Welcome!
State Policy, Payment & Advocacy

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2014 APTA State Policy & Payment Forum  
September 13  
Seattle, WA
APTA Vision

“Transforming society by optimizing movement to improve the human experience”
<table>
<thead>
<tr>
<th>Issue Discussion</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DRY NEEDLING</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TELEHEALTH</strong></td>
<td></td>
</tr>
<tr>
<td><strong>U.R.U.M. COMPANIES</strong></td>
<td></td>
</tr>
<tr>
<td><strong>BIG DATA AND COMMERCIAL PAYERS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>PT PRACTICE ACTS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>PAYMENT REFORM</strong></td>
<td></td>
</tr>
<tr>
<td><strong>NETWORK ADEQUACY</strong></td>
<td></td>
</tr>
<tr>
<td><strong>OTHER PROVIDERS &amp; INFRINGEMENT ISSUES</strong></td>
<td></td>
</tr>
</tbody>
</table>
Your poll will show here

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Dry Needling

APTA definition:

Dry needling (DN) is a skilled intervention used by physical therapists that uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, neural, muscular, and connective tissues for the management of neuromusculoskeletal pain and movement impairments.

\^ neural

Description of Dry Needling In Clinical Practice: APTA Educational Resource Paper
Dry Needling
2014 APTA activity

GUIDELINES: PHYSICAL THERAPIST SCOPE OF PRACTICE
BOD G02-14-18

Physical therapy, which is limited to the care and services provided by or under the direction and supervision of a physical therapist, includes...

2) alleviating impairment and functional limitation by designing, implementing, and modifying therapeutic interventions that include, but are not limited to:
   – dry needling
Dry Needling
2014 APTA activity

Included in the revised Guide to Physical Therapist Practice 3.0 (released Aug. 2014).

http://guidetoptpractice.apta.org/

Chapter 38 – Manual Therapy Techniques.

No definition for DN included.
Dry Needling
Guide 3.0

- Manual therapy techniques may include the following:
- Manual lymphatic drainage
- Manual traction
- Massage
  - Connective tissue massage
  - Therapeutic massage
- Mobilization/manipulation
  - **Dry needling**
  - Soft tissue
  - Spinal and peripheral joints
- Neural tissue mobilization
- Passive range of motion
Dry Needling
Current status
Dry Needling

- State regulatory boards are struggling with education/training requirements. Often mandated to due to chiro/physician hours, for acupuncture or because of political negotiations.

- X amount of hours ≠ competency.

- Be careful with terminology, be wary of a definition.
Telehealth

Telehealth is the use of secure electronic communications to provide and deliver a host of health related information and health care services, including but not limited to physical therapy related information and services for patients and clients;

Used to enhance patient and client interactions, and encompasses a variety of health care and health promotion activities, including but not limited to education, advice, reminders, consultations, screenings, assessments, interventions, and monitoring of interventions;

2014 APTA House of Delegates. RC 08-14
Telehealth

APTA Position:

Telehealth is an appropriate model of service delivery for the profession of physical therapy when provided in a manner consistent with association positions, standards, guidelines, policies, procedures, Standards of Practice for Physical Therapy, Code of Ethics for the Physical Therapist, Standards of Ethical Conduct for the Physical Therapist Assistant, the Guide To Physical Therapist Practice, and APTA Telehealth Definitions and Guidelines; as well as federal, state, and local regulations.

2014 APTA House of Delegates. RC 08-14
Telehealth: State Legislative Goals

• To include language in state physical therapy statutes (Practice Acts) or PT Board regulations that recognize telehealth as a mode of delivery of services for physical therapist services.
• Provide appropriate definitions and guidance language for licensees.
• Create a licensure mechanism to manage the interstate licensure issues.
Telehealth

• State that the patient is located is the state of jurisdiction. If PT is providing services to a patient via telehealth, the PT needs to be licensed in the same state that the patient is located.

