutory authority, is arbitrary and capricious, and contradicts CMS' statements in the 2019 PFS final rule.

The proposed application of the 10% standard to care delivered separately and concurrently by a PTA/OTA is inherently complex, flawed, and prejudicial for outpatient therapy providers. Adopting the policy as proposed, coupled with the proposed rate reductions to Current Procedural Terminology (CPT) code work and practice expense (PE) relative value units (RVUs) for physical therapists, will result in large reimbursement reductions to the professions of physical therapy and occupational therapy beginning in 2021 and continuing through 2022 and future years. These reductions threaten to negatively impact beneficiary access to medically necessary therapy services.

As discussed in more detail below, CMS has misinterpreted the congressional intent of Section 53107 of the BBA, thereby **exceeding its statutory authority** in its proposed application of the 10% threshold to the total treatment minutes, whether services are furnished concurrently or separately. Further, the policy proposals included within the 2020 PFS proposed rule **directly contradict** CMS' previous statements in the CY 2019 PFS Final Rule (83 FR 59452). Finally, the proposed documentation requirements associated with the new CQ/CO modifiers are **exceedingly burdensome and conflict with the Administration's "Patients over Paperwork Initiative."**

Proposed policy fails to align with congressional intent

The congressional intent of the therapist assistant provisions in Section 1834(v) of the Social Security Act was to better align payments with the cost of delivering therapy services given that therapist assistant wages are typically lower than therapist wages. In other words, the discount would apply to services, or parts of services, furnished *independently* by the therapist assistant. The congressional intent was not to apply an adjustment to a physical therapist's services furnished when the therapist assistant was providing a "second set of hands" to the therapist for safety or effectiveness reasons.

However, in the CY 2020 PFS proposed rule, as part of the 10% *de minimis* standard established in the CY 2019 PFS final rule, **CMS is proposing that when a therapist is furnishing care and requires the help of a therapist assistant as a "second set of hands" for safety or effectiveness purposes, the therapist's time is ignored for payment purposes, and this treatment time is instead counted toward the therapist assistant 15% payment adjustment policy.** For example, if a therapist spent the entire 60-minute *service* providing direct care to a patient, but during that session they required the side-by-side assistance of a therapist assistant for 7 minutes, the entire hour of service would be subject to the 15% therapist assistant adjustment.

APTA strongly opposes CMS' proposed application of the 10% standard when the PTA/OTA participates in the service concurrently with the therapist for only a portion of the total time that the therapist delivers a service. Team-based therapy indicates that the therapist is involved the entire duration of the service and requires a second set of skilled hands to support care delivery. The assistant supports the therapist during care delivery. When care is furnished as a team, meaning the therapist is delivering care the entire time with the support of the assistant, the time spent by the assistant is irrelevant. The documentation would reflect that the assistant assisted the therapist in the care but that the therapist was involved in delivering care for the entire duration.

Value-based payment models highlight the importance of a team approach to improve the health of individuals and populations as well as the quality and efficiency of health care delivery. Team-based care is defined by the National Academy of Medicine as "...the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality

care.”² Team-based care is widely recognized as a more valuable way to deliver health services. Patients being treated by a physical therapist and PTA at the same time are receiving better value than they would have had they been treated alone. In the real world, the interaction of the physical therapist and PTA involves a collaborative effort to achieve the best patient outcomes.

If both a physical therapist and PTA are furnishing care to a patient, it is evident by the very nature of the service that it requires two professionals and that it is a highly skilled procedure. For example, an individual who has suffered a stroke needs physical therapist services to learn how to walk again. In such scenario, the PTA might assist the patient to maintain the upright position and perform weight shifting, which is required for the patient to take a step. At the same time, the physical therapist would provide neuromuscular re-education by assisting the patient with foot placement and verbal cues as well as preventing the knee from buckling when weight is put on the weak leg. Although the physical therapist and PTA can be in either position, there is no feasible way for the treatment to be performed without both skilled professionals. The skills of both also are necessary when the patient is a fall risk. In 2014 alone, older Americans experienced 29 million falls, causing 7 million injuries and costing an estimated **\$31 billion in annual Medicare costs**.³ For example, a PTA may walk with a patient who is a risk for falling to allow the physical therapist to stand behind the patient and assess the patient’s gait. **It is nonsensical to diminish reimbursement for services when safety precautions are implemented, and the overall value of the care is increased. CMS’ purposeful attempt to pay less for highly skilled and technical services is incongruent with the agency’s goals to promote the delivery of high-quality, value-based care within a patient-centered health care delivery system.**

The proposed application of the 10% standard to concurrently-delivered care (eg, team-based therapy) is a gross overreach of CMS’ authority afforded to it by Congress. **Reimbursement should be driven first by the therapist’s time associated with the service. Any therapist direct care time, whether alone or overlapping with an assistant, should be credited to the therapist. Moreover, reducing reimbursement for the entirety of the service when the physical therapist and PTA are working collaboratively in a team-based manner is counter to the health care system’s shift toward rewarding value over volume.** Requiring the CQ/CO modifiers to be applied when the minutes furnished by the therapist assistant are greater than 10% of the total minutes spent by the therapist furnishing the service is wholly unjust and, as previously stated, exceeds CMS’ statutory authority and has serious implications for beneficiary access to care.

