August 30, 2012

Administrator Marilyn Tavenner
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-2379-P
Mail Stop C4-26-05
750 Security Boulevard
Baltimore, MD 21244-1850

RE: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2013; file code CMS-1590-P

Dear Administrator Tavenner:

The American Academy of Neurology (‘AAN’ or ‘Academy’) is the premier national medical specialty society for neurology representing more than 25,000 neurologists and neuroscience professionals, and is dedicated to promoting the highest quality patient-centered neurologic care. A neurologist is a physician with specialized training in diagnosing, treating, and managing disorders of the brain and nervous system such as epilepsy, Parkinson’s disease, Alzheimer’s disease, stroke, migraine, multiple sclerosis, and brain injury. The AAN has reviewed the Centers for Medicare & Medicaid Services’ (CMS) Proposed Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2013 [CMS-1590-P] and respectfully offers comments related to these topics for your consideration:

- Improving the Valuation of the Global Surgical Package
- Defining Post-Discharge Transitional Care Management Services
- Primary Care Services Furnished in Advanced Primary Care Practices
- DME Face-to-Face Encounters
- Physician Payment, Efficiency and Quality Improvements - Physician Quality Reporting System
- Physician Compare Website
- The Electronic Prescribing (eRx) Incentive Program
- Application of the MPPR to the TC and PC of Advanced Imaging Procedures for Group Practices
- Physician Value-Based Payment Modifier

Improving the Value of the Global Surgical Package

The Academy supports CMS’ goal of examining global surgical packages to determine whether they are appropriately valued by gathering more information on the Evaluation and Management (E/M) services that are typically furnished with surgical procedures. In 2005 and 2012, the Office of the Inspector General (OIG) published reports concluding that the RVUs for the global surgical package are too high because they include the work of E/M services that are not typically furnished within the global period for the reviewed procedures.
The number of post-operative visits is now determined largely from a RUC survey of about 30 or more surgeons. As noted by the OIG research, that method often does not meet the requirements of an evolving resource-based payment system.

The resource-based physician payment mechanism must accurately value the physician time, work intensity, and practice expense. The global payment methodology has removed CMS’ ability to audit the accuracy of Harvard or RUC valuation for services with a global period. As procedures change over time, so do the frequency and intensity of post-operative visits. In addition, there is no documentation requirement for post-operative visits, so CMS cannot audit the actual frequency or intensity even if data were reported. Not to mention, CMS cannot track those instances when post-operative follow-up is provided by a different physician or in a different geographic location.

We recommend that CMS establish auditable documentation requirements for inpatient and outpatient post-operative visits of varying time and intensity, since the cost of documentation, in time and practice expense, is a direct part of the resource use to provide the service. Post-operative visit notes might follow the same documentation as for E/M visits, but simpler requirements may be adequate. We recommend further that CMS establish G-codes through which a large sample of surgeons might report the number and intensity of post-operative visits. Finally, we recommend that CMS track E/M services provided to surgical patients within the global period, by a different physician, for the same or similar diagnosis, to begin to understand what portion of post-operative visits may now be billed in addition to the 90-day global fee.

Most large health systems and ACOs are likely to require detailed information of this type, including the number and type of post-operative visits by provider, since those data will inform payment rates to each physician. Now that mature IT can capture and store data on individual services more easily than in the past, we recommend that CMS consider whether the global payment system might be outdated, and whether a resource-based payment system might better pay for services individually as medically necessary and as provided.

Defining Post-Discharge Transitional Care Management Services

We are deeply appreciative of the leadership CMS has taken in recognizing the non-face-to-face care that physicians are performing when providing transitional care management (TCM) services. The AAN agrees with many of the concepts behind the proposed G code for TCM services, but we urge CMS to accept the TCM and complex care coordination (CCC) CPT® codes recently passed by the CPT Editorial Panel and currently undergoing RUC review in lieu of its G code proposal. If implemented, the CPT TCM codes will not only accomplish the goal of CMS to improve care for chronically ill patients and reduce the rehospitalization rate, but will also better reflect how TCM services are actually delivered. In addition, even though CMS did not propose to implement CCC codes for 2013, we believe that the CPT CCC codes address the concerns CMS expressed in the proposed rule regarding the need to ensure that care coordination payments be made to "advanced primary care practices" that have the capability to provide effective care coordination and who can identify the patients that will most benefit from those services.

