Emergency Department EDPMA Practice Management Association

September 13, 2021

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

Submitted electronically via www.regulations.gov

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

Dear Administrator Brooks-LaSure:

On behalf of the Emergency Department Practice Management Association (EDPMA), we appreciate the opportunity to provide comments on the calendar year (CY) 2022 Medicare Physician Fee Schedule (MPFS) proposed rule. EDPMA represents independent emergency physician groups and their practice partners. Our members serve approximately half of all visits to emergency departments in the nation.

MEDICARE PHYSICIAN FEE SCHEDULE PAYMENT PRESSURES

EDPMA urges the Agency to consider our comments in the context of the unique circumstances in which emergency physicians are practicing. Emergency medicine occupies a unique position in the continuum of care, and as such, we believe warrants policies that recognize this unique role. Emergency departments fulfill their statutory obligation to provide emergency care without regard to the ability to pay due to the Emergency Medical Treatment & Labor Act (EMTALA). Increasingly, the emergency department is seen not as a health care resource to be avoided, but a key stabilization and decision point for patient disposition. The role that emergency departments play in delivering health care and ensuring patient access is pivotal in supporting the country's medical safety net. EDPMA is extremely concerned by the proposed cut to the CY 2022 MPFS conversion factor of 3.75%. While we understand that this is due to the lapsing of a Congressional provision that boosted the CY 2021 conversion factor, the impact

on our practices will be drastic. Amidst the numerous, ongoing economic challenges that emergency departments are facing during the COVID-19 public health emergency (PHE), this reimbursement reduction is slated to occur at the same time as the reintroduction of the 2% Medicare sequestration cut from the *Budget Control Act* and a new potential sequestration reduction of 4% due to PAYGO rules and the passage of the *American Rescue Plan*. These mounting cuts and financial pressures are short-sighted and wholly unwarranted.

Emergency medicine practices are on the front lines of the ongoing COVID-19 pandemic. The public health emergency has stretched resources for these practices and will continue to put pressure on the financial stability of these practices. Despite facing dire financial circumstances, emergency physicians continue to provide EMTALA-mandated care; however, they have far fewer tools at their disposal to remain solvent during the pandemic than other specialties because of the EMTALA mandate. We acknowledge the role that Congress plays in avoiding these cuts, but we urge you to consider these comments in this context.

We provide a detailed discussion below of each item on which we are commenting. In summary, EDPMA makes the following recommendations regarding policies addressed in the proposed rule:

- **Telehealth**
    - Support for maintaining CPT 99281 – 99285 and CPT 99291 and 99292 as approved Medicare Telehealth Services through at least 2023.
    - CMS should extend the direct supervision flexibility to allow for virtual supervision through at least the end of 2023.
- **Split (or Shared) Services Evaluation and Management (E/M) Services**
    - CMS' definition for split (or shared) services should track the CPT Code manual guidance to convey the concept of jointly providing the work during the same visit.
    - CMS should explicitly define in which facility settings split (or shared) visits may be billed, and how this definition relates to the definition of "institutional setting" used to determine when the Medicare "incident to" billing rules apply.
    - CMS should define "same group" for purposes of split (or shared) visits as including being employed by, or an independent contractor affiliated with, the same entity, or an independent contractor who is billing through the same entity, or where the physician is obligated to perform the supervisory service for that particular NPP on the patient's date of service for the particular split (or shared) visit regardless of the billing entity status. In defining "same group," CMS also should consider the circumstances of opioid use disorders to ensure that it does not interfere with other policies to address the opioid epidemic.
    - Since emergency department E/M visits are unique for purposes of determining whether a split (or shared) visit has occurred, CMS should consider a separate policy for split (or shared) ED E/M visits.
    - For purposes of determining the "substantive portion" in the context of the ED E/M code set, the qualifying activities should be based on joint involvement in Medical Decision Making ("MDM") during the patient's same visit before

discharge from the emergency department, as MDM is the key component of the delivery of an ED E/M service.
    - In regards to documentation, CMS should state in regulation that an attestation by the physician stating that he or she was involved in the care of the patient during the ED visit and was responsible for the MDM component of ***that*** patient's ED E/M visit is sufficient documentation in the clinical record for substantiation as to who is the appropriate billing provider during an ED E/M visit.
- **Critical Care Services**
    - CMS should reinstate its previous guidance on critical care services that extend beyond midnight so that if it is one episode (continuous), the time is added to the previous day on which the service was initiated, but if the time breaks, then a new initial service day would be started on the date on which the delivery of critical care services recommences.
    - CMS should not bundle critical care services into all global procedural packages.
    - CMS should not require that billing for initial critical care services be limited to one claim per specialty/group.
    - Support for CMS' policy on time and billing for split (or shared).
    - CMS should avoid an across-the-board prohibition on E/Ms being provided on the same day as critical care services.
    - In terms of documentation, CMS should specify that an exact number of minutes is not required, but that documentation of a time range is an acceptable format.

