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September 13, 2021

Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1751-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-1751-P Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Brooks-LaSure:

On behalf of the more than 9,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), we appreciate the opportunity to submit comments to the Medicare Physician Fee Schedule proposed rule. AAPM&R is the national medical specialty organization representing physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

VII.C. Changes in Relative Value Unit (RVU) Impacts

AAPM&R recognizes the proposed decrease to the conversion factor of 3.75% is a result of the expiration of a commensurate payment increase specified in the Consolidated Appropriations Act, 2021, which Congress only made available for 2021. In partnership with a range of medical specialties, we have already begun voicing our concerns to Congress about the negative impacts this cut will have to medical practices. Continued cuts to the conversion factor will exacerbate the financial challenges practices are facing because of the COVID-19 public health emergency (PHE).
AAPM&R urges CMS to work with Congress on long term solutions that will provide for positive updates to the conversion factor every year.

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II.B. Determination of PE RVUs
3.d. Clinical Labor Pricing Update

AAPM&R agrees with the proposal to update clinical labor pricing for 2022, as it has not been updated since 2002. Furthermore, we agree the United States Bureau of Labor Statistics is a reasonable source for clinical labor pricing data. However, we recognize that the implementation of this update will result in a significant reduction to many individual procedures including many services provided by physiatrists due to budget neutrality requirements. Data comparing proposed 2022 practice expense RVUs to 2021 practice expense RVUs for five of the many codes physiatrists bill that will be impacted by this policy change are included in the table below.

CPT Code	Descriptor	2021 NF PE RVU	Prop. 2022 NF PE RVU	% Change
64418	Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve	1.43	1.34	-6.3%
64462	Paravertebral block, thoracic; second any additional injection site(s)	1.02	0.90	-11.8%
64600	Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental or inferior alveolar branch	10.15	8.93	-12.0%
95873	Electrical stimulation for guidance in conjunction with chemodenervation	2.00	1.65	-17.5%
95885	Needle EMG, each extremity, with related paraspinal areas; limited	1.65	1.37	-17.0%

Many other codes procedures performed by physiatrists will be impacted similarly if this policy takes effect. CMS has estimated the net effect of this change to be 0% for Physical Medicine & Rehabilitation. However, because of the range of practice patterns for physiatrists, we believe there will be some practices far more negatively impacted than others. For those practices most negatively impacted, the cuts created by the clinical labor pricing update are not sustainable given the challenges they are already facing due to the PHE. ***AAPM&R recommends a four-year transition to the new clinical***

labor cost data. A transition to the new data will mitigate the immediate and significant negative impact to the codes negatively affected by the policy. However, at the conclusion of the four years transition, the overall impact will be as originally proposed. ***AAPM&R continues to urge CMS to work with Congress on long term solutions to budget neutrality requirements that, for too long, have prevented physician payments from increasing commensurate with physician costs.***

Finally, we recommend CMS consider more timely and frequent updates to the clinical labor pricing data in the future. For example, implementing new data every five years could be considered. More frequent updates would prevent such dramatic shifts in value.

II.D. Telehealth and Other Services Involving Communications Technology

1c. Revised Timeframe for Consideration of Services Added to the Telehealth List on a temporary basis

AAPM&R appreciates the steps CMS has taken to ensure coverage of services provided via telehealth during the PHE. The creation of Category 3 on the Medicare Telehealth Services List has ensured that CMS could offer coverage for services for which there is likely clinical benefit but not enough evidence to determine if they meet Category 1 or 2 criteria. AAPM&R supports continuation of coverage for Category 3 services beyond the PHE to allow CMS to better assess whether these services may meet Category 1 or 2 criteria. Therefore, ***AAPM&R supports the proposal to cover Category 3 services through the end of CY 2023***.

1e. Payment for Medicare Telehealth Services Furnished Using Audio-Only Communication Technology

AAPM&R strongly urges CMS continue coverage for telephone visits (CPT codes 99441-99443) through the end of 2023 by adding them to the telehealth services list on a Category 3 basis. Additionally, AAPM&R urges CMS to continue covering audio-only evaluation and management services through the end of 2023. COVID-19 has highlighted the strengths of telehealth as it has allowed patients to access much needed care in a safe way. It has also highlighted the instances in which restricting coverage to audio-visual technology creates a barrier to care for certain patient populations and circumstances. For certain beneficiaries, audio-visual technology is simply not an option. For example, this may be due to lack of access or technological agility. Furthermore, some encounters simply do not require face-to-face contact.

Audio-only technology is critical for patients with limited access to audio-visual technology and/or an ability to understand how to use such technology. Additionally, broadband access is lacking for many of the nation's patients. Allowing multiple access modalities reduces this barrier and ensures that all patients can access the benefits of telehealth equitably. Physiatrists have reported using telephone-only visits in place of real-time audiovisual telehealth for a variety of different types of patient encounters. For example, audio-only telehealth has been used by physiatrists to conduct follow-up visits with spinal cord injury patients typically seen in the outpatient hospital setting. These patients can verbally report on their function, improved or worsening spasticity, and bowel issues even though a physical exam is not completed. A historical account of these conditions can result in a process of medical decision making similar if not identical to when a service is provided face-to-face. The Academy strongly supports maintaining the current level of access and reimbursement for audio-only services over the next two years.

II.E. Valuation of Specific Codes

18. Destruction by Neurolytic Agent (CPT Codes 64633, 64634, 64635 and 64636)

AAPM&R was one of several specialties presenting revised values for the destruction by neurolytic agent code family to the American Medical Association Relative Value Scale Update Committee (AMA RUC). We appreciate the CMS decision to accept the RUC's recommendation to maintain current values for add-on codes 64634 and 64636. However, we are concerned that CMS chose not to accept the RUC's recommendation of 3.42 work relative value units (wRVUs) for base codes 64633 and 64635. As noted in the rule, CMS is instead using a total-time ratio methodology for these codes to propose 3.31 wRVUs for 64633 and 3.32 wRVUs for 63635.

The CMS proposed wRVUs of 3.31 for CPT code 64633 and 3.32 for CPT code 64635 are lower than the survey 25th percentile work RVU of 3.36 and places these services out of rank order with similar services such as the top key reference code 64625 *Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)* (work RVU = 3.39, 30 minutes intra-service time and 98 minutes total time). CPT codes 64633 and 64635 are slightly more intense and complex than 64625 due to the anatomical differences in anatomic locations. While CPT code 64625 requires more injections, CPT codes 64633 and 64635 are in a much more clinically complex location, requiring greater clinical expertise. CPT codes 64633 and 64635 also require more

total time than 64625, and the RUC recommended median wRVU of 3.42 maintains the proper rank order between these services.

