American Academy of Physical Medicine and Rehabilitation

aaPM&R

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September 8, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1631–P
P.O. Box 8013, Baltimore, MD 21244–1850

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Proposed Rule

Dear Mr. Slavitt:

On behalf of the more than 8,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAMP&R), we appreciate the opportunity to submit comments to the proposed rule: *Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Proposed Rule* that was published in the Federal Register on July 15, 2015. Physiatrists are specialists in the field of physical 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.

CY 2016 Identification of Potentially Misvalued Services for Review

Review of High Expenditure Services across Specialties with Medicare Allowed Charges of $10,000,000 or More

In this Proposed Rule, CMS re-ran the high expenditure screen and identified 118 high expenditure services as potentially misvalued. **The AAPM&R notes that CPT® codes 97032, 97035, 97110, 97112, 97113, 97116, 97140, 97530 and G0283 are all currently referred to the CPT Editorial Panel as the entire Physical Medicine and Rehabilitation section is undergoing revision.**

CCM and TCM Services

Payment for CPT Codes Related to CCM Services

In the CY 2015 PFS final rule (79 FR 67719), CMS stated that beneficiaries with two or more chronic conditions as defined under the chronic care management (CCM) code

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can benefit from the care management services and the Agency wants to make this service available to all such beneficiaries.

Physiatrists treat patients across all care settings, including outpatient clinics, inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and long term acute care hospitals (LTACHs), often treating chronically ill patients and coordinating care for patients suffering from chronic disabling conditions such as stroke, spinal cord injury (SCI), and traumatic brain injury (TBI). Managing these conditions is often labor intensive and requires physiatrists to coordinate a patient's care with the rehabilitation team. For example, a patient with multiple trauma and a TBI is best managed by a physiatrist overseeing and coordinating care with physical, occupational and speech therapists in addition to an Orthotist/Prosthetist as needed, and medication reconciliation. Another good example is a patient with a SCI: it is not uncommon for a physiatrist to assume a primary care role due to the majority of organ systems being affected by the SCI. In this situation, a physiatrist often coordinates care among therapists as above in addition to preventative care (e.g. vaccinations to prevent pneumonia), bowel and bladder management, treatment of osteoporosis, chronic wound care, adjustments to durable medical equipment, coordinating care with family, private care givers or home health care, etc.

AAPM&R believes that Physiatry is the appropriate specialty to determine the medical necessity of these services for beneficiaries. With appropriate medical rehabilitation services and programs across the continuum of care, patients can regain significant function, returning to fulfilling and productive lives in their homes and communities, and that at a lower cost to the government.

Methodology for Establishing the Direct PE Inputs Used to Develop PE RVUs

New Supply and Equipment Items

In this Proposed Rule, CMS received recommendations from the RUC on the use of supply and equipment items that already exist in the direct PE input database for new, revised, and potentially misvalued codes. One of the recommendations included the radiofrequency generator (EQ214) for codes 41530, 43228, 43229, and 43270. Historically a new item will be created, however, in this case the current radiofrequency supply code was used and the price was decreased significantly. **AAPM&R recommends that CMS create a new code for the radiofrequency generator used to provide the services described by CPT codes 41530, 43228, 43229, and 43270. The device used to perform these services is significantly different than that used to provide the service described by CPT codes 64633, 64634, 64635, and 64636. The current price correctly represents the device used in the destruction of paravertebral facet joint nerve(s) by a neurolytic agent.**

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Incident to Proposals: Billing Physician as the Supervising Physician and Ancillary Personnel Requirements

Billing Physician as the Supervising Physician

For CY 2016, CMS proposes to remove the last sentence from § 410.26(b)(5) specifying that the physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) upon whose professional service the incident to service is based. The AAPM&R has concerns with this proposal and strongly urges CMS not to adopt this change.

While the Academy agrees that the physician who initiates the plan of care should supervise the service to be able to bill for incident-to, the AAPM&R believes that to ensure adequate care for a patient a person of comparable clinical training should be able to supervise and bill for the incident-to service under their national provider identifier. This proposal eliminates the ability of providers practicing together with comparable competencies, to cover for each other. **AAPM&R believes that the proposed change will severely impact beneficiaries' access to care and create undue burden on providers as it will require a detrimental change in current practice.**

Additionally, the Academy agrees with CMS that the provider who initiated the plan of care should have a personal role in, and responsibility for, the services furnished as a result of the care plan developed. **Thus, we recommend that the provider who is not supervising, but initiated the plan of care be required to review and attest to the accuracy of the plan of care and any services provided that they did not supervise.**

Other Provisions of the Proposed Regulations

Physician Compare Web site

In this Proposed Rule, CMS is proposing to expand the information on whether providers participated in Medicare quality programs to include a green check to mark indicate if an individual eligible professional or group practice received an upward adjustment for the Value Modifier.

For the 2018 Value Modifier, this information is proposed to be based on 2016 data and included on the site no later than late 2017. While AAPM&R supports continuous improvement towards healthcare transparency, CMS must first evaluate carefully to what extent patients and physicians are visiting the Physician Compare website and using the information for healthcare decision making. Also, the lack of a green check mark attached to an eligible professional may indirectly be perceived as a downward payment by a consumer, even if the eligible professional received a neutral adjustment. **AAM&R recommends CMS conduct further analysis on how patients and physicians are using the Physician Compare website to influence healthcare**

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decision making and share this information with the physician community to receive more meaningful feedback on how to improve the current website. AAPM&R also urges CMS to not add a green check mark until this further analysis has been completed and accepted by the physician community.

