American Academy of Physical Medicine and Rehabilitation

aaPM&R

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August 29, 2013

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1600-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: File Code-CMS-1600-P; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2014; Proposed Rule; (July 19, 2013).

Dear Administrator Tavenner:

As an important member of the physician community, the American Academy of Physical Medicine and Rehabilitation (AAPM&R) appreciates the opportunity to comment on the 2014 Physician Fee Schedule proposed rule. The AAPM&R is the national medical society representing more than 8,000 physiatrists, physicians who are specialists in the field of physical medicine and rehabilitation (physiatry). Physiatrists treat adults and children with acute and chronic pain, persons who have experienced catastrophic events resulting in paraplegia, quadriplegia, traumatic brain injury, spinal cord injury, limb amputations, rheumatologic conditions, musculoskeletal injuries, and persons with neurologic disorders or any other disease process that results in impairment and/or disability.

Quality

PQRS

Although the Academy supports the use of quality measures and the need to provide more flexibility within the PQRS program, we remain concerned with a few of the proposed changes. We are specifically interested in the proposal to increase quality reporting requirements to qualify for incentive payments in 2016 from three to nine measures. If this proposals stands, the reporting burden for PM&R would be unduly exacerbated due to the lack of measures that are considered applicable to the practice of physiatry. Unlike many other physicians who are held to diagnostic-specific quality measures or process measures related to a diagnosis, physiatrists concentrate on improving functional outcomes and quality of life within populations with a wide degree of inter- and intra-patient group variability. Measures that reflect the outcomes

of care important to the beneficiaries that physiatrists typically treat, those with disabling conditions and complex co-morbidities, have not been fully developed or tested. While the proposed rule includes a recommendation to add a functional status assessment measure for complex chronic conditions, this measure is limited to patients with an active diagnosis of heart failure.

Another concern relates to the proposal to eliminate the claims-based reporting mechanism. As the claims-based reporting mechanism is the most widely used, the Academy feels eliminating this option would place undue pressures on small practices that are working hard to move towards being totally digital, but are not there yet. As the health care system continues to move toward an electronic platform, it is reasonable to assume that the claims data reporting mechanism will become less popular in the coming years, ultimately reducing the burden on CMS to analyze quality measures data. The Academy believes this issue will resolve itself, as it is likely to be phased out naturally as providers move to EHR systems at a reasonable pace.

Clinical Quality Data Registries (CQDRs)

Despite the requirement for Qualified Clinical Data Registries to include one outcome measure, the Academy remains concerned that current registry data is reflective of a snap shot in time, as opposed to longitudinal outcomes. It is critical that any quality data collected is able to show the true value of care. In the case of many of the patients treated by physiatrists, a snap shot would not be representative of the value of their treatment, as these beneficiaries' outcomes rely on a continuum of care designed to restore or maintain function that may continue throughout the person's lifetime, in order to live independently and with a high quality of life. Furthermore, one of the challenges associated with longitudinal functional status measures is the variability of outcomes of risk adjusted groups, which make valid benchmarking virtually impossible to achieve. Despite the challenges that the practice of PM&R encounters with respect to quality and outcomes measures, we continue to work hard on developments in this area and we certainly recognize the importance of measuring and paying for outcomes.

The Academy encourages CMS to ensure that there is ample time for specialty societies to review the list of approved registries, the measures that have been selected for inclusion in each registry, and that there is some oversight in ensuring measures are validated properly.

Physician Compare

After several conversations with the physician compare team and numerous written comments on the subject, the proposed redesign does not address what the Academy has identified as an underlying flaw; permitting chiropractors to self-identify themselves as specialists in "Physical Medicine, Sports Medicine and Rehabilitation". When searching the category "Physical Medicine, Sports Medicine and Rehabilitation" for PM&R physicians using the physician search tool, chiropractors are incorrectly listed among physicians. Allowing chiropractors to self-report themselves as specialists in "Physical Medicine, Sports Medicine, and Rehabilitation," instead of specialists of chiropractic medicine, as either a

primary OR a secondary specialty, will inappropriately aggregate quality data between PM&R physicians and chiropractors and skew the PQRS data, as data collected from the two groups is not comparable. The medical encounters provided by chiropractic doctors are not analogous to that of board-certified PM&R physicians, therefore, chiropractors should not be permitted to self-identify within an ABMS designated specialty or subspecialty.

Furthermore, implementing prospective models of payment reform, such as the proposed value-based payment modifier, will become problematic as the algorithm would be based on a distorted data set. This could negatively impact future quality incentive payment rates for physicians specializing in PM&R. We urge CMS to modify the website to accurately reflect the specialty of PM&R as there are definitive differences between the requirements of PM&R training and that of chiropractic training.

Therapy Services – Critical Access Hospitals

The Academy is concerned about the CMS proposal to apply therapy caps to critical access hospitals (CAHs) permanently effective January 1, 2014. The Agency provides a detailed analysis of the legislative and regulatory rationale for applying the caps and associated exceptions process (if an exceptions process is required by law) to this setting.

The AAPM&R opposes this payment policy especially given the unique nature of CAHs. CAHs are paid at a higher rate than providers paid under the fee schedule and must be located at least 35 miles from any other hospital, which demonstrates the unique nature of this setting and the beneficiaries it serves. Because CAHs play an important role as safety net providers of care in many communities, it would be devastating to apply this flawed policy, especially because the most vulnerable beneficiaries would be most at risk for reaching the therapy cap.

