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SUBMITTED VIA ELECTRONIC MAIL

September 6, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd
Baltimore MD 21244-1850

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; CMS 1654-P

Dear Administrator Slavitt:

On behalf of the more than 8,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), we appreciate this opportunity to submit comments on the 2017 proposed Medicare physician fee schedule rule. Physiatrists are specialists in the field of physician medicine and rehabilitation (physiatry) and 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.

Our physicians serve a disproportionate number of individuals with physical disabilities, especially those with mobility impairments. As an Academy, we have long aligned ourselves with the interests of persons with disabilities and chronic conditions, and have promoted policies to increase access, choice and quality of health care services to improve health and function, quality of life and independent living. We are pleased to comment on the following priority issues for physiatrists in the proposed rule.

1. Proposed HCPCS G-code to Improve Payment Accuracy for Care of People with Mobility-Related Disabilities

The proposed rule seeks to address a long-standing problem related to health disparities of people with disabilities by establishing a new add-on “G” code that physicians could use to receive accurate payment for the extra clinical time, accessible equipment, and expertise required to provide access and quality care to people with disabilities, particularly Medicare beneficiaries with mobility impairments. The proposed rule cites the National Healthcare Disparities Report



produced by the Agency for Healthcare Research and Quality for the proposition that access and quality disparities derive from a “range of payment challenges, accessibility issues with equipment and facilities, communication obstacles, and sometimes lack of practitioner understanding of how to assess and fully address the needs and preferences of people with disabilities.” CMS-1654-P, page 193.

This broad statement of disability disparities, with which we agree, is followed by a proposal to establish an add-on HCPCS billing code, a “G” code, to improve payment accuracy for physicians who treat people with “mobility-related disabilities.” The fee schedule value of this code is proposed to be approximately \$44.36 and could be charged by physicians who see beneficiaries with mobility impairments to more accurately account for any required additional physician and clinical staff time, skilled assistance throughout the visit to safely move and adjust the patient, and added costs of specialized equipment such as wheelchair-accessible scales, examination tables, and other equipment used to accommodate the beneficiary with a disability.

The Academy thought long and hard about this aspect of the proposed rule. We applaud CMS and the HHS Office of Minority Health for offering a concrete proposal with significant funding to meaningfully address this problem. Frankly, 40 years after the issuance of disability nondiscrimination regulations impacting physicians who receive federal funds, and 26 years after passage of Americans with Disabilities Act which applies to physicians’ office and all places of public accommodation, it is alarming that these disability-based disparities still exist. As physicians who serve a disproportionate number of beneficiaries with disabilities and mobility impairments every day, we are on the front lines of treating this beneficiary population.

We would *like* to support this proposal on behalf of our patients as a major step toward reducing disability disparities in healthcare, but unfortunately, we cannot support this proposal in its current form for two reasons. First, the proposal is narrowly focused on beneficiaries with mobility impairments and favors one disability subgroup over another.¹ This is inequitable at best and potentially

¹ We appreciate the fact that CMS is proposing the creation of additional codes to reflect additional payment for patients with cognitive impairments who need care planning services, and patients with behavioral health conditions who require collaborative care management. While the Academy supports the creation of these codes as noted later in this comment letter, these codes will not address the time and resource needs of patients in the context of a routine physician office visit. In addition, there is no proposal to establish a new code for patients with communication disorders who require additional time, resources or technologies to effectively communicate with medical staff.

discriminatory at worst. Second, granting a physician the ability to bill the Medicare program an additional fee in order to provide accessible health care services creates a copayment obligation on the beneficiary. Surcharges of this nature on individuals otherwise protected by federal disability nondiscrimination laws are prohibited.

The proposal in its current form is intended to meaningfully address the serious problem of health care disparities in access and quality experienced by Medicare beneficiaries with disabilities. But the proposal focuses narrowly on compensating physicians for “the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lifts, and adjustable padded leg supports).” CMS-1654-P, page 196. The Academy asks why, in addition to this particular G-code for mobility impairments, similar G-codes could not be established to cover the following situations:

- a. A patient with severe cognitive issues who requires additional staff time to treat in the context of a routine physician office visit;
- b. A person with communication disorders who requires additional time and, perhaps, technology, to effectively communicate; or
- c. An individual with severe emotional/behavioral health issues who requires greater than average time and resources during a physician office visit.

In short, while we admire and support the intent of the proposal, we believe it is fundamentally unfair as written, in that it selects winners and losers among the beneficiary population. Worse yet, all of the individuals cited herein have supposedly been guaranteed equal access to health care services for the past several decades.

