August 26, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, SW
Washington, DC 20201 http://www.regulations.gov

RE: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012; Proposed Rule: 42 CFR Parts 410, 414, 415 et al.,
Federal Register / Vol. 76, No. 138 / Tuesday, July 19, 2011 /Proposed Rules

Dear Sir or Madam:

On behalf of the Healthcare Billing and Management Association's (HBMA) over 750 member companies, we are pleased to submit our comments on the Notice of Proposed Rulemaking (NPRM) regarding the Medicare Physician Fee Schedule as published in the July 19, 2011 *Federal Register.*

HBMA is a non-profit trade association of companies providing medical billing and related services to physicians, hospitals, non-physicians (ambulance, DME, ASC, IDTF, Rural Health Clinics, FQHCs, etc.) and other health care organizations throughout the United States. For nearly twenty years HBMA has been the billing industry organization recognized for education, advocacy and cooperation in all matters that affect the processing of provider claim-related data, compliance and management services. Our member companies process in excess of 350 Million claims annually and serve virtually every clinical specialty, in every setting, in every state.

Our members include companies with over three thousand employees and dozens of branch offices down to sole practitioners with solo practices as clients. The average member billing company employs approximately thirty, serves 100 or more physicians and processes 40,000 or more claims per month. Some of our members (but far less than half) supply the practice management systems used by their office-based clients, while others receive information in electronic, as well as paper forms on behalf of their hospital-based, office-based and non-physician clients. As it is with practices handling their own billing, data arrives, moves and leaves by a host of means, not all of it electronic.

For over fifteen years, HBMA has worked closely with CMS and other federal agencies on all matters related to Medicare, billing rules, payment policy and compliance. We have provided comments,

testimony, private and public input related to patient privacy as well as offering a wide array of education materials, conference programs, references, announcements and targeted training for our member companies and their employees and clients. Our members routinely assist their physician clients with the transition, implementation and compliance with Medicare rules and regulations and strive to be a trusted advisor and reliable source of expertise on the Medicare program's requirements.

BACKGROUND

It is estimated that as many as a third of all claims submitted on behalf of physicians are submitted by an HBMA member company. Our Association's members are intimately involved in the preparation and submission of Medicare claims to every MAC Contractor, Carrier and DMERC on behalf of providers in every state and U.S. Territory. We have reviewed the NPRM and prepared comments on some of CMS' proposed rules that specifically affect our members, their provider clients and/or their individual or shared responsibilities.

We have also included comments on a matter of great concern to all providers, and our members, about which billing companies have both a unique perspective and substantial, current experience. Although CMS' NPRM did not specifically solicit comments about the operational aspects of SGR transitions, our 2011 experiences, we believe, warrant the comments provided.

1. SGR related reduction to the Medicare Conversion Factor

We are aware that CMS was obligated, by law, to publish the formulaic recalculation of the Medicare Conversion Factor (CF). HBMA recognizes that CMS has little latitude in making legislatively mandated cuts in physician payments due to the Sustainable Growth Rate (SGR) formula. We encourage CMS to do all it can, within the agency's authority, to prevent the projected 29.5% cut from taking place.

Reducing the Conversion Factor from its current level to $23.9635 would have a devastating impact on physician income and, ultimately, access to care for Medicare beneficiaries. In our communication with the thousands of physicians served by HBMA's member companies, we have been told, almost universally, that such a cut would be a proverbial "show stopper," forcing practices to cease serving Medicare patients entirely, or drastically reducing their Medicare patient load – simply to survive.

The oft-repeated 11th hour Congressional intervention to prevent the scheduled CF reduction has, unfortunately, also had more than one "13th hour" intervention, resulting in retroactive payment adjustments after "reduced" claims had been processed. The subsequent claim reprocessing and payment adjustments have caused significant and costly rework by providers, billing companies, clearinghouses and software vendors, without any meaningful income to even match the additional costs created. We are certain the same – or greater – expenses fell upon Medicare contractors, as well.