AAPM&R has significant concerns with the methodology used by CMS to achieve the revised recommended values. The codes used to achieve the total-time ratio methodology have arguably outdated survey data, with code 54164 having been last surveyed in 2001 and 68371 having been last surveyed in 2003. Furthermore, the codes are not clinically appropriate comparisons. AAPM&R surveyed its members, in partnership with several other societies, in 2020 to identify appropriate values for these codes. We strongly encourage CMS to consider current survey data from physicians who perform these procedures in the valuation of these codes.

AAPM&R recommends CMS accept the RUC recommended wRVU of 3.42 for both CPT codes 64633 and 64635.

19. Destruction of Intraosseous Basivertebral Nerve (CPT Codes 646X0 and 646X1)

AAPM&R was one of several societies involved in presenting recommendations for valuation of new CPT codes 646X0 and 646X1 to the RUC. Upon review, the RUC recommended 25th percentile survey values for both codes. AAPM&R supports this recommendation.

646X0

Regarding 646X0, *Thermal destruction of intraosseous basivertebral nerve, inclusion of all imaging guidance; first two vertebral bodies, lumbar or sacral,* CMS has proposed a wRVU of 7.15 which is based on a crosswalk to CPT code 63650 *Percutaneous implantation of neurostimulator electrode array, epidural* (work RVU = 7.15, 60 minutes intra-service time and 170 minutes total time). This comparison code appears to have been selected arbitrarily as there is no clinical foundation for the comparison of 646X0 to this code. We strongly recommend that instead CMS consider the comparison of this code to the key reference service codes 22514 and 22513, which are far more clinically similar to 646X0.

Key reference service codes:

- 22514 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral*

body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar (wRVU = 7.99, 45 minutes intra-service time and 150 minutes total time), and

- 22513 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic* (wRVU = 8.65, 50 minutes intra-service time and 155 minutes total time)

The value for code 646X0 is appropriately bracketed between these two codes because the performance of the procedures closely aligns with the steps taken to perform 646X0.

AAPM&R strongly recommends that CMS reconsider the recommended reduced wRVU in favor of the RUC recommended value. The RUC recommendation is based on survey data, reflective of input from practicing physicians who perform the procedure, as well as clinically relevant comparison codes.

AAPM&R recommends CMS accept the RUC recommended wRVU of 8.25 for CPT code 646X0.

646X1

Regarding 646X1, *Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; each additional vertebral body, lumbar or sacral*, CMS has proposed a wRVU of 3.77, which is based on the determined relative difference between 646X0 and 646X1. While we recognize that CMS believes this methodology to be valid, AAPM&R is concerned that it appears extremely arbitrary and deviates significantly from standard methodologies used by the RUC. As is the case with code 646X0, AAPM&R strongly encourages CMS to instead look to the survey data obtained from practicing physicians who perform this procedure. We strongly recommend that CMS consider the comparisons made by the RUC to the key reference services selected by the survey participants, which are clinically similar to 646X1.

Key reference service codes:

- 22515 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)* (wRVU = 4.00 and 30 minutes intra-service time), and
- 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)* (wRVU = 6.50 and 45 minutes intra-service time).

The value for code 646X1 is appropriately bracketed by these two codes.

AAPM&R recommends CMS accept the RUC recommended wRVU of 4.87 for CPT code 646X1.

37. Remote Therapeutic Monitoring (CPT Codes 989X1, 989X2, 989X3, 989X4 and 989X5)

AAPM&R appreciates CMS's review and approval of RUC recommend wRVUs for new codes 989X4 and 989X5 for remote therapeutic monitoring. We are encouraged by the continued efforts of CMS to support mechanisms for billing remote services.

We recognize that there may have been some confusion in the interpretation of who may be most likely to bill these codes. In the instance of musculoskeletal system therapeutic monitoring, physiatrists and physical therapists are likely to bill for these services and were involved in the RUC process for recommending values for the codes. Given that these codes are found in the general medicine section of the CPT codebook, we do not agree with the assessment that the codes cannot be billed by physical therapists. If implemented, we believe restricting physical therapists from providing these services would unnecessarily and inappropriately limit the utility of this new code family.

AAPM&R encourages CMS to clarify the limitations around the remote therapeutic monitoring code family and to clearly articulate that physical therapists may bill these codes, based on the understanding that the codes are found in the general medicine section of the CPT codebook.

43. Comment Solicitation on Separate PFS Coding and Payment for Chronic Pain Management

AAPM&R appreciates CMS' consideration of new reimbursement policies for chronic pain management services and agrees that creating new separate coding and payment for medically necessary activities involved with chronic pain management is necessary. Many physiatrists are leaders of health care teams that provide care for patients presenting both acute and long-term chronic pain management needs. Physiatrists treat countless conditions resulting in the manifestation of pain including spinal cord injury, multiple sclerosis, post-stroke pain, fibromyalgia, peripheral neuropathy pain, limb amputations and phantom pain. AAPM&R believes that pain is a subjective and personal experience that widely varies by patient and condition. Access to appropriate personalized pain care for each individual patient is a key determinant in the successful management of a patient's pain, and we believe that appropriate reimbursement for chronic pain management services will help ensure that individuals have access to the personalized pain care they need.

AAPM&R recognizes that the current opioid epidemic is one of the most devastating public health threats to our society and shares the widespread concern regarding the risk that opioids pose to the individual patient and the public when not used appropriately. Conversely, we recognize that chronic pain is the cause of suffering for more than 100 million Americans[1]. As such, our specialty strives to mitigate overprescribing and to reduce stigma as well as the undertreatment of chronic pain. AAPM&R appreciates CMS' recognition of the challenges clinicians face in providing patient-centered chronic pain management treatments, while also making strides to reduce the impact of the opioid crisis.

