AMRPA
AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

September 27, 2019

The Honorable Seema Verma
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-1715-P, Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Updates to the Quality Payment Program; 84 Fed. Reg. 40,482 (August 14th, 2019).

Dear Administrator Verma:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we write in response to the proposed rule for the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) published in the *Federal Register* on August 14, 2019. AMRPA is the national trade association representing more than 625 freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals, referred to by Medicare as inpatient rehabilitation facilities (IRFs). The vast majority of our members are Medicare participating providers and in 2017, IRFs served 340,000 Medicare beneficiaries with more than 380,000 IRF stays.[1]

AMRPA members also provide rehabilitation services across the continuum of care beyond the inpatient hospital, including hospital outpatient departments, physician offices, comprehensive outpatient rehabilitation facilities (CORFs) and therapy clinics. As part of this continuum of care, our members submit claims under Part B of the Medicare program for a variety of services, including physician visits, physical therapy, occupational therapy services, speech-language pathology and a number of other elements of care.

IRFs treat patients with some of the most complex and serious conditions. Continued rehabilitation is an essential component of recovery from these types of conditions, and it is important that CMS keep the need for rehabilitation services for the more complex and vulnerable patients in mind when modernizing the Medicare program. There are a number of proposals in this year's proposed rule that would have notable effects on patients in need of continued rehabilitation services, and we offer comment on those proposals in the following sections of this letter.

[1] Medicare Payment Advisory Commission (MedPAC), "Chapter 10: Inpatient Rehabilitation Facility Services," Report to the Congress: Medicare Payment Policy, March 2019.

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I. AMRPA Opposes CMS' Proposed Application of the Payment Reduction for Services Provided by Therapy Assistants, p. 59,654

The Bipartisan Budget Act of 2018 (referred to herein as "the statute") requires CMS to reduce payment for any therapy services "furnished in whole or in part by a therapy assistant (as defined by the Secretary)."[2] In order to determine when a service is furnished "in part" by a therapy assistant (TA), CMS proposes a *de minimis* threshold. CMS proposes that the *de minimis* threshold is reached when greater than 10 percent of the service is furnished by the TA. Under this standard, CMS also proposes that any time spent by the TA independent of the therapist or concurrently with the therapist will count towards the *de minimis* threshold. CMS proposes to apply this same standard to timed and untimed therapy services.

AMRPA strongly disagrees with CMS' proposed interpretation of when a therapy service is furnished "in part" by a TA on numerous grounds, including that the interpretation:

- Runs contrary to the plain language and intent of the statute;
- Is unnecessarily broad and will be burdensome in its implementation;
- Discounts the highly skilled services required of a therapist; and
- Could ultimately harm Medicare beneficiaries' access to needed rehabilitation services.

In all, AMRPA believes that CMS' approach to interpreting the "in part" language is focused far too much on therapists' timing/minutes, rather than on the training and skills needed by a therapist to deliver care – even if assisted by another member of the team. Even when a TA is assisting a therapist, the therapist's expertise is often still guiding and ultimately furnishing the services. AMRPA believes that a TA is only *furnishing* the service when the TA is delivering care without any direct guidance from the therapist, and CMS policy must reflect this critical nuance in order to avoid inadvertent impacts on care delivery and access.

A. Time Spent Concurrently by the TA and the Therapist Should Not Count Towards the *De Minimis* Threshold

The plain reading of the statutory language in question makes clear that CMS should not count time spent concurrently by both the therapist and TA towards the *de minimis* threshold. It is not reasonable to conclude that in instances when both the TA and the therapist are involved in the service, that it is actually the TA furnishing the service and not the therapist. Therefore, the plain reading of the statute clearly requires that only time spent *independently* by the TA – which is the only time it can be reasonably concluded the TA is furnishing the services – count towards the *de minimis* standard. In situations in which the therapist and TA provide services *concurrently*, the service is appropriately considered to be provided by only the therapist.

Beyond just the plain reading of the statute, we believe that applying the payment adjustment only when the TA provided the services independently of the therapist aligns with the purpose of this statutory provision. The intent of this statutory

[2] 42 U.S.C. § 1395m(v)(1).

provision was to more closely align payment with *resource use.* When a TA is substituted entirely for a therapist, resource use is *lower* since a lesser trained clinician is utilized to furnish the service. In the case of a TA performing a service entirely independently from a therapist, a payment reduction is the logical outgrowth of the diminished resource use.

