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Hartford Hospital (CT)

Health First Inc. (FL)

Mercy Health System (AR, KS, LA, MS, OK, TX)

Our Lady of the Lake Regional Medical Center (LA)

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August 31, 2012

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
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RE: CMS-1590-P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013; Proposed Rule (Vol. 77, No. 146), July 30, 2012

The following comments are submitted by the Provider Roundtable (PRT), a group composed of providers who gathered to generate comments on the 2012 Physician Fee Schedule Proposed Rule, as published in the *Federal Register* on July 30, 2012.

The Provider Roundtable (PRT) includes representatives from 14 different health systems from around the country. PRT members are employees of hospitals. As such, we have financial interest in fair and proper payment for hospital services paid under both OPPS and MPFS, but do not have any specific financial relationship with vendors.

The members collaborated to provide substantive comments with an operational focus that we hope CMS staff will consider during the annual MPFS policymaking and recalibration process. We appreciate the opportunity to provide our comments to CMS. A full list of the current PRT members is provided in **Appendix A.**

Please feel free to contact me at (704) 512-6483 or via email at: *John.Settlemyer@ carolinashealthcare.org*.

Sincerely,

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Hospital, SNF, or CMHC Post-Discharge Care Management

Post-Discharge Transitional Care Management Services, Proposed GXXX1

The PRT is in emphatic agreement with CMS' statement in the 2013 MPFS Proposed Rule (reprinted from the 2012 MPFS rule) that the "*E&M CPT codes of 99201-99215 do not appropriately capture the significant coordination services involved in post-discharge care.*"

We commend CMS for recognizing this important component of care, which has not previously been acknowledged as a vital part of the work required to ensure that beneficiaries receive high-quality care. Since the number of primary care providers who perform services in the hospital setting is declining, it is even more important for hospitalists and/or specialists to communicate with beneficiaries' primary care providers.

We believe that the introduction of the new, proposed G-code supports CMS' goal to improve both quality of care and beneficiary outcomes, and to avoid financial burdens on the health care system stemming from readmissions and/or subsequent illnesses.

In the past, CMS has provided extensive education and guidelines instructing providers on proper documentation requirements, such as with E&M levels. In order for the new G code to work as intended, CMS will need to provide detailed guidelines on what services must occur as part of the new code and how these services should be documented. The PRT encourages CMS to ensure that providers have the intense education and clear instructions needed to accurately and appropriately bill this new G-code.

Similar New Code Needed for Physician Supervision for Nursing Home Patients

Along the same lines, the PRT wishes to highlight a similar service that we believe is critical but currently under-acknowledged by CMS.

This service is *physician supervision for nursing home patients*, CPT codes 99379 and 99380: "*physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy within a calendar month*."

CPT code 99379 reflects 15-29 minutes of supervision; CPT code 99380 reflects 30 minutes or more of physician supervision for nursing home patients.

Every nursing home patient must have an attending physician who is responsible for the patient's total care. This care includes, but is not limited to, managing the chronic conditions, managing current medications, reviewing and responding to lab work, radiology exams, cardiology exams and other testing performed, corresponding with other health care providers (such as psychiatrists, cardiologist, orthopedic surgeons, etc.) who may be involved in the patient's care,

communicating with facility staff regarding new problems or changes in existing problems and the need for changes in new or existing medications.

This is an extensive list of responsibilities, and the attending physician often spends many hours each month communicating with the nursing home staff to supervise the patient's overall care. These supervision services are rendered *in addition to* the work captured by codes for initial nursing facility care (CPT codes 99304 - 99306) and subsequent nursing facility care (99307 – 99310), which describe services that are rendered face-to-face and within the nursing facility.

Nursing facility supervision services resemble home health supervision (HCPCS code G0181) and hospice supervision (HCPCS G0182) services more than initial and subsequent nursing facility care.

