CODING REFORM PILOT TEST

Executive Summary

Background
In 1997 the Balanced Budget Act (BBA) created the Medicare therapy cap. The BBA also included a directive to create a new payment system for rehabilitation services. Since that time, the American Physical Therapy Association (APTA) has been actively pursuing payment reform for the physical therapy profession, which encompasses efforts on payment, regulatory, and legislative fronts. In more recent years, as APTA began to explore the ways physical therapy can be incorporated into the evolving value-based health care system, it became apparent that the current procedure-based coding system must be replaced with a more bundled, per-session system. Therefore, APTA began developing a new, per-session coding system that would better integrate into value-based payment models.

APTA’s coding proposal is working its way through the American Medical Association’s (AMA) Current Procedural Terminology (CPT) Editorial Panel and Relative Value Update Scale Committee (RUC) process. This comes after several transformations since 2010 to refine and improve the proposal, based on input and discussion primarily with the 12 other provider groups that have been working in conjunction with APTA to develop the new coding system. APTA and these provider groups, including the American Occupational Therapy Association (AOTA), bill the physical medicine and rehabilitation CPT codes and are part of the AMA Physical Medicine and Rehabilitation (PM&R) work group. AMA charged the work group with fine tuning the new code language.

The new codes emphasize the severity of the patient’s condition and the complexity of the decision making required by the physical therapist. The codes also incorporate the use of standardized tests and measures to help the physical therapy profession begin to report standardized data elements. This will enable outcomes, and ultimately the value of physical therapy, to be measured more uniformly.

Purpose
To advance meaningful coding reform APTA contracted with the Post-Acute Care Center for Research (PACCR) to test the reliability of the new proposed PM&R codes. In addition to reliability, the study was also designed to determine the usability of the new codes and to identify issues with the coding language. This would allow APTA to identify language that may be confusing or unclear to providers, so any such issues could be resolved before the new coding system was implemented. This is a first in the CPT process; no other provider group has tested proposed codes in this way before implementing them.

Testing
The pilot test was conducted in 2 phases between May and December 2014. Phase I used vignettes describing physical therapy patients in multiple practice settings including musculoskeletal, neuromuscular, cardiovascular, pulmonary, pediatric, orthopedic, and geriatric. PACCR developed the

Please note: The information provided is offered for general informational purposes only. It is not offered or intended, nor should it be relied upon, as legal advice. Legal doctrines, statutes, and case law vary from state to state. You should consult with your own attorney for specific legal advice on particular legal issues.
vignettes with input from physical therapists in different practice settings, and physical therapists reviewed them for clarity and clinical validity before the Phase I testing.

There were 4 testing sites during Phase I: Charlotte, Chicago, Los Angeles, and Philadelphia. Participants were required to be practicing physical therapists with at least 1 year of experience, be familiar with CPT coding, and complete training for the proposed new PM&R codes. Participants were given up to 2 vignettes based on their practice type and asked to assign the applicable evaluation and intervention codes using the proposed PM&R codes. Participants were encouraged to denote areas of confusion with the code set or the vignettes.

Phase II expanded on Phase I by asking physical therapists to use the proposed codes on a small number of their own patients. Recoding past patient visits with the new coding system allowed PACCR to better gauge the usability of the proposed terminology, definitions, and comprehensiveness of the code set when applied to actual patients.

Phase II was conducted at 2 testing sites: Intermountain Health Care in Salt Lake City and UPMC in Pittsburgh. Again, participants were required to be practicing physical therapists with at least 1 year of experience, be familiar with CPT coding, and participate in a training session for the new codes. Participants were given 2 patients who had been predetermined to have a diagnosis of low back pain, total knee replacement, or cerebral vascular accident. These patient cases had been treated by the participating physical therapist and received between 4 and 20 therapy visits. Following the training, the participants were required to re-code each visit using the proposed codes.