With respect to the additional fee that would flow to the physician from the Medicare program under this proposal, the patient would be obligated, as with most Medicare Part B services, to cover a 20 percent copayment. This would impose a “surcharge” on Medicare beneficiaries with mobility impairments to obtain accessible health care services, even though they are already entitled to them under federal law. Imposing a surcharge on individuals with disabilities violates federal civil rights laws that prohibit such fees on individuals with disabilities in order to receive equal access to services provided by a recipient of federal funds (under Section 504 of the Rehabilitation Act of 1973) or provided by a place of public accommodation (under Title III of the Americans with Disabilities Act of 1990). For instance, Title III of the ADA states:

“Charges. A public accommodation may not impose a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids, barrier removal, alternatives to barrier removal, and reasonable modifications in policies, practices or procedures, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.” See, 28 CFR Sec. 36.301

All physicians who accept Medicare payments or invite the general public to access their services are covered by these long-standing federal civil rights laws. Finally, this additional copayment may also serve as a disincentive for beneficiaries with mobility impairments to seek out physician care if their financial resources do not permit them to pay an additional copayment of approximately \$9 every time they visit a physician.

Unless the proposed G code is reconsidered and additional codes are created to ensure that all beneficiaries with disabilities are treated in an equitable manner, and unless CMS agrees to cover this G code(s) at 100 percent cost-sharing the way preventive services are treated, thereby eliminating any additional payment obligation on the patient, the Academy cannot support this proposal. However, we commend CMS for its efforts in seeking ways to address this intractable problem and we look forward to continuing to work together to find ways to address health care disparities of all kinds, especially disability-based disparities.

2. **Misvalued Code Screen for 0-Day Global Services Typically Billed with an E/M Service with Modifier 25**

- **Trigger Point and Tendon Sheath or Ligament Injections:** We strongly object to the inclusion of codes 20550, 20552 and 20553 on the list of potentially misvalued codes. All of these codes were surveyed last year and are listed on Table 23 of the proposed rule as codes that are being proposed for revaluation. Thus they do not meet the screen criteria.

In addition, with respect to CPT Code 20550, the summary of recommendation form states that this service may typically be reported with an E/M service and the RUC accounted for this in its valuation recommendation.

- **Arthrocentesis:** For similar reasons, we do not believe the arthrocentesis codes (CPT Codes 20600-20610) belong on the list of potentially misvalued codes. These codes were either valued within the last 5 years and thus do not meet the screen criteria or the RUC reaffirmed the values when it reviewed

other arthrocentesis codes in January of 2014. In addition, the RUC Summary of Recommendation form for 20600 and 20605 stated that the service is typically reported with an E/M code and the RUC accounted for this in its valuation recommendation.

- **Osteopathic Manipulation:** We also object to the inclusion of the osteopathic manipulation codes (CPT Codes 98925-98929). When these codes were valued, the RVUs were reduced to account for the fact that they are typically reported with an E/M service. The physician work and PE RVUs for these services reflect only work and practice expense unique to osteopathic manipulation and specifically exclude work and PE that would accompany an E/M service.

For all of the above reasons, these codes are not misvalued and should not be considered as such. We request that CMS remove these codes from the list.

3. New and Revised Codes

- **Fluoroscopic Guidance:** CMS is proposing work RVUs for CPT Codes 77002 and 77003 of 0.38 instead of 0.54 and 0.60, respectively, recommended by the RUC on the grounds that they are similar in work to CPT Code 77001 for which the RUC recommended work RVUs of 0.38. We strongly disagree with this proposal.

The physician work, intensity, and complexity of 77001 are significantly less compared to 77002 and 77003. This was reflected in the recommendations of the specialty societies and the RUC agreed. We urge CMS to acknowledge the variation in intensity and physician work required for these services and to accept the RUC recommendation of a work RVU of 0.54 for CPT Code 77002 and 0.60 for 77003. Alternatively, we request that these codes be referred to the Refinement Panel for further consideration.

- **Neurostimulator pulse generator systems:** We support the proposal to maintain the current work and PE RVUs for the analysis of neurostimulator pulse generator systems (CPT Code 95971-95972). These codes were revalued in 2015 and there is no reason to make any changes. We therefore agree with CMS' proposal to keep the current RVUs.
- **Epidural Injections:** We also strongly support CMS' proposal to accept the RUC recommendations for the eight new epidural injection codes (CPT Codes 623X5-X12).

