ATHLETICO
PHYSICAL THERAPY

September 2, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-1770-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies (the "Proposed Rule")

Dear Administrator Brooks-LaSure:

Athletico Physical Therapy ("Athletico") is submitting these comments on the following topics: 1) proposed supervision requirements for physical therapy ("PT") and occupational therapy ("OT") services in outpatient settings; 2) the coding, billing, and valuation changes to Remote Therapeutic Monitoring services (Codes 98980/GRTM3 and 98981/GRTM4); 4) potentially underutilized services, and 3) the need to clarify that physical and occupational care providers are "qualified health professionals" for purposes of the new HCPCS codes GYYY1 and GYYY2.

Athletico is uniquely positioned to comment on this Proposed Rule. Athletico currently operates over 930 clinics across 25 states and Washington D.C., representing over 8,000 employees who help provide over 5 million patient visits annually. Our patients report a 98% satisfaction rating and our talented healthcare professionals help our patients achieve clinical outcomes that are among the industry's best. For example, in 2021 Athletico was recognized as top-tier provider for the 2021 MIPS reporting period as Athletico therapists achieved the highest possible scores in the Exceptional Performance Category across our network.

At the outset of this comment letter we offer one important observation: Your proposals, as currently drafted, will directly and adversely impact our health care professionals and their patients. We have intentionally tried to be constructive with the changes suggested herein. These changes will greatly improve the outcomes of the care we provide <u>without increasing the cost of that care to the Medicare and Medicaid programs</u>.

I. A Brief Summary of How Prior CMS Reimbursement Policies Have Impacted PT and OT Services

Here is a remarkable fact: over the last 11 years, despite inflation increasing at 31.81%, health care inflation increasing by 35.38% and PT and OT services being the health care profession most adversely affected by the COVID-19 public health emergency ("PHE"),[1] CMS has cut reimbursement for our services by approximately 18%.

[1] See Kurt Gillis, Policy Research Perspectives: Changes in Medicare Physician Spending During the COVID-19 Pandemic available at https://www.ama-assn.org/system/files/2021-03/prp-covid-19-medicare-physician-

Recent Medicare Part B Outpatient Therapy Reimbursement Cuts	
2011 MPPR Cut	**20%** cut to every practice expense RVUs of "always" therapy code billed after the first "always therapy code.
2013 MPPR Cut	**50%** cut to every practice expense RVUs of "always" therapy code billed after the first "always therapy code.
2018 National Correct Coding Initiative	**5.5%** cut to CPT 97110 (therapeutic exercises) reimbursement; AND **7.1%** cut to CPT 97140 (manual therapy) reimbursement
2018 Physician Fee Schedule Cuts	**2%** cut to therapy services
2019 Physician Fee Schedule Cuts	**1%** cut to therapy services
2021 Physician Fee Schedule Cuts	**9%** cut to therapy services before Congressional intervention mitigated to **3.6%** cut.
2022 PTA Differential	**15%** cut to services provided by PTA/OTA
2022 Proposed Physician Fee Schedule Cuts	**3.5%** cut to therapy services before Congressional intervention mitigated to **1.2%** cut.
2023 Proposed Physician Fee Schedule Cuts	**1%** cut to therapy services
Medicare Sequestration	**2%** cut to therapy services
Total Combined Impact All Cuts[2]	**18%** estimated cut to therapy services

These cuts have all occurred at the same time that four separate, independent reports were issued by government entities, including HHS itself, saying that reimbursement cuts to PT and OT services are limiting access to care in ways that are contributing to the significant rise in the nation's opioid epidemic.[3] The first such report issued by The President's Commission on Combatting Drug Addiction and the Opioid Crisis found that "a broader range of pain management and treatment services – including…physical therapy…should be adequately reimbursed by payers, including CMS."[4] The Pain Management Best Practices Inter-Agency Task Force Report recognized that multimodal, non-opioid therapies like physical therapy are underutilized in the perioperative and MSK injury settings.[5] In light of this underutilization, two other major federal reports have recognized that incomplete or inconsistent reimbursement policies serve as a barrier to patients being able to access non-opioid alternatives like physical therapy.[6] To remove these barriers, the Commission on Combatting Synthetic Opioid Trafficking recommended increasing

spending.pdf (There was a 34% reduction in Medicare Physician Fee Schedule spending for physical therapists – the most severely impacted specialty under the Medicare Part B program. See Ex. 5, The cumulative reduction in MPFS spending by provider specialty).

[2] This combined impact does not account for the 2018 NCCI edits that are specific to two CPT codes and therefore difficult to estimate the total impact across the profession or Athletico's platform.

[3] See, The President's Commission on Combatting Drug Addiction and the Opioid Crisis (November 1, 2017); Strategy to Combat Opioid Abuse, Misuse, and Overdose (October 2018); Pain Management Best Practices Inter-Agency Task Force Report (May 9, 2019); and Commission on Combatting Synthetic Opioid Trafficking (February 2022)

[4] The President's Commission on Combatting Drug Addiction and the Opioid Crisis (November 1, 2017); Strategy to Combat Opioid Abuse, Misuse, and Overdose (October 2018)

[5] Pain Management Best Practices Inter-Agency Task Force Report (May 9, 2019)