In summary, our recommendations are as follows:

- CMS should implement the CPT TCM codes for CY 2013 and should use the RUC recommendations for physician work, direct practice expense inputs and professional liability RVUs, as the basis for making payment.
- The physician or other health professional who performs the facility discharge services should also be able to report TCM services.
- CMS should assign clinical staff type RN/LPN only for the clinical staff work for TCM codes because those are the only two clinical staff types who perform clinical staff TCM activities.
• CMS should bundle the first post-discharge visit into the TCM codes. This can be accomplished by adopting the CPT TCM codes.
• The TCM codes should be reported 30 days after the date of discharge.
• No Physician Fee Schedule budget neutrality adjustment is needed due to the implementation of TCM code(s). CMS should revise its budget neutrality analysis to include the savings that will accrue under Medicare Part B due to the use of these codes. These savings will completely offset any additional payment made due to implementing the TCM code(s).
• CMS should implement the CPT CCC codes in CY 2013 and use the RUC recommendations for work, practice expense inputs and professional liability as the basis for payment.

**Primary Care Services Furnished in Advanced Primary Care Practices**

CMS is proposing to pay physicians for primary care services furnished in an advanced primary care practice. These practices would implement a model home supporting patient-specific care with an emphasis on prevention and early diagnosis and treatment. The AAN is pleased that CMS recognizes the importance of care coordination and is proposing to put in place mechanisms supporting these efforts. Neurologists often provide the majority of evaluation and management services for patients with chronic conditions such as Alzheimer’s disease, epilepsy, Multiple Sclerosis and Parkinson’s disease. In this role, they are responsible for the ongoing treatment, management and follow-up of their patients.

The AAN is generally supportive of the advanced primary care practice model and would like to emphasize that neurologists should be allowed to participate as the "carved out" home for patients with chronic neurologic disease. The AAN understands that these practices would need to be accredited as an advanced primary care practice in order to receive the enhanced payment. The AAN recommends that the CMS should develop their own accreditation criteria using the five functions of comprehensive primary care used in the Comprehensive Primary Care initiative as a baseline:

- risk-stratified care management.
- access and continuity
- planned care for chronic conditions and preventive care
- patient and caregiver management
- coordination of care across the medical neighborhood

The Academy believes that the CMS should sort out the essentials of the accreditation criteria, but that many of the structural and process details, in particular, developing outcome measures, should be determined by local systems. This approach would create more consistent standards for identifying advanced primary care practices and could provide greater transparency in the accreditation process. It could also reduce the cost to the physician practice for accreditation.

CMS recognizes that attribution of a beneficiary to an advanced primary care practice is a potential issue and is seeking input on the approach to best determine the practice that is functioning as the advanced primary care practice. The AAN suggests that the CMS employ the Group Practice Reporting Option (GPRO) Quality and Resource Use Reports (QRUR) to assign beneficiaries. In this method, attribution is assigned based on the preponderance of E/M codes and more than two E/M visits to the group. The AAN believes that until there is a better system that not only attributes the decisions to the beneficiary, but also ensures that beneficiaries remain with an established system, i.e. ACO, CMS should assign beneficiaries to advanced primary care practices via the GPRO.

**DME Face-to-Face Encounters**

In an effort to reduce fraud, waste and abuse, CMS is proposing for 2013 that, as a condition of payment, a physician must have documented and communicated to the DME supplier that the physician or a physician assistant (PA), nurse practitioner (NP) or certified nurse specialist (CNS) has had a face-to-face
encounter with the beneficiary no more than 90 days before the order is written or within 30 days after the order is written. CMS is also proposing to add Manual Wheelchair accessories to the DME list of specified covered services.