For these reasons, the PRT requests that CMS consider the value of these services to beneficiaries and create a new HCPCS code that appropriately captures the significant effort involved in physician supervision for nursing home patients. We request a new G-code, possibly G0183, to allow appropriate coverage for these key services.

Cross-system Impact of Proposed New GXXX1 Code

The PRT would also like to share the comments that we are submitting related to CMS-1589-P, the 2013 OPPS proposed rule. We believe it is important for the physician services division of the agency to understand the implications that the implementation of the care transition code will have on provider-based (hospital-based) clinics that bill the facility charge. We note that it is imperative for hospitals to be able to statistically capture the information from provider-based clinics. The OPPS rule comments commence as follows and are reprinted in their entirety:

The PRT would like to thank CMS for its proposal for a new GXXX1 code, defined as "*all non-face-to-face services that are related to the transitional care management that are furnished by the community physician or non-physician practitioner within 30 calendar days following the date of discharge from an inpatient acute care hospital, psychiatric hospital, long-term care hospital, skilled nursing facility, and inpatient rehabilitation facility; hospital outpatient for observation services or partial hospitalization services; and a partial hospitalization program at a CMHC, to community-based care*." The PRT believes that having a code specifically for reporting post-discharge transitional care management services will allow providers to report the care provided across the continuum and result in better reporting of both services that are currently provided and services that will be provided in the future.

We note that — in the case of many integrated delivery networks and hospitals with provider-based clinics — when the care is being transitioned to the patient's treating physician or non-physician practitioner, that provider is performing care management services in outpatient hospital departments (i.e., provider-based clinic). In these cases, the costs for supporting staff and other resources are borne by the hospital operating the provider-based clinic; these represent legitimate outpatient hospital costs. Therefore, it is important that these costs be reported correctly with the new proposed G-code. Reporting these costs with separate charges and this proposed G-code on outpatient hospital claims from the hospital's clinics means that the costs can *no longer* be included in hospital E/M clinic visit guideline criteria.

The PRT is aware that many hospitals include care coordination in their E/M facility-level guideline criteria and, as a result of this new code, will realize a drop to a lower-level visit code. A drop in the visit level and reporting the G-code with a status indicator "N" will result in hospitals seeing a decrease in payment. Hospitals cannot be recognized for these legitimate costs. Conversely, when a free-standing clinic bills the GXXX1 code, it will receive separate payment, per the Medicare Physician Fee Schedule's proposed rule. Yet, when an outpatient hospital clinic bills this code on its institutional claim, it will receive no separate payment.

In fact, if the code is billed at the end of the 30-day period (as CMS proposes) and it was the only service billed, the claim will be rejected as a claim with an "N" status-only charge and code on the claim. By definition, this code reflects the non-face-to-face services, and is designed to recognize the facility's resources used for services performed in provider-based clinics. To this end, the PRT believes that the code should have a status indicator of "S", with APC payment, and that it should *only* be billed when the care coordination is performed by a qualifying physician or non-physician practitioner in a hospital-based outpatient department.

We do not believe CMS has had an opportunity to think this policy through from the perspective of provider-based clinics. We recommend that CMS follow its current policy of *not* receiving 1500 claims unless the physician or non-physician practitioner provides face-to-face professional services. If CMS wants to track this code for services provided by the physician or non-physician practitioner on the 1500 claim from a provider-based clinic, then the agency needs to explicitly define this goal. Furthermore, when the place of service is 22 for outpatient hospital on the 1500 claim, there should be no separate payment — since the correct policy is that the hospital receives payment under OPPS for this provider-based clinic service.

Therapy Services

The PRT is disturbed that CMS has singled out outpatient rehabilitation services for application of onerous and overly complicated billing requirements. While we understand that the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) required CMS to develop a "claims-based data collection strategy," we assert that the billing and coding process for therapy services is already sufficiently complex to accomplish this requirement.

It should be noted that Physical Therapists (PT), Occupational Therapists (OT), and Speech Therapists (Speech) are in extremely short supply and facilities across the nation have very tight budgets. These factors make it impossible for hospitals and other therapy providers to simply hire more therapists to comply with the proposed regulations, which are extremely resource-intensive.

