Atrium Health (GA, NC, SC)

Avera Health (IA, MN, NE, ND, SD)

Central Florida Health (FL)

Community Hospital Anderson (IN)

Franciscan Missionaries of Our Lady Health System (LA)

Hartford Healthcare (CT)

Kaiser Permanente, Southern California Permanente Medical Group (CA)

SSM Health (IL, MO, OK, WI)

University of Pittsburgh Medical Center (PA, NY)

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-1715-P, Room 445-G
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

September 26, 2019

RE: Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations [CMS-1715-P]

Dear Administrator Verma:

The PRT appreciates the opportunity to provide comments to CMS for Revisions to Payment Policies under the Physician Fee Schedule (PFS) and Other Changes to Part B Payment Policies Proposed Rule.

The following comments are submitted by the Provider Roundtable (PRT), a group composed of providers who gathered to generate comments on the 2020 Physician Fee Schedule Proposed Rule, as published in the *Federal Register* on August 14, 2019.

The Provider Roundtable (PRT) includes representatives from 13 different health systems, serving patients in 19 states. PRT members are employees of hospitals. As such, we have financial interest in fair and proper payment for hospital services by CMS, 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 process. We appreciate the opportunity to provide our comments to CMS. A full list of the current PRT members is provided in **Attachment A.**

Please feel free to contact me at 765-298-2110 or via email at: *trinker@ecommunity.com*.

Sincerely,

Terri Rinker, MT (ASCP), MHA
PRT Chair and
Revenue Cycle Director
Community Hospital Anderson
Anderson, IN

Proposed Payment for Outpatient PT and OT Services Furnished by Therapy Assistants

The PRT understands that the payment reduction for services furnished by Physical Therapy Assistants (PTA) and Occupational Therapy Assistants (OTA) has been made final, and we appreciate the scenarios provided in this Proposed Rule. While the examples were helpful, the PRT has concerns regarding consistent and accurate reporting of modifiers in the correct order to ensure appropriate payment while not adding to providers' administrative burden.

- **The PRT requests clarification on the order for reporting multiple modifiers.**

With the implementation of modifiers CQ (for PT) and CO (for OT) for therapy assistants, there will be multiple modifiers required on a single charge line on the claim to appropriately represent the service provided.

For example, when a physical therapy (PT) service is provided, modifier GP is required. If the service reported is in addition to another separately identifiable service (e.g., PT and OT both see the patient on the same date of service), modifier 59 may be necessary. If the service provided is in excess of the established therapy limits, modifier KX must also be appended. And, finally, if the PTA is involved, new modifier CQ would apply as well. This service would be represented on a claim as "97062 CQ GP 59 KX" (formatted appropriately based on electronic or paper claims standards).

CMS has a long-standing FAQ, which states that modifiers that impact payment should be in the first position. Based on the purpose of modifiers CQ and CO, and the guidance of the FAQ, these modifiers should precede modifiers GP and GO on the claim.

Because the therapy discipline modifiers have been required since 1998, most organizations have the GP and GO modifiers hard-coded in their chargemaster, meaning that, when the charge is entered, the modifier is automatically reported on the claim with the CPT code. The process of adding the new modifiers CO and CQ is going to be quite challenging and will be even more burdensome if providers must then manually change the modifiers' order to meet the "payment modifiers go first" guideline. We believe that this creates a natural exception as the therapy indicator is always reported for therapy services. It would be virtually impossible for a provider to add every possible combination of modifiers to the chargemaster in order to meet both Medicare and non-Medicare payer reporting requirements.

The National Uniform Billing Committee (NUBC) allows up to four modifiers per line item on a claim; however, the NUBC does not specify the order in which modifiers must be reported. CMS' claims processing system needs to be able to adjudicate the modifiers *in any order*, since hospitals need flexibility to use systems to get all modifiers on the claim, but it is too burdensome and challenging to then have to manually intervene to change the order. This adds more costs to the process.