When both the therapist and TA furnish services concurrently, resource use is *higher* since two skilled clinicians are engaged in furnishing the services (rather than just one). Applying a payment reduction in this situation produces an illogical result that could not have been Congress' intent. AMRPA finds it difficult to believe that Congress intended to apply a payment reduction to instances where resource use is lower – such as when a TA totally replaces a therapist – *and* when resource use is higher, such as when services are provided concurrently by *both* a TA and a therapist.

On the contrary, AMRPA believes the "in part" language in the statute is appropriately interpreted as referring to when the TA *independently* furnishes a portion of the service in lieu of the therapist. Therefore, the payment reduction should only be applied when the total time spent by the TA independent of the therapist exceeds the *de minimis* standard. Stated another way, the payment reduction should not be applied when the total time spent by the therapist – whether concurrent with a TA or not – exceeds 90 percent.

AMRPA would also like to point out that CMS makes no distinction regarding skilled versus unskilled activities when it comes to concurrent furnishing of services by both the TA and therapist. This also produces a backwards result. If a therapist needs a second pair of hands to furnish a service, the therapist could utilize an unskilled staff member (such as a clinic technician) to assist and therefore avoid a payment reduction. However, if the therapist utilizes the more skilled staff member – the TA – a payment reduction is applied. This again produces a nonsensical result and demonstrates why CMS' interpretation of "in part" is inherently problematic. AMRPA urges CMS to instead employ a commonsense interpretation of the statute and apply the reduction when a TA provides a portion of the services independent of the therapist, and when those services are skilled services.

CMS' interpretation of "in part" would also disincentive use of TAs in critical contexts. To the extent they can independently furnish services, TAs allow therapists to treat more patients or more complex patients in a given timeframe. This is why it is appropriate for a payment reduction to be applied when TAs are utilized to *independently* provide services, and why it is financially feasible for therapists to receive this payment reduction when that occurs. However, if a therapist is also forced to take a pay cut when it utilizes the TA for concurrent services, the financial outcome of utilizing a TA is simply untenable. In practice, this policy would either force therapists to either use lesser skilled staff members to avoid payment reduction, or provide care to fewer patients. Neither of these options are in the best interest of

Medicare beneficiaries, showing the unintended, adverse consequences of this interpretation.

In sum, AMRPA believes CMS' interpretation of "in part" is contrary to both the plain language and spirit of the statute, and creates a perverse payment structure that strays from any logical connection to resource use. In addition, this interpretation may disincentivize the use of TAs and lower the clinical capacity of therapists. Therefore, CMS should not include concurrent services in the definition of services provided in part by a TA.

B. CMS Should Permit Multiple Units of Timed Service Codes to be Billed on Separate Claim Lines

In the proposed rule, CMS suggests providers will not be able to bill multiple units of the same timed service code on separate claim lines to avoid having the TA modifier applied across multiple units. Specifically, CMS states that providers:

> "need to look at the *total minutes* for all the billed units of the service, and compare it to the minutes of the service furnished by the PTA/OTA as described above in order to decide whether the 10 percent *de minimis* standard is exceeded. If the minutes of the service furnished by the PTA/OTA are more than 10 percent of the *total minutes* of the service, the therapist or therapy assistant would assign the appropriate CQ or CO modifier."[3]

This overly broad application of the statutory requirement is arbitrary, places unnecessary burden on providers, and will lead to a very high number of claims being subject to the payment reduction. By way of illustration, if a TA was involved in only 15 minutes of the 45 minutes total that a therapist provided a timed service code, the provider would need to apply the modifier to all three units of the billed code – even though the therapist provided two units of the service without any involvement from a TA. From a logical and administrative viewpoint, the modifier should only apply to the unit of service involving the TA. Adopting this alternative approach would also avoid unnecessary and harmful reduction in payments for therapy services.