Outpatient Prospective Payment System (OPPS) Cap on Physician Fee Schedule Practice Expense Relative Value Units (PE-RVUs)

The AAPM&R opposes capping payments to services performed in the non-facility setting when those payments are greater than what is paid when the same service is performed in either the hospital outpatient or ambulatory surgical center (ASC) facility setting. Implementing this proposal could have real consequences on beneficiary cost and access for affected procedures. Many of the services identified are low volume procedures, therefore, it is reasonable to assume that hospitals could cover lower payment for those services. However, since Ambulatory Payment Classification Codes (APCs) are designed to over pay some services and under pay others, hospitals accept that the cost of services will average out over time. For physicians who are not paid the hospital rate for services within the same APC cannot offset their losses. This will force physicians to perform procedures in a more cost sustainable setting.

Shifting patients to a facility setting is an undue burden for private practices that are already putting much of their resources into adopting electronic health records and moving towards

reporting quality measures without the resources, both staff and financial, that facilities and hospitals enjoy. Furthermore, while beneficiaries generally pay 20% of the Medicare-approved amount for the physician service in either setting, services performed in the outpatient setting also require the patient to make a copayment. This could negatively impact the ability of fixed-income patients to afford medically necessary care. Furthermore, moving services to the facility increases total costs to Medicare, as the additional APC/ASC payment rate must be paid on top of the physician rate. It is important to note that these higher costs would be subsumed by all parties not because of improved patient care, but because of an arbitrary reduction.

Additionally, by forcing these services to be shifted into hospital facilities, patients in rural and low-income areas will face access to care barriers. Physiatrists treat some of the most vulnerable beneficiaries living with multiple chronic conditions and disabilities. By shifting these patients to an outpatient hospital for various procedures, especially in a rural area, could add significant travel time, something that may not be feasible for this patient population.

Code: 76942, Ultrasonic guidance for needle placement

The AAPM&R agrees with CMS's proposal to replace the current equipment of *room, ultrasound, general, EL015 with the ultrasound unit, portable, EQ250* for CPT code 76942 *Ultrasonic guidance for needle placement, imaging supervision and interpretation.* However, the Academy strongly disagrees that this change in equipment constitutes a change in the typical kinds of procedures reported with 76942. Furthermore, CMS states that the CPT code 20610 *Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)* is the code most frequently reported with 76942. CPT code 20610 is a surgical procedure and 76942 is an imaging supervision and interpretation (S&I) service. For S&I codes, activities occur in addition to the base surgical codes. Many of the clinical staff activities included in the S&I code do not occur with the surgical code.

Reducing the direct practice expense (PE) inputs for clinical staff and equipment minutes associated with 76942 from 58 to 23 based on an altered intra-service time assumption is not based on sound analysis. In addition, a CPT coding proposal has been prepared by the specialty societies for the October 2013 CPT Editorial Panel meeting to bundle CPT codes 20610 and 76942 and these bundled codes will be reviewed for both work and practice expense at the April 2014 RUC meeting. All aspects of the services, including intra-service time and PE inputs will be reviewed at that time. **The AAPM&R requests that CMS delay implementation of changes to the work intra service time and PE clinical staff time and equipment time, until the RUC has had an opportunity to review the code and account for any efficiencies that have developed since the code was last reviewed and as a result of bundling.**

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Complex Chronic Care Management Services (CCCM)

The Academy applauds CMS for working with the American Medical Association (AMA) to develop this progressive model of patient care. Because physiatrists treat mostly beneficiaries with multiple chronic conditions and disabilities, it is important that PM&R be considered to participate in this model if they meet the patient care requirements. It would be counterproductive to limit this program to primary care only, when many beneficiaries who meet the criteria detailed in the proposed rule may prefer medical management by a physician specializing in maintaining or improving functional status and quality of life.

Furthermore, the AAPM&R would recommend that CMS revise the requirement that a practice "must employ one or more advanced practical registered nurse or physician assistant." CMS staff have clarified that this does not impact the level of clinical staff working with the physician to provide the service, but rather is a metric to identify the necessary infrastructure and capability to provide CCCM. The Academy disagrees with the provision that employment of this level of staff be a consideration in final implementation. There are certainly practices that employ registered nurses who are well qualified to provide care management. Second, we have significant concerns with the discussed Electronic Health Record (EHR) requirements. While physicians look forward to a future when EHR is available with total interoperability of all providers real time 24 hours per day and 7 days a week, this is not yet attainable for too many physicians. Physicians, who would otherwise be qualified to provide CCCM and can demonstrate timely access to a patient's medical records, should be eligible to report CCCM as systems transition to more sophisticated and coordinated EHRs.

Additionally, CMS indicates that some suggest that practices could be recognized as medical homes by a national organization, such as the National Committee for Quality Assurance (NCQA) or the Joint Commission, to demonstrate met standards to provide CCCM. The Academy believes that any physician practice should be able to qualify for payment of CCCM as long as the individual practice meets the practice requirements established to report these individual codes. We do not support a requirement that physician practices be certified as primary care medical homes in order to receive payment for complex chronic care management.

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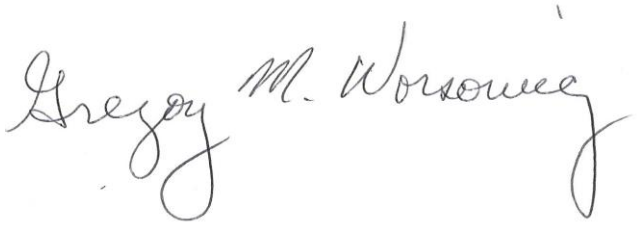
The American Academy of Physical Medicine and Rehabilitation thanks CMS for the opportunity to share its thoughts on the CY14 Physician Fee Schedule. If you have any questions or require more information, please contact Sarah D'Orsie, Director of Government Affairs, at sdorsie@aapmr.org, or (202) 349-4277.

Sincerely,



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