• Intrastate vs. Interstate
Definitions:
Telehealth is the use of electronic communications to provide and deliver a host of health-related information and healthcare services, including, but not limited to physical therapy related information and services, over large and small distances. Telehealth encompasses a variety of healthcare and health promotion activities, including, but not limited to, education, advice, reminders, interventions, and monitoring of interventions.
Definitions:

“Consultation by telehealth” means that a physical therapist renders professional or expert opinion or advice to another physical therapist or professional healthcare provider via electronic communications or computer technology from a distant location.
Definitions:

“Electronic Communications” means the science and technology of communication (the process of exchanging information) over any distance by electronic transmission of impulses including activities that involve using electronic communications to store, organize, send, retrieve, and/or convey information.
Licensure Exemptions:
The following persons are exempt from the licensure requirements of this [act] when engaged in the following activities:

4. A physical therapist who is licensed in another jurisdiction of the United States if that person is providing consultation by telehealth, as defined in [Definitions, Article 1.02], to a physical therapist licensed under this [act].
Telehealth

How do we solve the licensure portability issues related to interstate treatment?

National or Federal licensure?

Special Telehealth license?

Interstate Licensure Compact for PT?
Telehealth
Interstate Licensure Compact

• Legal contract agreement between participating states. States must pass legislation to “sign on” to the compact to allow for participation.

• Allows for portability of a state license and recognition of that license by other states, provided those states are participants in the interstate compact.

• Approximately 215 compacts exist on a variety of topics. One that you are most familiar with is...
Telehealth
Drivers License Compact (DLC)
Telehealth

Federation of State Boards of Physical Therapy (FSBPT) is moving forward with investigating this concept. APTA is part of the FSBPT Task Force.

APTA House of Delegates position in support of a interstate licensure compact for PT.

What would a PT interstate compact look like?
Telehealth

On the Horizon...

- Technology hurdles have gone down, and demand for telehealth services will likely increase.
- Increase in telehealth state legislation, primarily dealing with reimbursement.
- More state regulatory boards are exploring this issue (MD, GA). Increase in state legislation (FL, LA)
- APTA state chapters will need to consider adding telehealth to their state legislative agenda.
APTA Telehealth Toolkit

http://www.apta.org/telehealth
PT Practice Acts

What’s in a practice act?

• Licensing board structure – combined board or independent
• Licensing requirements and types of licenses
• Definition of “physical therapy” (scope of practice – what’s included, what’s excluded)
• Referral requirements – unrestricted direct access or provisions/restrictions
• PTA supervision requirements
• Title and term protection
• Continuing ed/competence requirements for renewal
2014 PT Practice Act Bills: Major Revisions

Delaware HB 359
New Jersey AB 1648 (pending)
US Virgin Islands

Resource for revisions:
FSBPT Model Practice Act
2014 PT Practice Act Bills: Defining “Physical Therapy”

Arizona SB 1154: Dry needling ✓
Illinois HB 1457: Non-surgical invasive techniques
Ohio HB 220: Ordering imaging, clarify diagnosis
Utah HB 367: Dry needling ✓
Wash. HB 2160: Spinal manipulation ✓
Wisconsin SB 496: Ordering x-rays
2014 Direct Access Bills

Oklahoma  ✓

Before: Evaluation only


Effective Nov. 1, 2014

Provisions:

– Treatment without a referral may be provided for up to 30 days
– Referral required under workers’ compensation
2014 Direct Access Bills

**Michigan**  
Before: Evaluation only

SB 690 – Sponsored by Sen. John Moolenaar  
Effective Jan. 1, 2015

Provisions:  
– Treatment without a referral may be provided for up to 21 days or 10 visits  
– Also adds term protection for “doctor of physical therapy”
Direct Access:
Where Are We Now?
Direct Access: Where do we go from here?

• Move more states toward *unrestricted* direct access by continuing to remove restrictions in state laws and regulations.

• With a major milestone reached, it’s a good opportunity to pivot the conversation to focus on *quality* (not quantity) of direct access laws in the states.

• Continue to advocate for payment of direct access with insurers.

• Continue to advocate for direct access at the Federal level.

• On the horizon for 2015: State bills planned in Florida, Georgia, Louisiana, New Mexico, Texas, Virginia
2014 PT Practice Act Bills: Other Changes

Alaska HB 242: Practice act sunset ✓
Arizona HB 2089: Practice act sunset
Colorado SB 99: Provisional licensure ✓
Illinois SB 3115: Removed prohibition on testimonials
Maryland HB 401: Criminal background checks
Mass. HB 176: Title protection for DPT ✓
Mass. HB 175: Independent PT Board
Other Providers & Infringement