AAPM&R believes that access to specialists, like physiatrists, who have appreciable skill in pain management and accurate diagnosing for underlying

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[1] Institute of Medicine. Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and
Research. Washington, DC: The National Academies Press; 2011. https://doi.org/10.17226/13172. Available at
https://www.ncbi.nlm.nih.gov/books/NBK92521/. Accessed May 7, 2018.

conditions that manifest physical pain, is vital. Physiatrists often report that for many patients with chronic pain, their prior healthcare discussions shift away from a focus on remedying the actual condition and instead focus solely on reducing or alleviating patients' pain. To that end, physiatrists work with patients to develop effective pain management plans, based on accurate assessment and diagnosis, in order to help patients understand and address the underlying cause of their chronic pain. Physiatrists engage in shared decision-making with these patients, educating them on the clinical pathological process and all potential treatment options, including risks, benefits, and alternatives. They work with patients to set clearly defined goals to reduce or eliminate pain and help patients improve the quality of their day-to-day functioning by prescribing and managing several modalities of care and working collaboratively with other health care providers.

AAPM&R members have reported that impractical time constraints placed on physicians serve as barriers that negatively impact their ability to properly assess, diagnose, and provide the appropriate attention and care required for patients with chronic pain management needs. We have previously encouraged CMS to incentivize collaboration and care coordination amongst multiple disciplines, including increased compensation for multidisciplinary consultations for high complexity patients, to ensure patients have access to comprehensive pain-management models to treat the various factors that influence a patient's perception of pain and the efficacy of their treatment. Patients with complex pain management needs typically require more extensive visits and follow up. As such, we encourage CMS to ensure adequate reimbursement for the time required to manage patients with complex, pain management needs.

AAPM&R agrees that CMS should creating separate coding and payment for medically necessary activities involved with chronic pain management and for achieving safe and effective dose reduction of opioid medications when appropriate. In the proposal, CMS includes activities, not limited to diagnosis; assessment and monitoring; administration of a validated rating scale(s); development and maintenance of a person-centered care plan; overall treatment management; facilitation and coordination of any needed behavioral health treatment; medication management; patient education and self-management; crisis care; specialty care coordination such as complementary and integrative pain care, and SUD care; and other aspects of pain and/or behavioral health services, including care rendered through telehealth modalities. AAPM&R agrees with the aforementioned activities and also believes that drug screen monitoring and checking prescription drug monitoring programs (PDMPs) should be explicitly listed (rather than

included in the assessment and monitory category), given the amount of time it takes to complete these activities.

AAPM&R appreciates that CMS has identified several existing codes which it may use as a model for chronic pain management coding. CPT code 99483 for Cognitive Assessment and Care Plan includes many elements of pain management assessments including, but not limited to, medical decision making of moderate or high complexity, functional assessment, medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, and creation of a written care plan. Similarly, HCPCS code G2064/CPT code 99X22 for comprehensive care management services for a single high-risk disease is also reasonably compared to chronic pain management. AAPM&R would support creation of a code similar to HCPCS code G2064/CPT code 99X22, for comprehensive care management services for a single high-risk disease, to manage patients with complex, pain management needs. Our physicians suggest that an "all-inclusive" package to support all services necessary for the care of complex patients would be helpful. For example, individuals with pain who frequently visit emergency rooms may require long office visit times, coordination of care with social workers and case managers, mental and behavioral health support, communications to ER physicians and nurses, and numerous medication adjustments. A fixed rate for multidisciplinary interventions for pain management (i.e., pain program, virtual, in person, or hybrid) could also prove to be helpful.

While inpatient multidisciplinary programs or outpatient multidiscipline programs are ideal, we recognize the substantial cost associated with providing this type of care per patient. Like choosing candidates for specific therapies, having a guideline for patient selection for these services will be crucial to identify candidates who would benefit most from such treatment, and to help contain associated costs. AAPM&R would also be supportive of a separate code for non-opioid pain management similar to G0108, for Diabetes outpatient self-management training services. This code could include teaching self-management, evidence-supported pain management techniques such as mindfulness, meditation, coping skills, and physician counseling of the patient on diet, exercise, sleep, and other lifestyle changes shown to reduce pain.

AAPM&R, again, supports creating new separate coding and payment for medically necessary activities involved with chronic pain management. AAPM&R appreciates CMS consideration of such coding and would welcome the opportunity to assist the agency in the further development of

coding and reimbursement options for physicians and clinicians who provide care for individuals in need of comprehensive pain management services.

II.F. Evaluation and Management (E/M) Visits
1. Split (or Shared) Visits
AAPM&R appreciates the continued efforts of CMS to update Evaluation and Management (E/M) coding to reflect current practice. However, we are concerned that the changes proposed to split (shared) billing rules could create significant additional administrative burden in inpatient coding. Specifically, we note that defining the term "substantive portion" as "more than half of the total time spent by the physician and non-physician practitioner performing the visit" suggests that time must be closely documented. Our understanding is that this rule would require physicians and non-physician practitioners (NPPs) to track the time they spend to the minute to determine appropriate billing. While CMS references the changes to E/M billing for office visits, as stated in this rule, those changes do not currently apply to in-patient visits. As such, visits performed by physicians or NPPs would still be billed under the current level selection criteria using unit/floor time or elements of history, physical examination or medical decision making. However, for all split (shared) visits the time for each member of the care team would have to be tracked and documented separately. AAPM&R believes this will create barriers to compliance which may discourage appropriate use of split/shared visits.

AAPM&R recommends that CMS delay implementing the new definition of "substantive portion" criteria until E/M guideline changes are implemented for inpatient services.

Further, AAPM&R supports the recommendation to change to split (shared) billing requirements to allow new and established patient visits to be billed split (shared).

And finally, AAPM&R agrees that services performed in the Skilled Nursing Facility/Nursing facility should not be precluded from split (shared) billing. Physiatrists are often leaders in the SNF setting, where team-based care is critical to the delivery of optimal care.

II.G Billing for Physician Assistant (PA) Services
AAPM&R recognizes that the proposed changes to Physician Assistant (PA) billing are the result of provisions of the Consolidated Appropriations Act of 2021. We recognize that these changes will allow PAs to bill Medicare consistent with other advanced practice providers (APPs), specifically Nurse

Practitioners and Certified Nurse Specialists. PAs are recognized as valuable members of a physician-led care team. In ongoing consideration of the role of PAs, AAPM&R encourages CMS to consider the significant differences in the training required for PAs as compared to physicians. Physicians attend four years of medical school, followed by residency training of three-to-seven years, and completion of 10,000-16,000 hours of clinical training, compared to a typical PA program is only 27 months with 2,000 required clinical hours. The rigorous training physicians undergo support physicians' role as leaders of the care team. Considering every state requires PAs to practice with some level of physician involvement, any changes to the billing authority of PAs as proposed in the PFS must be done within the parameters of state law and must not negatively impact the quality of patient care.