AMRPA therefore urges CMS to permit providers to bill multiple units on different claim lines when the TA is only partially involved in the units being billed. Providers should be allowed to bill one line with the modifier for all units that the TA was involved in beyond a *de minimis* amount, and another line with that same service for any units the TA was not involved beyond a *de minimis* amount. There is no reason for CMS to prohibit the use of multiple claim lines in billing, which is entirely consistent with the relevant statutory language. In fact, CMS previously asserted its intention to use this exact approach, stating in the CY 2019 Physician Fee Schedule (PFS) final rule that:

[3] 84 Fed. Reg. 40482, 40562 (emphasis added).

"if a therapist assistant furnished one unit (15 minutes) and the therapist furnished 2 units (30 minutes) of the same procedure code that is defined to be billable in 15-minute increments, one unit of the procedure code would be billed on the claim line with the modifier for the therapist assistant's services and two units of the procedure code would be billed on another claim line without the assistant modifier."[4]

This CY 2019 PFS language shows that CMS itself determined that permitting providers to bill multiple units on different claim lines is the most rational approach to this billing issue. CMS now appears to be reversing itself and adopting a more burdensome policy, with no explanation to stakeholders. AMRPA opposes this policy reversal and urges CMS to finalize its policy as explained in the CY 2019 PFS rule and permit providers to utilize multiple claim lines for the same services.

C. The Modifier Should Not Be Applied (1) To Evaluation Services and (2) When Clinical Judgement by the Therapist is Required

CMS proposes to apply the modifier to all services that the TA is involved in – both timed and untimed – and regardless of whether the service requires clinical judgement. However, this approach is flawed since under current Medicare rules, evaluation services cannot be performed by a TA.[5] Further, the same rules prohibit TAs from making clinical judgements or decisions.[6]

While a TA may assist with evaluative services to a limited extent, the therapist is required to be involved directly with the evaluation and is ultimately responsible for synthesizing the observations made during the evaluation. This is a highly skilled service that a TA is prohibited from performing under Medicare rules. Therefore, a TA cannot be considered to have furnished this service, even partially. It follows that a TA's involvement in an evaluative service is therefore *per se* either unskilled or *de minimis*, and should not trigger a payment reduction.

Similarly, any service that requires clinical judgement cannot be considered to have been furnished by the TA, since Medicare rules also prohibit TAs from making clinical judgements. When clinical judgement is involved, any involvement by the TA would have been secondary, and therefore either *per se* unskilled or *de minimis*, relative to the role of the therapist's skilled decision-making in providing that service. Therefore, if any unit of service that is being billed required clinical judgement, the modifier should not be required to be applied to that service.

AMRPA therefore asks CMS to limit the application of the modifier to only services provided independently by the TA beyond the *de minimis* threshold and which did not

[4] 83 Fed. Reg. 59452, 59659.
[5] Medicare Benefit Policy Manual (MBPM) Chapter 13, § 230.1(C) – Practice of Physical Therapy ("PTAs may not provide evaluative or assessment services, make clinical judgments or decisions; develop, manage, or furnish skilled maintenance program services; or take responsibility for the service.")
[6] *Id.*

require the clinical judgement of the therapist. Evaluations, which inherently require the clinical judgement of therapists, should be fully exempt from the modifier's payment reduction.

D. CMS Proposed Documentation Requirements Are Unnecessarily Burdensome

The statutory requirement for a payment reduction and TA modifier will unavoidably produce added burden to therapists, as therapists will need to closely monitor TAs' activities throughout the day to determine when the modifier is and is not needed. CMS' documentation proposal, however, creates new burdens for providers without any accompanying policy rationale.

CMS proposes to add a requirement that the treatment notes contain a separate statement that explains the application or non-application of the modifier for each service furnished that day. This means that providers, who may bill four or more different services in a visit, will need to justify the use or non-use of the modifier multiple times for every single patient visit. These requirements will be extremely time consuming for therapists, and divert valuable resources away from patient care.

Furthermore, this proposed requirement is unnecessary because therapists are already required to write treatment notes and progress reports, which could include all of the necessary information needed for a contractor to determine the TA's involvement in the services. A requirement for a separate statement for each and every unit of service is duplicative, and runs counter to the Administration's goals of eliminating redundant administrative tasks for Medicare providers. In addition, there is no statutory requirement for separate and distinct documentation to justify use or non-use of the modifier. Finally, the proposal does not reflect the fact that many providers do not use TAs in their practices, and yet these providers would be required under the proposal to explain their non-inclusion of the TA modifier for each and every service they provide.