[6] Id

provider reimbursement for prescribing opioid alternatives to reduce the reliance on prescription opioids.[7] However, in every year since these reports have been released, CMS has reduced reimbursement for physical therapy services, which has led to continued underutilization of physical therapy services at a time when America's opioid epidemic is growing at alarming rates. Fortunately, CMS's Proposed Rule contains provisions that could, with appropriate changes, facilitate increased access to physical therapy services as a safe and effective non-opioid alternative to the treatment and management of chronic pain. In addition to opioids, reducing access to PT and OT services is also associated with increased falls and fatalities among the elderly,[8] increased emergency room visits,[9] increased utilization of expensive imaging services and surgeries.[10]

II. CMS should align PT and OT supervision requirements in outpatient settings to state law.

42 C.F.R. § 410.60(a)(3)((ii) requires that outpatient physical therapy services that are provided by a physical therapist assistant ("PTA") in private practice be provided under the direct supervision of a physical therapist ("PT"). A similar requirement exists for occupational therapy assistants ("OTA") in private practice at 42 C.F.R. § 410.59(a)(3)((ii). As noted in the Proposed Rule, the March 31, 2020, COVID-19 IFC changed the definition of "direct supervision" during the PHE to allow the supervising professional (the PT or OT, for example) to be immediately available through virtual presence using real-time audio/video technology (the "Temporary Exception"), instead of requiring their physical presence. The CY 2021 PFS final rule finalized the continuation of the Temporary Exception through the end of the calendar year in which the PHE ends. For the 2023 PFS final rule, however, CMS should take a much simpler and easier to administer approach: align the supervision of PTAs and OTAs in private practice to state law.

CMS adopted the current direct supervision requirement for physical and occupational therapists in private practice ("TPP") in 2004.[11] When adopting this policy, CMS consulted a report by the Urban Institute that found that eight jurisdictions (seven states and Washington DC) had supervision requirements that were as stringent as CMS's direct supervision requirement.[12] Furthermore, in 2004,

[7] Commission on Combatting Synthetic Opioid Trafficking (February 2022)
[8] See Reducing the Risk of Falling and Injuries From Falls: Research on the Value of Physical Therapy available at https://www.apta.org/contentassets/2447f36979594707914bd74185e0b597/apta-handout-falls-research.pdf
[9] Preventing Hospital Readmissions: Research on the Value of Physical Therapy, American Physical Therapy Association, available at https://www.apta.org/contentassets/5e1b77e5cbf5422bb4574a119ed0d30f/apta-hospital-readmission-handout-10-20-2020.pdf
[10] See, for example, Heidi A. Ojha, Rachel S. Snyder, and Todd E. Davenport, Direct Access Compared With Referred Physical Therapy Episodes of Care: A Systematic Review, 94 Physical Therapy 14 (2014)
[11] 69 FR 66355; Bianca K. Frogner, Kenneth Harwood, C. Holly A. Andrilla, Malaika Schwartz, and Jesse M. Pines, Physical Therapy as the First Point of Care to Treat Low Back Pain: An Instrumental Variables Approach to Estimate Impact on Opioid Prescription, Health Care Utilization, and Costs, 53 Health Services Research 4629, 4638 (2018); Brigid Garrity, Christine McDonough, Omid Ameli, James Rothendler, Kathleen Carey, Howard Cabral, Michael Stein, Robert Saper, Lewis E Kazis, Unrestricted Direct Access to Physical Therapist Services Is Associated With Lower Health Care Utilization and Costs in Patients With New-Onset Low Back Pain, 100 Physical Therapy 107 (2020); Elizabeth Arnold, Janna La Barrie, Lisley DaSilva, Meagan Patti, Adam Goode, and Derek Clewley, The Effect of Timing of Physical Therapy for Acute Low Back Pain on Health Services Utilization: A Systematic Review, 100 Archives of Physical Medicine and Rehabilitation 1324, 1331-33; Daniel I Rhon, Suzanne J Snodgrass, Joshua A Cleland, Tina A Greenlee, Charles D Sissel, and Chad E Cook, Comparison of Downstream Health Care Utilization, Costs, and Long-Term Opioid Use: Physical Therapist Management Versus Opioid Therapy Management After Arthroscopic Hip Surgery, 95 Physical Therapy 348
[12] Maxwell, Stephanie, Cristina Boccuti, and Kathryn Tong. "Supervision of Physical Therapist Assistants: Analysis of State Regulations." Washington, DC: The Urban Institute (2002)

PTAs and OTAs were not licensed in every state, which meant that some states did not have administrative mechanisms for censuring or revoking the license of a PTA.[13] However, today, only one state has a supervision requirement as stringent as Medicare for PTAs in private practice ("PTAPP"), while 49 states have supervision requirements that are less than Medicare's requirements for PTAPPs.[14] Furthermore, PTAs are licensed or certified in all 50 states and Washington DC.[15] This means that every jurisdiction in America now has a process to censure or revoke the license of a PTA. Much has changed since CMS last changed the supervision requirements for TPPs, and permanently allowing general supervision of TPPs would go a long way to updating CMS's regulations to reflect modern practice capabilities of TPP professionals.

Aligning Medicare supervision requirements to state law would have tremendous benefits to Medicare beneficiaries because it would significantly increase access for Medicare beneficiaries to therapy professionals. Under CMS's current rules, a TPP must be present in the office suite and immediately available to furnish assistance and direction whenever a PTA or OTA is providing services to a Medicare beneficiary. This requirement significantly reduces the number of potential appointment times that a Medicare beneficiary may choose from when they need of care. For example, in many Athletico clinics, we employ one PT and/or OT in a clinic. Due to CMS's supervision rules, if that PT/OT is not physically present in the clinic, then a PTA/OTA cannot be treating Medicare beneficiaries. This limits the PTA/OTA's ability to treat Medicare beneficiaries to the 40 hours per week that the PT/OT is in the clinic; eliminating the ability to offer additional appointment times in the evenings and/or weekends. The inability to offer additional treatment times leads to delays in care that adversely affect a beneficiary's care. Permanently aligning supervision to state law is increasingly important due to rising levels of clinician burnout[16] and increasingly severe workforce shortages, especially in rural and underserved areas. According to a report from HHS Assistant Secretary for Planning and Evaluation health care worker shortages are expected to

[13] Id.