The PRT respectfully requests that CMS consider facilities' restrictions in both staffing and budgets when it considers methods for implementing the MCTRJCA regulations. Our goals are consistent with the agency's — both the PRT and CMS seek to maintain access to needed services and provide effective, high-quality services to the Medicare beneficiaries we serve. The proposed regulations would hamper efforts to achieve those goals.

Use Diagnoses Codes to Capture Functional Status

CMS proposes this new system because it believes that the diagnosis codes are insufficient to capture the patient's functional status. The agency states, in its discussion about various methods for collecting data, "*…we believe that the primary diagnosis on the claim is a poor predictor for the type and duration of therapy services required*."

The PRT agrees with CMS, when *only* the principal diagnosis is used. This is not necessarily the situation, however. Secondary diagnoses *also* appear on the outpatient claim and provide additional information regarding the patient's clinical condition. They can also indicate functional limitations, for example, when hemiparesis is coded as a secondary diagnosis. In addition, the imminent implementation of the ICD-10 system will advance the use of diagnosis codes to better define the patient's clinical picture.

The PRT believes that, since diagnosis coding has long been a part of the billing process, diagnosis codes should be used to assist in data collection activities. This is preferable to CMS implementing a new system that relies on additional and onerous documentation and claims coding, as is the case with the proposed system of G-codes plus severity modifiers.

Furthermore, we note that the "Development of Outpatient Therapy Payment Alternatives" (DOTPA) is due to be published during the second half of CY 2013. The PRT suggests that CMS continue with the current payment cap with medical review for requested exceptions until *after* the DOTPA report has been published and analyzed. Otherwise, CMS runs a very large risk that it will implement this radically new process in January 2013 and then be forced to change the process upon review of the DOTPA report. It would be unfair and burdensome to force providers to change systems twice in such a short period of time (and it would be particularly challenging for institutional providers who are just now coming under the payment cap regulation).

We request that CMS use diagnosis codes as part of the data collection process, and then create a viable system that responds to the findings of the DOTPA report during CY 2013. The current process of requesting an exception to the set payment cap amount only applies to a small percentage of the patient population. The payment cap exception process would be much more manageable for hospitals and other providers than applying multiple G-codes and modifiers to every claim.

CMS' Proposal to Report G-Codes and Modifiers Regarding Beneficiary Status is Overly-Complex

The PRT believes that the proposed system of reporting HCPCS G-codes along with severity modifiers is too complex and will likely result in CMS receiving consistently poor information *at least* during the first two to three years of its use. This overly complex process will require a significant level of education and time to implement in a compliant manner – and consume time and resources that hospitals simply cannot spare. We suspect that it will take several years of practice, provider education, and revisions to providers' documentation systems before CMS will be able to consider the data reliable enough to use in making future payment decisions.

The PRT suggests that CMS will have better success in capturing functional status and severity through the use of a quality data registry rather than attempting to capture the information via

claims data. To illustrate this problem, the PRT provides the following summary of the G-code proposal's complexity:

- First, the therapist must submit the correct CPT-4 therapy procedure code for the service ordered, provided, and documented.
- Then the therapist must simultaneously submit both a "current status" G-code (which may be a generic functional limitation code or a specific functional limitation code) at the initial encounter and after either the 10 days of treatment or 30 calendar days (whichever is less) *and* a projected "goal status" G-code.
- At the end of treatment, a third type of G-code (the "discharge status" code) must be submitted along with another "goal status" G-code.
- For each of the G-codes (current, goal, or discharge status), the therapist must calculate a modifier that appropriately reflects the severity or percent of limitation being reported.