- Acupuncturists
- Athletic Trainers
- Chiropractors
- Exercise Physiologists
- Kinesiotherapists
- Massage Therapists
- Music Therapists
- Naturopathic Physicians
- Occupational Therapists
- Orthotists and Prosthetists
- Personal Trainers
- Recreation Therapists
Athletic Trainers

**Issues:** Expanding scope of practice; payment mandates

- Moving away from defining practice as the treatment of “athletes” with “athletic injuries” sustained as a result of participation in organized sports
- Change to treating “illness and injury” in “individuals” and “patients”
Athletic Trainers

The statutory title of “athletic trainer” is a misnomer... Athletic trainers provide medical services to all types of people, not just athletes participating in sports...In other countries, athletic therapist and physiotherapist are similar titles.

From NATA’s “Profile of Athletic Trainers”, January 2012.
Accessed 9/9/13
Athletic Trainers

2014 Legislation: Passed

Alaska HB 160: Licensure
Louisiana HB 691: Minor scope change
Washington HB 2430: Workers’ compensation
Athletic Trainers

2014 Legislation: Didn’t Pass

California AB 1890: Title and term protection (vetoed)
Florida HB 669: Scope expansion
Mass. HB 997/SB 457: Payment mandate (study)
Mass. SB 1832: Scope expansion (pending)
Minn. HF 2360/SF 858: Scope expansion
NY AB 6678/SB 4465: Scope expansion (pending)
Utah HB 240: Scope expansion
W. Virginia HB 4413/SB 587: Licensure
Chiropractors

**Issue:** Scope expansion

Hawaii HB 1831/SB 2478
Minneapolis HF 1850/SF 1665

None passed
**Massage Therapists**

**Issues:** Licensure, scope of practice, payment

- **Alaska HB 328:** Licensure - passed
- **Indiana HB 1293:** Licensure (currently certified)
- **Kansas HB 2187:** Licensure
- **Minn. HF 1925:** Licensure
- **New York SB 3737:** Payment
- **NY AB 6634/SB1114:** Workers’ Comp
- **Oklahoma SB 1926:** Licensure
- **Vermont HB 644:** Licensure
Emerging Professions

Primary issue: Licensure
Secondary issues: Scope expansion and payment

Music Therapists
Licensed: North Dakota, Nevada, Georgia
2014 bills: IA, MN, RI (passed), UT (passed)
Things to look for:
Emerging Professions

Naturopathic Physicians
Licensed: 17 states and DC
2014 bills: HI, ID, IL, IA, MD, MA, NJ, NY, RI
Things to look for: Inclusion of “naturopathic physical medicine”, “naturopathic manipulation”, and similar terms
Emerging Professions

Personal Trainers
Licensed: None; required to register in DC
2014 bills: Florida, Massachusetts
Bills intro previously: Georgia, New Jersey
Emerging Professions

Recreation Therapists
Licensed: NH, NC, OK, UT; registered in WA; certification required in CA
2014 bills: New Mexico, New York
Bills intro previously: Maine (vetoed)
Things to look for:
Network Adequacy
Definition

• For Marketplace Plans:
  
  • “Network of providers sufficient in number and type to assure all services will be accessible without unreasonable delay.”

• States may have more stringent NA standards
Insurer perspective

- Increased cost/ risk ACA provisions
  - No medical exclusions
  - No increased premium based on medical status
  - Limited premium increase w/age
  - Cover children to age 26
  - Cover EHB
  - No lifetime cap
Insurer Response

- Limit provider participation
- Select contracting
- Drive volume to “value” providers
- Narrow networks
- Ultra narrow networks
- Broad network….Choice=higher premium
- Premium 5 to 20% lower in narrow network
- Limit out of network benefit
- Increase out of pocket
Who does this affect?

- Exchange enrollees
  - McKinsey report:
    - Narrow network plans available to 92% customers
    - Narrow network plans 48% of products
    - Broad network plans available to 90% customers
- Medicare advantage
- Commercial
Reported Benefit of Narrow Networks

• Integration of services
• Coordination between payer/provider
• More available data
• Better adherence to protocols
• Reduced duplication/testing
• Reduced fragmentation
Issues

• Adequate coverage?
• Patient Access?
• Consumers informed?
• Availability of provider listings?
• Premium vs out of pocket
• Affordability vs choice
• Bills for out of network services
• Numerous lawsuits
Future