[14] See: AL Admin. Code §700-X-3-.03 (3)(b); AK Admin. Code 12 AAC 54.510 (e); AZ Revised Statutes 32-2043 (B); AR Admin. Rule IX; CA 16 CCR § 1398.44; CA 16 CCR § 1398.44; CT Gen. Statues Title 20 Chapter 376 § 20-66 (3); DE Admin. Code Title 24 Chapter 2600 Rule 1.2.2 and 1.2.3; FL Admin. Code 64B17-6.001; GA Rule 490-5-.01; GA Rule 490-5-.01; ID Admin. Code IDAPA 24.13.01.016.02; IL Compiled Statutes 225 ILCS 90 Sec 2 (7); IN Admin. Code 844 IAC 6-1-2 (g); IA Admin. Code 645.200.6(1); KS Admin. Regulations 100-29-16 (2)(b); KY Admin. Regulations 201 KAR 22:053 Section 4; LA Admin. Code Title 46 Part LIV § 333 (B)(2)(d); ME Rule 02-393 CMR Chapter 4; MD Regulations COMAR 10.38.01 (B)(12); MA Reg 259 CMR § 5.02 (3)(c); MI Admin. Code R 338.7138 (2); MN Statutes § 148.65 Subdivision 3; MS Admin. Code Part 3103 Chapter 8 Rule 8.2 (1)(e); MO Regs 20 CSR 2150-3.090 (3)(D); MT Code 37-11-105 (1); NE Admin. Code 172 NAC 137-006.01; NV Admin Code NAC 640.592 (1)(c); NH Statutes § 328-A:11 (IV); NJ Statutes § 45:9-37.13; NM Admin. Code 16.20.6.8 (D); NC Admin. Code 21 NCAC 48C.0201; ND Admin. Code 61.5-05-01-02; OH Admin. Code 4755-27-04 (C)(2); OK Admin. Code Rule 435:20-7-1 (a)(2)(A); OK Admin. Code Rule 435:20-7-1 (a)(2)(A); PA Rule 49 Pa Code § 40.173; RI Code of Regs 216-RICR-40-05-13.4.7 (A)(2); SC 1976 Code § 40-45-300 (B); SD Codified Law 36-10-35.9 (1); TN Rule 1150-01-.02 (2)(a); TX Admin. Code 22 TAC § 322.3; UT Statute 58-24b-401 (2)(a)(i); VT Code of Rules CVR 04-030-240 § 3.4 (a); VA Admin. Code 18 VAC 112-20-90 (D); WA Admin. Code 246-915-181 (5)(a); WV Admin. Rule § 16-1-8 8.2; WI Admin. Code Rule PT 5.01 (2)(c); and WY Regs Chapter 7 Sect 5 (a)(ii).

[15] https://www.apta.org/your-practice/licensure/pt-and-pta-licensure

[16] See Ries, Eric. "Beating Burnout." APTA, February 1, 2019. https://www.apta.org/apta-magazine/2019/02/01/beating-burnout (noting that often "PTAs are treated like glorified techs and made to feel that their input isn't welcome. That is a recipe for demoralization and burnout." Because PTAs have the capabilities and training to work under general supervision, CMS's direct supervision requirement prohibits PTAs from practicing at the top of their training. By adopting the Temporary Exception, CMS would be fully recognizing PTAs capabilities and empowering PTAs to help Medicare beneficiaries, which can help reduce demoralization and burnout within the profession.)

persist after the pandemic.[17] Therefore, allowing for permanent flexibility for the supervision of PTAs and OTAs can help the therapy industry maintain adequate levels of staffing to provide services for Medicare beneficiaries.

When CMS changed the supervision standard for TPPs to direct supervision, it noted that "changing the level of supervision of therapy assistants from personal to direct will help improve access to medically necessary services."[18] Similarly, our proposed change would allow PTAs/OTAs to provide treatment to Medicare beneficiaries at times when a PT/OT is not physically able to be in the clinic, thereby improving timely access to medically necessary services for Medicare beneficiaries.

a) Timely access to physical therapy has been proven to improve outcomes and reduce healthcare costs for patients.[19]

Furthermore, this change does not have any financial cost to the Medicare program; in fact, it is likely to create cost savings. In the only study that has examined the effects of jurisdiction supervision requirements on therapy utilization, it was found that "[s]tate requirements for full-time onsite supervision of the PTA were associated with 3.1 more visits" during the treatment episode.[20] The authors of the study speculated that patients require fewer visits in jurisdictions with less stringent supervision rules because the added flexibility helped to avoid disruptions in a patient's plan of care. Athletico's internal data supports this finding. While most clinics operated by Athletico are private practice providers, we also operate several rehab agencies that provide outpatient physical therapy services. In these rehab agencies, PTAs and OTAs can provide therapy services to Medicare beneficiaries under general supervision. Our internal data revealed that these clinics have a utilization of three fewer visits per episode of care compared to our private practice clinics, despite being operated in the same way.