As scope of practice issues related to the role of APPs continue to be considered, AAPM&R would like to alert CMS to our position statement – *Optimizing the Role of the Advanced Practice Provider in Physiatry-led, Patient-Centered, Team-Based Care*. Per this statement, "The Academy strongly opposes the independent practice of APPs and other non-physician clinicians in the provision of rehabilitation care. In rehabilitation care, APPs must work closely with a physiatrist that services in a supervisory role. The Academy is opposed to training or advocating for APPs to practice independently of physiatrists."

III.F. Appropriate Use Criteria for Advanced Diagnostic Imaging
AAPM&R supports the proposal to delay the penalty phase of the AUC program until the later of either January 1, 2023 or January 1 of the year following the end of the PHE. AAPM&R supports eliminating the AUC program and has shared this recommendation with Congress in collaboration with a multi-specialty effort. However, in the absence of full repeal, AAPM&R supports efforts to delay and reduce the burden of the AUC program. Specifically, we urge CMS to consider the degree to which the AUC program and QPP requirements overlap and create duplicative burden for physicians already overwhelmed by the variety of administrative burdens associated with care delivery.

III.H Pulmonary Rehabilitation, Cardiac Rehabilitation and Intensive Cardiac Rehabilitation
AAPM&R would like to thank CMS for considering the parallels between pulmonary rehabilitation (PR) and cardiac rehabilitation/intensive cardiac rehabilitation (CR/ICR), and we support CMS' overall proposal to align the programs. Currently, cardiac rehabilitation and pulmonary rehabilitation are

treated very differently by the regulations, even though both provide necessary care to patients in need. ***AAPM&R encourages CMS to reimburse pulmonary rehabilitation in alignment with cardiac reimbursement since cardiac rehabilitation is reimbursed at a much higher rate than pulmonary rehabilitation.*** Like cardiac rehabilitation, pulmonary rehabilitation requires a multidisciplinary approach including monitored exercise therapy, education, emotional supportive therapy, and nutrition. Additionally, it is resource and time intensive with many patients requiring frequent vital sign and oxygen saturation monitoring and the use of supplemental oxygen to maintain acceptable oxygen saturations. The existing financial reimbursement model is not viable for many sites and this is reflected in the paucity of programs for the numbers of patients requiring. ***Additionally, AAPM&R strongly supports adding COVID-19 as a covered condition for PR access and discusses CMS' proposals further below.***

Currently, only hospital-based CR/ICR programs are reimbursed appropriately while community CR/ICR programs are not paid at a rate that can sustain them. The hospital-based programs are reimbursed at approximately $130-140 per session while community settings, rural settings, and private practice settings are reimbursed at about $40 per session. This discrepancy is unsustainable for non-hospital-based programs, which is why CR/ICR programs are not commonly provided outside hospitals, ultimately creating socioeconomic and racial disparities in access to healthcare for patients who do not live near a hospital with a CR program. ***We encourage CMS to increase the reimbursement rate for non-hospital-based programs so that everyone may have access to the rehabilitative care they need, including but not limited to the millions of people recovering from COVID-19 or experiencing Long COVID.***

The clarification that a separately billable evaluation and management (E/M) service may be furnished by the medical director or other PR or CR/ICR staff physicians working in the program in connection with establishing and signing the individual treatment plans (ITPs) on or before the first day of PR or CR/ICR is helpful. However, we want to point out that this will not be billable by outside physicians.

In addition to CMS' proposed changes to the regulations, ***AAPM&R asks CMS to update the regulations to allow PR and CR patients to be seen at the same time and the same setting.*** Currently, these two services cannot be provided at the same time and same place, resulting in offices offering PR on

some days and cardiac on others. Because CR is currently reimbursed at a higher rate than PR, practices that can provide both will typically provide CR more regularly. For example, CR will be provided 3-4 days a week and PR will be provided once a week but, on that day, CR cannot be provided. This is an unnecessary hindrance.

Under § 410.49(b), Medicare part B covers CR and ICR for beneficiaries who, among other conditions, have experienced stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35 percent or less and New York Heart Association class II to IV symptoms, despite being on optimal heart failure therapy for at least six weeks. AAPM&R would like to take this opportunity to point out that the six-week threshold is too conservative and that CR and ICR should be covered for heart failure patients who can tolerate rehabilitation sooner after discharge. The six-week threshold was chosen after the HF-ACTION trial,[2] which was designed to demonstrate the benefits of cardiac rehabilitation and ensure there would be no adverse events. Many patients who suffer heart failure are vulnerable to readmission. For those who can tolerate a rehabilitation program sooner, as determined by their physician, they should be able to as it will provide closer monitoring which can prevent readmissions.

AAPM&R strongly supports CMS' proposal to cover PR for Medicare beneficiaries who have been diagnosed with severe manifestations of COVID-19, defined as requiring hospitalization in the ICU or otherwise, and who experience continuing symptomatology, including respiratory dysfunction, for a least 4 weeks post discharge. Additionally, it should be noted that many patients were treated for acute COVID-19 in the community environment and never hospitalized, yet still have and develop severe manifestations including shortness of breath, activity related hypoxemia and related functional limitations and disabilities. Such patients will also require PR. This expanded definition is appropriate to ensure that the many patients who are suffering symptoms of Long COVID can access these programs. Long COVID is estimated to affect 10-30% of people who were infected

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[2] O'Connor CM, Whellan DJ, Lee KL Ketyian SJ, Cooper LS, Ellis SJ, Leifer ES, Kraus WE, Kitzman DW, Blumenthal JA, Rendall DS, Houston Miller N, Fleg JL, Schulman KA, McKelvie RS, Zannad F, Pina IL. Efficacy and Safety of the Exercise Training in Patients With Chronic Heart Failure: HF-ACTION Randomized Controlled Trial. JAMA. 2009; 201(14):14539-1450. doi: 10.1001/jama.2009.454.

with SARS-CoV-2 infection, including those who were asymptomatic.[3] Considering the rampant infection rate of the virus, the estimates of people experiencing Long COVID symptoms in the United States is over 11 million.[4] Many of these patients will need PR and/or CR/ICR, even if the damage to their lungs and/or heart are not visible on current imaging tests. It is important to clarify that for those who experienced severe COVID-19, it is not necessarily beneficial for them to wait four weeks between when they are discharged from the hospital or recovered from the acute COVID-19. It may be better for them to have access to a PR and/or CR program sooner. For example, a patient who had severe COVID and subsequent interstitial lung scarring may be recovered enough to be independent at home but get winded after walking a block. This person would need access to rehabilitation and would have no reason to wait four weeks.