It appears that CMS' claims processing system may already be able to do this, as claims that report modifier GP followed by modifier 59 (a modifier that affects payment determinations) process and reimburse appropriately. We believe that this can be the case for the therapy assistant modifiers also. The modifiers could be recognized in a specific order, but not have to be listed in that order on the claim. We urge CMS to work with providers to ensure that the claims

processing system can adjudicate claims appropriately regardless of the reporting order of modifiers.

- **The PRT recommends that CMS create flexibility in the claims processing system regarding the order in which modifiers must be reported and still adjudicate claims appropriately. NUBC does not specify the order and providers need some flexibility due to system limitations and to not create additional cost to the system.**

- **If CMS will not allow flexibility, then it becomes imperative for CMS to provide very specific instructions regarding the order of modifiers, not by stating "payment modifiers" but by providing the order in which specific modifiers must be reported. CMS must also reiterate and reinforce the modifier-ordering concept and expectation for providers.**

New Therapy Assistant Modifiers and the *de minimus* Requirement

We understand that CMS needs a mechanism to validate whether the new modifiers should be added and that, to impact the payment to providers when therapy assistants are involved, the documentation requirements are going to create additional burden for the providers. Measuring two and three minutes of a PTA or OTA's time does nothing to improve patient care. As a group, we have spent an inordinate amount of time brainstorming and investigating the most cost-effective ways that our individual organizations could operationalize this requirement. Quite frankly, most of the options are not what we would consider to be "cost-effective."

If a provider determined that it was more cost-effective to add the CQ or CO modifier to all services provided by a PTA or OTA, regardless of the actual time spent, would there be a compliance risk? This process would mean that a provider would always be paid 85% of the fee schedule amount, even when the time spent by the OTA or PTA was in fact under the *de minimus* threshold of 10% of total time.

A provider would never be overpaid in this situation, but may sometimes be underpaid. The care to the beneficiary would not suffer or change, but the provider would make a business decision based on the cost required to time activities, document the time, and add or remove modifiers.

The PRT requests that CMS review this scenario and determine that this would be acceptable since it is based on the premise of keeping healthcare costs down and not adding burden to the operational process. CMS would have to provide specific instructions to contractors and/or auditing bodies that this process has been vetted with the agency and was deemed to be an acceptable business decision.

- **The PRT recommends that CMS create flexibility within the claims processing system to accept modifiers in any order but to process them based on a hierarchy, with the payment modifiers being first, followed by the rest of the modifiers.**

- **If the above recommendation is not accepted, the PRT urges CMS to publish specific instructions regarding which modifiers must be reported first, second, etc. This guidance should include specific scenarios. Using the earlier example above, modifier GP comes before CQ, which comes before 59, which comes before KX (or whatever the order would be).**

- **The PRT recommends that CMS issue a determination that if the individual provider determines it is more cost effective to always append modifiers CO and CQ when therapy assistants are involved in the patient's treatment rather than calculating the *de minimus* standard, CMS will recognize that as a business decision of the individual provider, and consider it compliant reporting. CMS would also provider instructions to contractors and other auditing entities that this is acceptable for therapy assistant services.**

Coinsurance for Colorectal Cancer Screening Tests

CMS is soliciting public input on whether physicians should be required to notify patients, in advance of having colorectal screening tests, that if something is found that requires attention (i.e., a biopsy or polyp removal) the test is considered to be a diagnostic test. Per Medicare's benefit policy, the patient is responsible for the coinsurance for any diagnostic tests. CMS also states that the agency has no authority to waive the copay.

The PRT members are certainly not attorneys, and we believe CMS' attorneys have given this proposal ample review. We recommend, however, that CMS consider the following comments.

As stated in the Proposed Rule, sections 1834(d)(2)(C)(ii) and 1834(d)(3)(C)(ii) state that, if screening tests lead to a diagnostic procedure, payment shall *not* be made for the screening test but is made, instead, for the diagnostic test. The PRT believes that this could be interpreted to mean that payment should not be made for *both* screening and diagnostic tests. There is nothing in the text to indicate the procedure will be reimbursed as a diagnostic exam rather than a screening exam, with a different payment methodology. Also, if the test remains a screening exam, the copayment will be waived.