Neurologists prescribe wheelchairs (manual, motorized) particularly for their patients with chronic multiple sclerosis and neurodegenerative disorders (i.e. ataxias, Amyotrophic Lateral Sclerosis). Patients treated for these chronic conditions have relationships with their neurologists and often go to their neurologist instead of their designated “primary care” physician for manual wheelchair accessories.

The AAN supports the CMS’ efforts in reducing costs attributed to fraud, waste and abuse of DME and does not oppose the face-to-face requirement. To that end, the AAN believes that it would be appropriate if the physician either signs or cosigns the pertinent portion of the medical record documenting that the beneficiary was evaluated or treated for a condition relevant to an item of DME on that date of service or that the physician specifically initials the history and physical examination documenting that the beneficiary was evaluated or treated for a condition relevant to an item of DME on that date of service. Physicians should be able to use electronic health records (EHR) with either option.

However, requiring the physician to document that the PA, NP or CNS had a face-to-face encounter with the beneficiary is an administrative burden to the physician. The Academy appreciates that CMS has recognized this and has proposed a G-code estimated at $15 to compensate a physician who documented that a PA, NP or CNS practitioner has performed a face-to-face encounter for the manual wheelchair accessory. The AAN respectfully requests clarification by CMS on a couple of items surrounding this requirement:

- Has this requirement or similar restrictions had a positive, noticeable impact in reducing fraud, waste and abuse of DME?
- Do the expenses to CMS (proposed $15 G-code) and providers (real costs minus $15) save enough on DME fraud to justify this provision? If so, will the savings be redistributed to physicians?

The AAN is supportive of the overall goal of CMS to reduce fraud, waste and abuse of DME, but cautions the CMS in implementing requirements that may not have been proven to be effective.

**Physician Payment, Efficiency and Quality Improvements - Physician Quality Reporting System**

The AAN appreciates CMS’ efforts to align incentive programs and its commitment to continue to do so in the future. We believe that this will maximize the number of eligible providers participating in multiple programs and also reduce reporting burdens placed on providers. We also believe that CMS’ proposal to not apply a negative payment adjustment in 2015 and 2016 to eligible professionals who submit quality measures via PQRS but do not meet the threshold criteria for the incentive (e.g. 50% for claims based reporting) will also encourage participation among providers.

The AAN agrees that reducing the minimum number of patients from 30 to 20 will make it easier for individual eligible professionals to participate in the program. The AAN also agrees that waiting to adopt a 12-month only reporting period until after the 2014 reporting year will be better for those eligible providers who are participating in the program.

In addition, the Academy commends CMS for its proposal to once again include neurology specific measures in the PQRS program. CMS should be aware that the AAN recently submitted measures for consideration for additional epilepsy and Parkinson’s disease measures and new measures for distal symmetric polyneuropathy. It is important for CMS to continually consider additional measures that
allow for greater participation in the program by more specialties. As 2013 approaches, it is imperative that as many providers as possible have options for participation in the PQRS to avoid penalties in 2015.

The AAN, however, requests clarification on how CMS will determine exceptions to a measure. For instance, if an eligible provider is using administrative claims data to report in the PQRS and has an eligible exception, how will CMS account for those cases where the measure is not performed?

Finally, CMS is currently proposing that only those groups which are larger than 25 eligible professionals can report through the online system, groups which are smaller must report via the traditional methods. As CMS moves forward with their plans to align payment programs, the AAN believes that it would make sense if CMS allowed all measures groups as part of the GPRO reporting option to be more inclusive of all types of physician groups. Streamlining the submission process for both large and small groups in the future would make it less confusing.

**Physician Compare Website**
The CMS will begin public reporting of physicians participating in the PQRS using the GPRO web interface in 2012. While this will affect few neurologists, there are some neurologists in larger multispecialty practices that are participating via the GPRO reporting option. The AAN agrees that this will allow for a smooth transition of public reporting. As public reporting moves forward, the AAN requests that we should have an opportunity to comment on those measures or reporting methods that CMS chooses to make available through the Physician Compare website.

