Atrium Health (NC, SC, GA, AL)

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

Community Health Network (IN)

Erlanger Health System (TN)

Franciscan Missionaries of Our Lady Health System (LA)

Hartford Healthcare (CT)

Oregon Health & Science University (OR)

SSM Health (IL, MO, OK, WI)

University of Florida Health Shands (FL)

University of Pittsburgh Medical Center (PA, NY)

September 13, 2021

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

Re: *CMS-1751: Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements.*

Dear Ms. Brooks-LaSure,

The Provider Roundtable (PRT) submits the following comments on the Medicare Physician Fee Schedule, as published in the *Federal Register*.

The Provider Roundtable (PRT) includes 15 representatives from various 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 past 18 months have been incredibly difficult for providers and, we are sure, for CMS as well. In addition to the pandemic's obvious stress on health care providers, our organizations have faced financial stress, we have lost co-workers to COVID-19, and we have experienced exponential increases in the quantity of work required as the rules under which we operate were (understandably) changing on a daily basis. The PRT truly appreciates CMS's efforts to keep providers informed through the After-Hour Calls during the early months of the Public Health Emergency (PHE).

In the past, the members of the PRT have collaborated to provide substantive comments with an operational focus that we hope CMS staff would consider during the annual OPPS policymaking process. We have always felt that our comments made a difference in the process—even when CMS did not agree with us or adopt our recommendations. Because of the ongoing PHE and our increased

workloads, the PRT has not been able to comment on as many topics as normal, or provide as much detail in our comments, as we normally do and as we would have liked.

We appreciate the opportunity to provide our comments to CMS and hope that next year we will all be able to meet in person and contribute more in-depth comments on more topics. 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

Pulmonary Rehabilitation, Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Services.

For CY 2022, CMS proposes regulatory text changes to establish consistency in terminology, definitions, and requirements across Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR), and Intensive Cardiac Rehabilitation Services (ICR). To reduce burden, CMS also proposes to separate Pulmonary Rehabilitation "physician standards" into "medical director standards" and "supervising physician standards" and to remove the requirements that a physician have direct patient contact to review his or her treatment plan every 30 days. Additionally, CMS proposes to add COVID-19 as a covered condition for PR provided certain conditions are met.

- **The PRT fully supports all efforts to standardize terminology, definitions, and requirements across PR, CR, and ICR services.**

The proposed revisions will also enable stakeholders that have an interest in both PR and CR/ICR programs to compare requirements and implement programs more easily.

The PRT also agrees with CMS' proposal to remove the PR direct physician-patient contact requirement and to add coverage of PR for beneficiaries who were hospitalized with a COVID-19 diagnosis and experience persistent symptoms, including respiratory dysfunction, for at least four weeks after hospital discharge.

Changes to Beneficiary Co-insurance for Certain Colorectal Cancer Screening Tests

The PRT thanks CMS for recognizing the confusion the beneficiary coinsurance causes for our patients, and for making adjustments. Our organizations have heard from upset beneficiaries who do not understand why they owe coinsurance when they had a screening test that was supposed to be covered at 100%. Many times, the beneficiary says something to the effect that, had they known, they would not have had the screening done because the polyp removed was benign.

The PRT is concerned that now Medicare patients will hear the coinsurance is being eliminated, and one of two things will happen:

1. The beneficiary will hear that there is no coinsurance but will not understand that this is being implemented as a tiered decrease in coinsurance until 2030, and is likely to be even angrier at providers when a coinsurance is required.
2. The beneficiary will understand that they may still have coinsurance requirements and will chose to delay this important screening exam, with potentially life-threatening results.

Some health care providers would like to waive the coinsurance to avoid either of the two situations above. Compliance experts have differing viewpoints. Some consider this waiver to be an inducement and will not allow it to happen. Others feel that if it is not advertised, and it is a better business decision to waive the coinsurance than to have angry patients calling the facility (which requires staff time and resources to resolve), then the waiver is *not* an inducement.