APTA also disagrees with CMS’ use of the term “concurrent” when discussing team-based therapy under this proposed policy. This term is not currently defined in the law, regulation, or Medicare Manuals in any manner that would reflect when two clinicians (therapist and therapist assistant) are providing care to a beneficiary at the same time. In fact, the proposed use of the term “concurrent” in the context of determining the *de minimis* threshold conflicts with the definition of “concurrent” in the SNF Minimum Data Set Resident Assessment Instrument (MDS-RAI) manual guidance (see below).

² Creating Patient-centered Team-Based Primary Care. AHRQ. <https://pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care#ref1> Accessed August 2, 2019.

³ CDC Press Release 2016 <https://www.cdc.gov/media/releases/2016/p0922-older-adult-falls.html>

Concurrent minutes—Enter the total number of minutes of therapy that were provided on a concurrent basis in the last 7 days. Enter 0 if none were provided. Concurrent therapy is defined as the treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident regardless of the payer source for the second resident. For Part B, residents may not be treated concurrently: a therapist may treat one resident at a time, and the minutes during the day when the resident is treated individually are added, even if the therapist provides that treatment intermittently (first to one resident and then to another). For all other payers, follow Medicare Part A instructions.⁴

Additionally, CMS uses the term “team” in the context of Part B outpatient therapy as described in the “11 Part B Billing Scenarios for PTs and OTs” educational resource.⁵ This resource references care being delivered to one patient at the same time by two professionals as “team-based therapy.” Thus, defining and using the term “team” and not “concurrent” in the context of this policy would alleviate much potential confusion. **Therefore, we recommend that CMS adopt the term “team” to describe the time that the therapist and therapist assistant work together to furnish a service.**

As stated above, we strongly oppose the proposed approach to assigning the CQ/CO modifiers when team-based care is delivered. Under Medicare policy, the physical therapist is responsible for the patient’s plan of care and the PTA furnishes services under the direction and supervision of the physical 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 *service* during that time period should be identified as a therapist’s services and be allocated to the therapist. **Only services furnished in whole or in part *independently* by the assistant should be attributed to the 10% *de minimis* standard for the assignment of the CQ/CO modifiers. Therefore, we propose that CMS instead define “in whole or in part” to mean skilled therapy services furnished by a therapist assistant under the supervision of a therapist, but *independent* of any time the therapist is furnishing the *service*.** Services furnished jointly by a therapist and assistant *team*, where the assistant is supplementing the therapist’s services, are to be considered therapist services and should not be attributed to the assistant’s time in the determination of the CQ/CO modifier *de minimis* standard.

APTA acknowledges that Section 53107 of the BBA allows for significant latitude on the part of the agency in its interpretation of the term “in part.” A federal agency’s interpretation of a statutory provision it is charged with administering may be entitled to deference.⁶ Deference is granted unless the agency’s interpretation is contrary to clear congressional intent or frustrates the policy Congress sought to implement.⁷ Also, deference is due the agency’s interpretation of a

⁴ MDS RAI Manual Section O. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>

⁵ https://www.cms.gov/Medicare/Billing/TherapyServices/Downloads/11_Part_B_Billing_Scenarios_for_PT_and_OTs.pdf

⁶ Bear Lake Watch, 324 F.3d at 1073.

⁷ Biodiversity Legal Found. V. Badgley, 309 F.3d 1166, 1175 (9th Cir. 2002)

statute unless the plain language is unambiguous with regard to the precise matter at issue.⁸ Although the plain language of Section 53107 is not unambiguous, it is obvious that Congress does not permit application of the modifier for outpatient physical therapy or occupational therapy services furnished by the physical or occupational therapist, respectively. However, CMS' proposed application of the 10% standard policy devalues the critical role played by the therapist during the delivery of care by requiring the application of the CQ/CO modifier to services furnished by the physical or occupational therapist. Beginning in 2022, this would result in physical therapist and occupational therapist services being reimbursed at 85% of the PFS. **Unless our recommended revised definition is adopted, the 15% payment adjustment would extend beyond congressional intent and would improperly apply a payment cut to a therapist's services. Such a cut would result in unintended consequences that could harm Medicare beneficiaries.** Specifically, the proposed policy could create access barriers for beneficiaries with conditions such as morbid obesity and stroke, and postsurgical procedures that require direct care from 2 therapy clinicians simultaneously. Pursuant to 5 USC § 706, a court shall hold agency actions, findings, and conclusions that are in excess of statutory jurisdiction, authority, or limitations to be unlawful. **If the policy is finalized as proposed, CMS would be exceeding the authority granted to it by Congress in Section 53107 of the BBA. Therefore, APTA strongly recommends that CMS apply the 10% standard in accordance with the authority afforded to it by Congress.**