• NAIC Model NA regulations in progress
• States introducing NA regulation
• New regulation/guidance for FFM effective 2015
• FFM plans must submit list of certain providers in network:
  – Hospitals
  – Mental health
  – Oncology
  – Primary Care
What APTA and Chapters should do:

• Advocate on behalf of the profession
• Advocate on behalf of patients
• APTA monitors Fed regulations
• Be aware of state specific NA standards
• Provide comment on proposed NA regulations
• Align with other stakeholders
• Provide resources
Utilization Management / Utilization Review Companies
Major Issues w/UM companies

• Policy
  – Definition medical necessity
  – Assessment of function
  – Method visit approval

• System
  – Failed/untested technology
  – Delayed approvals
  – Administrative burden

• Patient Access
  – Interrupted treatment
  – Denied/delayed approval medical necessary services
Increased Use of UM Companies

• Increased PT spend

• PPACA provision: Med loss ratio
  – Purpose: limit insurer profit
  – Insurer must spend % premium $ for medical care
  – Premium rebates if medical % not met
  – 2014 rebates totaled $330 mill
Med Loss Ratio

– Med sized companies: 80% medical/ 20% admin
– Large sized companies: 85% medical/ 15% admin
– UM/ quality management included in medical
– Outsourcing allows payer to fix cost
– Reduces admin/increases medical spend
– Reduces rebates
Insurer Goals

• Reduce cost
• Control utilization
• Address outliers
APTA Mission

• Do its due diligence in advocating on behalf of the profession to ensure physical therapists are able to treat patients based on their clinical judgment and decision making and full scope of licensure, not based on arbitrary policies and protocols.
Response

- Begin dialogue now
- Offer insurer/ER viable alternative
- Value based
  - Patient centered
  - Triple Aim ACA
- Cost stability structure benefits all stakeholders
- Develop consistent message
- Collect data demonstrating ST/LT affect of PT on outcomes
What is APTA doing?

• Developing UM strategy
• UM Tool kit
• Integrity in Practice Campaign
• Registry
• Innovations 2.0 templates
• CPG development
• In dialogue / educating / developing relationships with payers and self insured companies on better models of care
Where to go from here

• Be the driver of change
• Be part of the solution
• Demonstrate measurable value
• Share risk/innovate
• Identify opportunities
• Consider all stakeholders
Introduction

• Big Data is a large volume of Data in structured or unstructured form
• The rate of data generation has increased exponentially by increasing use of data intensive technologies
• Processing or analyzing the huge amount of data is a challenging task
• It requires new infrastructure and a new way of thinking about the way business and IT industry works
Big Data Characteristics

- Volume
- Velocity
- Variety
- Worth
- Complexity

<table>
<thead>
<tr>
<th>Volume</th>
<th>Velocity</th>
<th>Variety</th>
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<tbody>
<tr>
<td>Structured</td>
<td>Batch</td>
<td>Semi structured</td>
</tr>
<tr>
<td>Unstructured</td>
<td>Near time</td>
<td>Unstructured</td>
</tr>
<tr>
<td>Real time</td>
<td>Real time</td>
<td>Semi structured</td>
</tr>
<tr>
<td>Transactions</td>
<td>Streams</td>
<td>Unstructured</td>
</tr>
<tr>
<td>Tables/Files</td>
<td></td>
<td>Structured</td>
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</table>
Challenges in Big Data

- Privacy and security
- Data access and sharing of information
- Analytical challenges
- Technical challenges
- Manpower
Advantages of Big Data

- Understanding and targeting consumers
- Understanding and optimizing business process
- Improving science and research
- Improving healthcare and public health
- Financial trading
Big Data Resources

• All Payers Claims Database (APCD)
• Health Care Cost Institute – Aetna, Humana, and UHC (starting in 2015)
• Kaiser Health News
• America’s Health Insurance Plans
• World Health Care Congress
• Health Affairs
• Commercial Payers (e.g. Optum/UHC)
• AMA RUC database
• National Association of Insurance Commissioners (NAIC)
Health Care Cost Institute

• Data contributors: Aetna, Assurant Health, Humana, Kaiser, UnitedHealthcare
• Currently holds one of the largest private health insurance claims databases available for public reporting and academic research purposes
• Certified as the first national “Qualified Entity” (QE), making it the first organization to have full access to national Medicare claims data for reporting on the costs and quality of health care services
• Build on the robust commercial health plan data set and offer the most comprehensive information available about the price and quality of health care services
Health Care Spending Growth Low

In 2012, spending on health care for people under age 65 with employer-sponsored insurance grew at historically low rates (4.0%). Total spending grew by $181 to $4,701 per person and consumer out-of-pocket spending grew by $35 to $768 per person.