Therefore, in the spirit of CMS' Patients over Paperwork initiative, CMS should withdraw its proposed documentation requirement and allow the TA's involvement to be noted in the treatment notes or progress reports already required by Medicare rules. This approach will provide maximum flexibility to providers to adapt to an already burdensome new policy and lessen any negative impacts.

Overall, and as AMRPA detailed in response to last year's proposed rulemaking, the Association remains very concerned about the impact of the proposed TA payment reduction on all Medicare patients, and particularly the complex patients treated in IRFs. IRFs treat patients with severe functional deficits that require ongoing treatment on an outpatient basis, often for extended periods of time. Due to these patients' functional states, their outpatient services may often require a second staff member to assist in furnishing the services. An overly broad application of this payment reduction could therefore create serious care and access issues for these patients. AMRPA therefore urges CMS take as narrow view as

possible when applying this modifier in the interest of one of Medicare's most vulnerable patient populations.

AMRPA would also like to remind CMS that there is a national shortage of therapists.[7] Some projections indicate that the shortage could remain for decades to come.[8] TAs have been, and will continue to be, vital in making up for the shortage of therapists to provide rehabilitation services. CMS should be especially mindful of this when implementing this policy, as any disincentive to utilize TAs could have long-term effects on therapy access.

To conclude, AMRPA finds that CMS' proposed policies run contrary to the plain reading of the statute and the spirit of the law, which aimed to align payments with efficiencies created by use of a TA. Instead, CMS' proposal would actually diminish payments when resource use is higher – such as is the case when a TA provides services concurrently with a therapist – and would create significant financial burdens for providers. Other provisions would adversely impact the utilization of TAs and create payment challenges for therapists, such as the application of the modifier for skilled clinical judgment and the prohibition on billing multiple units of TA services on separate claim lines. Finally, AMRPA calls on CMS to withdraw its proposed documentation policy to avoid placing additional administrative burden on therapists.

II. AMRPA Recommends CMS Finalize its Proposed Changes Pertaining to Outpatient Evaluation and Management (E/M) Visits While Also Taking Further Steps to Minimize Payment Reductions for Other Providers, p. 40,670

CMS proposes to rescind its previously finalized policies and instead proposes to continue to recognize and pay for 4 levels of outpatient Evaluation and Management (E/M) visits for new patients and 5 levels of E/M visits for existing patients, all with distinct payment amounts. In addition, CMS proposes to adopt increased values for these outpatient E/M codes, as well as to change the criteria by which physicians choose which levels of visit to bill. CMS also proposes two new add-on codes that can be used by providers when billing outpatient E/M codes. AMRPA offers comments on several aspects of the proposal immediately below.

A. AMRPA Recommends CMS Finalize its Proposal to Retain Separate Payment Amounts and Update Payment Values for E/M Visits but also Take Steps to Mitigate the Budget Neutrality Effects of this Proposal

In response to the CY 2019 Physician Fee Schedule proposed rule, AMRPA urged CMS not to finalize its proposal to consolidate payment amounts for outpatient E/M visit levels. As we explained at the time, patients treated in IRFs often continue to need complex care services after discharge from an IRF, and this continuing care is essential for a full and meaningful recovery. AMRPA had serious concerns that the proposal to consolidate payment levels – which would lower payments for level 4 and 5 visits – would jeopardize access to care for patients with complex medical needs. AMRPA is

[7] A Model To Project The Supply And Demand Of Physical Therapists 2010-2025. American Physical Therapy Association (retrieved from http://www.apta.org/WorkforceData/ModelDescriptionFigures/).
[8] *Id.*

encouraged to see that CMS no longer proposes to consolidate payment amounts for E/M visit levels.

In addition, AMRPA concurs with CMS' proposal to update the values of E/M visit levels based upon recommendations from the American Medical Association RVS Update Committee (AMA). These updated values more closely correspond with the resources spent on furnishing E/M services to patients. These new values would also appropriately compensate physicians who treat complex patients that require extensive care coordination and monitoring.