HBMA encourages CMS to develop a better, more efficient process for making future payment adjustments in the event Congress allows the SGR cut to take effect on January 1, 2012, only to subsequently rescind the cut, retroactively.

To illustrate, in 2010 Congress retroactively restored the SGR related cuts that had previously taken effect. While we and our physician clients welcomed the rescission/restoration, the medical community is still – over a year later – suffering through the consequences of the administrative and financial adjustments that ensued. Many medical practices – and their billing companies – were required to complete dozens and dozens – or hundreds and hundreds – of pages of paperwork to recoup small amounts (often for less than $50) in retroactively adjusted Medicare payments.

The effect has been that, for practices and their billing vendors, the cost of obtaining the Medicare payment was more than the value of the retroactive payments the physician was owed. Consequently, many physicians simply chose to write off this money, enduring the loss of income rather than lose even more to recover it. Furthermore, some of the adjustments have also led to the absolute duty to issue beneficiary refunds (balances may be waived, but not refunds) for less than 10¢! Understandably, beneficiaries are puzzled by a bill – or a check – for a few pennies, despite an explanatory letter, which created even more costs in the form of telephones calls to providers and billing companies for an explanation for what has happened and why.

The HHS OIG belatedly opined that providers could elect to forego billing beneficiaries for the additional amounts. This alleviated anxiety about creating a compliance risk if balance billing were forfeited, but compounded further provider's and billing company's anxiety over how to handle the supplemental payments and beneficiaries' liability, as well as refunds.

This entire process created enormously complex billing system and bookkeeping problems as practices and billing companies tried to reconcile the payment adjustments and discrepancies – first down, then up – as well as how to calculate and/or collect beneficiary copayments and/or deductibles, issue refunds or forgive small amounts. Once again, this became "salt in the wound" of the original reduction, since the "solution" was even more costly than the original reduction.

Again, as with the underlying SGR problem, we recognize that this is a problem that Congress created and CMS was charged with "cleaning up." However, we believe that if CMS were to work more closely with the provider community and medical billing industry, future problems and administrative headaches (for both Medicare and providers) such as this could be minimized or avoided entirely.

RECOMMENDATIONS

A. HBMA recommends that CMS convene a workgroup of representatives from the provider community, medical billing and compliance professionals to develop a more administratively reasonable, cost efficient and compliant mechanism for reprocessing

under/over-paid claims, should there be events similar to the ones that occurred in the past and in 2010 – 2011.

B. If similar SGR-related events occur in the future, we recommend that CMS advise Congress that they should also appropriate a supplemental, "reprocessing payment" for providers and Medicare contractors, perhaps paid on a per-claim basis, to offset the burdensome, unfunded mandate created by legislative delay.

2. Quality Reporting Initiatives – Physician Quality Reporting System (PQRS)

The PQRS program, originally known as the PQRI program, has evolved over the four years of its existence. CMS has gone to considerable effort to adjust and refine the operation of the program and make it more operationally effective.

HBMA has an active Survey Committee and we regularly seek data, feedback and input from our members about many CMS programs, initiatives and, on occasion, CMS requests comments from billing professionals. HBMA's surveys generally produce a participation level that is considered statistically relevant. Our PQRI/PQRS survey data revealed that only a small percentage of practices that outsource their billing have elected to participate in either program, largely for financial reasons. Specifically, the bonus payments are less than the additional cost of submitting the data, even when the billing company imposes no additional fee for providing their support of PQRS participation. We did not, of course, obtain data from practices that do not outsource, but have no basis to believe that participation levels are different among practices that handle billing within the practice.

The proposed changes in the PQRS program do not appear to offer any material participation efficiencies or improvements in the incentive payment levels to suggest that practices that have elected non-participation will observe improvements that will lead them to reconsider. The spectre of future payment reductions for non-participation in PQRS is, we believe, the opposite side of the same coin and reductions will not materially alter a practice's decision. In addition, a payment reduction could serve as the final "tipping point" for practices to partially or completely abandon treating Medicare patients, citing the "hassle factor."