Additionally, between now and the end of the COVID-19 public health emergency (PHE) there is an allowance for remote PR and CR via telerehabilitation. A permanent telerehabilitation option would significantly increase participation in both PR and CR, which will continue to benefit patients with COVID-19 after the PHE ends. ***AAPM&R recommends CMS add PR and CR to the telehealth services list on a permanent basis following the PHE to ensure access and increase medically necessary participation.***

Finally, AAPM&R supports the proposed revisions to align regulatory text regarding the standards for the PR medical director and the supervising physician found at § 410.47(c) and (d) with the corresponding CR/ICR medical director and supervising physician text. Particularly, we agree that two different physicians should not necessarily be required. Small programs do not have capacity for multiple physicians while large programs may have many physicians supervising. We do ask that CMS clarify the role of the Resident and Fellow level trainings. AAPM&R encourages CMS to clarify that residents, while they cannot bill for their services, be able to act as extenders of supervising physicians. Additionally, while there are not Accreditation Council for Graduate Medical Education (ACGME) fellowships in cardiac rehabilitation or pulmonary rehabilitation, there are non-ACGME fellows who should be involved in the provision of care by

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[3] Rubin R. As Their Numbers Grow, COVID-19 "Long Haulers" Stump Experts. JAMA. 2020;324(14):1381–1383. doi:10.1001/jama.2020.17709.
[4] Estimated Disease Burden of COVID-19. Centers for Disease Control and Prevention. January 19, 2021. https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/burden.html.

providing hands on care with a physician supervising. Fellows providing care may be able to bill.

IV. Summary of the Quality Payment Program Proposed Provisions

Advancing to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs— Request for Information

As we have mentioned in the context of other CMS quality programs, AAPM&R appreciates CMS' goal to transition to all digital quality measures by 2025, but is concerned that this goal may be too ambitious and that it fails to recognize that adoption of certified EHR technology (CEHRT) among post-acute care (PAC) providers is substantially lower than in other settings since PAC providers were not eligible for federal incentives offered under the Electronic Health Record (EHR) Incentive Programs to adopt and use CEHRT. As a result, EHR adoption in PAC settings is uneven, with providers using a variety of often inadequate and non-standardized systems, and often resorting to self-developed templates to make their EHRs more user-friendly. As physicians who practice in such PAC settings, our members must contend with these limitations as they consider their own obligations under physician quality programs.

As CMS moves more towards digital measurement, the disparity in EHR adoption could put PAC providers – and the physicians who practice in such settings – at a major disadvantage in terms of quality reporting compliance or impose other challenges that providers in other settings may not face. If CMS wants to move the needle towards universal digital quality measurement, it will need to thoughtfully consider approaches to incentivize the adoption of CEHRT within PAC settings, including financial incentives like those offered in the acute and ambulatory settings, as well as bonus points and reporting flexibilities for those in PAC settings who voluntarily use CEHRT to collect and submit quality data. We also have heard from our members that grants to fund pilot programs that use HIT to improve continuity of care across the rehabilitation spectrum and solve other safety/quality issues would be helpful. In general, we believe that more widespread adoption of CEHRT within the PAC setting will not only improve quality reporting among PAC providers, but also build enhance the quality reporting capabilities of physicians who practice in such settings. Enhanced care coordination and communications between ambulatory, acute, and post-acute care settings will also follow.

AAPM&R appreciates that in CMS' discussion of how to define digital quality measures (dQM), it recognizes a variety of meaningful data sources beyond the traditional EHR, including instruments (e.g., medical devices and wearable devices), patient portals or applications (e.g., for collection of patient-generated health data), and clinical data registries. These alternative data sources are critical resources for capturing the outcomes of our patients and often provide more nuanced data points than EHRs, alone. Ideally, data from all of these sources would be combined to provide a complete picture of a patient's care. However, we are not quite there yet.

Although FHIR-based standards are promising in terms of their potential to bridge data from a variety of health information technology sources, we are concerned that gaps remain related to the usability of the data. This is particularly a problem in the context of EHRs exchanging electronic health information (EHI) with registries. For example, although the bulk data exchange capability contained in FHIR Release 4 could potentially be valuable for exchanging data with registries, it would require a very large bulk data extract capability to be truly effective given the large volume of unique patient data contained in registries. Since this approach appears to still be in the early stages of development, we encourage CMS to work with the Office of the National Coordinator for Health IT (ONC) to conduct real life testing of the scalability of data extract capabilities before this approach is implemented for exchanging data with registries.

We are also concerned that the goal of semantic interoperability through APIs will only go so far without natural language processing or human curation of clinical notes, both of which are resource intensive and often unsuccessful. ONC has skipped straight to application programming interfaces (APIs) and FHIR as the solution to interoperability challenges, but many entities lack standardized and codified data elements. Unfortunately, development of these resources is often very costly and requires technical support. As a result, we recommend that CMS work with ONC to provide technical assistance for organizations looking to develop HL7 standards.

In general, the ongoing lack of true interoperability between EHRs and registries impedes the collection and analysis of data needed to accurately assess and appropriately improve quality of care. While some registries have found methods to work around this lack of interoperability, such efforts have required significant investments of time and resources. A regulatory framework that focuses on both improving the exchange of EHI with

registries and increasing the usability of such data will promote efficient exchange of information and allow providers and clinicians to more effectively make use of registries, not only for quality improvement programs, but also for the promotion of research and public health. We urge CMS to continue working with ONC to address these ongoing challenges.

MIPS Values Pathway (MVP)

AAPM&R appreciates CMS' ongoing effort to streamline MIPS, reduce burden, and improve the value of performance data produced by the program. However, we remain concerned that the current MVP framework does not make sufficiently restructure the program in a manner that would make it more meaningful to both participants and patients. These concerns are discussed in more detail below.