Appropriate Use Criteria for Advanced Diagnostic Imaging

- Support for CMS' decision to delay the AUC program another year and urges CMS to work with Congress to fully repeal the program.

Merit-Based Incentive Payment System (MIPS)

- EDPMA supports the goals of the MIPS Performance Pathways (MVP) framework, but is concerned that it does not sufficiently address fundamental concerns with MIPS and should not be considered as a mandatory pathway at this time.
- CMS should not mandate that multispecialty groups that report MVPs form subgroups starting with the CY 2025 MIPS performance period/2027 MIPS payment year. CMS also should not require subgroups to be single specialty for purposes of MVP reporting.
- CMS should evaluate COVID-19-related flexibilities that would allow it to maintain the current performance threshold of 60 points for 2022. However, if that is not possible, CMS should rely on a performance threshold of 75 points and ensure that other MIPS scoring policies account for this increase in the performance threshold.
- CMS should not increase the data completeness threshold to 80% beginning with the 2023 MIPS performance period.
- CMS should reconsider making proposed changes to its MIPS scoring policies in 2022, particularly as practices are still dealing with the aftermath and resurgence of COVID-19.

TELEHEALTH & OTHER SERVICES INVOLVING COMMUNICATIONS TECHNOLOGY

Medicare Telehealth Services List

We appreciate the CMS effort to continue to address service delivery via telehealth during the ongoing COVID-19 PHE. As part of CMS' previous work in this area, CMS discusses the Medicare Telehealth Services Category 3 designation, which it created for adding services to the Medicare telehealth services list on a temporary basis during the public health emergency (PHE) for the COVID-19 pandemic. This category describes services that were added during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but there is not yet sufficient evidence available to consider the services for permanent addition to the approved Medicare Telehealth Services List. According to previously finalized policies, codes designated at Category 3 telehealth services would be eligible to be delivered as telehealth services through the end of the calendar year in which the PHE ended.

CMS previously designated the following codes as Category 3 telehealth services:

- **CPT 99281** (*Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor*)
- **CPT 99282** (*Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity*)
- **CPT 99283** (*Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity*)
- **CPT 99284** (*Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function*)

- **CPT 99285** (*Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function*)
- **CPT 99291** (*Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes*)
- **CPT 99292** (*Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service*)

In the CY 2022 MPFS proposed rule, CMS proposes to extend the Category 3 status of these codes from "the end of the calendar year in which the PHE ends" to "through calendar year 2023." ***EDPMA supports the CMS proposal to maintain CPT 99281 – 99285 and CPT 99291 and 99292 as approved Medicare Telehealth Services through at least 2023.***

Expiration of PHE Flexibilities for Direct Supervision Requirements

In reviewing the evolution of the direct supervision requirements, CMS highlighted that prior to the PHE, direct supervision required the immediate availability of the supervising physician or other practitioner. This standard stated that although the professional need not be present in the same room during the service, the "immediate availability" requirement means in-person, physical availability, not virtual. As one of the many flexibilities provided during the COVID-19 PHE, CMS changed the definition of "direct supervision" for supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be "immediately available" through virtual presence using real-time audio/video technology. CMS previously finalized a policy to extend this flexibility through the end of the calendar year in which the PHE ends or December 31, 2021, whichever occurs later.

As part of this proposed rule, CMS requests input on whether this flexibility should be continued beyond the current expiration policy. ***EDPMA requests that CMS extend the direct supervision flexibility to allow for virtual supervision through at least the end of 2023 to align with the proposed policy for Category 3 approved Medicare Telehealth Services***. While CMS should also begin to consider extending this flexibility permanently for certain services, we believe that in order to create stability in the delivery of and access to care in a changing health care environment even if the PHE has been lifted for a stated period of time, it would be appropriate to extend these flexibilities through a time certain regardless of the moment in time in which the PHE officially ends.

EVALUATION AND MANAGEMENT (E/M) SERVICES

Split (or Shared) Visits

CMS puts forward a number of proposals related to policies for billing split (or shared) services in a facility setting. CMS states that its intention is to institute policies to align with the Current Procedural Terminology (CPT) manual guidance. The CPT manual language regarding split (or shared) services states:

> *A shared or split visit is defined as a visit in which a physician and other qualified healthcare professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of a service for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and or other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).*

CMS proposes to define the key term, 'split (or shared) services' "*as an E/M visit in the facility setting that is performed in part by both a physician and an NPP who are in the same group in accordance with applicable laws and regulations.*" Instead, ***EDPMA recommends that CMS' definition should track the CPT Code manual guidance in order to also convey the concept of jointly providing the work during the same visit – concepts that are implied but not expressed in CMS's proposed definition***. Therefore, ***EDPMA recommends the following CMS definition for split (or shared) services:***

> "as an *E/M* visit in the facility setting where both a physician and an NPP jointly provide, in part, the work related to a patient's visit and where both that physician and that NPP are in the same group in accordance with applicable laws and regulations."