- **The PRT supports CMS' proposal to eliminate the coinsurance. We request, however, that CMS allow providers to waive the coinsurance even earlier than 2030 if they elect to do so.**

- **We also request that CMS explicitly address this situation fully in the Final Rule, so providers that do want to reduce the coinsurance at a faster pace than CMS understand that they can do so without fear of violating any CMS rules.**

Radiology Appropriate Use Criteria

Modifier MH was created for use in the Appropriate Use Criteria (AUC) program as a way for furnishing providers to report the services that were ordered without the AUC information being provided; this modifier enables CMS to determine which ordering physicians/NPPs were not providing the required information to the furnishing providers. The AUC program is prescribed in the Social Security Act 1864 (q) 5 and 6. The Act requires that the Secretary determine, on an annual basis, which ordering professionals are outlier professionals, in that they are not providing the necessary information to the furnishing providers who are performing and billing for the ordered services. The purpose is for CMS to then require the outlier professionals to obtain prior authorization for the services and become compliant with the AUC program. Two years of data are to be utilized. (See **Attachment B**. Recognizing Appropriate Use Criteria for Certain Imaging Services.)

Even with delay of mandatory reporting of the modifiers under the AUC program due to the COVID-19 PHE, CMS has not published (nor apparently even considered) which professionals are outliers and for whom the phase of preauthorization is required. Instead, CMS states that, when the AUC program entered the payment penalty phase, the plan was that qualifying settings would no longer need this modifier because claims would, at that point, be required to either include AUC consultation information or indicate why the information is not required in order to avoid AUC program claims processing edits.

The PRT strongly disagrees with this assertion.

Modifier MH was created *specifically* to indicate which ordering professionals were outliers so that the Secretary could impose requirements to ensure this program was followed. The PRT submits that CMS is, once again, putting the onus on furnishing providers (professional, free-standing facilities and hospital facility providers) to enforce CMS' regulations.

While we agree that, in order to bill for a service, all information must be obtained and provided by the furnishing provider(s), we do NOT agree that CMS should push its responsibility onto furnishing providers. Furnishing providers receive an authenticated order for a medically necessary service and must follow those orders as the ordering physician is driving the care of the patient. Now, CMS wants to force furnishing providers to either put a hold on a service in order to obtain AUC information or provide a service without receiving reimbursement. The latter will then be held against furnishing providers as a means of "inducement" because the service was provided for "free."

- **The PRT vehemently disagrees with CMS' proposal to repurpose modifier MH.**

This modifier is integral to the Secretary having the information to follow the instructions/ requirements specified in the SSA. If CMS wants to create a new modifier or value code for furnishing providers to use in those specific settings where the claim is not required to report AUC consultation (e.g., Critical Access Hospitals, Maryland Total Cost of Care, etc.), then the PRT has no objection. It is NOT appropriate, however, for CMS to change the intent of modifier MH under the AUC program.

- **The PRT recommends that CMS not change the use of Modifier MH but retain the modifier and enforce the provisions in the Social Security Act regarding outlier (noncompliant) ordering professionals.**

- **The PRT recommends if CMS wants to use a modifier for reporting services furnished by professionals in entities that are exempt from the AUC program, a new modifier should be created.**

- **The PRT also recommends that CMS consider requesting a new value code to be used for facility reporting on a UB-04 when the entity is exempt.**

Physical Therapy and Occupational Therapy Services

Beginning in January 2022, CMS will begin reducing payment by 15% for Medicare Part B services provided by physical therapy assistants (PTAs) and occupational therapy assistants (OTAs) when modifier CQ or CO is appended to the service, as prescribed by section 53107 of the Bipartisan Budget Act of 2018.

CMS proposes to revise the *de minimis* standard established to determine whether services are provided "in whole or in part" by PTAs or OTAs. Specifically, CMS proposes to revise the *de minimis* policy to allow a timed service to be billed without the CQ/CO modifier in cases when a PTA/OTA participates in providing care to a patient with a physical therapist (PT) or occupational therapist (OT), when the minimum time for Medicare billing requirements for the timed service is met, without consideration of the minutes furnished by the PTA/OTA (i.e., satisfying the "8-minute rule").

For services that require multiple units to be billed to represent the time of the service, CMS proposes to allow one 15-minute unit to be billed with the CQ/CO assistant modifier and one 15-minute unit to be billed without the CQ/CO modifier when the PT/OT and the PTA/OTA each provide between 9 and 14 minutes of the same service.

Overall, the *de minimis* standard would continue to be applicable in the following scenarios:

- The PTA/OTA independently furnishes a service, or a 15-minute unit of a service "in whole" without the PT/OT furnishing any part of the same service. In instances where the service is not defined in 15-minute increments including: supervised modalities, evaluations/ reevaluations, and group therapy.