Although the current MVP framework offers sets of measures and activities focused around a single specialty, condition, or patient population, it does little to meaningfully connect the four siloed performance categories, other than thematically, or to streamline reporting across the categories. As a result, clinicians will continue to face unnecessary reporting burden and duplicative accountability— for example, by requiring clinicians to report quality measures that capture actions already reflected in improvement activities and vice versa. This will also perpetuate incomplete assessments of value since cost measures still fail to align with quality measures. It is critical that cost and resource use measures are used only in the context of quality measures since reporting a cost measure in the absence of quality data will not provide patients with the complete picture of information needed for healthcare decision-making; furthermore, cost measures that are not tied to quality performance may create inappropriate incentives to limit care that may contribute to patient harm.

The MVP framework also does little to recognize the complexities of many common conditions, such as stroke, low back pain, and arthritis, and the teams of health professionals that manage such conditions. Instead, it continues to rely on the current inventory of MIPS measures, which often do not produce meaningful data for patients and clinicians, and are driven by an incentive payment system that does little to encourage team-based approaches to specific episodes of care. CMS insists on including population health measures in each MVP to promote shared accountability and team-based approaches to care. However, the population health measures proposed to date are inappropriate for a clinician-level accountability program since they are too broad and attempt to hold clinicians responsible

for aspects of care that are beyond their direct control. Instead, we urge CMS to support specialty societies with the development of more innovative measures (e.g. patient-reported functional assessment measures) and to work with specialties to identify opportunities to adapt measures used under other CMS programs, such as the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program, for use under MIPS to minimize reporting burden and promote alignment.

AAPM&R is also concerned that the MVP framework does not meaningfully address the ongoing lack of relevant cost measures for many specialties and continues to rely on total cost of care measures, which are confusing and do not provide actionable data for clinicians seeking to manage resource use. In response to this ongoing gap in measures, CMS proposes a process for stakeholders to engage in cost measure development. However, in order for this process to succeed, specialty societies need better access to more comprehensive Medicare claims data, as well as cost performance data. QCDRs, for example, do not know how their participants are performing on cost or how they are even being attributed, which makes it challenging for specialty societies to understand value and where cost measures are working, not working, and are still needed. Without access to data, specialty societies are limited in how they can help CMS to move the needle forward on cost measurement. In addition to better access to data, CMS should also provide more flexibility for cost measures developed by specialty societies as part of a candidate MVP. For example, a specialty society may wish to leverage its QCDR to align applicable quality measures with an appropriateness measure that addresses resource use, even if it is not a cost measure in the traditional sense. Allowing for this type of innovation and flexibility would result in a greater number of clinically relevant cost measures for specialists at a quicker rate than developing claims-based measures.

Similarly, the MVP framework does not promote innovation or flexibility in the Promoting Interoperability (PI) category. Instead, CMS insists on requiring all MVP participants to comply with the exiting all-or-nothing PI measure set, which does not recognize the diversity of clinical practice and the meaningful application of digital technologies. Clinicians should have the flexibility to demonstrate meaningful use of EHRs in more innovative ways that account for differences in practice makeup, infrastructure, and experience with health information technology, as well as the needs of their patient populations. For example, CMS could offer a larger inventory of measures that focus less on the functionalities of CEHRT, since this is

something vendors must already ensure their products comply with, and more on innovative ways of capturing, applying and sharing electronic data, such as implementation of practice improvements based on patient-generated electronic health data; use of clinical registries that incorporate EHR data; and use of electronic platforms, including apps, that allow clinicians to better communicate with patients. Given the ongoing limitations of the PI category, AAPM&R supports CMS' proposal to extend special status exemptions, such as automatic re-weighting of the PI category to 0% for hospital-based clinicians and groups, to MVP participants. We also support CMS' proposal to maintain application-based PI exceptions for clinicians who lack control over the availability of certified EHR technology (CEHRT).

Finally, we are concerned that MVPs do not provide a straightforward glidepath to Advanced APM participation. It is unclear how MVPs would help clinicians prepare to take on and manage financial risk through an APM when the current inventory of measures is so flawed and the program scoring rules fail to align with most current Advanced APMs. For example, although the Bundled Payments for Care Improvement- Advanced model (BPCI-A) includes some measures that align with MIPS, practices that participate in the model must either submit the measure data twice to CMS—once under BPCI-A and once under MIPS – or report on a separate set of measures under the APM Performance Pathway. A true glidepath would align requirements between the two programs in a way that minimizes duplicative or excessive reporting.

In light of these concerns, AAPM&R appreciates that CMS proposes to begin offering MVPs on a voluntary basis starting in 2023. However, we urge CMS to reconsider sunsetting traditional MIPS and making MVPs mandatory by 2028. It is too premature to consider sunsetting traditional MIPS and making MVPs mandatory by 2028 since we do not yet know what the future landscape will look like in terms of practice trends and business/employment models, the available inventory of measures, data collection and submission capabilities, and interoperability. Instead, we urge CMS to work with stakeholders to identify ways that it can more fundamentally improve the program, such as by providing multi-category credit for value-driven activities; incentivizing investments in the development of more meaningful and actionable measures; adopting scoring policies that encourage the use of more innovative measures; and ensuring better alignment of measures and reporting requirements across programs, settings, and APMs.

As CMS continues to work with stakeholders to develop MVPs, it is critical that the process is clinician-led and transparent so that the groupings of measures and activities make clinical sense and so that all relevant stakeholders have an opportunity to share their expertise and perspective. CMS also should make the public aware of its intentions for future MVP development priorities so that specialty societies can collaborate early on. Finally, we request that CMS provide clear and timely feedback on why a candidate MVP may not have been accepted.

Subgroup Reporting

As part of its MVP framework, CMS proposes to establish voluntary subgroup reporting to help provide patients and clinicians with information that is clinically meaningful at a more granular level. The intent of the subgroup reporting proposal is to move away from large multispecialty groups reporting on the same set of measures, which may not be relevant or meaningful to all specialists that participate within a multispecialty group. CMS is concerned that some current group submissions do not accurately reflect the performance of all clinicians within the group, do not provide all clinicians with results that lead to data-driven improvements in quality, and do not provide patients and caregivers the granularity of data needed to make informed decisions. CMS also believes that transitioning multispecialty groups to subgroup reporting will address some inherent gaming risks, where clinicians in a group may rely on the performance of other clinicians (of a different specialty) within the group to meet quality reporting requirements.