Finally, making this change poses no risk to patient safety. First, the regulation and licensing of medical professionals to protect the public health and safety is a task reserved to states by virtue of their police powers.[21] As such, state regulators are well equipped to analyze the appropriate supervision levels

[17] Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce, Assistant Secretary for Planning and Evaluation Office of Health Policy, Issue Brief (May 3, 2022)
[18] 69 FR 66355
[19] See, for example: The Moran Company. Initial treatment intervention and average total Medicare A/B costs for FFS beneficiaries with an incident low back pain (lumbago) diagnosis in CY 2014; Bianca K. Frogner, Kenneth Harwood, C. Holly A. Andrilla, Malaika Schwartz, and Jesse M. Pines, Physical Therapy as the First Point of Care to Treat Low Back Pain: An Instrumental Variables Approach to Estimate Impact on Opioid Prescription, Health Care Utilization, and Costs, 53 Health Services Research 4629, 4638 (2018)(finding that patients with low back pain who accessed physical therapists first had lower utilization of high cost medical services and significantly lower out-of-pocket costs); Elizabeth Arnold, Janna La Barrie, Lisley DaSilva, Meagan Patti, Adam Goode, and Derek Clewley, The Effect of Timing of Physical Therapy for Acute Low Back Pain on Health Services Utilization: A Systematic Review, 100 Archives of Physical Medicine and Rehabilitation 1324, 1331-33 (2019)(finding that early access to physical therapy, within thirty days from onset of low back pain, was associated with decreased health care services utilization and decreased health care costs); and Dongchun Wang, Kathryn Mueller & Randy Lea, The Timing of Physical Therapy for Low Back Pain: Does It Matter in Workers' Compensation, Workers Compensation Research Institute, September 2020 (finding that starting therapy within seven days of injury had lower costs than those initiating therapy fifteen days or more following an injury).
[20] Resnik L, Feng Z, Hart DL. State regulation and the delivery of physical therapy services. Health Serv Res. 2006
[21] See Dent v. West Virginia, 129 U.S. 114 (1889) (stating that individual states, in the exercise of their police power to provide for the general welfare of their people, may exact from parties before they can practice medicine a degree of skill and learning in that profession); and Hawker v. New York, 170 U.S. 189 (1898) (agreeing that a state

necessary for patient protection. Since 2004, all but one state has decided that a supervising physical therapist does not need to provide direct supervision of a PTA, indicating that such a requirement is not necessary to protect the public's health and safety.

Second, PTA/OTAs are highly skilled professionals that deliver extraordinary care to patients with very low risk to the patients that they serve. In fact, in a study that examined professional liability claims in the physical therapy profession, it was found that, despite accounting for 24% of the workforce, PTAs only accounted for 12% of total indemnities paid for malpractice claims.[22] Furthermore, of the malpractice claims brought, only 1.6% of claims were related to a failure to supervise other providers.[23] Beyond the claims data, Athletico currently operates 20 rehab agencies that utilize PTAs and OTAs under a general supervision standard. Our data shows that there is no difference in the number of patient safety related incident reports between the two settings, suggesting that providing general supervision of PTA/OTAs does not increase risk to patients.

Third, another study that examined professional liability claims in the physical therapy profession found that the largest indemnities paid to patients occurred in acute rehabilitation hospitals ("IRF").[24] CMS does not define the level of supervision required for PTA/OTAs for inpatient hospitals and therefore, defers to state law. If PTA/OTAs can provide care under the general supervision of a PT/OT within an IRF, where patients tend to be more clinically fragile than patients seen in other settings,[25] then it stands to reason that PTA/OTAs can provide services under the Temporary Exception while in outpatient private practice clinics.

III. CMS's proposed changes to Remote Therapeutic Monitoring ("RTM") services for musculoskeletal ("MSK") conditions would reduce patient access.

To guarantee that our patients have access to the best physical and occupational therapy care possible, Athletico has been piloting RTM services, and early outcomes results have been overwhelmingly positive. Our pilot has revealed that engaged patients utilizing the RTM services (the "RTM Patients") have been more adherent with the therapy plan of care. According to our outcomes data, compared to patients that have not received the RTM services, RTM Patients are experiencing significantly better functional outcomes, clinically meaningful reductions in pain, and fewer therapy visit during a plan of care.

These outcomes are supported by a recent report that examined strategies for improving care for people with MSK disorders. That report found that, early adherence to a physical therapy plan of care resulted in 60% lower costs for patients after a two-year follow-up period.[26] For these reasons, Athletico supports CMS's continuation of RTM services, but with the changes outlined below.

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exercising its constitutional police powers may prescribe the qualifications of one engaged in any business so directly affecting the lives and health of the people as the practice of medicine).

[22] Physical Therapy Professional Liability Exposure: 2016 Claim Report Update, A Comparative Analysis From CNA and Healthcare Providers Service Organization (2016)

[23] Id.

[24] Physical Therapy Professional Liability Exposure Claim Report: 4th Edition; From CNA and Healthcare Providers Service Organization (2020)

[25] Id.