Proposed policy fails to satisfy arbitrary and capricious standard

Under the arbitrary and capricious standard under the Administrative Procedure Act (APA), “the agency must be able to provide the ‘essential facts upon which the administrative decision was based’ and explain what justifies the determination with actual evidence beyond a ‘conclusory statement.’”⁹ “An agency decision that is the product of ‘illogical’ or inconsistent reasoning; that fails to consider an important factor relevant to its action, such as the policy effects of its decision or vital aspects of the problem in the issue before it; or that fails to consider ‘less restrictive, yet easily administered’ regulatory alternatives will fail the arbitrary and capricious test.”¹⁰

Over the last year, APTA has worked diligently—through comment letters and numerous meetings with CMS staff—to advocate for application of the 10% *de minimis* standard in such a way that will continue to allow outpatient therapy providers to deliver high-quality care to their patients with minimal administrative and financial disruptions. Many of our members also submitted comment letters, echoing our concerns and recommendations. We do not believe that CMS' proposed provisions in this rule reflect that our concerns and recommendations have received appropriate consideration. Moreover, within the rule, CMS offers no explanation or rationale for how the proposed 10% calculation was developed or why the recommendations put forth by the national associations representing therapy providers were so freely dismissed. Moreover, the proposed policy not only fails to comport with any of the recommendations put

⁸ Royal Foods Co. v. RJR Holdings Inc., 252 F.3d 1102, 1106 (9th Cir. 2000)

⁹ Congressional Research Service “A Brief Overview of Rulemaking and Judicial Review” citing United States v Dierckman, 201 F.3d 915, 926 (7th Cir. 2000) (quoting Bagdonas v Dept of the Treasury, 93 F.3d 422, 426 (7th Cir. 1996)); Allied-Signal, Inc v Nuclear Reg Commission, 988 F.2d 146, 152 (D.C. Cir. 1993).

¹⁰ Congressional Research Service “A Brief Overview of Rulemaking and Judicial Review” <https://fas.org/sgp/crs/misc/R41546.pdf> Accessed August 15, 2019.

forth by stakeholders, but there also is a lack of consideration on the part of the agency for the economic and social impacts of the policy, if it is finalized, on patients, small businesses, and employees—therapists and therapist assistants and other staff.

Here, we do not believe the agency’s policy, if finalized as proposed, would satisfy the arbitrary and capricious standard under the APA. CMS has offered no explanation or rationale for its decision to require application of the 10% *de minimis* standard in the manner as currently proposed. Further, it is apparent that CMS did not afford adequate consideration to the policy effects of its decision, nor did the agency consider the less restrictive proposals put forth by stakeholders.

Proposed policy conflicts with CMS’ statements in 2019 PFS final rule

CMS’ proposed application of the 10% standard when the therapist assistant and the therapist each separately furnish portions of the same service is in **direct conflict** with its response to comments in the 2019 PFS final rule (83 FR 59452), in which the agency outlined its policy regarding application of the modifier when the therapist and therapist assistant furnished portions of the same service.

Commenters on the 2019 PFS proposed rule “recommended that CMS allow for reporting of the same code, on the same day, for the same beneficiary on 2 different claim lines to distinguish between those code units furnished by a therapist and those furnished by an assistant in reference to the 15-minute timed intervention codes and the group therapy code (CPT code 97150).”¹¹ CMS responded, stating it wished to offer clarification to commenters’ concerns and alternatives. CMS proceeded to explain that its claims-processing system allows for the differentiation of the same procedure code on different line items, and provided an example of how the CQ/CO modifier policy would apply when the same service was furnished separately by the therapist and assistant, noting that the units furnished by the therapist assistant for the procedure code would be billed on the claim line with the modifier for the therapist assistant’s services, and the units furnished by the therapist for the same procedure code would be billed on another claim line without the therapist assistant modifier.

Specifically, CMS stated:

“We offer clarification on some of the commenters’ concerns and alternatives, as follows... CMS claims processing systems already allow, when not constrained by other policies such as Medically Unlikely Edits (MUEs), the same procedure code to be reported on two different claim lines as long as there is a different modifier used to uniquely identify the service and prevent the service from being considered a duplicate. For example, if a therapist assistant furnished one unit (15 minutes) and the therapist furnished 2 units (30 minutes) of the same procedure code that is defined to be billable in 15-minute increments, one unit of the procedure code would be billed on the claim line with the modifier for the therapist assistant’s services and two units of the procedure code would be billed on another claim line without the assistant modifier.”¹²

¹¹ CY 2019 PFS Final Rule p. 59659 <https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf>
Accessed August 15, 2019.

¹² CY 2019 PFS Final Rule p. 59659 <https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf>
Accessed August 15, 2019.

The agency clearly is contradicting itself now, several months later, in proposing to require that the CQ/CO modifier apply when the minutes furnished by the assistant are greater than 10% of the total minutes—the sum of the minutes spent by the therapist and therapist assistant for that service, thereby *not* allowing for the same procedure code to be reported on 2 different claim lines. This calls into question the soundness of the proposed policy. Further, the discrepancy between the two policies will create significant confusion among therapy practitioners, as well as Medicare beneficiaries, because APTA, as well as other stakeholders, have been educating professionals and the public based upon the discussion of the CQ/CO modifier policy in the 2019 PFS final rule.