**The Electronic Prescribing (eRx) Incentive Program**
The Academy supports streamlining of the various incentive programs, including exemptions to the eRx program for those participating in the EHR Incentive Program, as well as the PQRS-EHR Pilot Program. The AAN supports the addition of the group reporting option of 2-24 eligible professionals (instead of 25+ to have a GPRO option). However, we would recommend a GPRO threshold of reporting the encounter to less than 225 times for groups of 2-10, as individual eligible professionals would need to report 25 times. A reporting threshold of 225 times is extremely burdensome and difficult for smaller practices reporting as a group. According to a 2009 AAN census, 27.8% of US based neurologists are in a neurology group practice setting (with an average number of 7.5 neurologists in a group), 24.1% are in solo practice and 24.0% are in a University-Based Group (with an average number of 26.6 neurologists in a group). Many neurologists practice in smaller group settings and may have difficulty meeting the proposed reporting threshold. We would make the same recommendation for the 6-month 2014 payment adjustment reporting period. Again, the minimum requirement of 225 for these group practices is extremely burdensome and unrealistic.

The AAN agrees with CMS’ proposal to add two new hardship exemptions for eligible physicians participating in the EHR Incentive Program:

- Eligible professionals or group practices who achieve meaningful use during certain eRx payment adjustment reporting periods
- Eligible professionals or group practice who demonstrate intent to participate in the EHR Incentive Program and adoption of Certified EHR Technology

The AAN also agrees with CMS’ proposal to allow eligible physicians participating in the EHR Incentive Program to request a hardship exemption in 2012 for the 2013 payment adjustment if they meet one of the two above proposed hardship exemptions. The AAN requests that CMS allow a reasonable amount of time (i.e. 60 days) once the final rule is issued to allow eligible professionals time to apply for the hardship exemption. AAN supports submitting through the Communication Support Page to stay consistent with the previous year. However, we would like to recommend that eligible physicians who
currently use an EHR system should be able to submit their data directly from the EHR system or EHR registration page.

**Application of the MPPR to the TC and PC of Advanced Imaging Procedures for Group Practices**

For services furnished on or after January 1, 2013 CMS will apply the MPPR to both the PC and the TC of advanced imaging procedures to multiple physicians in the same group practice (same group NPI). Under this policy, the MPPR will apply when one or more physicians in the same group practice furnish services to the same patient, in the same session, on the same day.

The AAN strongly opposes this policy because it is not a rational cut based on analysis of the efficiencies of reading successive scans of the same patient on the same day as opposed to reading them on different days. While there is some rationale for the application of the MPPR to the TC (i.e. increased through-put efficiency with reduced patient waiting, sign-in and positioning times), there is no justification for the reduction of professional fees as no similar efficiency is obtained. Further, CMS offers no specific details regarding the “efficiencies” it hopes to save in the reduction of the professional component. There is no basis to cut physician payment in this way because the time associated with reading successive imaging studies taken in the same session on the same patient is exactly the same as if the images were taken in different sessions days, weeks, or months apart. There are no efficiencies in the intra-service period.

When reading an image from an MRI for example, the physician must look at all the sequences, slices, and views. The work involved with viewing the images from one body part is not affected by the need to review images of a second body part. The physician would still have to look at all the images and dictate a report and there is no carry over to the second imaging scan regarding the effort or time it takes to read each successive image.

While the Relative Value Update Committee database describes slightly different pre- and post- service period descriptions, for many of the codes there are some similarities. Most pre-service periods require reviewing the patient’s history and previous scans, and most post-service periods require dictating and reviewing a report as well as communicating the findings to the referring physician. The only efficiencies may exist in the pre-service period where the medical history and previous scans would not need to be reviewed twice if the scans of two different body parts were performed in the same session. However, the AAN feels that reviewing and interpreting the actual scans are where the effort is spent and any efficiencies outside of reviewing and interpreting the scans is de-minimus.