Under its proposal, multispecialty groups may report as groups or choose to form subgroups to report MVPs starting with the CY 2023 and CY 2024 performance periods/2025 and 2026 MIPS payment years. However, beginning with the CY 2025 MIPS performance period/2027 MIPS payment year, CMS proposes that if a multispecialty group would like to report MVPs, it could only do so if it forms subgroups. CMS does not anticipate the need to require single specialty groups to form subgroups in order to report an MVP.

AAPM&R agrees with CMS that subgroup reporting could provide more direct attribution of quality measure data and results to clinicians, which could lead to more valuable, meaningful, and actionable results that contribute to patient care and improvement. ***However, we do not believe that subgroup reporting should be made mandatory starting in 2025, due to the large administrative burden it could create for multi-specialty practices. As we look to the future, where technology will hopefully allow for the***

submission of discrete data elements and CMS will be able to automatically calculate measure performance for clinicians, subgroups, and groups practices, it may be more appropriate to reconsider mandatory subgroup reporting. However, at this point in time, it is premature for CMS to finalize this requirement.

Scoring Policies: Traditional MIPS and MVPs

CMS is required under statute to set a MIPS performance threshold each year for purposes of determining MIPS payment adjustment factors. Starting with the 2022 performance year/2024 payment year, the performance threshold for a year must be either the mean or median of the final scores for all MIPS eligible clinicians for a prior period specified by CMS. In this rule, CMS proposes to use the 2019 MIPS payment year as the prior period and the rounded mean final score of 75 points as the 2022 performance year/2024 payment year performance threshold.

Simultaneously, CMS proposes to modify some of its current scoring polices, beginning with the 2022 performance period/2024 payment year, in an effort to move away from transition year policies and to simplify the program. These proposals would impact measures under traditional MIPS, as well as MVPs, and include:

- Ending the policy of offering bonus points for reporting additional outcome and high priority measures and for end-to-end electronic reporting of quality measures, beginning with the 2022 performance period/2024 MIPS payment year.
- Removing the 3-point floor for each measure that can be reliably scored against a benchmark and instead scoring the measure from 1 to 10 points if it has a benchmark, meets the case minimum requirement, and meets the data completeness requirement.
- Removing the 3-point floor for measures that cannot be scored based on performance because they do not have a benchmark or do not meet the case minimum (generally 20 cases). Small practices would continue to earn 3 points on these measures, but practices of other sizes would now receive zero points.
- Adding a 5-point floor for new measures in the program for all collection types for their first two years in the program so long as they meet the data completeness requirement
- Maintaining the current 7-point scoring cap policy for topped out measures.

AAPM&R appreciates CMS' proposal to set the performance threshold at the lowest possible value it could select based on historical performance. At the same time, we are concerned that clinicians will continue to face unique challenges in 2022 related to both COVID-19 and other scoring policies proposed in this rule that will make it exceptionally difficult to meet the 75-point performance threshold and avoid a penalty. Viewed in light of other Medicare payment cuts that physicians will face in the years ahead, we strongly urge CMS to continue to offer a COVID-19-related hardship application under the MIPS Extreme and Uncontrollable Circumstances policy for 2022. We also urge CMS to ensure that other MIPS scoring policies finalized for 2022 performance/2024 payment account for CMS' proposed increase in the performance threshold.

If the aforementioned scoring proposals are finalized, our specialty would be at a major scoring disadvantage since four of the 12 measures that make up the MIPS Physical Medicine specialty set currently lack a benchmark and seven measures are currently subject to the 7-point topped out measure scoring cap for at least one data submission mechanism. ***We request that CMS not finalize the removal of the 3-point floor for measures that lack a benchmark. Moreover, we would ideally like to see CMS apply the proposed 5-point floor to not only new measures, but also existing measures that have historically lacked a benchmark to incentivize the use of more clinically focused measures that specialty societies have invested heavily in, but that have unfortunately gone unused for many years due to misguided scoring policies. We also recommend that CMS maintain bonus points for reporting additional outcome/high priority measures and end-to-end electronic reporting of quality measures in order to incentivize more robust data collection.*** Taken together, these policies should help clinicians who are making a good faith effort to comply with the program meet the increased performance threshold and avoid a penalty.

Finally, CMS is opting not to apply a validation process, similar to the Eligible Measures Applicability (EMA) process used under traditional MIPS, to determine the availability and applicability of measures for MVP Participants. Since MVPs will focus on a condition or specialty, CMS believes MVPs will be selected and reported because of the applicability to a clinician's practice and patients. ***AAPM&R requests clarification on this policy. Specifically, what would happen if an MVP participant opts to participate through an MVP using a QCDR and the MVP only includes two QCDR measures? Would CMS require the participant to only report on those two measures for full credit under the quality category or would***

CMS expect the clinician to report additional measures through a different data collection mechanism to meet the MVP's four measure requirement?

Accommodations for Small Practices

CMS notes that 85% of clinicians who are not engaged with MIPS (who do not submit data) are clinicians in small practices. CMS proposes multiple policies throughout this rule to accommodate these clinicians and encourage greater engagement in MIPS. For example, as noted above, CMS proposes to maintain the 3-point scoring floor for small practices. In regards to redistribution policies for clinicians in small practices, CMS proposes that when the Promoting Interoperability performance category is reweighted, the Quality category will be weighted at 40%, the Cost performance category will be weighted at 30%, and the Improvement Activities performance category will be weighted at 30%. When both Cost and the Promoting Interoperability performance category are reweighted, Quality will be weighted at 50% and Improvement Activities will be weighted at 50%. Finally, beginning with the CY 2022 performance period/CY 2024 MIPS payment year, CMS proposes to no longer require an application for clinicians and small practices seeking to qualify for the small practice hardship exception and reweighting. Instead, CMS would assign a weight of 0% to the Promoting Interoperability performance category and redistribute its weight to another performance category or categories. ***AAPM&R strongly supports these proposals, which would reduce reporting burden for small practices with infrastructure and resource limitations.***

Proposed Changes to the Query of Prescription Drug Monitoring Program (PDMP) Measure under the Electronic Prescribing Objective

AAPM&R appreciates the CMS proposal to maintain the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program (PDMP) measure as optional and worth 10 bonus points for the CY 2022 performance period/2024 MIPS payment year. Our organization strongly encourages physician use of state PDMPs to receive real time reports on patients' controlled substance prescriptions; without the PDMP data, there is no way for a physician to receive the information necessary from other providers and pharmacies to coordinate the care of the individual patient. AAPM&R also supports the enhancement of a national PDMP database and interoperability of state PDMPs so that pharmacies and clinicians can have access to controlled substances dispensing data across state boundaries to monitor prescription drug use and to detect potential prescription drug misuse.