We believe this to be a reasonable approach to defining split (or shared) visits and provide more clarity to MACs that have added administrative burden to practices in their approaches to accounting for split (or shared services).

- "Facility Setting": ***For purposes of clarity, CMS should explicitly define in which facility settings split (or shared) visits may be billed, and how this definition relates to the definition of "institutional setting" used to determine when the Medicare "incident to" billing rules apply.*** For example, we understand that the Medicare split (or shared) visit billing rules apply to services furnished in the emergency department, outpatient hospital, and inpatient hospital settings, including critical care services. We understand that the Medicare "incident to" billing rules apply to services furnished in "non-institutional settings", meaning "all settings other than a hospital or skilled nursing facility." However, the "incident to" billing rules do not specify whether emergency department or outpatient hospital services are considered to be services provided in a "non-institutional setting." In establishing the definition for split (or shared) services, CMS should clearly distinguish in which facility settings these rules apply, and in which settings the "incident to" billing rules apply.

- "Same Group": As mentioned above, CMS proposes that the physician and the NPP must be in the "same group" for the physician and NPP to bill for a split (or shared) visit. CMS does not specifically define "same group" in the context of split (or shared) visits, but requests comment on whether it should provide further definition. ***EDPMA recommends that CMS should provide further definition, and in that regard, EDPMA recommends that CMS define "same group" for purposes of split (or shared) visits as including being employed by, or an independent contractor affiliated with, the same entity, or an independent contractor who is billing through the same entity, or where the physician is obligated to perform the supervisory service for that particular NPP on the patient's date of service for the particular split (or shared) visit regardless of the billing entity status.*** This specific definition would address CMS' concern that some definitions for "same group" would place practitioners in the same group without any guarantee that the providers are working closely together. Therefore, if a physician is responsible on the day of the patient's split (or shared) visit for supervising an NPP, then that physician and that NPP would be considered part of the "same group" caring for the patient during that split (or shared) visit. Regardless of the billing entity organization for the physician and NPP, if that physician is playing the role of supervisory physician and, therefore, is held legally responsible for the care being provided by the NPP, including their licensure being at risk, then CMS needs to consider that, under these specific split (or shared) visit circumstances, both the physician and the NPP are part of the "same group."

  We also request that CMS carefully consider its approach in the circumstances of opioid use disorders to ensure that it does not interfere with other policies to address the opioid epidemic. In the area of toxicology/addiction medicine provided by an ED provider, as well as a toxicology provider, if that provider was an NPP we are under the understanding that the "same group" definition would not be an issue given that they are separate providers. We ask that CMS review these scenarios to ensure that its approach to "same group" does not interfere with patient access to substance abuse disorder treatment in the emergency setting.

- Substantive Portion: See discussion below under "Qualifying Activities."

- Qualifying Activities: CMS proposes that the activities that can be included in the time count for purposes of determining the "substantive portion" of an E/M visit are the same activities that would be used for purposes of counting time in split (or shared) visits. This list includes the following (regardless of whether they involve direct patient contact):
  - Preparing to see the patient (for example, review of tests)
  - Obtaining and/or reviewing separately obtained history
  - Performing a medically appropriate examination and/or evaluation
  - Counseling and educating the patient/family/caregiver
  - Ordering medications, tests, or procedures

- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/ family/caregiver
- Care coordination (not separately reported)

CMS states that providers would not count time for the performance of other services that are reported separately, travel, and teaching that is general and not limited to discussion that is required for the management of a specific patient.

In itemizing these qualifying activities for purposes of the "substantive portion" time count, CMS acknowledges that the entire construct of emergency department E/M visits is different and asks whether it should consider different qualifying activities for application to E/M split (or shared) visits in the emergency department. ***EDPMA agrees with CMS that the entire construct of emergency department E/M visits is unique for purposes of determining whether a split (or shared) visit has occurred. For that reason, EDPMA believes it is imperative that CMS consider a separate policy for split (or shared) ED E/M visits***. To that end, time is not a key component of the ED E/M code set given the nature of the services described by those codes, nor should it be. Even if time were maintained for determining the "substantive portion," CMS's proposed application of the list of activities that are meant to describe office and outpatient E/M visits would be misplaced for E/M coded visits in the emergency room. ***EDPMA recommends that, for purposes of determining the "substantive portion" in the context of the ED E/M code set, the qualifying activities should be based on joint involvement in Medical Decision Making ("MDM") during the patient's same visit before discharge from the emergency department, as MDM is the key component of the delivery of an ED E/M service.*** Merely counting time in the emergency department setting could shift the billing provider to the clinician who is not responsible for the ultimate MDM that is determined for that particular patient. The clinician responsible for the ultimate MDM that is determined for the patient should be the clinician billing for the split (or shared) ED E/M visit, as it is the ultimate MDM that is determined for the patient that is the Medicare Part B benefit that is being purchased for that patient.