Services delivered entirely by the therapist should be paid at 100% of the PFS, regardless of whether other units of the same code were performed by the therapist assistant. Therefore, we strongly recommend that CMS withdraw its proposed policy within the 2020 PFS proposed rule and remain consistent with its statements made in the 2019 PFS rule, that is, that time-based codes may be billed on separate lines when a physical therapist and PTA are able to differentiate the amount of time/units delivered by each provider on the same day for the same beneficiary, thereby allowing the same code to be listed on two separate line items on the claim, one claim line with solely the GP/GO modifier and the next claim line with the GP/GO modifier and the CQ/CO modifier. **We urge CMS to recognize, as it did in the 2019 PFS final rule, that affixing the 2 different types of modifiers to the claim to differentiate the delivery of services is permitted under the policy.**¹³

CQ/CO Modifier Documentation Requirements

Proposed documentation requirements conflict with CMS’ Patients over Paperwork initiative

Within the proposed rule, CMS 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 that the outpatient therapy provider be required to add a statement in the medical record for *each* line of *every* claim to explain why this modifier was *used or not used*.**

APTA strongly opposes CMS’ proposal that beginning January 1, 2020, therapy providers will be required to explain in the treatment notes, via a short phrase or statement, the application or non-application of the CQ/CO modifier for each service furnished that day. The proposed documentation requirements associated with the new CQ/CO modifiers are extremely burdensome and conflict with the Administration’s “Patients over Paperwork Initiative.” If a provider has a mechanism to provide evidence whether a specific service was furnished *independently* by a therapist or an assistant, or was furnished “in part” by an assistant in sufficient detail to permit a medical record reviewer to determine whether the *de minimis* threshold was met, the provider should not also be required to separately document this information in a narrative note.

¹³ Refer to Appendix A of this comment letter to examine APTA’s responses to the agency’s clinical vignettes included in the proposed rule.

The increased burden to therapy providers to indicate in daily treatment notes that an assistant was or was not used runs contrary to CMS' efforts to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience, particularly at a time when provider frustration and burnout is at an all-time high and, beginning January 1, providers will be forced to comply with a complex and confusing new modifier system. Further, the Medicare Benefit Policy Manual (MBPM) Chapter 15 Section 220 already includes extensive documentation requirements, and Chapter 5 of the Medicare Claims Processing Manual Section 20.2 includes extensive detail 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."

With implementation of the therapist assistant modifier policy, providers will be forced to familiarize themselves with when and how to report another new modifier, creating an additional burden on an already over-burdened profession. The proposed policy also will force providers to develop an intricate tracking system to accurately track each minute of a therapist assistant's day, thereby imposing additional regulatory obstacles "that get in the way of providers spending time with patients."¹⁴ **Thus, APTA finds it wholly unbelievable that CMS is also proposing to adopt new documentation requirements to accompany application of the new modifiers. Not only are the proposed documentation requirements duplicative of what the agency already requires to be included in the documentation, but imposing such requirements is contradictory to CMS' Patients over Paperwork initiative—the agency's own internal process to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience.** This, in turn, conveys a sense that CMS is being vindictive towards outpatient therapy providers, creating a divisive environment for therapy providers enrolled in the Medicare program. **For these and the reasons discussed below, we strongly urge the agency not to adopt new documentation requirements.**

First, there is no statutory requirement that outpatient therapy providers explain in the documentation why a modifier was or was not applied for each code. Moreover, as stated above, there already exist significant requirements for documentation to support the billing, and CMS is "not proposing changes to these documentation requirements in this proposed rule" to minimize burden. As such, at a time when outpatient therapy providers are being forced to comply with a new coding requirement and attempting to grasp the convoluted modifier policy put forth by CMS, it is completely unjustified to impose a new documentation requirement on therapy providers that is wholly duplicative of current requirements.

In addition, it appears that CMS has ignored the fact that some outpatient therapy providers do not employ PTAs (or OTAs). Thus, requiring such providers to document solely the nonapplication of the CQ/CO modifier for each service only serves to further invoke provider frustration and stress, doing nothing to contribute to the delivery of high-quality, cost-effective care.

¹⁴ CMS Patients over Paperwork <https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/PatientsOverPaperwork.html> Accessed August 13, 2019.

Second, the *current* documentation requirements associated with supporting the number of 15-minute timed units billed on a claim for each treatment day are significant. As CMS acknowledges in the 2020 PFS proposed rule, providers are required to document the total timed-code treatment time in the medical record, and document each timed service in the treatment note, whether or not it is billed, because the unbilled timed service(s) can impact billing. The minutes that each service is furnished can be, but are not required to be, documented. CMS also requires that each untimed service be documented in the treatment note to support these services billed on the claim, and that the total treatment time for each treatment day be documented—including minutes spent providing services represented by the timed codes (the total timed-code treatment time) and the untimed codes.