As for the post-service period, again, there are no efficiencies to be gained as the report must still be dictated and reviewed by the physician. Dictating the results of one scan will have no bearing on the time necessary to dictate the results of another scan. Secondly, communicating the results of one scan to a referring physician will also take the same amount of time as it would to communicate the results of two scans from the same session. Consequently, the AAN opposes CMS’ proposal to apply the MPPR to the PC of advanced imaging services for multiple physicians in a group practice.

Bearing in mind that CMS’ goal is to reduce expenses, the AAN would be remiss to not mention that applying the MPPR to the PC may create a situation where physicians would schedule studies on different days that would generate additional costs through extra/redundant office visits (to review previous testing, then order additional studies). Not to mention the inconvenience to patients and the negative impact on their access to care. Therefore, the AAN posits that the most reasonable and cost effective solution would be for CMS to encourage concurrent/sequential testing by not applying the MPPR to the PC. It would be less expensive for CMS (if the MPPR is applied to the TC), more efficient for the imaging center (increased through-put), more convenient to the patient (increased access) and more fairness for the interpreting physician (if the MPPR is not applied to the PC).
Physician Value-Based Payment Modifier

The AAN appreciates CMS’ intent to align the value-based modifier with the PQRS and to utilize claims data in order to reduce administrative burden on groups of physicians. The Academy also supports CMS’ goal to provide better healthcare to Medicare beneficiaries in a cost effective manner. CMS is proposing that physicians who successfully report in PQRS can receive a payment adjustment (upward or downward) through a quality tiering approach. The AAN recommends that CMS should allow physicians to elect the quality tiering approach via the self-nomination process or a CMS web-based registration system instead of it being automatically applied by CMS. In the CY 2013 proposed physician fee schedule, CMS is proposing to not apply a negative payment adjustment in 2015 and 2016 to eligible physicians who submit quality measures via PQRS even if s/he does not meet the threshold criteria for the incentive. The AAN supports this proposal and recommends that CMS also not apply a downward adjustment to the value-based modifier of eligible physicians who do not meet the reporting threshold. Last, the AAN is pleased that CMS is proposing to include the following neurology specific individual measures in the PQRS GPRO web-interface, claims, registries and EHR reporting mechanisms for 2013 and beyond:

- Stroke
- Epilepsy
- Sleep apnea
- Dementia
- Parkinson’s disease

However, we are concerned that CMS is proposing that group practices with 100 or more eligible professionals can only use the PQRS GPRO web interface or PQRS administrative claims as quality reporting methods to determine their value-based modifier. We would like to point out that none of the measures for either of these reporting options include neurology specific measures. Therefore, it would be difficult, if not impossible, for neurologists to report quality data. The AAN recommends that group practices with 100 or more eligible professionals should be allowed to report their quality data using GPRO claims, registries or EHRs because the group can select the quality measures that they will report.

CMS is proposing to initially focus on outlier physicians at the beginning of implementation but will gradually increase the scope of the value-based modifier to all physicians by January 1, 2017. The AAN is concerned that CMS will compare physicians on the measure reported without taking into consideration the physician’s specialty. For example, if CMS is measuring quality data for physicians who order sleep tests, will CMS compare data for sleep specialists only or include data for all physicians who ordered sleep tests? In this scenario, sleep specialists will appear to be severe outliers with regard to the number of sleep tests ordered. The AAN requests that CMS make every effort to compare physicians by specialty and not just by the quality measure so that data can be accurately compared and evaluated.

The AAN appreciates the opportunity to provide comments on this proposed rule. Should you have questions about our comments or require further information, please contact Daneen Grooms, Manager of Regulatory Affairs, at dgrooms@aan.com or (202) 525-2018.

Sincerely,

Bruce Sigsbee, MD, FAAN
President, American Academy of Neurology