APTA Private Practice
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Small business professionals restoring function to America - one patient at a time.

Examples submitted for the Small Business Committee Oversight Hearing, *"Burdensome Red Tape: Overregulation in Health Care and the Impact on Small Businesses."* -- July 19, 2023

General impact statement: Given the current pressures on therapy providers, including recent year-over-year fee schedule cuts, rehabilitation therapists are united in seeking opportunities to reduce administrative burden without compromising patient safety or quality of care as a way to mitigate the impact of these payment cuts for therapy providers and our physician colleagues, as well as to best serve our patients expeditiously and without financial risk to their therapist providers.

MEDICARE

PTA supervision

Background: Medicare allows for general supervision of physical therapist assistants (PTAs) by physical therapists and occupational therapy assistants by occupational therapists (OTAs) in all settings, except for outpatient private practice under Part B, which requires direct supervision. While therapy providers must comply with their state practice act if state or local practice requirements are more stringent than Medicare's, the standard in 48 states is general supervision of OTAs and PTAs, making this outdated Medicare regulation — which arbitrarily applies only to private practice — more burdensome than almost all state requirements. The inconsistency of supervision policies between settings limits employment opportunities for PTAs and OTAs as well as jeopardizes the needs of Medicare beneficiaries in medically underserved and rural communities that rely so heavily on their services.

Statement for the Record: Standardizing a "general supervision" requirement under Medicare for private practices will help ensure continued patient access to needed therapy services and give small therapy businesses more workforce flexibility to meet the needs of beneficiaries. Reducing this overburdensome supervision requirement would enable PTAs in outpatient therapy settings to provide care to patients at the top of their license (following a physical therapist's plan of care). According to an independent report published by Dobson & Davanzo in September 2022, this change in supervision is estimated to save $271 million over 10 years.

Plan of care signature requirement relief

Background: Medicare Part B guidelines permit Medicare beneficiaries to receive therapy evaluation and treatment services with or without a physician order. The PT, OT, or SLP may evaluate that patient, formulate a plan of care, and commence treatment. Under current certification requirements, the therapy provider must submit the plan of care to the patient's physician and have it signed within 30 days in order to receive payment—regardless if that patient arrived at physical therapy with an order for therapy services.

Statement for the Record: The time and resources spent by both therapists and physicians in procuring a timely signature adds unnecessary cost, potentially delays essential services, and fails to contribute to improved quality of care. We could reduce administrative burden for both the physicians and the physical therapists by clarifying a new care coordination model such that when outpatient therapy services are provided under a physician's order, the plan of care certification requirements shall be deemed satisfied if the qualified therapist submits the plan of care to the patient's referring physician within 30 days of the initial evaluation. The order would confirm the physician's awareness of the therapy episode and proof of submission of the plan of care would demonstrate the coordination and collaboration between the physician and the therapist. In the case where a patient went directly to a physical therapist for care, the existing model could remain in place to ensure a "closed loop" of communication and care coordination. In either case, a physician would continue to have the authority to modify the plan of care from the physical therapist.

Medicare credentialing

Background: Currently, Medicare credentials a Medicare enrolled physical therapist to practice at an individual outpatient therapy practice location. If the practice has multiple locations, the physical therapist must be credentialed at each location.

Statement for the Record: Credentialing of therapists in a multi-location practices per address is wasteful and unnecessary. Instead, a provider credentialed by Medicare at one location of a practice should be considered a credentialed to provide care at all of the locations of that practice group.

PRIVATE INSURANCE/MEDICARE ADVANTAGE

Prior authorization for MA plans and private insurance

Background: Health insurers, including many Medicare Advantage (MA) plans, require providers to obtain prior authorization for certain medical treatments or tests—including physical therapy care—before they can provide care to their patients. In a 2018 report, the Department of Health & Human Services' (HHS) Office of the Inspector General raised concerns that prior authorization was being used to limit services and payment, after an audit revealed that MA plans ultimately approved 75% of requests that were originally denied. In April 2022 another HHS OIG report found that "Although some of the denials that we reviewed were ultimately reversed by the [MA Organizations (MAOs)], avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs."

Statement for the Record: Prior authorization frequently results in administrative burdens for providers which diverts precious time away from patient care and delays approval for necessary physical therapy services. As evidenced by both OIG reports, it is not uncommon for therapists to follow all required guidelines from the MA plan and still receive rejections. Furthermore, it is not clinically appropriate to ration care solely based upon the volume of services. In many cases, the patient understands that delaying care may severely hinder their recovery, but is wholly unaware of the presence of prior authorization and utilization management hurdles that result in physical therapists and other providers being forced to decide between furnishing an uncovered service at their own expense or risk the patient's health and well-being by waiting for a plan to authorize medically necessary care. The *Seniors Timely Access to Care Act* which got a lot of attention last Congress is soon to be reintroduced in order to address this issue and reduce some of the remaining administrative burdens.

VALUE OF ACCESS TO PHYSICAL THERAPY

- Utilization of physical therapy improves physical function which allows seniors to be more involved members of their communities and to continue to have a positive economic impact (as employees, volunteers, or consumers)
- Continued access to care results in more efficient plans of care that have better results (delays in care can result in poorer outcomes or higher overall cost—either because that episode of care will take longer, or because the functional outcome will be reduced and result in future functional limitations which will require further interventions)
- Access to PT is an important non-pharmacological approach to pain management