Third, while we appreciate that CMS eliminated Functional Limitation Reporting in 2019, there are many other administrative burdens facing the physical therapy profession, as has been communicated in numerous comment letters to the agency, most recently APTA’s response to CMS’ request for information on ideas to reduce administrative burden. Therefore, we question why CMS would consider imposing new documentation requirements on therapists and therapist assistants when the agency has indicated its intention to reduce administrative burden, thus making providers question the agency’s authenticity in their efforts to put patients first.

Fourth, the proposed documentation requirements far exceed the requirements put forth by various Medicare administrative contractors (MACs) for other similar modifiers, such as the modifier that must be affixed to the claim when an assistant at surgery assists the physician. “An assistant at surgery is a physician who actively assists the physician in charge of a case in performing a surgical procedure.”¹⁵ “Procedures billed with the assistant-at-surgery physician modifiers -80, -81, -82, or the AS modifier for physician assistants, nurse practitioners and clinical nurse specialists, are subject to the assistant-at-surgery policy.”¹⁶ MACs merely require the operative note to clearly document the assistant surgeon’s role during the operative session. (Additionally, when the modifier is 82, documentation must include information relating to the unavailability of a qualified resident in this situation).

Fifth, as previously alluded to, the treatment notes and progress reports already include all of the requisite information a medical reviewer may need to ascertain whether a therapist assistant was involved in the delivery of care (and thus whether the modifier is appropriately affixed to the claim beginning in 2020). To that end, we disagree with the argument that the CQ/CO modifier policy explanation would in any way 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 use against providers to justify a technical denial despite the fact that the medical record may otherwise contain sufficient documentation to justify the use or non-use of the CQ/CO modifier.

Sixth, we are unaware of any requirement for physicians or physician assistants and nurse practitioners (PAs and NPs) to explain via a short statement 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

¹⁵ Medicare Claims Processing Manual Chapter 12 Section 100.1.7 <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf> Accessed August 13, 2019.

¹⁶ *Id.* at Section 20.4.3.

delivered to each patient in a day. Moreover, CMS has not provided any justification or rationale as to why within the 2020 PFS proposed rule the agency is proposing to add new flexibilities for medical record documentation requirements for professional services furnished by physicians, PAs, and APRNs in all settings while in the same proposed rule imposing new documentation requirements on outpatient therapy providers. It is seemingly another arbitrary decision designed to punish outpatient therapy providers.

APTA also strongly opposes any requirement that time for individual services be documented in the treatment note. Again, due to the burden it would impose on providers and the unnecessary nature of such documentation—on top of the fact that CMS already requires the total timed code treatment minutes and total treatment time documented in the record—such requirement would only further fatigue outpatient therapy providers. **Rather, we recommend that CMS instruct its contractors to better follow the documented time guidelines outlined in MBPM Chapter 15 Section 220.3.** This would result in fewer claim denials, thereby reducing the number of appeals plaguing the Medicare appeals system.

The ongoing onslaught of unjustifiable, overwhelmingly burdensome policies being imposed on therapy providers that are unrelated to improving patient care are unfortunately compelling a greater number of therapy providers to choose not to treat Medicare beneficiaries. We fear that this will only exacerbate the already growing problem of limited access to therapy providers. In conclusion, the documentation requirements proposal serves no meaningful purpose and will take time away from direct patient care. **Given that the documentation requirements policy fails to effectively align with the goal of delivering high-quality, value-based care within a patient-centered health care delivery system, we strongly recommend that CMS not finalize this proposal.** We also suggest that in the future CMS afford greater consideration to how its proposals may **negatively** impact the ability of providers to deliver care.

Determining whether the 10% *de minimis* standard is exceeded

Within the rule, CMS puts forth 2 methods by which a provider may determine whether the 10% *de minimis* standard is exceeded. While we appreciate CMS' clarification regarding how to determine whether the 10% standard is exceeded—which would require the provider to round up to the whole number and add 1 minute, we question CMS' judgment when putting forward these proposed methods in rulemaking. Point blank: There is nothing simple about it. **It is outrageous that CMS expects therapy providers—particularly those who do not employ administrative staff and must perform all the coding and billing themselves in addition to treating patients—to engage in division, addition, multiplication, and rounding merely to determine whether to affix a modifier to the claim.**

APTA **implores** CMS to recognize the significant complexities associated with the proposed application of the 10% standard, as illustrated in this example: “For example, the CQ/CO modifiers would apply when either (1) the PTA/OTA concurrently furnishes 2 minutes of a total 8-minute service by the therapist furnishing paraffin bath treatment (HCPCS code 97018) because 2 minutes is greater than 10 percent of 8 minutes (0.8 minute, or 1 minute after rounding); or (2) the PTA/OTA furnishes 3 minutes of the service separately from the therapist who furnishes 5 minutes of treatment for a total time of 8 minutes (total time equals the sum of

the PT/OT minutes plus the separate PTA/OTA minutes) because 3 minutes is greater than 10 percent of 8 total minutes (0.8 minute rounded to 1 minute).”¹⁷ It is unrealistic for CMS to expect outpatient therapy providers to adapt to such a convoluted policy.