4. Chronic Care Management and Prolonged E/M Services

We strongly support CMS' proposal to separately pay for complex chronic care management services (CPT Codes 99487 and 99489) and to accept the RUC recommended RVUs for these services. Psychiatrists often provide care to individuals with complex chronic conditions that involve significant time not captured by other codes. This includes both time spent with the patient and non-face-to-face time. It often involves coordination of care with the clinical teams in post-acute care facilities including SNFs and inpatient rehabilitation hospitals and units. The proposal to unbundle these services and allow separate payment will help ensure that patients, especially those with disabilities, receive the level of care to which they are entitled.

We also commend CMS for its proposal to increase payment for prolonged E/M services (CPT Code 99354) and to pay separately for non-face-to-face prolonged E/M services (CPT Codes 99358 and 99359). We appreciate that CMS is recognizing the significant work and care coordination that is involved in caring for individuals with complex health care needs. We believe these changes will promote high quality care for our aging and disabled populations.

5. Behavioral Health Services

We are pleased that CMS has proposed to pay for behavioral health integration services focused on collaborative care management through the addition of several new G-codes. These codes will provide for a more team based approach to addressing behavioral health issues. Many patients cared for by psychiatrists including, in particular, those with stroke and traumatic brain injury, have behavioral health needs that must be addressed. This proposal has the Academy's strong support because it will increase access to care for these Medicare beneficiaries.

6. Payment for Cognitive Care Planning and Assessment

We support CMS' proposal to create a new G code to pay for assessment and care planning for patients with cognitive impairments. Many of our patients, in particular those with stroke or traumatic brain injury, have cognitive impairments. Assessing these patients and developing a plan of care involves obtaining detailed histories from the patient and family members and can be very time consuming. We are pleased that CMS will recognize separate payment for this service by a physician or other health care professional.

7. Appropriate Use Criteria for Advanced Imaging

We support the goals of the appropriate use criteria required by Section 218(b) of the Protecting Access to Medicare Act (PAMA) to ensure proper use of advanced imaging procedures. However, we are concerned that the proposed regulations implementing the program may inappropriately deter physicians from ordering advanced imaging procedures even when medically necessary and clinically appropriate.

The proposed rule fails to clarify the obligations of the ordering physician to consult CDSMs especially when ordering services that do not fall within the identified priority areas. If the proposal is intended to require ordering physicians to consult AUCs for all advanced diagnostic services, it is unclear why the proposal only requires CDSMs to include AUCs for the focus areas. We strongly urge that the final rule clarify the obligation of the ordering physician in this regard.

We also believe it is important that the AUCs included in the CDSMs be transparent and that a non-proprietary option be available. We also believe that required reporting that AUCs were consulted should not create additional administrative burdens for ordering physicians. We believe ordering physicians should be able to document their rationale or decision making in the medical record in the form of a narrative or statement that appropriate AUCs were consulted.

8. Data Collection for Global Services

CMS is proposing a claims-based data collection that would be applicable to all physicians and to all 10-day and 90-day global services. To implement this, CMS would create eight new G codes that clinicians would have to report to describe each 10 minutes of care furnished before or after a procedure or surgery.

AAPM&R has serious concerns about the breadth of the data collection process which appears to go well beyond the agency's statutory mandate. Although we understand and appreciate CMS' interest in obtaining robust data, we believe this will create an enormous documentation burden for physicians who are already struggling to deal with a legion of new requirements and reporting obligations imposed by the MIPS program. The requirement that data be collected for each 10-minute segment is both unprecedented and unreasonable. Physicians have no experience documenting services in 10 minute intervals. We believe it is highly unlikely that the data collected through the use of the proposed new G codes will


yield reliable information. We strongly urge that CMS restrict its data collection to a representative sample of physicians as intended by Congress when it enacted section 523(a) of MACRA.

9. Refinement Panel Process

The Academy is very disappointed that CMS has proposed to effectively eliminate the Refinement Panel as a process for considering relative value appeals. The Academy supports the AMA's request that CMS open the Refinement Panel review to all procedures and services that are under CMS review during the current rulemaking process. This process creates the best mechanism for gathering and utilizing expertise from physicians and other health care professionals to determine resources used in the provision of services to Medicare beneficiaries.

Thank you for the opportunity to comment on this important proposed rule. If the Academy can be of further assistance to you on this or any other rule, please contact Kate Stinneford at 847-737-6022 or by email at kstinneford@aapmr.org for further information.

Sincerely,



Annie Davidson Purcell, D.O.
Chair
Reimbursement and Policy Review Committee