[26] Americans in Motion: Intelligence for improving care for musculoskeletal disorders, which cause pain for millions and are a top driver of health care usage and costs; Evernorth Research Institute (2020)

a) **The parenthetical code descriptions for the newly proposed GRTM codes provide a disincentive for PT/OTs to provide RTM services to Medicare beneficiaries.**

The new parentheticals to the GRTM3 and GRTM4 HCPCS Codes (the "Management Codes") include two new harmful requirements that would disincentivize the provision of RTM services to any Medicare patient that does not start their therapy treatment at the beginning of the month.

i.) **CMS should remove the requirement that CPT codes 98975 and 98977 be billed prior to billing for GRTM3 and GRTM4.**

First, GRTM3 requires that CPT codes 98975 and 98977 (together, the "Education and Device Codes") to be billed prior to reporting GRTM3 and GRTM4. This is problematic because the Education and Device Codes, which may be billed once during a thirty (30) day period, require sixteen (16) data transmissions prior to billing. While 16 data transmissions may not be a problem for codes billed over a 30-day period, the Management Codes are billed based on the services provided during a calendar month. This means that, if a Medicare beneficiary begins therapy on the 16th of a month, it will be impossible for the patient to report 16 days of data. The following table illustrates the potential problem and disincentive to providing RTM services under the proposed G-codes:

Period Patient is Receiving RTM Services	Number of Days of Data Transmitted	Clinician RTM Work Minutes
December 16 – 18, 2022	1 day	2 minutes
December 18 – 24, 2022	3 days	8 minutes
December 25 – 31, 2022	4 days	10 minutes
January 1 –7, 2023	3 days	9 minutes
January 8 – 14, 2023	4 days	11 minutes
Total	15 days	40 minutes

In the above example, because the patient did not start therapy until after the middle of the month, it is impossible for the patient to transmit 16 days of data. Therefore, even though the clinician spends 20 minutes or work on providing RTM services in two different calendar months, the clinician would not be able to bill for any of the services provided to the patient. This means that the therapist will be uncompensated for 40 minutes of time spent helping the patient. The risk of providing 40 minutes of work that will not be compensated will serve as a significant disincentive to providing RTM services to Medicare beneficiaries. Therefore, CMS should remove the requirement that CPT codes 98975 and 98977 be billed prior to billing for the Management Codes.

Alternatively, CMS should amend the code descriptor for the Management Codes to require that the 20 minutes of RTM treatment assessment services be provided over a thirty (30)-day period. Aligning the Management Codes and the Education and Device Codes to be tracked over the same 30-day period would eliminate the disincentive to starting a patient on RTM services after the midway point of the month.

https://d17f9hu9hnb3ar.cloudfront.net/s3fs-public/2022-08/Evernorth%20Americans%20in%20Motion%20Musculoskeletal%20Report.pdf

ii.) **CMS should remove the requirement that at least 16 days of data must be reported prior to billing for GRTM3 and GRTM4.**

The additional parenthetical included in the code descriptor for the Management Codes requiring that at least sixteen (16) days of data must be reported to bill for GRTM3 and GRTM4 serves as another disincentive to providing RTM services to Medicare beneficiaries. The below table illustrates the problem:

Period Patient is Receiving RTM Services	Number of Days of Data Transmitted	Clinician RTM Work Minutes
December 16 – 18, 2022	1 day	2 minutes
December 18 – 24, 2022	4 days	8 minutes
December 25 – 31, 2022	5 days	10 minutes
January 1 –7, 2023	4 days	9 minutes
January 8 – 14, 2023	5 days	11 minutes
Total	19 days	40 minutes

In the above example, the patient reports 19 days of data over a 30-day period, and the clinician furnishes 20 minutes of RTM services in two different calendar months. Under the CY 2022 rules for RTM services, the clinician could bill for the Education and Device Codes once and CPT 98980 for both December and January. However, under the Proposed Rule for CY 2023, the clinician would not be able to bill the Management Codes at all because the patient did not transmit 16 days of data for either the calendar month of December or January. Again, under the Proposed Rule, the clinician would be forced to provide 40 minutes of uncompensated care, creating another significant disincentive to providing the RTM services. Therefore, CMS should remove the parenthetical from the Management Codes that requires at least 16 days of data to be reported.

Alternatively, CMS should amend the code descriptor for the Management Codes to require that the 20 minutes of RTM treatment assessment services be provided over a thirty (30)-day period. By aligning both the Education and Device Codes and the Management Codes to cover the same rolling 30-day period, the clinician in the above example would be able to bill for both the Education and Device Codes and the GRTM3 code, thereby restoring the economic incentive to provide RTM services to Medicare beneficiaries.

b) **CMS should restore the Practice Expense for the Management Codes that are billed by physical and occupational therapists.**

In the Proposed Rule, CMS is proposing to cut the practice expense portion of the Management Codes billed by non-physician qualified health care professionals (i.e.: physical and occupational therapists). Because GRTM3 and GRTM4 do not include “incident to” activities in the PE, neither of the two codes include clinical labor inputs in the direct PE. However, cutting the clinical labor inputs from the Practice Expense fails to recognize that PTAs and OTAs can provide RTM Services under the direction of a PT/OT and that the clinical labor cost of PTAs and OTAs is greater than the clinical labor costs of medical assistants, nursing assistants, and other techs that can provide RTM services “incident to” a physician.

Over the last year, Athletico has been using PTAs to help deliver the RTM services to Medicare beneficiaries. These PTAs are specifically trained in how to perform the RTM services, and we believe this training plays a key role in delivering the superb outcomes that we have seen through this service. However, these PTAs come at a substantial clinical labor cost. Furthermore, it is imperative that PTs and OTs be able to leverage therapy assistants to deliver RTM services. Clinician burnout is already increasing at alarming rates. It is unreasonable to add expect PTs and OTs to add RTM services to their already full case load. Therefore, the ability to leverage therapy assistants to provide these services is the only way that CMS can realize its stated goal of increasing beneficiary access to RTM service.