Our members who supported clients' participation in PQRI in the first two years noted that, despite diligent (and verifiable) submission of data, bonus payments were either not received at all or were for amounts that were significantly smaller than their data projected. In the early development of the program, there was, essentially, no way for a provider or their representative to seek or secure information about why their results – or the complete lack thereof – were entirely absent or lower-than-expected. As a result, many practices abandoned participation. Once again, there are no proposed changes that suggest practices have incentives to reconsider participation in PQRS.

In addition, several of our larger member companies (>1Million claims/month) actively assisted their clients with PQRI/PQRS participation and reported significant, unresolved problems with material discrepancies between the data submitted and the data used by CMS to calculate participation bonus payments. Efforts to diagnose and resolve these problems by these companies' Compliance Officers and seasoned, senior executives were fruitless; in fact, they were often unable to identify anyone within CMS who could address their questions, even if was to point out errors by the providers and/or company.

These experiences have left many in our industry highly disappointed, as well as skeptical of the integrity of the PQRI/PQRS program. When asked by clients about possible participation, our members feel, reluctantly, obliged to truthfully report on their actual experiences and caution practices about the economic and operational value of additional work associated with this program.

REGISTRIES

Some HBMA member companies are, or have applied to become, a Registry, in order to facilitate the submission of PQRS data for those practices that have elected to participate in the program. Our members are puzzled by the limitations proposed in the NPRM, inasmuch as the general goal would seem to be more participation, regardless of format(s). Limiting an entity to being "either/or" a Registry or EMR submitter seems illogical, absent any stated rationale for the limitation.

One HBMA member company notes that they have some practices utilizing an EMR, whereas others have not implemented (and may never) an EMR. They have, thus far, employed a claims-based submission process, but look forward to transitioning to a Registry approach. However, for those practices that have adopted an EMR, they would like to submit data via EMR, as well, and believe that there should not be a restriction to one or the other.

The NPRM also makes reference to a "validation strategy" requirement (pp. 265 – 269) but we found the reference to be vague and not based on existing industry terminology or methods. We are unable to support, comment on or object to the proposed requirement. We are, however, concerned that it may be duplicative to existing Compliance Programs within practices and billing companies, which routinely conduct sampling and review (described by the HHS OIG as "Monitoring and Auditing") of all work processed, particularly when the work involves coding, claim accuracy, or added data, such as PQRS measures. It may be that a Compliance Program will satisfy the "validation" expectations, but we found nothing in the NPRM to guide our consideration of that possibility or that such an assumption might be true.

Of equal concern is that without any information on the meaning or possible requirements, we have no basis on which to evaluate the possible costs of a "validation strategy" and whether the requirement would be easily integrated into current workflow, or would be so costly and/or burdensome that it renders serving as a Registry economically unfeasible.

The proposed changes in the definition of what constitutes a "group practice" for PQRS purposes seem logical. We also agree that the registry approach to PQRS participation has simplified and strengthened the integrity and reliability of the program.

RECOMMENDATIONS

A. Based on HBMA member feedback, the "carrot" and "stick" incentives associated with PQRS are, currently, neither. We recommend that, despite well-known budget challenges, CMS investigate how PQRS incentives might be made more financially relevant. It is our observation and belief that unless or until the incentives are, truly, incentives – either way – meaningful participation will not occur.

B. Registry options should permit and support multiple pathways/formats.

C. The term "validation strategy" should be clarified and more fully defined. Once defined, CMS should solicit further formal (NPRM) or, at least, informal input, from interested parties before adopting final rules and/or policies.

3. Expansion of the Multiple Procedure Payment Reduction (MPPR)

Current Medicare policy reduces the Technical Component (TC) payment for certain "families" of diagnostic imaging procedures[1] by 50 percent for the second and subsequent procedures provided during the same "session." CMS proposes to expand the MPPR to the Professional Component (PC) of certain Advanced Imaging Services (CT, MRI, and Ultrasound), that is, the same list of codes to which the MPPR on the Technical Component (TC) already applies in calendar year 2012.