Moving forward, we encourage CMS to afford more consideration to how its proposals may detract therapy providers from delivering high-quality care to patients and, in fact, may accelerate provider burnout, prompting more outpatient therapy providers to leave the Medicare program and/or choose not to enroll as a participating or nonparticipating provider.

Impact of Policy on Rural and Underserved Areas

Access to health care services is critical to good health, yet Medicare beneficiaries, particularly who reside in rural areas, face a variety of access barriers. Access to physical therapy services in rural, medically underserved, and health professional shortage areas often depends on the availability of physical therapists and PTAs. Payment decisions that limit the provision of services by PTAs are even more detrimental in rural health care. Physical therapists and PTAs often work as a team to ensure early and uninterrupted access to care. A physical therapist evaluates the patient, develops the plan of care and treatment goals in collaboration with the patient and family, and may engage a PTA to deliver some of the necessary interventions. This team approach is even more critical in rural areas, where a physical therapist may need to cover a larger geography. Working together with a PTA, the physical therapist can ensure that the patient’s care is not interrupted when the physical therapist needs to evaluate and/or update the plan of care for a patient in another location.

Unfortunately, the 15% Medicare PFS payment reduction for services furnished “in whole or in part” by the PTA will have a detrimental impact on the ability of rural physical therapy providers to continue to deliver care. The payment reduction coupled with application of the geographic indices will unfairly penalize providers in rural, medically underserved, and health professional shortage areas. **Moreover, the 15% reduction will be on top of payment reductions in rural areas resulting from the fee schedule’s geographic indices in addition to the reduction imposed as a result of the multiple procedure payment reduction (MPPR), which reduces the practice expense RVUs for physical therapist services.** Access to medical care is already dwindling in rural localities. Physical therapists and their assistants play a crucial role in bridging these gaps in access to care. But the therapist assistant payment reduction puts the financial viability of rural physical therapy practices at risk. Absent action by CMS, the therapist assistant payment reduction will exacerbate the growing problem of limited access to medical care throughout much of rural America.

Therefore, APTA strongly recommends that CMS use its requisite authority to mitigate the harm on patients in rural and underserved communities that would otherwise result from the 15% reduction for physical and occupational therapy services furnished in whole or part by PTAs and OTAs, which is scheduled to take effect in 2022, through 1 of 2 mechanisms:

¹⁷ CY 2020 PFS proposed rule 40561 <https://www.govinfo.gov/content/pkg/FR-2019-08-14/pdf/2019-16041.pdf>

1. **Create a class-specific geographic index for physical and occupational therapy services furnished by PTAs and OTAs to offset the payment reduction in rural areas.**
2. **Establish incentive payments for RVU data collected from rural physical and occupational therapists to offset the PTA and OTA payment reduction in rural areas.**

Interaction Between Therapist Assistant Payment Differential and Other Medicare Payment Policies

APTA has serious concerns that reconciliation of the modifier and payment differential policy with other Medicare payment policies will create serious confusion among providers and patients. We seek clarification from CMS regarding how the 15% reimbursement cut will be impacted by other Medicare payment policies. For example, how will the MPPR be applied; is the 15% reduced from the fee schedule amount prior or subsequent to application of the MPPR? How will this policy impact calculation of the RVU? We also request clarification on how the beneficiary coinsurance will be calculated if the service is wholly or partially furnished by the therapist assistant, as well as how the proposed new modifier and differential policy will interact with the National Correct Coding Initiative edits, sequestration, the KX modifier exceptions process permanently extended by BBA, and the 59 modifier, as well as any other applicable modifiers.

Conclusion

APTA thanks CMS for the opportunity to provide comments on the CQ/CO modifier policy included within the 2020 PFS Proposed Rule. We look forward to working with the agency in revising the proposed policy in this rule prior to its finalization to ensure that Medicare beneficiaries continue to have access to medically necessary physical therapy services in the outpatient setting. Should you have any questions regarding our comments, please contact Kara Gainer, director of regulatory affairs, at karagainer@apta.org or 703/706-8547. Thank you for your consideration.

Sincerely,



Sharon L. Dunn, PT, PhD
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy
President

Appendix A

APTA response to CMS clinical vignettes:

Scenario 1: Where only one service, described by a single HCPCS code defined in 15-minute increments, is furnished in a treatment day:

1. The PT/OT and PTA/OTA each separately, that is individually and exclusively, furnish minutes of the same therapeutic exercise service (HCPCS code 97110) in different time frames: the PT/OT furnishes 7 minutes and the PTA furnishes 7 minutes for a total of 14 minutes, one unit can be billed using the total time minute range of at least 8 minutes and up to 22 minutes.

Billing Example: One 15-minute unit of HCPCS code 97110 is reported on the claim with the CQ/CO modifier to signal that the time of the service furnished by the PTA/OTA (7 minutes) exceeded 10 percent of the 14-minute total service time (1.4 minutes rounded to 1 minute, so the modifier would apply if the PTA/OTA had furnished 2 or more minutes of the service).

- **Disagree.** The time should be credited to the therapist, just as it is when two different services are performed (see vignette #3) and the total minutes of the codes qualify for billing 1 unit, as the PT/OT furnished that service independently of the PTA/OTA.