CMS states that due to budget neutrality restraints, there will be a significant reduction in payments for many providers if this E/M payment adjustment is finalized, particularly for specialties that bill procedural-based codes. While AMRPA is fully supportive of CMS' plans to continue to pay physicians using different rates for different E/M visit levels, as well as to update the values of the corresponding payments, AMRPA is concerned about the potential harm to patients that could occur as a result of these budget neutrality adjustments.

According to CMS estimates, physical and occupational therapists would see an 8 percent reduction in payments if this E/M proposal is finalized. AMRPA notes that this payment reduction has the potential to harm the very same patients CMS seeks to help via this E/M proposal. A multidisciplinary team approach to caring for patients is one of the hallmarks of care provided in an IRF, and that treatment approach often continues on the outpatient basis after a patient is discharged. It will be beneficial for these complex patients to continue to have access to physicians that are adequately compensated via these updated E/M visit levels. However, it will be detrimental to these same patients if they cannot receive the rehabilitation treatment recommended by these physicians due to a sharp decrease in Medicare reimbursement for these services.

AMRPA recognizes the challenges faced by CMS in responding to concerns with E/M payment levels while adhering to the budget neutrality requirements embedded in the PFS. To that end, AMRPA encourages CMS to take affirmative steps to avoid such a reduction in payments for providers that bill procedure services such as physical and occupational therapists. This should include working with Congress to explore updates to the PFS conversion factor to counter any budget neutrality effects of this proposal, as well as exploring CMS' own authority to modify payments in other ways to account for this change in E/M payment levels.

Therefore, AMRPA supports CMS' proposal to continue to pay separate visit levels for outpatient E/M visits, as well as to update the payment levels of these visits, *so long as* CMS also takes steps to mitigate any harmful effects this change might have on vital specialties such as physical and occupational therapy.

B. AMRPA Supports CMS' Proposal to Change How Physicians Choose Which Level of E/M Visit to Bill and Also Encourages CMS to Find Additional Ways to Alleviate Burden for Physicians

Currently, physicians must determine which E/M visit level based on a combination of three factors (history of present illness (HPI), physical exam, and medical decision making (MDM)). CMS proposes to replace this framework and instead allow physicians to choose the level of visit based upon either MDM or based upon the total time spent during the day of the visit on that patient. In addition, physicians would need to document relevant information in the medical record in a manner sufficient to support the level of visit.

AMRPA supports these proposed changes as an initial step. Replacing the more than 20-year old existing framework with these simplified options will more closely align Medicare policy with the modern practice of medicine. However, AMRPA would like CMS to be mindful that this change will result in only minimal burden reduction for physicians. Delivering high quality care mandates that physicians continue to include robust documentation for all patients, including elements of HPI, exam, and others. In addition, and as CMS notes in the proposed rule, providers must also continue to document for purposes of demonstrating medical necessity for Medicare claims. Therefore, physicians anticipate this change will result in only nominal changes when put into practice.

AMRPA recommends CMS continue to explore ways to more meaningfully reduce administrative burden for physicians. In response to CMS' most recent Request for Information (RFI) on reducing provider burden, AMRPA provided extensive comments on how to best modernize and refine the current regulatory framework, particularly for physicians practicing in IRFs who face unique and antiquated documentation requirements. **AMRPA recommends CMS finalize these proposed changes, but also encourages CMS to continue to work with stakeholders like AMRPA to further modernize and refine Medicare rules to match the needs of present day medical practice.**

C. AMRPA Recommends CMS Finalize its Proposal to Add Two New Add-On Codes for Outpatient E/M Services

CMS proposes two new add-on codes for outpatient E/M services. The first add-on code would be for each additional 15 minutes of E/M services provided on the day of the visit. The second add-on code would be for primary care physicians or physicians treating complex patients or conditions. This second code is meant to account for additional resources spent on providing primary care or care for complex patients, such as time spent coordinating care.