If adopted, the MPPR would apply to both the PC and the TC of the specified codes. Full payment would be made for the PC and TC of the highest paid procedure and payment would be reduced by 50 percent for the PC and TC for each additional procedure furnished to the same patient in the same session. In theory, this proposal is based on the expected efficiencies in furnishing multiple services in the same session due to duplication of physician work in the pre- and post-service period, with less work reduction intra-procedure.

The proposed rule states that this policy is consistent with the long-standing reductions for surgical procedures performed on the same date. We would point out, however, that prior rules have contained MPPR language that include a variety of "reduction rates" for various medical services and we question why the surgical MPPR was chosen as the baseline rule for this proposal.

[1] NOTE: *A majority of Radiology practices outsource their billing. As a result, a significant number of HBMA member companies handle Radiology billing, some of them exclusively in that specialty. In addition, outsourced Radiology billing, almost universally, includes assignment of CPT/HCPCS and ICD-9 CM codes. Our comments are based on HBMA members' unique perspective in this specialty.*

It is redundant, for example, to apply a "patient registration" discount to the PC of services when "patient registration" is already accounted for in the TC. That situation does not present itself in the surgical environment due to the fact that there is not a TC and PC for a given surgical procedure.

The proposed rule utilizes the term "sessions." In other comments, CMS uses the term, "encounter." In practical clinical application, session, date and encounter do not mean the same thing and using the terms interchangeably causes great confusion about the intent of the proposed rule and when reductions are applicable.

Finally, CMS implies that they are considering expanding this policy to other diagnostic imaging services and other non-imaging diagnostic procedures and seeks feedback on such an expansion.

OBSERVATIONS:

CMS provides no research or analytical data to support the contention that this MPPR is similar to the surgical MPPR, or that similar savings are achievable, or excess payments are currently made, for the provider of the professional component, as may be achievable on the technical component cost of performing advanced imaging procedures. For the vast majority of diagnostic radiology interpretations, the physician does not have pre- or post-procedure work and the intra-service work is identical for all interpretations. Each image must be individually and completely interpreted based on the unique medically necessary indications for that specific test. For example, the fact that an MRI of the brain was interpreted does not equate to any less work, malpractice risk or time to interpret a CT of the thorax on the same day or at the same session or encounter, nor is there any identifiable component for which the interpreting physician is being paid twice.

Whether a physician is reading multiple images for a single patient or single images for multiple patients, the time and effort of the physician are not substantially different. CMS proposes that when a physician reads multiple images for a single patient, there should be a reduction in the professional component but when a physician reads single images for multiple patients there is no payment reduction. We do not believe this premise is supportable by any published data, analytics or statistics and that it is based on assumptions and not facts of demonstrable efficiencies.

A recent article published in the *Journal of the American College of Radiology* (JACR) clearly demonstrates that "savings" from efficiencies within the professional component of advanced diagnostic imaging services are minimal and vary greatly across modalities. In fact, this peer-reviewed analysis, which was conducted by an expert panel of radiologists using the American Medical Association Resource-Based Relative Value Scale Data Manager, shows that efficiencies within the professional component could account for a payment reduction ranging from a low of 2.96 percent for computed tomography (CT) to a maximum of 5.45 percent for ultrasound. These findings clearly illustrate that there is an extreme disconnect between CMS' policy proposal and actual medical practice.

Absent such a credible analysis, it appears that CMS is attempting to adopt policy based upon unrelated experience and is circumventing the CPT valuation process through the RUC. We strongly oppose MPPR expansion to the professional component and other imaging services or diagnostic procedures until such time as there is unbiased research that indicates that the presumed savings are achievable.

RECOMMENDATIONS

A. CMS should withdraw this recommendation as it relates to the PC of currently identified imaging procedures until such time as there is research data to support the underlying assumption or reduce the reduction amount from CMS 50% to the figures identified in the JACR study.

B. Any consideration of expansion of the MPPR policy to the professional component of diagnostic testing and the technical component of other diagnostic modalities or procedures should be suspended until such time as there is research data to support the underlying assumption.

CMS should ask industry stakeholders to obtain relevant cost data to objectively test the assumptions regarding provider cost savings and associated discount to the program.