- The PTA/OTA furnishes 8 minutes or more of the final unit of a billing scenario in which the PT/OT furnishes less than 8 minutes of the same service. When both the PTA/OTA and the PT/OT each furnish less than 8 minutes for the final 15-minute unit of a billing scenario.

The PRT understands that CMS is bound by legislation to implement the assistant differential, but we urge CMS to delay implementation of the payment differential until January 1, 2023. Doing so will give providers additional time to educate staff on the additional proposed revisions to the *de minimis* standard and mitigate the impact of this payment differential policy on therapy services provided by assistants. This delay is necessary to reduce administrative burden and give CMS and therapy providers alike time to prepare for the change.

We also note that the regulations for implementing the assistant differential are very complex. We believe that implementing this policy will be complicated within clinical settings, given the short time frame between release of CMS' Final Rule and the differential taking effect. Providers also need more time to update electronic health records and billing systems to align with the new *de minimis* policy. For this reason, we urge CMS to provide additional education to providers about how to appropriately utilize the modifier. This is yet another reason why a delay would be beneficial to all parties.

- **The PRT supports CMS' proposed changes regarding application of the *de minimis* standard and application of the therapy modifiers.**

- **The PRT urges CMS to delay implementation of this policy. CMS needs additional time to provide clear and consistent guidance and fully educate providers on its implementation. This delay will also provide therapy providers with the time necessary to ensure minimal disruption in patient care**.

Evaluation and Management (E/M) Visits

The PRT commends CMS' efforts with respect to modifying the current regulations on split/shared Evaluation and Management (E/M) visits.

CMS relied on guidance found in the *Medicare Claims Processing Manual* (MCPM) to allow physicians to bill for visits performed in part by a non-physician practitioner (NPP) and/or eligible provider (EP) outside of the physician office setting. In response to a 2021 petition requesting a review of the Medicare Claims Processing instructions, CMS withdrew the instructions regarding split/shared visits and critical care services and is now seeking provider feedback on the new proposals.

In consideration of CMS' multiple-part proposal, the PRT provides our comments below.

1) Who Can Bill for Split or Shared E/M Visits

The PRT applauds CMS' expansion regarding providers who can bill for split/shared E/M services. This is a great benefit for NPPs/EPs who provide these services today.

The agency proposes to modify its current policy and permit the billing provider to report a split/shared E/M visit for new and established patients, critical care services, and certain E/M visits provided in a Skilled Nursing Facility (SNF). We applaud CMS for including new patient visits, and critical care services as reportable split/shared visits as we agree that the physician and NPPs work as a team to care for patients.

CMS also proposes to modify the current regulations by defining "substantive portion of a visit" as more than half of the total time spent by the physician or NPP/EP performing the visit. CMS proposes that the billing practitioner must be the individual who performed more than half of the total time of the visit.

The PRT does not support this part of the proposal as written.

A physician's expertise and experience typically outweighs those of an NPP/EP. The PRT believes that, when the visit level is based on time, the substantive portion of the visit should be determined by both quality and quantity. Physicians who spend time with patients provide a substantial portion of the visit simply because of their clinical expertise. A physician can easily provide more than half of the "substantive portion of the visit" related to content and clinical expertise, but this portion does not require 50% of the time involved. The PRT requests that CMS change the requirement to less than 50% of the shared/split visit's time, in recognition of the physician's clinical expertise involved in providing care.

If the visit is determined based on medical decision-making (MDM), then any documented contribution by the physician should be considered to be the substantive portion of the visit. As noted above, physicians do not always need an exorbitant amount of time to assess and make medical determinations. When a physician is involved and the documentation supports their contribution (such as updating a plan of care, interpreting lab work, and prescribing the means for resolution of clinical conditions), however, then that is substantive. In these types of scenarios, the physician should be the billing provider.

The PRT recommends that CMS:

- **Change the portion of the time required for a physician to be involved in a split/shared visit to some lower percentage (i.e., 25%, 30%) of the total time when the visit is billed based on time.**

- **Allow the "substantive" requirement to be met when the documentation supports physician involvement in the medical decision making and agree that the physician would be the billing provider for the split/shared visit.**

2) Critical Care Services

CMS proposes to adopt the CPT prefatory language regarding the definition of "critical care services."