CMS proposes only two sets of three functional limitation G-codes: one set of primary codes and one set of secondary codes. Yet, a patient often has three, four, or more functional limitations. Under the proposed system, the therapist will *only* be able to treat two functional limitations at one time. In order to treat additional functional limitations, the therapist must wait until the primary and/or first of the secondary limitations is resolved. At that point, the therapist can stop coding on that limitation, and begin coding the third functional limitation — using the same set of codes that had been used for the now-resolved functional limitation.

Yet, this does not reflect that way in which therapy services are actually provided. Therapists who identify a patient as having more than two functional limitations never treat the first two limitations until they are resolved and *then* begin treating additional limitations. This would be inefficient patient care and unnecessarily extend the treatment period with absolutely no benefit to the patient. Initiating the proposed system with just two sets of functional limitation codes is counter-productive to CMS' goal to increase efficiency and reduce unnecessary services.

A second problem is presented by the fact that, for each of these G-codes, the provider must calculate and attach a modifier that describes the patient's severity and/or percent of limitation. Because CMS is not going to recommend or prescribe any specific functional assessment, therapists will select what they believe, in their professional estimation, to be the most appropriate assessment tools — but then will have to convert the scores captured by those tools to correlate with the percentage range of one of the 12 severity modifiers that CMS proposes.

A third problem is presented by the fact that therapists do not always need to use formal assessment tools for secondary limitations. Therapists often identify that a patient has more than one functional limitation at the onset of therapy, and develop related treatment goals for these limitations. They may not, however, need to use a formal assessment tool in order to do so. For this reason, the PRT requests that CMS not require the reporting of secondary functional limitations. Therapists should be allowed to select the most clinically significant functional limitation to be reported and not be overloaded by being required to perform additional and unnecessary tests.

CMS also requested comments on the three separate pairs of G-codes discussed in the CY 2011 PFS rule. We agree with CMS' assessment that these G-codes are "*potentially redundant and confusing*" and add that, in our view, they will provide the agency with little meaningful data.

Assessment Tools

CMS asked for comments on assessment tools that are used to assign the modifier percentage of limitation. Feedback from the PRT facilities' clinical therapists indicates that many, varied assessment tools are available and used by therapists in their daily work. The specific assessment tool used depends on the body part and/or the functional limitation of focus. It should be noted that Physical Therapists, Occupational Therapists, and Speech Therapists all use different assessment tools. For these reasons, one assessment tool cannot be applied to all situations in order to apply a modifier.

The use of multiple assessment tools also presents complications under the proposed system. Each of the many assessment tools that are regularly used by therapists would require the measure score to be converted to the percentage scale of the specific modifier in order to assign the correct severity modifier. Whenever a therapist used a new assessment scale, the therapist would have to understand how to correctly convert the results to the correct modifier percentage scale. Electronic medical records might be able to assist in converting assessment scales to the correct modifier but it takes time and resources to modify documentation programs, convince vendors to apply the needed programming changes, and depending on the assessment scale used, the conversion calculations would differ from tool to tool.

Regardless of whether CMS uses a 5-point, 7-point, or 12-point scale, assignment of the modifiers will be burdensome for clinical therapists. While therapists use assessment tools every day, they have never before been required to convert one scale reading to another in order to assign a modifier to a G-code on the patient's claim. This process is confusing, overly complex, and certain to generate faulty data. As previously noted, the PRT believes that CMS will capture more accurate and complete data through a process that does not rely on claims data, such as a registry.

Adaptation for G-Codes by Select Categories of Functional Limitations

If CMS decides to use "Select Categories of Functional Limitations" rather than generic G-codes, the PRT urges the agency not to require therapists to report more than the primary functional limitation. A set of generic codes to indicate the primary functional limitation will be easier and less complicated to implement than requiring multiple sets of category codes with associated sets of G-codes ("current status," "goal status," and "discharge status"). This type of data collection is needlessly complicated and will be burdensome to therapists. As the PRT has noted, it is not appropriate for the claims process and should be handled via a quality reporting mechanism instead.