Results
Phase 1 testing included 108 physical therapists. The majority of the participants identified their primary area of practice as musculoskeletal, and they practiced in a private practice setting. However, home health, hospital-based outpatient clinics, and skilled nursing facilities were also common practice settings. The average participant was licensed for 19 years and spent over 60% of his or her time in clinical practice.

Phase II testing included 33 physical therapists. Of those, 82% identified their primary area of practice as musculoskeletal, and 18% identified as neuromuscular. The majority of the participants worked in hospital-based outpatient clinics; however, private practice and inpatient rehabilitation facilities were also represented. The average therapist participating in Phase II had been licensed for 14.5 years.

In Phase I, moderate interrater reliability was found for the evaluation codes and intervention codes. However, the study did reveal some confusion when physical therapists were coding patients who fell into the mid-level body structure function (BSF) intervention codes.

The Phase II results revealed that the musculoskeletal cases tended to be coded using the lower-level evaluation and intervention codes, while the neuromuscular cases were more often coded using the higher-level codes. The testers rarely used the activities of daily living (ADL) and instrumental activities of daily living (IADL) codes. Phase II also showed matching patterns between the current CPT codes and the proposed codes; for example, therapeutic exercises (97110) and manual therapy (97140) were often matched with the lower-level BSF codes. Neuromuscular reeducation (97112) and gait training (97116)

Please note: The information provided is offered for general informational purposes only. It is not offered or intended, nor should it be relied upon, as legal advice. Legal doctrines, statutes, and case law vary from state to state. You should consult with your own attorney for specific legal advice on particular legal issues.
often corresponded to the higher-level proposed BSF codes. Phase II also revealed less consistency between the new code level and the clinical components of physical effort and direct contact.

**Recommendations**

Overall, participants in Phase I and Phase II believed that the new proposed coding system better reflected the scope of physical therapist practice than the current system. However, based on the responses and the feedback given in both phases of testing, PACCR made recommendations to help improve the proposed PM&R codes.

In general, participants reported that it would be helpful if definitions for certain terms were included in the new coding system, such as personal factors and clinical decision making. PACCR recommended clarifying the coding language to better distinguish between the different intervention levels and also refining the instructions for the proposed coding system. PACCR also suggested looking at the direct contact component of the codes. It appeared from both phases that the amount of direct contact may not have a strong correlation to the level of the evaluation or intervention code the physical therapist selects.

In addition to the PACCR recommendations, patterns also emerged in the comments from participants. Many participants recognized the need for training when the new coding system is implemented. Several commented that documentation standards will need to change, and physical therapists will, for example, need to provide more detailed information regarding clinical decision making, the level of patient complexity, and changes in a patient’s status. In Phase II, the components of the proposed codes were presented in a chart rather than a text paragraph, and Phase II participants noted that the chart format made it easier for them to determine which code to select. APTA will use these participant comments to develop training and educational materials on the new codes.

**Next Steps**

APTA is working with PACCR and the AMA PM&R work group to improve the coding proposal based on the preliminary results of the pilot study, and to clarify any coding language that was confusing to participants. APTA already has made modifications to the proposed evaluation and reevaluation codes based on the pilot test results. The association is now editing the coding language for the intervention codes and is considering whether additional testing is needed to determine if the edited language improves the reliability of the coding system.

**Summary**

APTA tested the coding proposal not to validate that the proposed codes as if they were in final form, but rather to determine what improvements could be made to help physical therapists better understand and use the new system. APTA’s goal is to position physical therapy as an integral component of the new value-based health care system by reforming payment to better articulate the value of physical therapy, achieve appropriate regulation, and transition from a model based on the number of procedures performed to one focused on the management and outcomes of patients. APTA continues to work with PACCR, AMA, and other stakeholders to improve the coding system and ensure that these coding changes meet the desired goals of the profession.

**Please note:** The information provided is offered for general informational purposes only. It is not offered or intended, nor should it be relied upon, as legal advice. Legal doctrines, statutes, and case law vary from state to state. You should consult with your own attorney for specific legal advice on particular legal issues.