

SGR REFORM AND THERAPY CAP REPEAL

Legislative Principles of the American Physical Therapy Association, the American Occupational Therapy Association and the American Speech-Language-Hearing Association

Outpatient Therapy Services and SGR/MPFS Reform

Physical therapists, occupational therapists, and speech-language pathologists provide critical outpatient health care services to beneficiaries that enable individuals to remain in their homes and communities and function at their highest possible level. The Medicare Physician Fee Schedule (MPFS) is used in Medicare Part B claims to report outpatient therapy services, and we are therefore acutely aware of the threat of annual fee schedule reductions, the cost to repeal the flawed sustainable growth rate (SGR) formula, and its impact on beneficiaries' access to health care services. We support reform but firmly believe that efforts to repeal or reform the SGR should reflect the role of both physicians and non-physicians in outpatient Medicare services.

Our Associations collectively recommend that the following principles be considered for inclusion in SGR legislation:

Repeal of the Medicare Therapy Cap on January 1, 2014

Since the inception of the SGR and the therapy cap in 1997, annual extensions to fix both policies have moved together in the SGR/Medicare extenders package (for CY 2013, the therapy cap is \$1,900 for occupational therapy and \$1,900 for physical therapy and speech-language pathology, combined). The Associations believe it is imperative to provide a long-term solution to the therapy cap in any legislative effort to reform the SGR. Including therapy cap reform in the larger SGR package will ensure that Medicare beneficiaries will continue to have access to medically necessary therapy services. The therapy cap is uniquely problematic in that it is a statutory provision directly preventing Medicare beneficiaries from receiving covered services after an arbitrary, artificial dollar limit.

Alternative Payment and Coding System for Outpatient Therapy

Our Associations support movement to a per-session payment system no later than January 1, 2016. Physical therapy, occupational therapy, and speech-language pathology should be treated as separate and distinct services under any payment system or systems.

When the therapy cap was created in 1997, Congress charged the Centers for Medicare & Medicaid Services (CMS) to develop an alternative payment system for outpatient therapy. The therapy community is proposing to reform payment for outpatient physical therapy and occupational therapy services by transitioning from the current timed codes system to a per-session system. This type of coding and payment methodology better describes services furnished in a session, reflects the professional clinical reasoning and judgment of the therapist, and provides policymakers and payers with a more accurate payment system that ensures the integrity of medically necessary services. The therapy community is working through the American Medical Association's Current Procedural Terminology (CPT) and Relative Value Update Committee (RUC) process to recommend a new payment and coding system to CMS for Physical Medicine and Rehabilitation Codes (97000 series). Under the reform, payment for outpatient therapy would remain under the MPFS. CPT codes associated with the evaluation and treatment of speech-language pathology related conditions have been billed at per-session rates since the development of those codes. As such, the new payment and coding system under development would apply to physical therapy and occupational therapy.

Cost Saving Recommendations

Medical Review: A system of medical review for claims over a threshold amount of \$3,700 (\$3,700 for occupational therapy and \$3,700 for physical therapy and speech-language pathology, combined) was first instituted in 2012. Claims above this figure represent the top 5% of all outpatient therapy claims; this is the figure that the Associations proposed and that CMS implemented. Our Associations support a permanent policy of medical reviews of high utilization therapy claims once the therapy cap is repealed.

We recommend that this policy continue for claims exceeding \$3,700 for services in 2014, and be thereafter adjusted annually using the Medicare Economic Index (MEI). We are monitoring the medical reviews process but based on problems identified with the current iteration of the process, we would also recommend refinements to the current medical review process to ensure timely submission and review of claims, such as streamlining and simplifying forms, electronic submission and proof of receipt, the use of peer reviewers, and enforcement of the Congressionally-mandated 10 business day turnaround time for decisions. Making this policy permanent—as opposed to just a one-year policy—will provide CMS with added incentives to make the process more effective and efficient.

We view this medical review process as a cost saving alternative to the therapy cap that will ensure beneficiary access to medically necessary therapy services without requiring yearly extensions of the therapy cap exceptions process. While the current therapy cap exceptions process ensures access to therapy services, we believe a refined medical review process will better assure appropriate utilization in a manner that is effective and appropriate.

Focus on Outliers: We recommend that CMS focus medical and/or other discretionary reviews of therapy claims on outlier claims. Reviews should be targeted; focusing on certain high-cost geographic areas (as identified by MedPAC), particular providers, diagnoses, number of episodes per year, and other factors, rather than consist of blanket reviews that are burdensome to both CMS and to providers.

Quality Outcomes for Medicare Patients

Consistent with ongoing efforts to link payment to quality, therapists have worked with CMS and others to develop, implement, and report on quality measures, and the Associations continue to work internally to develop measures specific to each therapy discipline. In 2013, the therapy community began a new system of functional data collection coordinated by CMS that will provide us with additional information. We support continuation of this program with evidence-based refinements in order to collect more accurate information on patients and on the services they received.

Moratorium on the Multiple Procedure Payment Reduction

As part of the American Taxpayer Relief Act of 2012, Congress increased the multiple procedure payment reduction (MPPR) policy applied to outpatient therapy from 20% in private practice and 25% in facilities to 50% in all outpatient settings as of April 1, 2013. We remain concerned that this flawed policy will have a significant impact on therapy payment and patient care, even as the therapy community is actively working to move away from multiple procedure services in an alternative payment system. The increased MPPR of 50% will result in a 7% cut for outpatient therapy reimbursement. Coupled with the previous 7% reduction in payment from the original MPPR in 2011 and the 2% sequestration cut, the cumulative reductions of over 15% in two years equate to a considerable impact for therapy services which will ultimately impact patient access and care. We urge Congress to place a moratorium on the increase from 20/25% to 50% MPPR until implementation of a new coding and payment system.

In addition, the way in which the MPPR is applied across disciplines on a given treatment day is inappropriate. We request that Congress work to ensure that the MPPR is applied separately to the disciplines, as they are separate Medicare benefits and distinct services.