2. The PT/OT and PTA/OTA each separately, exclusive of the other, furnish minutes of the same therapeutic exercise service (HCPCS code 97110) in different time frames: The PT/OT furnishes 20 minutes and the PTA/OTA furnishes 25 minutes for a total of 45 minutes, three units can be billed using the total time minute range of at least 38 minutes and up to 52 minutes.

Billing Example: All three units of CPT code 97110 are reported on the claim with the corresponding CQ/CO modifier because the 25 minutes furnished by the PTA/OTA exceeds 10 percent of the 45-minute total service time (4.5 minutes rounded to 5 minutes, so the modifier would apply if the PTA/OTA had furnished 6 or more minutes of the service).

- **Disagree.** One unit of 97110 should be billed without the CQ/CO modifier, as the therapist wholly furnished 1 unit of 97110. Two units should be billed with CQ/CO modifier, as the therapist assistant wholly furnished 2 units of 97110.

3. The PTA/OTA works concurrently with the respective PT/OT as a team to furnish the same neuromuscular reeducation service (HCPCS code 97112) for a 30-minute session, resulting in 2 billable units of the service (at least 23 minutes and up to 37 minutes).

Billing Example: Both units of HCPCS code 97112 are reported with the appropriate CQ or CO modifier because the service time furnished by the PTA/OTA (30 minutes) exceeded 10 percent of the 30-minute total service time (3 minutes, so the modifier would apply if the PTA/OTA had furnished 4 or more minutes of the service).

- **Disagree.**
 - 97112: The therapist wholly furnished 2 units 97112 and is assisted by the therapist assistant. The therapist assistant's time is irrelevant. No modifier affixed to claim.

Scenario 2: When services that are represented by different procedure codes are furnished. Follow our current policy to identify the procedure codes to bill and the units to bill for the service(s) provided for the most time. CMS proposes that when the PT/OT and the PTA/OTA each independently furnish a service defined by a different procedure code for the same number of minutes, for example 10 minutes, for a total time of 20 minutes, qualifying for 1 unit to be billed (at least 8 minutes up to 23 minutes), the code for the service furnished by the PT/OT is selected to break the tie – one unit of that service would be billed without the CQ/CO modifier.

1. When only one unit of a service can be billed (requires a minimum of 8 minutes but less than 23 minutes):

(a) The PT/OT independently furnishes 15 minutes of manual therapy (HCPCS code 97140) and the PTA/OTA independently furnishes 7 minutes of therapeutic exercise (HCPCS code 97110). One unit of HCPCS code 97140 can be billed (at least 8 minutes and up to 22 minutes).

Billing Example: One unit of HCPCS code 97140 is billed without the CQ/CO modifier because the PT/OT exclusively (without the PTA/OTA) furnished a full unit of a service defined by 15-minute time interval (current instructions require “1” unit to be reported). The 7 minutes of a different service delivered solely by the PTA/OTA do not result in a billable service. Both services, though, are documented in the medical record, noting which services were furnished by the PT/OT or PTA/OTA; and, the 7 minutes of HCPCS code 97110 would be included in the total minutes of timed codes that are considered when identifying the procedure codes and units of each that can be billed on the claim.

- **Agree.** 97140 is wholly furnished by the therapist. The 7 minutes of 97110 furnished by the therapist assistant are documented within the total treatment time.

(b) If instead, the PT/OT independently furnished 7 minutes of CPT code 97140 and the PTA/OTA independently furnished a full 15-minutes of CPT code 97110, one unit of CPT code 97110 is billed and the CQ/CO modifier is applied; the 7 minutes of the PT/OT service (CPT code 97140) do not result in billable service, but all the minutes are documented and included in the total minutes of the timed codes that are considered when identifying the procedure codes and units of each that can be billed on the claim.

- **Agree.** 97110 is wholly furnished by the therapist assistant and the modifier should be applied. The 7 minutes of 97140 furnished by the therapist are documented within the total treatment time.

(c) If the PT/OT and PTA/OTA each independently furnish an equal number of minutes of CPT codes 97140 and 97110, respectively, that is less than the full 15-minute mark, and the total minutes of the timed codes qualify for billing one unit of a service, the code furnished by the PT/OT would be selected to break the tie and billed without a CQ/CO modifier because the PT/OT furnished that service independently of the PTA/OTA.

- **Agree.** The time should be credited to the therapist, just as it is when one service is performed and the total minutes of the codes qualify for billing 1 unit, as the PT/OT furnished that service independently of the PTA/OTA.

(d) If instead, the PT/OT furnishes an 8-minute service (CPT code 97140) and the PTA/OTA delivers a 13-minute service (CPT code 97110), one unit of the 13-minute PTA/OTA-delivered service (CPT code 97110) would be billed consistent with our current policy to bill the service with the greater time; and the service would be billed with a CQ/CO modifier because the PTA/OTA furnished the service independently.

- **Agree.**

2. When two or more units can be billed (requires a minimum of 23 minutes), follow current instructions for billing procedure codes and units for each timed code.