- **The PRT supports this proposal, since it aligns with HIPAA transaction code sets.**

Specifically, for critical care services that are provided by a sole physician or NPP, the agency proposes to require the use of CPT code 99291 to report the first 30-74 minutes of services

provided on a specific date, with the code being reported only one time per date of service. CMS also proposes that CPT code 99292 be used for any additional 30-minute increments of care that are provided to the same patient.

- **The PRT supports this use of CPT code 99292 as it follows AMA guidance.**

CPT code 99292 is an add-on code, so claims processing edits expect it to be reported on the same date of service as the primary CPT code 99291. For this reason, continued critical care time should be reported with the date of service on which the care was initiated—even if services extend beyond midnight and into a separate calendar date. If a patient was stable and experienced *a separate* critical care episode on the following date, CPT code 99291 would be reported on that calendar date.

- **We further recommend that, if critical care services extend beyond midnight (12:00 am), the agency require all critical care codes to be billed with the date of service on which they began, very similar to the regulations for the Outpatient Prospective Payment System (OPPS) (e.g., hours for observation services).**

CMS also proposes that, when more than one physician or NPP furnishes critical care services to the same patient on the same date, the services would be covered as long as the documentation supports that each practitioner's service(s) are both medically necessary and not repetitive. When critical care is provided concurrently by multiple practitioners in the same specialty and in the same group, to the same patient, on the same date of service, the initial provider rendering the service would report CPT 99291 (initial 30-74 minutes) and the provider(s) of additional critical care services would report their time using CPT code 99292 (subsequent time intervals). CPT code 99291 would be reported only once for a patient on a single date of service by practitioners in the same specialty in the same group. Both CPT codes (99291, 99292) would be billed on the same claim.

- **The PRT supports this proposal.**

CMS additionally proposes that when one practitioner starts furnishing critical care services, but the services do not meet the required time for reporting CPT code 99291, and then a separate practitioner (in the same specialty and group) continues delivering critical care services to the same patient on the same date of service, the practitioners' aggregated time would meet the requirement to bill CPT code 99291. Until the time threshold described in CPT code 99291 has been met, CPT code 99292 would not be reported unless additional critical care service minutes are provided to the same patient on the same date of service. (Note that 99291 is defined as 30–74 minutes; at 75 minutes, a second interval starts, indicated by CPT code 99292.)

- **The PRT supports this proposal.**

We also agree that practitioners should document, in the medical record, the total time critical care services were provided by each reporting practitioner. We also agree that the actual time critical care services start and stop should not have to be documented. Documentation should be specific enough to enable medical reviewers to determine the basis of the patient's critical injury or illness, the role played by each clinician in treating the patient's condition(s), and the time each practitioner spent providing critical care services.

CMS also proposes that a practitioner cannot bill another E/M visit code for the same patient, on the same date that a critical care service is provided. CMS proposes that this restriction apply to practitioners in the same specialty in the same group.

- **The PRT rejects this proposal, because it conflicts with the AMA's current CPT coding guidance and critical care services have limited reporting**.

The CPT guidance states that: *"Critical care and other E/M services may be provided to the same patient on the same date by the same individual."*

Critical care involves time spent in specific, life-saving care, and ends when the patient is stabilized, or their crisis has been resolved. Practitioners continue to care for these patients, but critical care does not continue after the patient's crisis resolves.

The PRT believes that CMS must allow providers to bill the additional care provided on the same date of service either before or after providing critical care services. Caring for these very ill patients can be time-consuming, separate from the critical care time block. When this happens, and providers report a critical care and E/M code on the same date of service and for the same patient, CMS is not being billed for any duplicate time or service(s). Hence, the agency is not providing reimbursement for any duplicate time or service(s).

We note that, if CMS prevents practitioners from billing both E/M and critical care codes on the same date of service for the same patient, it will not only negatively impact the providers caring for these patients, but also will severely impact the data reported on claims. The claims data that CMS receives will understate the services and cost provided to the individual patient.

- **The PRT urges CMS not to prevent practitioners from billing both an E/M visit and critical care services (CPT 99291, 99292) on the same date of service.**

In addition, CMS proposes to include critical care services in 10- or 90-day global surgical packages. Critical care services, as defined by the AMA, were never intended to be included in global surgical packages. Critical care services are not a "typical follow-up" for a surgical procedure.