Unfortunately, cutting the practice expense for the Management Codes would reduce reimbursement for the first 20 minutes of RTM services provided by almost 40% and cut reimbursement for the second 20 minutes of RTM services by an additional 24%. Because of the high clinical labor costs of employing a PTA to provide these services, the proposed cuts would make it impossible to use PTAs to provide the RTM services, and thereby reducing Medicare beneficiary access to this valuable service. CMS can avoid this result by adopting one of the two following proposals:

1: CMS can create two additional GRTM codes (GRTM5 and GRTM6) for PTs and OTs that recognizes the clinical labor costs of PTAs and PTAs. These new GRTM codes should use the same non-facility work and practice expense values as the GRTM1 and GRTM2 codes. GRTM3 and GRTM4, therefore, would remain for other clinicians (such as psychologists, clinical social workers, and registered dieticians) that do not utilize assistants, while creating an avenue to compensate PTs and OTs for the clinical labor costs of their assistants; or

2: CMS can restore the Practice Expense payment to GRTM3 and GRTM4.

(c) CMS should permanently change the definition of "direct supervision" to allow the supervising professional to be immediately available through virtual presence using real-time audio/video technology (the "Temporary Exception") when the supervising professional is supervising RTM services.

Athletico appreciates CMS's recognition that imposing a direct supervision requirement for CPT codes 98980 and 98981 imposes burdens on physicians and NPPs who are delivering services to other patients. Athletico also supports CMS's proposal to adopt GRTM1 and GRTM2 to allow general supervision of the clinical labor found in the PE inputs for these codes. However, CMS's proposal would still require physical and occupational therapists in private practice to provide direct supervision of PTAs and OTAs. Therefore, if CMS does not permanently align supervision requirements to state law for those services provided by physical and occupational therapist assistants in private practice, then CMS should permanently allow the Temporary Exception for the supervision of PTA/OTAs providing RTM services.

As noted above, Athletico is currently relying on PTA/OTAs to perform RTM services for Medicare beneficiaries, relying on the Temporary Exception to satisfy the supervision requirements. Because RTM services were adopted by CMS for the first time in CY 2022, these services have only been provided while the Temporary Exception has been in effect. During this time, we have seen tremendous outcomes by relying on therapy assistants to provide the services, without any adverse effects for patients.

If CMS is only willing to adopt the Temporary Exception for a subset of services, then adopting the Temporary Exception for services that are intended to be provided remotely would be the natural place to start. Athletico applauds CMS for recognizing that direct supervision will impose unnecessary burdens on physicians and NPPs. However, if CMS desires to remove this burden from PTs and OTs in private practice, then CMS must adopt the Temporary Exception.

IV. CMS should remove unnecessary requirements that are delaying and adding unnecessary costs to care delivery.

CMS has stated that it is seeking comment on ways to identify specific services and to recognize possible barriers to improved access to high valued and potentially underutilized services for Medicare beneficiaries. One such underutilized service is physical therapy for the treatment of chronic pain.

Since 1999, America has lost over 1 million Americans to overdoses, with over 100,000 drug overdose deaths occurring in 2021 alone.[27] Of those over 100,000 overdose deaths in 2021, the CDC reports that over 75,000 overdoses were due to opioids, an increase of nearly 20,000 opioid related deaths in just one year.[28] While there are many factors that can lead to addiction and overdose, the National Institute on Drug Abuse recognizes that prescription opioids is a major risk factor for heroin use because 80% of heroin users start with the use of a prescription opioid.[29] Numerous studies have demonstrated that physical therapy is a safe and effective way to reduce the need for prescription opioids to manage MSK related pain.[30] Unfortunately, physical therapy has been underutilized in helping patients manage their chronic pain.

a) CMS's Plan of Care certification requirement leads to an underutilization of physical and occupational therapy services, harms patient health, and leads to unnecessary Medicare expenditures.

Section 220.1 of Chapter 15 of the Medicare Benefit Policy Manual (the "Manual") outlines the requirements that outpatient therapy services may only be provided when the services are or were

[27] https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm
[28] Id.
[29] https://nida.nih.gov/publications/research-reports/prescription-opioids-heroin/prescription-opioid-use-risk-factor-heroin-use
[30] See, for example, Thomas R. Denninger, Chad E. Cook, Cole G. Chapman, Timothy McHenry, and Charles A. Thigpen, The Influence of Patient Choice of First Provider on Costs and Outcomes: Analysis From a Physical Therapy Patient Registry, 48 Journal of Orthopaedic & Sports Physical Therapy 63 (2018); Bianca K. Frogner, Kenneth Harwood, C. Holly A. Andrilla, Malaika Schwartz, and Jesse M. Pines, Physical Therapy as the First Point of Care to Treat Low Back Pain: An Instrumental Variables Approach to Estimate Impact on Opioid Prescription, Health Care Utilization, and Costs, 53 Health Services Research 4629, 4638 (2018); Eric Sun, Jasmin Moshfegh, Chris A. Rishel, Chad E. Cook, Adam P. Goode, and Steven Z. George, Association of Early Physical Therapy With Long-term Opioid Use Among Opioid-Naive Patients With Musculoskeletal Pain, JAMA Network Open (2018); Elizabeth Arnold, Janna La Barrie, Lisley DaSilva, Meagan Patti, Adam Goode, and Derek Clewley, The Effect of Timing of Physical Therapy for Acute Low Back Pain on Health Services Utilization: A Systematic Review, 100 Archives of Physical Medicine and Rehabilitation 1324, 1331-33 (2019); and Daniel I Rhon, Suzanne J Snodgrass, Joshua A Cleland, Tina A Greenlee, Charles D Sissel, and Chad E Cook, Comparison of Downstream Health Care Utilization, Costs, and Long-Term Opioid Use: Physical Therapist Management Versus Opioid Therapy Management After Arthroscopic Hip Surgery, 95 Physical Therapy 348 (2018).