(a) The PT/OT furnishes 20 minutes of neuromuscular reeducation (CPT code 97112) and the PTA/OTA furnishes 8 minutes of therapeutic exercise (CPT code 97110) for a total of 28 minutes, which permits two units of the timed codes to be billed (at least 23 minutes and up to 37 minutes). **Billing Example:** Following our usual process for billing for the procedure codes and units based on services furnished with the most minutes, one unit of each procedure code would be billed – one unit of CPT code 97112 is billed without a CQ/CO modifier and one unit of CPT code 97110 is billed with a CQ/CO modifier. This is because, under our current policy, the two billable units of timed codes are allocated among procedure codes by assigning the first 15 minutes of service to code 97112 (the code with the highest number of minutes), which leaves another 13 minutes of timed services: 5 minutes of code 97112 (20 minus 15) and 8 minutes of code 97110. Since the 8 minutes of code 97110 is greater than the remaining 5 minutes of code 97112, the second billable unit of service would be assigned to 97110. The CQ/CO modifier would not apply to CPT code 97112 because the therapist furnished all minutes of that service independently. The CQ/CO modifier would apply to CPT code 97110 because the PTA/OTA furnished all minutes of that service independently.

- **Agree.**

(b) The PT/OT furnishes 32 minutes of neuromuscular reeducation (CPT code 97112), the PT/OT and the PTA/OTA each separately furnish 12 minutes and 14 minutes, respectively, of therapeutic exercise (CPT code 97110) for a total of 26 minutes, and the PTA/OTA independently furnishes 12 minutes of self-care (CPT code 97535) for a total of 70 minutes of timed code services, permitting five units to be billed (68 – 82 minutes). Under our current policy, the five billable units would be assigned as follows: two units to CPT code 97112, two units to CPT code 97110, and one unit to CPT code 97535. **Billing Example:** The two units of CPT code 97112 would be billed without a CQ/CO modifier because all 32 minutes of that service were furnished independently by the PT/OT. The two units of CPT code 97110 would be billed with the CQ/CO modifier because the PTA/OTA's 14 minutes of the service are greater than 10 percent of the 26 total minutes of the service (2.6 minutes which is rounded to 3 minutes, so the modifiers would apply if the PTA/OTA furnished 4 or more minutes of the service), and the one unit of CPT code 97535 would be billed with a CQ/CO modifier because the PTA/OTA independently furnished all minutes of that service.

- **Partially agree.**
 - 2 units of 97112: No CQ/CO modifier. (Correct)
 - 2 units of 97110: Here, 97110 was separately delivered by the therapist and assistant. According to CMS' statements in the 2019 PFS final rule, CMS should allow 1 unit

of 97110 to be billed with the CQ/CO modifier and 1 unit to be billed without the modifier, as the therapist wholly furnished 1 unit of 97110 and the assistant wholly furnished 1 unit of 97110. Hence, split billing should be permitted, in accordance with CMS' previous statements and guidance.

- 1 unit of 97535: CQ/CO modifier applied because the assistant wholly furnished the service. (Correct)

(c) The PT/OT independently furnishes 12 minutes of neuromuscular reeducation activities (CPT code 97112) and the PTA/OTA independently furnishes 8 minutes of self-care activities (CPT code 97535) and 7 minutes of therapeutic exercise (CPT code 97110) – the total treatment time of 27 minutes allows for two units of service to be billed (at least 23 minutes and up to 37 minutes). Under our current policy, the two billable units would be assigned as follows: one unit of CPT code 97112 and one unit of CPT code 97535. **Billing Example:** The one unit of HCPCS code 97112 would be billed without the CQ/CO modifier because it was furnished independently by the PT/OT; and, the one unit of CPT code 97535 is billed with the CQ/CO modifier because it was independently furnished by the PTA/OTA. In this example, CPT code 97110 is not billable; however, the minutes for all three codes are documented and counted toward the total time of the timed code services furnished to the patient on the date of service.

- **Agree**

- 1 unit of 97112: No modifier because therapist wholly furnished this service.
- 1 unit of 97535: CQ/CO modifier applied because assistant wholly furnished the service.
- 97110: The 7 minutes of 97110 are documented in the total treatment time

(d) The PT/OT furnishes 15 minutes of each of two services described by CPT codes 97112 and 97535, and is assisted by the PTA/OTA who furnishes 3 minutes of each service concurrently with the PT/OT. The total time of 30 minutes allows two 15-minute units to be billed – one unit each of CPT code 97112 and CPT code 97535. **Billing Example:** Both CPT codes 97112 and 97535 are billed with the applicable CQ/CO modifier because the time the PTA/OTA spent assisting the PT/OT for each service exceeds 10 percent of the 15-minute total time for each service (1.5 minutes which is rounded to 2 minutes, so that the modifiers apply if the PTA/OTA furnishes 3 or more minutes of the service).

- **Disagree.**

- 97112: The therapist wholly furnished 97112 and is assisted by the therapist assistant. The therapist assistant's time is irrelevant. No modifier.
- 97535: The therapist wholly furnished 97535 and is assisted by the therapist assistant. The therapist assistant's time is irrelevant. No modifier.