AMRPA supports both of these add-on codes. As previously discussed, patients discharged from IRFs often continue to be complex and time consuming patients, and ensuring adequate continuing care is crucial to a full recovery. Incorporating an add-on code for additional time ensures that there is not a disincentive to treat the most time-

consuming patients, who may require time beyond a typical level 5 visit. The same is true for the primary care and complex patient add-on code. **Therefore, AMRPA recommends CMS proceed with finalizing its proposals for these add-on codes.**

To summarize, AMRPA recommends the following pertaining to CMS' proposal for outpatient E/M services:

1. **AMRPA recommends CMS finalize the updated values for separate E/M visit levels, while also taking affirmative steps to ensure that there are not deleterious budget neutrality effects to specialties such as physical and occupational therapy.**
2. **AMRPA encourages CMS to finalize its proposal to reform the guidelines used for physicians to determine which level of visit to bill, and also to work to find additional ways to alleviate physician burden.**
3. **AMRPA supports CMS' proposal to create add-on codes for E/M services.**

III. AMRPA Supports CMS' Proposed Changes for Review and Verification of Medical Record Documentation, p. 40,547

CMS proposes that all clinicians billing Medicare will now only be required to review and verify (sign/date) any information entered into the medical record by any other physician, resident physician, student, or other members of the medical team. CMS would also define students to include students from all clinical disciplines. According to CMS, this means that physicians will not need to re-document information entered by a resident physician, nurse, or other team members.

AMRPA supports this change as it reduces unnecessary redundancies in medical records and alleviates burden on clinicians. This change may also streamline training programs by allowing residents or students to gain experience with medical record documentation. We request that CMS issue guidance to further clarify this change. While CMS explained this proposed change in broad terms in the proposed rule, the agency should take further steps to explain precisely what information still does or does not need to be separately entered in the medical record by the billing clinician across the various types and settings of care. For example, CMS should clarify how this change does or does not change documentation requirements in IRFs, where a physician is required to conduct and document very specific services. This further guidance will ensure this change achieves its intended result and does not result in confusion or avoidable claim denials.

AMRPA recommends CMS proceed with its proposed changes to requirements for review and verification of the medical record, and also issue guidance on what is or is not required of billing clinicians based on their particular setting of care.

IV. AMRPA Supports Efforts by CMS to Encourage Delivery of Care Management Services Including Chronic Care and Transitional Care Management Services, p. 40,548

In this proposed rule, CMS undertook an analysis of a number of care management services, such as chronic care management and transitional care management services. CMS cited research that these codes may be underutilized, despite evidence that patients whose clinicians bill for these services see relatively positive clinical outcomes. CMS is proposing a number of changes that it hopes will spur greater use of these types of care management services by physicians, including creation of care management codes that would be available for management of just one chronic condition. AMRPA is largely supportive of these proposed changes but also encourages CMS to work with the AMA to reduce administrative burden and ensure these codes are adequately valued.

A. AMRPA Recommends CMS Finalize its Proposed Changes to Transitional Care Management Services

Transitional care management (TCM) services are services provided by a physician following a discharge to community subsequent to an inpatient admission. While allowing these codes to be billed by Medicare, CMS also includes a list of codes that cannot be billed by a physician during the same 30-day post-discharge period if the physician also billed a TCM code. CMS now proposes to remove these restrictions. AMRPA supports this proposed change.

As previously mentioned, patients treated in IRFs are recovering from serious functional impairments following a major injury or illness. The stay in an IRF is often just the first step in recovery, and patients will need ongoing, coordinated care after discharge from an IRF. The TCM service codes attempt to properly reimburse physicians who are coordinating the patient's transition from inpatient to outpatient services. AMRPA agrees that this service should be billable by physicians even when billing other services in order to encourage coordination and oversight of plans of care. AMRPA also encourages CMS to work with the AMA to ensure these codes continue to be properly valued and carry proper descriptors, especially for physicians overseeing care for particularly complex patients. **Therefore, AMRPA supports CMS proposed change to allow TCM services to be billed with other E/M and related services.**

B. AMRPA Encourages CMS to Finalize its Proposed Changes to Chronic Care Management Services

CMS is proposing to modify both the non-complex and complex Chronic Care Management (CCM) codes. For the non-complex CCM code, CMS asserts that the code may be undervalued since it assumes only 20 minutes of staff time, and providers may be providing much more than 20 minutes. Therefore, CMS proposes to replace the single code with two codes; one code would be for the first 20 minutes of non-complex CCM, and an additional code would be an add-on code for each additional 20 minutes of services. These two codes would be "G codes," and as proposed, billing of CPT code 99490 would be disallowed by Medicare, at least temporarily. For the complex CCM codes, CMS proposes to remove the requirement that there be either

establishment or substantial revisions of a comprehensive care plan (CCP). CMS proposes to replace that language with the language found in the non-complex CCM code, which only requires establishment, implementation, revision or monitoring of the CCP.