The Proposed Rule notes that a screening test is furnished to patients in the absence of signs or symptoms of illness or injury. When a patient presents for a screening colonoscopy, there are no signs or symptoms of illness or injury, so there is no assumption that anything will be found during the procedure. Because Medicare has a different payment methodology for a screening vs. a diagnostic colonoscopy, modifiers trigger variations in beneficiary responsibility, which patients don't understand. Both a screening and diagnostic colonoscopy are covered services; therefore, it is inappropriate to provide patients with an Advanced Beneficiary Notice (ABN). Further, it is inappropriate from a clinical standpoint to offer the patient an opportunity to refuse the diagnostic test.

The PRT submits that if a colonoscopy was a screening procedure when it began, it should be considered a screening test regardless of the final outcome; the patient should be allowed that

screening benefit and not be assessed a co-pay. Conducting a biopsy or polyp removal should not transform the test automatically into a diagnostic procedure during a screening episode, because patient still does not have signs and symptoms.

Given the changes surrounding beneficiary responsibility for screening tests over the last several years, the PRT encourages CMS to analyze the statutes differently and find a way to correct this situation by waiving the beneficiary's copay.

If CMS cannot waive the copays, the PRT opposes any requirement for physicians to notify patients *before* the screening exam that they may incur a copay. The PRT is very concerned by adding to the provider's burden; providers already have a long discussion with our patients to convince them that this very unpleasant test and associated pre-procedure prep is beneficial to them. Adding a discussion of possible costs is only going to complicate and extend this process.

More importantly, the PRT is very concerned that patients may choose *not* to have the screening test due to fears about a potential copay. After all, the patient is not experiencing any signs or symptoms of illness or injury (the very definition of a screening test). We have extensive experience with patients who say, "If I had known this wasn't a screening test, I wouldn't have had it done. The polyp was benign, and now, I owe a coinsurance!"

- **The PRT opposes the requirement that physicians discuss possible copayments prior to performing a colorectal screening test.**

Physician Supervision for Physician Assistant (PA) Services

The PRT commends CMS for proposing to revise the current regulation regarding physician supervision requirements for Physician Assistants (PAs) to allow them to work "in collaboration" with physicians. All non-physician practitioners must act in accordance with state law and scope of practice rules, which includes medical direction and appropriate supervision levels. All non-physician providers, including PAs, are required to document clearly and concisely in the patient medical record for any service provided.

We agree this proposed change would better align physician supervision for the PAs services with that of the nurse practitioner (NP) and clinical nurse specialist (CNS) requirements. The collaboration between non-physician practitioners or the physician that oversees the PA is primarily responsible for his/her direction and management of services provided to patients. The supervising physician should be responsible to ensure the services provided by the PAs are medically necessary and appropriate.

- **The PRT appreciates and agrees with the proposal to revise the supervision requirements for physician assistants to follow state law and scope of practice requirements.**

Review and Verification of Medical Record Documentation

The PRT strongly supports CMS' efforts to eliminate unnecessary administrative barriers by simplifying and standardizing the approach to documentation requirements in the medical record.

The Proposed Rule outlines the intention to allow Physicians, NPs, PAs, and other Non-Physician practitioners to review and verify documentation rather than repeating documentation already provided by other physicians, residents, nurses, students or other members of the medical team, including notes documenting a practitioner's presence and participation in the services being provided to a patient. This will save a lot of time for the practitioner and allow preceptors more time to train the professionals and provide patient care.

- **The PRT applauds CMS' recognition of the duplicity and supports the proposal to allow professional preceptors to review and verify documentation provided by medical team members, PA, and NP, and students.**

Provider Roundtable

Attachment A: Provider Roundtable Members

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