Source: HCCI, 2013.
Notes: All data weighted to reflect the national, younger than 65 ESI Population. Data from 2011 and 2012 adjusted using actuarial completion.
All Payers Claims Database (APCD)

- The existing all payers’ claims databases includes 10 states at varying levels of implementation and usefulness.
- Maine, Massachusetts, and Colorado have the best data currently available.
- Kansas’s effort seems to have stalled in 2010.
- Vermont is currently looking for a new vendor to run its system.
- Tennessee has a system but no online presence.
Who Provides the Data?

- Commercial insurers
- Fully-insured companies
- Some self-insured
- Medicaid (some states)
- Third Party Administrators (TPA)
- Medicare – CMS (some states)
What's in the Data?

- Claims paid by insurance companies licensed in that state
- Medicare claims
- Pharmacy claims
- Hospital claims
- CPT codes, charged/paid/allowed amounts
Data Request Process

• Name and address of the person and/or company requesting the data;
• Name of entity with controlling interest over data requester (if applicable);
• Description of the data or other information sought (please be specific);
• The media on which the data is to be delivered;
• The purpose for which the data will be used (please be specific);
• If the requesting party intends to display any of the data on the Internet, the request must indicate this and provide detailed information;
• Whether or not an internal review board is to be utilized;
• Whether your organization is for profit or non-profit;
• Custodian of the data;
• The ultimate recipient or user of the data;
• The term during which the research will be conducted.
Conclusion and Next Steps...

- The impact of the Big Data have the potential to generate significant productivity growth for a number of sectors
- Big Data presents opportunity to create unprecedented business advantages and better service delivery

Summer 2015
- Contracting with visiting scholar to identify data sources and needs
- Identify gaps and perform thorough analysis of data collected
PAYMENT REFORM AND THE PHYSICAL THERAPY CLASSIFICATION AND PAYMENT SYSTEM
Payment Challenges: Rehab Provided in OP Setting

Pressing Need for Reform

- APTA Development of a Reformed Payment model
  - Began following the BBA 1997-98
  - 2010 more aggressively due to MPPR, MEDPAC and other legislative/regulatory pressures
- Guiding Principles for Reform include;
  - Visit/Session based with eventual transition to episodic model
  - Utilizes Clinical Judgment of the PT in context with assessment tools
  - Factors influencing reporting include;
    - Severity/complexity of the patients presentation with
    - The required intensity/complexity of the therapists clinical decision making and skill/expertise of techniques in the delivery of care
# A “Value” Mindset

**FIGURE 1. ELEMENTS OF CHANGE IN THE OLD/NEW BUSINESS MODEL**

*Source: Kaufman, Hall & Associates, Inc.*

<table>
<thead>
<tr>
<th>Element of Change</th>
<th>Today</th>
<th>Future</th>
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<tbody>
<tr>
<td>Care focus</td>
<td>Sick care</td>
<td>“Healthcare,” wellness and prevention, disease management</td>
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<tr>
<td>Care management</td>
<td>Manage utilization and cost</td>
<td>Manage ongoing health (and optimize care episodes)</td>
</tr>
<tr>
<td></td>
<td>within a care setting</td>
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<tr>
<td>Delivery models</td>
<td>Fragmented/silos</td>
<td>Care continuum and coordination (right care, right place, right time)</td>
</tr>
<tr>
<td>Care setting</td>
<td>In office/hospital</td>
<td>In home, virtual (e-visits, home monitoring, etc.)</td>
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<tr>
<td>Quality measures</td>
<td>Process-focused, individual</td>
<td>Outcomes-focused, population-based</td>
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<tr>
<td>Payment</td>
<td>Fee-for-service</td>
<td>Value-based (outcomes, utilization, total cost)</td>
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<tr>
<td>Financial incentives</td>
<td>Do more, make more</td>
<td>Perform better on measures, make more</td>
</tr>
<tr>
<td>Financial performance</td>
<td>Margin per service, procedure</td>
<td>Margin per life</td>
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The Value Equation: Providers Services and Patient Experience