In previous years, CMS finalized plans to make all 2015 PQRS measures for individual eligible professionals available for public reporting, and proposes in this rule to continue to make all PQRS measures available for public reporting annually. CMS also proposes to include benchmarks for PQRS measures based on PQRS performance rates, using the Achievable Benchmark of Care (ABC™) methodology. Although AAPM&R believes that ABC's™ approach to deriving benchmarks is data-driven, represents a level of excellence and is demonstrably attainable, as evidenced by many studies. The Academy also believes that chance fluctuations, small sample sizes or samples of unequal size can produce unstable performance measures using the ABC™ approach. Any pitfalls in data accuracy and utility need to be analyzed prior to expanding the data reported publicly. For example, physiatrists practice in large urban areas as well as in small rural areas where the population of patients may be similar but the amount of resources available may vary. Making comparisons across these practice settings without risk adjusting for factors not in the provider's control inappropriate. **AAPM&R strongly urges CMS to adequately educate physicians and consumers on the strengths and limitations of the ABC™ approach, test whether physicians and consumers alike understand the approach and determine how best to indicate any limitations of this approach on the website. Further, AAPM&R urges CMS to ensure a transparent appeals process with appropriate guidance is available for physicians prior to information becoming public.**

Physician Payment, Efficiency, and Quality Improvements—Physician Quality Reporting System

For CY 2016 PQRS reporting, CMS is not proposing to make any major changes to reporting via claims or registry. Therefore, providers reporting via claims or registry would be required to report 9 measures (including one cross-cutting measure), covering at least 3 National Quality Strategy domains, and report each measure for 50% of their Medicare Part B Fee-for-Service patients seen during the reporting period. Providers reporting via registry could also report 1 measures group on 20 patients (more than 50% of which must be Medicare Part B patients).

AAPM&R is in support of many of the new measures proposed for the 2016 PQRS reporting program. Specifically, the multiple chronic conditions measures group and the measures related to cognitive impairment. The Academy has strongly supported measures that reflect the outcomes of care important to the beneficiaries that physiatrists typically treat – those with disabling conditions and complex co-morbidities. The AAPM&R believes that the implementation of these types of measures is a step in the right direction.

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Although AAPM&R agrees with the elimination of many of the measures proposed for removal, **the Academy disagree with the removal of PQRS measure #33: Stroke and Stroke Rehabilitation – Anticoagulant Therapy Prescribed for Atrial Fibrillation.** As rationale for the removal of this measure CMS states that this measure is duplicated within the PQRS measure #32: Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy. PQRS measure #32, measures secondary stroke prevention which usually includes antiplatelet agents, not necessarily anticoagulation, and does not take into account evaluation for atrial fibrillation. **AAPM&R strongly urges that CMS maintain PQRS measure #33 for the 2016 reporting program**.

Value-Based Payment Modifier and Physician Feedback Program

In this Proposed Rule, CMS proposes to continue to apply the Value-Based Payment Modifier (VBPM) to all physicians in 2016, and continue to set the maximum upward adjustment under the CY 2018 (based on 2016 reporting) VM at +4.0 times an adjustment factor. CMS also proposes to set the amount of payment at risk under the CY 2018 VM at -4% for groups with ten or more eligible professionals, and at -2.0% for groups with between 1 and 9 eligible professionals, and groups and solo practitioners that consist only of non-physician eligible professionals. Quality tiering will apply to all providers that satisfactorily report PQRS in 2016, with only groups consisting of non-physician eligible practitioners being held harmless from downward quality tiering adjustments. CMS proposes to waive the VM for groups and solo practitioners if at least one eligible professional who billed under the groups Tax Identification Number (TIN) participated in the Pioneer ACO Model or other similar Innovation Center Models during the performance period.

While AAPM&R does not anticipate a significant negative or positive impact of the VBPM to physiatry, AAPM&R is concerned that CMS is setting the maximum upward adjustment when the Merit-Incentive-Payment System (MIPS) is expected to begin its performance year in 2017. The overlap between payment adjustments and performance years between the PQRS, VBM, and EHR programs ending and transitioning to MIPS will create confusion and undue burden for eligible professionals. The MIPS program intends to simplify reporting requirements and allow eligible professionals to spend more time on patient care rather than meeting reporting requirements. The next few years transitioning into MIPS will cause much confusion for eligible professionals. The Academy believes that CMS should relax VBPM implications for eligible professionals in 2016, and at the very least maintain the current program adjustments. Thus allowing providers the ability to devote more time to understanding MIPS and gaining more support for moving in the right direction of tying meaningful quality measurement to payment.

We appreciate the opportunity to comment on this proposed rule. The AAPM&R looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Jenny Jackson, Manager of Finance and

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Reimbursement in the AAPM&R Division of Health Policy and Practice Services. She may be reached at jjackson@aapmr.org or at (847)737-6024.

Sincerely,

Phillip Bryant, DO
Chair
Reimbursement and Policy Review Committee
American Academy of Physical Medicine and Rehabilitation