C. Provide specific clarification of the definitions applicable to the technical and professional components. While the technical component may occur on a single date or during a single date, encounter or "session," the professional interpretations may occur at various times that are not always contemporaneous with the technical services and are frequently performed by multiple providers. In fact, the most common scenario is interpretations by physicians with expertise in a specific modality and therefore by multiple radiologists. In the proposed rule, it does not appear that CMS considered, or was aware of, these variables when assuming cost savings. Clear definitions of session and encounter for both the technical and professional components should be published. All publications should be revised and incorporate consistent terminology.

4. Bundled Payments

The CMS 3 day payment window policy (1 day for specific types of hospitals) has bundled the technical component of diagnostic testing, and more recently non-diagnostic services related to the hospital admission, into the hospital IPPS payment. The bundling was determined by an exact diagnosis code match. CMS now seeks to modify the rule to bundle related outpatient physician services, when provided by a wholly owned or wholly operated hospital entity, into the inpatient payment, regardless of diagnosis match. The stated rationale is to make payment at the reduced hospital rate, rather than at the higher physician office amount. When a related admission occurs

within the 3 day payment window, physicians will be responsible for appending a modifier to convey the necessary payment information to Medicare.

Physicians in wholly hospital-owned or operated offices or clinics are frequently multi-specialty or completely unaffiliated, other than by common ownership, and not infrequently in different offices, clinics and/or geographic locations. The ability to identify patients who may be admitted by a different physician, specialty or practice will be extremely onerous, if not impossible. More importantly, to determine whether the admission by a different physician or specialty is related to a given encounter is even more problematic.

In the real-world operation of health systems, multi-site hospitals (including free-standing outpatient facilities, medical office buildings, imaging centers, etc.) it is unclear how admission information can be effectively communicated to all possible physicians, how quickly it will be conveyed, if at all, and how physicians who do not yet have shared medical records could possibly know if an admission is related to their services or what diagnoses the hospital or another physician designated as the admitting diagnosis.

We are also concerned about patient privacy protections and whether one specialty, for example a family practitioner, would have any reason to know about a psychiatric admission, if the sole purpose is to report a hypothetically possible related visit. Although this integration might be achievable in the future, with fully implemented, universal intraoperable health records, it is not reasonable in the current environment, with myriad combinations of electronic, paper, and other methods of medial record creation that do not have any means of sharing or communication.

For those physicians who rely upon third party medical billing companies and/or outsource coding, we see no viable mechanism for the billing company to obtain the necessary information to correctly append the proposed modifier. Data restrictions pursuant to HIPAA/HITECH compliance will quite appropriately prevent access to data that does not belong to their client.

We believe the difficulty in accurately identifying and reporting these services could result in inaccurate modifier utilization or an unavoidable failure to report the proposed modifier. We are concerned that this may expose physicians to unfair scrutiny and demands for overpayment recoupments.

In addition, the 3 day "window" poses an untenable operational challenge: suspend submission of a completed claim, pending manual determination (few entities, if any, have systems capable of performing this task automatically) of whether each patient claim to be billed was for a patient who was admitted and/or discharged within the 3 day time period. And, of course, the manual determination may create a violation of the patient's HIPAA privacy rights.

Finally, we are concerned that this policy could become a "poison pill" for many community health systems and practices in their area. We note that there are many hospitals currently buying medical practices as part of: an integration strategy; in response to possible ACO initiatives; to

assure the availability of critical specialty services in under-served communities; or, in order to engage in comprehensive contracting with large local insurers, to name only a few reasons. If the owned practices' billable services become under-paid, by being reduced, despite the practice's actual, fair-market-value office costs (nursing and support staff, EMR, rent, utilities, etc.) the economics of these transactions may be fatally undermined, to the detriment of the community.

RECOMMENDATION

We believe this proposed rule should be rescinded until such time as the implantation is feasible and attainable and that physicians can reasonably comply with the requirement.