**Old Model**
- Reward by unit cost
- Inadequate focus on care efficiency
- Payment for unproven services

**New Model**
- Reward health outcomes
- Lower cost while improving consumer experience
- Improve quality and safety
Value-Based Health Care Payment Systems

Figure 1. Continuum of Health Care Payment Methods

Making the Case for Payment Reform
Recommendations from “Phasing Out Fee for Service” (NEJM)

- Transition to Quality and Episodic methodologies should begin with “Blended” approaches
- Site Neutral Payments / Provider Neutral Payments
- Value “Patient Management” over “Procedures”
- Risk Sharing / Innovations Rewarded

We can either drive the change or be driven by it…
Key Elements of Current Approach

- Visit/Session Based Payment System
  - Movement towards reporting (coding) a session rather than specific interventions or unit based
  - Session described in context of clinical judgment of the therapist (level of care)

- Factors include the following characteristics:
  - Severity/complexity of the patients presentation
  - required intensity/complexity of the therapist’s clinical decision making and skill/expertise of techniques/services provided

- 97000 series collapsed with some selected codes remaining as separately reportable
- Initial focus on outpatient setting, but could be modified for other settings
- Focus on accurately communicating clinical reasoning and decision making by supporting choice of treatment level
Reporting Under a Per Session Payment Methodology

**Basic elements should include:**

- Majority of 49 current 97000 CPT codes collapsed into per visit/session code structure
- 4 codes each describing PT evaluations, OT and AT evaluations (3 Levels of IE, one code for eval of established POC’s)
- One Bundled code (ther ex, neuro re-ed, ther act, manual therapy, gt training) describing 5 levels of Interventions
- Codes to describe Cognitive, Psychosocial and ADL, IADL which would have 2 level
- Select services remain as “separately reportable”
  - (~14 services)
- Reporting based on complexity/severity of patient and intensity of therapist work.
Key Factors in Determining Payment

- A payment method based on the accurate and complete communication of the following:
  - Completed Patient Assessment Instrument
  - Evaluation of Clinical Presentation
  - Treatment and management options provided
  - Demonstration of Value associated with achievement of functional outcomes
PT, OT Evaluations 3 Initial, Development of POC
1 Re-Eval, est. POC

<table>
<thead>
<tr>
<th>Clinical Considerations &amp; Complexity of the Examination</th>
<th>Problem - Focused</th>
<th>Expanded</th>
<th>Comprehensive</th>
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<tr>
<td>Limited</td>
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<tr>
<td>Moderate</td>
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<td>2</td>
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</tr>
<tr>
<td>Significant</td>
<td></td>
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<td>3</td>
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<tr>
<td>Established POC</td>
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</table>
**Evolution of Model**

**Collapsing Levels of Interventions**

<table>
<thead>
<tr>
<th>Severity of Patient @ Visit / Intensity of Intervention</th>
<th>Low/Low</th>
<th>Moderate/Low</th>
<th>Moderate/Moderate</th>
<th>High/Moderate</th>
<th>High/High</th>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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- Patient’s presentation
- Clinical decision-making
- Selection of interventions / Risk to the patient
Timeline to Implementation

June-Aug. 2014
- Pilot testing - CPT
- Gathering of data

Sept.-Oct.
- Analysis of data
- Report to APTA-AOTA

Oct.
- Interim report to AMA CPT WG
- Discussion of revisions to potential Proposed revisions to model

Feb. 2015
- Presentation to CPT editorial Panel
- Upon approval, referred to Relative Value Committee

- Potential implementation through Medicare Fee Schedule
Moving Forward- Valuing Services for Payment

- After CPT code change proposal has been accepted,
- Proceeds to AMA Relative Value Update Committee (RUC) process
  - Member surveys to establish values for the various levels of service

Outcome: Values established resulting in pricing on fee schedule
Components of Provider Work

- Time to perform the service
- Technical Skill & Physical Effort
- Mental Effort & Judgment
- Stress associated with concern of risk to the patient

✓ AMA Surveys to Physical Therapists across the Country regarding practice and coding descriptors
The RUC Process
Survey for Work

- Clinical vignette
- Reference Code list
  - Per unit/procedure vs. per visit/session
- Pre, Intra & Post Service time
- Estimated utilization frequencies

- APTA will be soliciting/facilitating Therapists to complete Surveys