AMRPA favors these proposed changes and encourages CMS to finalize them. As with the TCM codes, it is important that providers are incentivized to coordinate care across disciplines and on an ongoing basis. Allowing for providers who spend more than 20 minutes on CCM services to continue to be compensated for their services is appropriate. In addition, removing barriers to billing CCM codes, such as requiring there be to a substantial revision to the CCP each time the code is billed, is a practical adjustment that will encourage utilization of these effective services.

AMRPA does have concerns that replacing CPT codes with G-codes could cause some confusion for providers. Therefore, AMRPA suggests CMS continue to work with the AMA to avoid these types of temporary codes in the future, and seek to minimize administrative confusion or burden when future CPT codes replace these G-codes.

AMRPA recommends CMS finalize its proposed changes to CCM service codes, but also work with the AMA to minimize provider burden or confusion with the use of and future transition from new G-codes.

C. AMRPA Urges CMS to Finalize its Proposal to Create Principal Care Management Services Codes

CMS is proposing the creation of new codes similar to CCM codes, but for patients with only one chronic condition, which it calls Principal Care Management (PCM) services. The first code CMS is proposing is a G-code for PCM that would require a single high-risk condition, at least 30 minutes of physician time, revision or development of a condition specific care plan, and either frequent medication adjustments or management of a condition that is unusually complex due to comorbidities. The second code would be the same, but for 30 minutes of clinical staff (non-physician) time.

AMRPA agrees with CMS that there is currently a gap in Medicare billing policy that does not permit physicians to bill for all types care management services. As CMS states, a physician that is providing services identical to CCM services, but for a patient with just one chronic condition, has no applicable care management code to bill. Therefore, AMRPA encourages CMS to create PCM codes to encourage utilization of care management services for patients that may only have one chronic condition. However, echoing our previous recommendation, AMRPA is concerned about the confusion created by using G-codes that may be eventually replaced with standard CPT codes. Because of this, AMRPA also recommends CMS collaborate with the AMA to ensure proper descriptors and valuations for these G-codes, and also to avoid confusion if these codes are eventually replaced with CPT codes.

AMRPA supports the creation of this code, but again encourages close coordination with AMA to ensure the code is properly valued and described, and to minimize administrative confusion.

To summarize, AMRPA recommends the following regarding CMS' proposals to alter care management service codes:

1. **AMRPA recommends CMS finalize its proposal to remove restrictions on billing Transition Care Management (TCM) codes.**
2. **AMRPA supports CMS' proposal to replace Chronic Care Management (CCM) codes with codes that will allow physicians to bill additional time spent on CCM services.**
3. **AMRPA encourages CMS to finalize its proposal to create Principal Care Management (PCM) codes to allow physicians to be compensated for time spent coordinating care for patients with only one chronic condition.**
4. **In order to avoid creating confusing G-codes in the future, AMRPA recommends CMS continue to work closely with the AMA so that existing CPT codes can be modified in lieu of replacing CPT codes with Medicare-only G-codes.**

V. AMRPA Encourages CMS to Develop a MIPS Value-Based Pathway (MVP) for IRF-based Clinicians, p. 40,731

In this proposed rule, CMS proposes broad revamp of the Merit-based Incentive Payment System (MIPS) through the creation of MIPS Value Pathways (MVPs). The creation of MVPs is intended to reduce confusion and redundancy in the MIPS reporting requirements and allow providers to participate in a pathway focused on their specialty. AMRPA agrees that CMS should undertake serious efforts to streamline MIPS, as certain components can be excessively burdensome and often only loosely tied to the delivery of quality medical care.

AMRPA welcomes modernization of the existing reporting requirements, which could come either through MVPs or through reforms to the current MIPS framework. In addition, AMRPA encourages CMS to closely consider how best to incorporate IRF-based clinicians into the MIPS program, since these clinicians have been excluded from several facets of MIPS. For example, CMS does not include IRF-based clinicians in either its "hospital-based" definition, or its "facility-based" definition, despite the fact that these clinicians deliver care in a hospital just like acute-care hospital-based clinicians.