furnished while the Medicare beneficiary is under the care of a physician.[31] However, as Section 220.1.1 of the Manual makes clear, Medicare does not require a referral or order from a physician prior to commencing therapy services. Furthermore, physical therapists enjoy some degree of direct access privileges (meaning that patients do not require an order or referral from a physician to receive physical therapy services) in all 50 states.[32] Unfortunately, Section 220.1.3 requires that a therapist's plan of care be certified by a physician or other NPP. Certification is indicated either by a dated signature on the therapists POC or some other document that indicates approval of the plan of care (the "Certification Requirement"). Such certification must be obtained as soon as possible, or within 30 days of the initial therapy treatment.

The Certification Requirement imposes a significant logistical and administrative burden on therapy professionals that frequently leads to delayed care as patients wait for busy physicians to sign a POC. These delays can result in the patient requiring additional therapy visits and result in worse outcomes. Moreover, physicians and other NPPs often require a patient come to their office for a visit before they will certify a POC. This requirement is often unpopular with patients and leads to increased costs for both Medicare beneficiaries and the Medicare system.

Timely access to physical and occupational therapy is vital to achieving high value care that delivers optimal results at a low cost. The Certification Requirement leads to an underutilization of timely PT and/or OT services that eventually leads to overutilization and wasteful spending. CMS should remove the POC certification requirement if there is documented evidence in the Medicare beneficiary's medical records that they are under the care of a physician or other NPP. For example, this would eliminate the Certification Requirement if the Medicare beneficiary came to therapy with a referral for the patient to receive therapy services. The Certification Requirement is a remnant of an outdated policy from a time when physical and occupational therapists could not treat patients without a referral from a prescription. CMS has the authority to change this outdated requirement and provide increased access to Medicare beneficiaries that will help deliver better health outcomes at a lower cost.

V. CMS should clarify that physical therapists can provide and bill for the new Chronic Pain Management and Treatment ("CPM") bundles (HCPCS GYYY1 and GYYY2).

Due to America's rapidly growing opioid addiction and overdose epidemic, Athletico applauds CMS's proposal to create separate coding and payment for CPM services. However, Athletico believes that the proposed HCPCS G-codes used to describe monthly CPM services can be improved in two ways:

Physical therapists have direct access in all 50 states.[33] This means that patients may access a physical therapist's services without a referral from their physician or other NPP. Physical therapists already provide the services to patients that are considered in the proposed HCPCS GYYY1 CPM code for chronic pain management. The following table includes the services included in the CPM codes, and an explanation of where these services fit within physical therapy practice:

[31] Citing 42 CFR 424.24(c)
[32] Levels of Patient Access to Physical Therapist Services in the US, American Physical Therapy Association, https://www.apta.org/contentassets/4daf765978464a948505c2f115c90f55/direct-access-by-state-map.pdf
[33] Levels of Patient Access to Physical Therapist Services in the US, American Physical Therapy Association, https://www.apta.org/contentassets/4daf765978464a948505c2f115c90f55/direct-access-by-state-map.pdf

Service	Physical Therapy Standard of Practice
Diagnosis, assessment, and monitoring	According to the American Physical Therapy Association's Standards of Practice for Physical Therapy (the "Standards of Practice"), physical therapist practice requires the physical therapist to perform an initial examination and evaluation (i.e.: **assessment**) to establish a **diagnosis** and prognosis prior to intervention.[34] The Standards of Practice also require that physical therapists produce data sufficient to allow evaluation, diagnosis, prognosis, and the establishment of a plan of care.
Administration of a validated pain rating scale or tool	The Standards of Practice require that physical therapist examinations include performance of appropriate physiological procedures, tests, and measures,[35] which include the administration of validated pain rating scales. Beyond the administration of validated pain rating scales, Athletico physical therapists utilize various psychosocial tools used to identify presence of other factors which may impact a patient's recovery, such as depression, fear, anxiety, anger, fear of movement, and self-efficacy concerns. These tools are vital to ensuring that we are treating all factors related to the patient's pain experience with which they are seeking treatment, rather than just the injury. Through this program, we use tools which are predictive in nature, enabling our therapists at the first visit to identify patients at risk of developing chronic conditions, so we can proactively address these issues during the course of care.
Development, implementation, revision, and maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes	The Standards of Practice require that physical therapists develop a management plan that includes a plan or care based on the best available evidence and consists of statements that specify the **goals** of the plan, the predicted level of optimal improvement (**desired outcomes**), and the interventions to be used (**clinical needs**).[36]
Overall treatment management	The Standards of Practice require that the physical therapist provide or direct and supervise intervention consistent with the results of the examination, evaluation, diagnosis, prognosis, and plan of care. The intervention must be consistent with best available evidence, in direct alignment with the patient's desired outcomes and goals and altered in accordance with changes in response or status.[37]
Medication management	The American Physical Therapy Association's position statement on pharmacology in physical therapist practice states that, "Physical therapist patient and client management integrates an understanding of a patient's or client's prescription and nonprescription medication regimen with consideration of its