- **The PRT strongly rejects this proposal.**

- **The PRT urges CMS to adhere to the AMA's definition of "critical care" and guidelines for reporting critical care and other E/M services by the same clinician for the same patient on the same date of service.**

3) Setting of Care: Hospital, Office, SNF

CMS proposes to change current regulations regarding NPPs/EPs' provision of services outside of the office setting for a split/shared E/M visit in order to differentiate between the current policy that is applicable to services furnished incident to the professional services of a physician in a physician office setting and the policy that is applicable to services furnished in a facility setting.

- **The PRT supports this proposal.**

4) Definition of Same Group

CMS requests information regarding a definition of "*same group"* for the purpose of billing a split/shared E/M visit.

- **The PRT recommends that CMS define "same group" as a physician and NPP who are in the same specialty, in order to align with the agency's definition of concurrent care.**

The PRT agrees that a tax identification number (TIN) is too broad to use for split/shared and critical care visits as commonly, different multi-specialist physicians and NPPs in the same practice use the TIN for facility-based providers. Defining "same group" by the TIN increases the probability that many visits by different specialists and their NPPs would be denied on the grounds that they constitute medically unnecessary concurrent care when in reality, the visits were not split/shared visits, although the claim would appear that way. Currently, NPPs do not register based on specialty, so a key piece of required information is not available. The PRT believes this can be mitigated by CMS explicitly recognizing the specialty of NPPs on claims.

- **The PRT urges CMS to adopt a national policy to prevent concurrent care denials when the NPP and physician are of different specialties and independently furnish complete E/M services for the same patient.**

The policy would apply to claims submitted by NPs (Specialty 50) and PAs (Specialty 97) and allow these providers to include the medical group specialty (on the 837 or paper CMS-1500 form) under which the NP or PA provided services (e.g., Specialty 20 or Specialty 26). Doing so will not only reduce provider burden but also allow practitioners in multi-specialty groups that share a single tax identification number to furnish patient care in a facility setting and report more specificity on the claims. This reporting specificity will prevent inappropriate claim denials for concurrent care and reduce burden related to appeals. When the physician and NPP are from the same specialty and same group, then the shared/split visit rules would apply.

5) Claim Modifier

CMS proposes to adopt the use of a new modifier to be reported by the billing practitioner and identify split or shared E/M visits.

- **The PRT supports this proposal.**

Attachment A: Provider Roundtable Members

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* *Non-voting past PRT member*

Updated July 2021

Attachment B. RECOGNIZING APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES

(5) IDENTIFICATION OF OUTLIER ORDERING PROFESSIONALS.—

(A) IN GENERAL.—With respect to applicable imaging services furnished beginning with 2017, the Secretary shall determine, on an annual basis, no more than five percent of the total number of ordering professionals who are outlier ordering professionals.

(B) OUTLIER ORDERING PROFESSIONALS.—The determination of an outlier ordering professional shall—

(i) be based on low adherence to applicable appropriate use criteria specified under paragraph (2), which may be based on comparison to other ordering professionals; and

(ii) include data for ordering professionals for whom prior authorization under paragraph (6)(A) applies.

(C) USE OF TWO YEARS OF DATA.—The Secretary shall use two years of data to identify outlier ordering professionals under this paragraph.

(D) PROCESS.—The Secretary shall establish a process for determining when an outlier ordering professional is no longer an outlier ordering professional.

(E) CONSULTATION WITH STAKEHOLDERS.—The Secretary shall consult with physicians, practitioners and other stakeholders in developing methods to identify outlier ordering professionals under this paragraph.

(6) PRIOR AUTHORIZATION FOR ORDERING PROFESSIONALS WHO ARE OUTLIERS.—

(A) IN GENERAL.—Beginning January 1, 2020, subject to paragraph (4)(C), with respect to services furnished during a year, the Secretary shall, for a period determined appropriate by the Secretary, apply prior authorization for applicable imaging services that are ordered by an outlier ordering professional identified under paragraph (5).

(B) APPROPRIATE USE CRITERIA IN PRIOR AUTHORIZATION.—In applying prior authorization under subparagraph (A), the Secretary shall utilize only the applicable appropriate use criteria specified under this subsection.

(C) FUNDING.—For purposes of carrying out this paragraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2019 through 2021. Amounts transferred under the preceding sentence shall remain available until expended.