5. Medicare Coverage and Payment of the Annual Wellness Visit

The Affordable Care Act expanded the preventive care benefits available to Medicare Part B beneficiaries. In addition to the existing "Welcome to Medicare" visit (also known as the Initial Preventive Physical Exam or IPPE) for new Medicare Part B beneficiaries, as of 2011 Medicare also covers an Annual Wellness Visit (AWV) for personal prevention plan services.

For 2011, the AWV (HCPCS codes G0438 and G0439) includes a personalized prevention plan of service (PPPS) as well as a variety of other services deemed essential. For 2012, CMS is proposing to incorporate a "Health Risk Assessment" as part of the annual wellness visit.

The proposed definition of a "Health Risk Assessment" is an evaluation tool that, at a minimum:

- Collects self-reported information about the beneficiary;
- Can be administered independently by the beneficiary or administered by a health professional prior to or as part of the AWV encounter;
- Is appropriately tailored to and takes into account the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy need;
- Takes no more than 20 minutes to complete;
- Addresses, at a minimum, the following topics:
    - Demographic data, including but not limited to age, gender, race, and ethnicity;
    - Self-assessment of health status, frailty, and physical functioning;
    - Psychosocial risks, including but not limited to depression/life satisfaction, stress, anger, loneliness/social isolation, pain, or fatigue;
    - Behavioral risks, including but not limited to tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual practices, motor vehicle safety (seat belt use), and home safety;
    - Activities of daily living (ADLs), including but not limited to dressing, feeding, toileting, grooming, physical ambulation (including balance/risk of falls), and bathing; and

- Instrumental activities of daily living (IADLs), including but not limited to shopping, food preparation, using the telephone, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances.

If implemented, the new policy will specify that the AWV take into account the results of an HRA; add the review (and administration, if needed) of an HRA as an element of both first and subsequent AWVs; incorporate the establishment of a written screening schedule for the individual, and add a separate assessment of memory. Further, although the proposed rule states the HRA can be self-reported by the beneficiary, options for administration, other than during the actual visit, include a phone interview or a secure web based administration in the patient's preferred language.

While all of Health Risk Assessment activities have value to the patient, we would note that to conduct these activities and engage the patient for this information will take additional time and work. The NPRM states CMS believes the current payment (equivalent to 99204 or 99214) is appropriate to reflect the additional time and/or resources that a provider will have to perform in order to meet this new service requirement. Although we recognize CMS does not utilize the CPT wellness visits codes, the very nature of the visits requires comprehensive services to address age and gender appropriate history and examination, as well as counseling/anticipatory guidance/risk factor reduction interventions. We believe this is consistent with the CMS requirements for the current IPPE and AWVs.

We disagree that the work for subsequent AWVs is comparable to 99214, which requires only a detailed history and examination, and an average time of 25 minutes. The work described by the CMS initial and subsequent wellness visits is very comprehensive and will almost certainly require far more than 25 minutes. We acknowledge that CPT 99204 requires a comprehensive history and examination but the intent and work of the codes is not synonymous with a wellness/preventive visit and an average time of 45 minutes is again less than the time required for the average annual visit.

More importantly, we believe the 2011 requirements that specify inclusion of: medical and family history, identification of all providers and suppliers of services, key measurements (vital signs, height, weight, BMI, etc.), cognitive impairment, depression risk, functionality and safety, written screening schedule, risk factors and treatment options, education and counseling and life style interventions adequately incorporate all of the key elements required by the Health Risk Assessment.

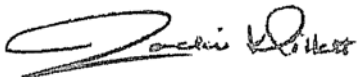
RECOMMENDATIONS

A. CMS should suspend application of the new policy until deficiencies, if any, in the current AWV requirements that would necessitate implementing the Health Risk Assessment can be quantified and validated.

B. CMS should adjust payment for the AWV to accurately reflect the more comprehensive services required.

HBMA appreciates the opportunity to respond to this NPRM and remains interested and available to work with CMS should you seek to modify or further research the practicality of the proposed rules or new or substitute rules. We will be happy to clarify or expand upon the comments submitted if doing so will aid CMS in formulating final rules.

Respectfully submitted,



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