[34] Standards of Practice for Physical Therapy, American Physical Therapy Association, https://www.apta.org/siteassets/pdfs/policies/standards-of-practice-pt.pdf
[35] Id.
[36] Id.
[37] Id.

	impact on health, function, movement, and disability. It is within the physical therapist's professional scope of practice to administer and store medication to facilitate outcomes of physical therapist patient and client management."[38] At Athletico, we have incorporated an opioid medication tracking program into patients' medical records that prompts therapists to ask and track whether patients are currently taking an opioid to help manage their pain.
Pain and health literacy counseling	The Standards of Practice require that the physical therapist provide intervention that emphasizes patient education.[39] At Athletico, our entire clinical and patient experience team is trained in pain neuroscience education. Pain neuroscience education helps provide insight into the biology and physiology of the pain experience. It helps educate the patient on how and why pain is felt by better understanding the multiple factors involved in the process. Understanding pain combined with movement and exercise prescribed by a physical therapist can be highly effective in facilitating a patient's recovery.[40]
Communication and care coordination between relevant practitioners[41]	The Standards of Practice requires that the physical therapist refer for additional services to meet the needs of the patient or client. The Standards of Practice also require, as appropriate, referral, consultation, or co-management with other providers[42] State licensing board also require physical therapists to refer patients to other providers when a patient's condition is beyond the scope of physical therapy practice.

As documented above, physical therapists are well equipped to provide the services included in the CPM bundle codes. Therefore, CMS should clarify in the FY 2023 Final Rule that physical therapists are among the qualified health professionals that may personally provide and bill the CPM bundle codes (GYYY1 and GYYY2). Alternatively, CMS should exercise its authority under Section 1848 of the Social Security Act to establish similar CPM bundled codes that are reimbursable to physical and occupational therapists that

[38] Pharmacology in Physical Therapist Practice, American Physical Therapy Association, https://www.apta.org/siteassets/pdfs/policies/pharmacology-in-physical-therapy.pdf
[39] Standards of Practice for Physical Therapy, American Physical Therapy Association, https://www.apta.org/siteassets/pdfs/policies/standards-of-practice-pt.pdf
[40] https://www.athletico.com/services/pain-therapy/
[41] Physical therapy is a proven safe and effective non-opioid alternative to treat MSK pain, and, when indicated, physical therapy has been shown to reduce the required dosage of prescription opioids. (See Sun, Eric, et al. "Association of early physical therapy with long-term opioid use among opioid-naive patients with musculoskeletal pain." JAMA network open 1.8 (2018): e185909-e185909.) Therefore, when finalizing the CPM bundle codes, CMS should make clear that, care coordination requires that physicians and other qualified healthcare providers must refer patients with chronic and MSK pain to physical or occupational therapy before billing the CPM bundle code. This requirement would lead to better outcomes for patients and save money for the Medicare system. (See, for example: Beyond Opioids: How Physical Therapy Transforms Pain Management To Improve Health: 2021, American Physical Therapy Association, https://www.apta.org/contentassets/b9421650038941469c75d06a0a191069/beyond-opioids-white-paper.pdf)
[42] Id.

are providing chronic care management services. Providing physical and occupational therapists with the ability to provide and be reimbursed for CPM bundled services would help to increase access to physical and occupational therapy in accordance with the recommendations of the opioid taskforces convened by the White House, the Department of Health and Human Services and Congress over the last five years.

VI. Summary

We thank CMS for the opportunity to provide comments to the Proposed Rule. Over the last decade, reimbursement for physical and occupational therapy has been cut to levels that threaten the viability of clinics and reduce access to our services. The current trends are unsustainable. While we understand the challenges created by the budget neutrality requirement of the MPFS, there are actions that CMS can take when finalizing the CY 2023 Final Rule that will increase access to physical and occupational therapy services. Therefore, we ask that CMS make the following changes to the Proposed Rule:

1.) Align supervision requirements for physical and occupational therapy assistants in private practice to state law.
2.) Remove the requirement that CPT codes 98975 and 98977 be billed prior to billing for RTM service Management Codes (i.e.: GRTM3 and GRTM4).
3.) Remove the requirement that at least 16 days of data must be reported prior to billing for RTM service Management Codes (i.e.: GRTM3 and GRTM4). Alternatively, CMS should change the time for when the 16 days of data must be reported from a monthly period to a rolling 30-day period.
4.) Restore the Practice Expense component to the RTM service Management Codes when RTM services are provided under a physical or occupational therapy plan of care to account for the clinical labor costs of PTAs and OTAs.
5.) Permanently allow for the immediate availability for direct supervision through virtual presence using real-time audio/video technology for supervision for therapy assistants providing RTM services.
6.) Eliminate the POC certification requirement for Medicare beneficiaries if there is other evidence in the medical record that the beneficiary is under the care of a physician or other NPP.
7.) Provide for greater access to physical and occupational therapy services that are underutilized in the treatment of chronic and MSK pain by clarifying that physical therapists may provide and be reimbursed for the CPM bundle codes.
8.) Provide for greater access to physical and occupational therapy services that are underutilized in the treatment of chronic and MSK pain by clarifying that physicians and other NPPs must refer appropriate chronic and MSK pain patients to physical and/or occupational therapy prior to being reimbursed for the CPM bundle codes.

ATHLETICO
PHYSICAL THERAPY

We appreciate your consideration of these comments on behalf of the thousands of Athletico employees and patients adversely impacted by the Proposed Rule.

Sincerely,

Christopher Throckmorton
Chief Executive Officer