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June 2, 2014

The Honorable Kevin Brady
Chairman
Ways and Means Committee
Health Subcommittee
1135 Longworth House Office
Building
Washington, DC 20515

The Honorable Jim McDermott
Ranking Member
Ways and Means Committee
Health Subcommittee
1135 Longworth House Office
Building
Washington, DC 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of more than 88,000 physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) thanks you and the members of the House Ways and Means Health Subcommittee for the opportunity to participate in the dialogue regarding the two-midnight policy, outpatient observation stays, and audits and appeals under Medicare. APTA commends your efforts to address these issues and we appreciate the opportunity to provide feedback on the impact these issues have on patients needing physical therapy services.

The Two-Midnight Rule

While the intention of the two mid-night rule was to provide further guidance and clarify the Medicare hospital inpatient admission criteria, the unintended consequences of the two-midnight policy are steep for patients and providers alike.

The two-midnight policy presumes that a hospital inpatient admission is appropriate for a Medicare beneficiary who requires a hospital stay that spans at least two midnights. Thus, a hospital stay that is less than two midnights should be considered outpatient and billed under Medicare Part B, with limited exceptions. APTA believes that the decision to admit a patient for an inpatient stay should be made by the physician and interdisciplinary team, including the physical therapist, and solely based on the clinical condition of the patient. Setting an arbitrary two-midnight rule can be harmful to patients, particularly those who are short stay with acute illnesses.

Recovery audit contractors (RACs) have been responsible for reviewing inpatient claims to determine whether an inpatient admission was necessary. If the RAC determines an inpatient admission should be denied, qualifying services that would have been considered reasonable and necessary had the patient been treated as an outpatient, including physical therapy, can be rebilled under Medicare Part B. While this policy appears to provide some relief for hospitals, it can have a harmful impact on a patient's access to

physical therapy services. Physical therapy services that are rebilled as outpatient services are subject to the Medicare therapy caps, manual medical review at \$3,700, and functional limitation data reporting requirements. Since the vast majority of RAC denials do not occur until more than one year after a patient was treated, resubmitting outpatient therapy claims with the required functional limitation reporting data would be nearly impossible. Thus, rebilling under Part B is very difficult because inpatient billing requirements are not the same as the reporting requirements for outpatient therapy services.

Observation Status

Observation care is often provided in the same hospital beds as inpatient care but is considered outpatient care and thus billed under Part B instead of Part A. As the number of patients placed under observation status for more than 48 hours continues to grow, this impacts Medicare outpatient therapy utilization as well as the financial liability of the beneficiary and the provider. APTA encourages the Committee to set a timeframe for observation status of no more than 24 hours.

Due to the risk of denials when classifying patients for an inpatient stay, there are instances where a patient's entire stay in the hospital which can span as much as 16 days, is classified as "observation" and therefore considered an outpatient stay. When a Medicare patient is placed on observation status, any physical therapy services received during this period count towards the Medicare therapy caps. Therefore, all of the physical therapy services received during this period are counted toward the \$1,920 therapy cap. Billing these services as outpatient therapy will limit patient access to physical therapy.

Observation status also has an impact on a patient's ability to enter skilled nursing facilities (SNFs) for a covered stay. In order to be eligible under Medicare Part A for the SNF benefit, a patient must have a qualifying 3-day hospital stay. Often times, SNFs find that a patient placed on observation status did not meet this requirement for SNF coverage. It is possible for therapy services in the SNF to be covered under the Part B program. However, the Medicare beneficiaries would then be responsible for the additional cost of coinsurance, leaving them vulnerable to higher out-of-pocket charges. This issue also affects home health agencies. Increasing the length of the observation period creates an administrative burden for post-acute care providers to comply with quality measurement programs relating to the prevalence of hospital readmissions for their patient population and other regulatory requirements such as functional reassessments in the home health setting.

Recovery Audit Contractors (RACs)

In addition to reviewing hospital billing claims, the RACs also manually review outpatient physical therapy services that exceed \$3,700. Since implementation of the RAC review process, problems have persisted with the manual medical review process. The most common issues providers experience include: lost documentation, no process for confirming receipt of claims, non-compliance with the 10-day review period, lack of an electronic submission process, and inaccurate denials.

Furthermore, physical therapy providers are also subject to the same appeals process as the hospitals for claims that are denied by the RACs. Thus, providers who appeal denials for claims over \$3,700 would go before an administrative law judge (ALJ) at the third level of appeal. As noted in the OMHA hearing on February 12, 2014, the backlog for hearing appeals at the ALJ level is significant and it can take several years before providers have an opportunity to have their appeal heard.

In order to address these issues, APTA believes that there needs to be standardization of the policies and procedures used by RACs to process manual medical review claims and a better opportunity to participate in “discussion” periods with the RACs before denials. This would allow providers to better prepare claims, and hopefully cut down on the backlog at the ALJ level. Additionally, as CMS is preparing to sign new contracts with the RACs in 2014, we encourage Congress to assist CMS in making this transition as smooth as possible in order to prevent further delays with claims processing.

APTA appreciates your work not only to address the above issues, but your continued efforts to reform the sustainable growth rate formula, the Medicare therapy caps, and the manual medical review process. We hope to work with you to find an appropriate solution to address the two-midnight policy, outpatient observation stays, and audits and appeals under Medicare. If the Subcommittee has questions or needs additional resources, please contact Mandy Frohlich, Senior Director of Government Affairs at mandyfrohlich@apta.org or 703-706-8548.

Sincerely,



Paul A. Rockar, Jr, PT, DPT, MS
President

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