PRT members discussed CMS' Table 19 with clinical therapists to gauge their reaction. The response was that a patient's functional limitation may very well fit into *more than one category*. Therapists are as varied in their approach to assessment and treatment as the individual patients are unique in their needs. Using the categories presented in Table 19 could require a therapist to use three sets of codes to describe one functional limitation. For example, for a patient who has

had an operative procedure to treat a hip fracture, the functional limitation can appropriately be captured by the ”Walking and Moving Around”, the “Changing and Maintaining Body Position”, and the “Self Care” categories. If forced to choose one category, one therapist might code the limitation as “Walking and Moving Around,” while another therapist might choose one of the other codes. Neither therapist would be wrong in their categorization. Without extremely clear definitions and guidelines for these categories’ use, different therapists are likely to use different categories. CMS will be deprived of reliable and consistent data and will have appropriate and accurate information in order to design a better payment system.

In addition, CMS does not specify why it proposes to require a third G-code for “discharge status”. The PRT believes that using a “current status” code and a “goal status” code will suffice. The last “current status” and “goal status” codes that are reported accurately represent the end of treatment and record the patient’s progress just as well as a “discharge status” code would. If the patient requires further treatment, another evaluation code would be submitted with “current status” and “projected goal status” codes. The evaluation code provides an indication that this is a new treatment period and a new “goal status” is being submitted.

Reporting Frequency

CMS has proposed that the “current status” code be reported every 10 treatment days, or 30 calendar days after treatment day one, whichever is shorter. We recommend that CMS change the reporting of “current status” to coincide with the last treatment day in the calendar month or the last day of treatment — whichever comes first.

Many providers bill recurring outpatient therapy claims on a monthly basis and this reporting schedule accommodates current therapy providers’ systems and processes. It would be much easier to implement edits to identify and stop claims that lack the appropriate status codes than to try to implement the action for every 10th treatment day.

CMS has indicated that the 10/30 frequency is consistent with provider documentation requirements, since progress notes are required in the same time frame. Many providers have included the needed elements of the progress report in their daily treatment notes. For these providers, remembering to submit a “current status” code every 10th treatment day would not coincide with documentation and would create an extra step for therapists to take. For consistency, progress note requirements can be changed to the last treatment day of the calendar month or the last day of treatment, whichever comes first.

As previously discussed, the “discharge status” codes are unnecessary, since the “current status” that is reported on the last day of treatment essentially reports the same information.

Implementation Date

While CMS has proposed a six-month testing period, the PRT feels that a minimum of a full year is required in order to ensure that CMS collects complete and accurate information

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Summary

The PRT believes that the process CMS proposes is too complex and will require a significant amount of education and time for hospitals to implement in a compliant manner. Reporting functional status and severity is more suited to a quality data registry methodology, and is not easily accomplished via claims data. For this reason, we recommend that CMS use a registry in conjunction with primary and secondary diagnosis codes, and not rely on additional documentation and claims coding to capture this information.

If CMS insists on implementing this proposal, the Provider Roundtable makes the following recommendations, which we believe are necessary to minimize the confusion, poor quality data, and provider burden that the proposed system will create:

- CMS should maintain the current payment cap with medical review for requested exceptions until after the DOTPA report is published and analyzed rather than implement a short-term system that will require revision based on the DOTPA report's outcomes.

- CMS should not use "discharge status" codes, which are unnecessary and add too much complexity to the proposed system. We recommend that CMS only use the "current status" and "goal status" G-codes.

- CMS should not require secondary functional limitations to be reported. Therapists should be allowed to select the most clinically significant functional limitation to be reported as the primary functional imitation.

- CMS should not develop and/or recommend one specific assessment tool for therapists to use in assigning the appropriate modifier, as this is not reflective of how therapists actually work.

- CMS should change the reporting frequency for the "current status" G-code to coincide with the last treatment day in the calendar month or the last day of treatment, whichever comes first.

- CMS should allow a full year to implement the new codes and modifiers to ensure that the new system generates compliant and accurate coding and billing.

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