It is important that physicians practicing in IRFs have a meaningful way to be recognized for their quality outcomes. IRF-based physicians spend time performing a unique mix of services, including screening patients for appropriate post-acute care placement, coordination of an interdisciplinary team, face-to-face functional-based patient assessments, and many more services. The care delivered in an IRF can dramatically alter patients' functional state and quality of life for years to come. There should be measures directly relevant to delivering care in this particular setting across all four categories of MIPS.

AMRPA is eager to meet with CMS, along with other relevant stakeholders, to ensure that CMS moves forward in a constructive fashion with effectively incorporating IRF-based clinicians into future MIPS reforms. AMRPA stands ready to work with CMS to modernize MIPS and to continue to provide the highest quality care to IRF patients.

Therefore, AMRPA suggests CMS continue to work closely with stakeholders to determine the most efficient path for reforming MIPS, and also work to account for the unique nature of IRF-based practice when making these further changes.

VI. AMRPA Recommends CMS Update the Relative Value Units for Physical and Occupational Therapy Evaluation Services (CPT codes 97161, 97162, 97163, 97165, 97166, 97167)

AMRPA recommends that CMS begin the process of reevaluating the values assigned to the evaluative services provided by physical and occupational therapists. Currently, CMS assigns the same value for all levels of occupational therapy (OT) and physical therapy (PT) evaluation services, regardless of complexity. This policy runs counter to the fact that high, moderate and low complexity PT and OT evaluation codes have distinct descriptors and typical time values. As a result, there is no additional reimbursement when a provider completes a high complexity evaluation that takes twice the time or more of a low complexity evaluation.

The differences in clinical decision making and time between these levels of visit should be reflected in the Work Relative Value Units (RVUs) for these codes. However, CMS assigns a Work RVU of 1.20 for all three levels of OT and OT evaluation services. AMRPA strongly questions this approach, given the descriptors that differentiate these codes use several different factors. In addition, due to changes in Practice Expense (PE) and Malpractice Expense (MP) RVUs, CMS is proposing a slight increase in the low complexity OT evaluation, but not the moderate or high complexity OT evaluation. This again creates a backwards incentive for a provider to spend less time with a patient and be paid more. Furthermore, this policy puts complex, vulnerable patients at risk of losing access to providers who perform complex evaluations.

AMRPA therefore recommends that CMS work with the Relative Value Scale Update Committee (RUC) to begin the process of updating these code values. CMS and the RUC should take into account the skilled services and clinical expertise needed for a therapist to perform more complex patient evaluations. This increase in resource use should be properly accounted for in the Work RVU. In addition, the need for advanced supplies and tools to evaluate more complex patients should similarly be accounted for in the PE RVU.

VII. AMRPA Disagrees with the Proposed Values of Cognitive Function Intervention (CPT Codes 971XX And 9XXX0), p. 40,601

AMRPA supports the creation of CPT codes 971XX and 9XXX0, which describe the first 15 minutes and every subsequent 15 minutes of therapeutic interventions that focus on cognitive function, respectively. However, AMRPA disagrees with CMS' proposal to assign a Work RVU of 0.50 for 971XX (first 15 minutes) and a Work RVU of 0.48 for CPT code 9XXX0

(additional 15 minutes). Cognitive function intervention is a highly skilled service that is labor intensive and requires expertise of a trained therapist. Services provided beyond an initial 15 minutes are no less labor intensive and require skilled service equal to or greater than the initial 15 minutes of service. Therefore, CPT code 9XXX0 should not carry a value lower than 971XX. AMRPA urges CMS to work with the RUC to reevaluate these values to ensure there is not an incentive to provide lesser duration of services or to break services into multiple days.

VIII. Conclusion

We appreciate CMS' efforts to engage stakeholders as it continues to modernize the Physician Fee Schedule and the Quality Payment Program. AMRPA and our members remain committed to working with CMS to create a more patient-centered Medicare program. If you have any questions regarding our comments, please contact Jonathan Gold J.D., Director of Government Relations and Regulatory Counsel (jgold@amrpa.org /202-860-1004).

Sincerely,

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