AAPM&R agrees that this is an important measure that can help to address the role that misuse of prescriptions drugs plays in the opioid crisis. CMS specifically solicits comments to understand to what degree all MIPS eligible clinicians be prepared to report on the current Query of PDMP measure (Yes/No response) in the near future. AAPM&R highlights that the cost of implementation to private practices should be considered prior to potentially requiring the Query of PDMP measure, compared to large institutions and academic centers who may find it easier to integrate the PDMP into their EHR. ***For the reasons stated by CMS, AAPM&R agrees that maintaining the measure as optional with bonus points for an additional year will allow for practices across states to be better prepared for implementation of the existing measure.***

Qualified Clinical Data Registries

AAPM&R echoes the concerns raised in the letter submitted by the Physician Clinical Registry Coalition (PCRC) and fully support all of their recommendations.

Public Reporting – Facility Affiliations

CMS proposes to add clinicians' facility affiliations on Care Compare, beyond the hospital affiliations currently displayed on individual profile pages, including inpatient rehabilitation facilities, skilled nursing facilities, and more. CMS notes that it would use claims data the same way it does to display hospital affiliations currently available on clinician profile pages, which CMS builds based on observing a clinician practicing at a given hospital caring for at least three different Medicare patients on three different dates of service in the preceding 6 months. While AAPM&R believes that providing information about clinicians' facility affiliations may provide some useful information to consumers seeking to make care choices, we are concerned that there may be some unintended consequences of the policy. For example, consumers may misinterpret what "affiliation" means and assume that there is a more formal relationship between the practitioner and facility than there really is. This could raise concerns about potential conflict of interest. Additionally, the three-patient threshold may be too low to provide meaningful information to patients, particularly when the affiliations are expanded beyond only hospitals. Many of our members may practice across multiple post-acute care settings, which may result in numerous affiliations identified on their Care Compare pages. We are also concerned that affiliated facilities may have poor quality performance, which may then reflect badly upon practitioners, even when they have little engagement or

influence on the facilities' quality indicators. For these reasons, ***we request that CMS proceed cautiously with any potential future display of facility affiliations on Care Compare.*** For example, we would encourage CMS to consider alternative, higher thresholds that may provide more actionable information when consumers turn to Care Compare to help select treating physicians. Additionally, we encourage CMS to undertake consumer testing specifically to understand how patients view, interpret, and apply facility affiliation information when multiple facilities are identified for a given practitioner, as well as how to best articulate how affiliations are determined and why clinicians may have multiple affiliations. Testing should also seek to ensure that consumers understand the nature of the "affiliation" and should probe consumers' perceptions of practitioners when they are affiliated with poor performing facilities on Care Compare. Such testing should occur prior to the reporting of additional facility affiliation.

Utilization Data RFI

Under MACRA, beginning with 2016, the Secretary is required to integrate utilization data information on Physician Compare. CMS previously implemented a policy to begin to include utilization data in a downloadable format in late 2017 using the most currently available data, and previously finalized that the specific codes to be included would be determined via data analysis and reported at the eligible clinician level. This information continues to be available today on www.data.cms.gov/provider-data.

CMS notes that while these data are useful to the healthcare industry, healthcare researchers, and other stakeholders who can accurately interpret these data and use them in meaningful analyses, the data are presented in a technical way that is not easily accessible or usable by patients, who do not frequently visit the website or understand medical procedure coding. This information also does not provide detail on the specific conditions clinicians treat. As such, CMS believes that utilization data may also have a place on clinician and group profile pages on Care Compare, if presented in a consumer-friendly way. CMS seeks comment on the potential types of utilization data that, if publicly reported, could help Medicare patients and their caregivers make informed healthcare decisions, as well as on technical considerations for presenting a specific affiliation between clinicians and diagnoses and/or procedures.

The AAPM&R strongly supports providing patients and caregivers with meaningful information to make informed healthcare decisions, including assistance with identifying specific types of clinicians experienced in performing specific types of procedures and/or treating specific conditions. However, we are concerned about the accuracy of utilization data and the

potential for misinterpretation or misuse of the data for healthcare decision-making since patients may inaccurately assume that utilization correlates directly to high quality or high value care. For example, a patient may view a clinician as high quality simply because the clinician performed a procedure at a high volume, when in fact, the clinician was overutilizing the procedure and inappropriately performing it on patients that did not truly need it. At the same time, a clinician with lower utilization may be perceived as inexperienced or low quality when, in fact, they only perform the procedure for appropriate, evidence-based indications. We recognize that CMS is required by statute to make utilization data available to the public, but we do not believe that utilization data are meant for consumer use or that such data align with Care Compare's goals. In the 2016 MPFS final rule, when CMS first finalized its policy to make utilization data available, it agreed with commenters that these data are not intended for or well understood by the average Medicare consumer. ***As such we recommend that CMS continue to limit the release of utilization data to a downloadable data file that can be used by stakeholders who have the capacity and resources to conduct more technical analyses.*** The dataset is that CMS relies on for utilization data is flawed in multiple ways. For example, the data are only representative of Medicare data and do not reflect other payers, such as Medicare Advantage, Medicaid, or private payers. As a result, the data may inaccurately portray clinicians as having no experience with conditions that they regularly treat/procedures that they regularly perform. CMS also expresses interest in applying a minimum experience level, such as the number of times a clinician performed a certain procedure or treated a certain condition. However, many services and diagnoses are distributed over large groups of procedure codes or diagnostic codes, which means that even if a clinician regularly performs a service, the tool could incorrectly list them as having no experience if no single code exceeded a minimum threshold.

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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 Carolyn Millett at 847-737-6024 or by email at cmillett@aapmr.org for further information.

Sincerely,

Thiru Annaswamy, MD
Chair, AAPM&R Quality, Practice, Policy and Research Committee