- Documentation: We recognize that there may be facility bylaws and state laws that require general supervision by a physician of the services provided by the NPP, and that some type of documentation differentiation is needed between when a physician is providing general supervision of the NPP for purposes of facility/state law versus when the physician is providing MDM for a particular patient during that patient's visit. In the past, there has been a difference of opinion across the various Medicare Administrative Contractors as to the type of documentation that would be sufficient to support billing for physician services when a split (or shared) visit has occurred. It is essential for CMS to be clear in its final rulemaking as to what type of documentation will be sufficient in this context so that both the MACs and the providers have certainty as to what

constitutes compliance. There are tremendous efficiencies achieved in the ED setting by having NPPs address an entire ED visit with general supervision by the physician. Nevertheless, there are times during a patient's visit when both the services of the NPP and the services of the physician are required to achieve the ultimate MDM that is determined to be in the best interest of the patient. Given all of our comments above, ***EDPMA recommends that CMS state in regulation that an attestation by the physician stating that he or she was involved in the care of the patient during the ED visit and was responsible for the MDM component of that patient's ED E/M visit is sufficient documentation in the clinical record for substantiation as to who is the appropriate billing provider during an ED E/M visit.*** EDPMA believes that, by including the requirement that the physician must attest that they were involved in the care ***during*** that patient's ED visit, this attestation should help all payers distinguish between those visits when the physician participated in the MDM before the discharge of the patient from the ED department versus a signature either the same day or later demonstrating that physician's supervisory role for purposes of facility/state law. In other words, if the physician is only playing the role of supervisor of the NPP, then the supervising physician's signature on the record would not constitute sufficient documentation of an ED split (or shared) visit. However, if the physician, in real time, participates in the MDM with the NPP before the patient is discharged from the emergency department, then that physician should be the billing clinician. Having the recordation of that physician's role in the MDM for the patient through a physician's attestation statement should be sufficient documentation to support billing that split (or shared) visit under the physician's Medicare number, with no dispute as to whether the medical record documentation was sufficient. Physicians know how important their signatures are in the course of their profession – whether it is to sign off as supervisor of a medical chart or sign off for a prescription or to order imaging services. Having such an attestation – true, correct and complete – is something that payers should be able to rely upon for the veracity of what is occurring during the ED visit. Lastly, we request that CMS identify acceptable attestations since in the past different MACs have identified the same attestation as acceptable and others have identified the same attestation as unacceptable.

Critical Care

Critical care services are generally described by the following CPT codes:

- CPT 99291 (*Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes*); and
- CPT 99292 (*each additional 30 minutes (List separately in addition to code for primary service*)

CMS generally proposes to adopt the CPT language regarding critical care services, which states, "critical care is the direct delivery by a physician(s) or other qualified healthcare professional (QHP) of medical care for a critically ill/injured patient in which there is acute impairment of one or more vital organ systems, such that there is a probability of imminent or life-threatening

deterioration of the patient's condition." In adopting this language, CMS also makes several proposals regarding practicing implications of billing these services.

- Critical Care by a Single Physician or NPP: CMS outlines that CPT language specifies that the billing practitioner should "report the total duration of time spent by the physician or QHP . . . even if the time spent by the practitioner on that date is not continuous; and that non continuous time for medically necessary critical care services may be aggregated." CMS proposes to adopt that CPT 99291 (i.e., first 30-74 minutes) should be used only once per date even if the time spent by the practitioner is not continuous on that date. Because the CPT manual does not address a specific scenario, CMS seeks comment on how practitioners should report CPT 99291 and 99292 "when a service extends beyond midnight into the following calendar day." ***EDPMA recommends that CMS reinstate its previous guidance on critical care services that extend beyond midnight so that if it is one episode (continuous), the time is added to the previous day on which the service was initiated, but if the time breaks, then a new initial service day would be started on the date on which the delivery of critical care services recommences***.

- Critical Care Visits & Global Surgery: CMS proposes to bundle critical care visits with procedure codes that have a global surgical period. ***EDPMA strongly opposes the CMS proposal to bundle critical care services into all global procedural packages.*** As CMS itself notes, critical care visits are already explicitly included in some 10- and 90-day surgery codes, and of course, there would not be separate billing in those instances. However, bundling critical care services into the value of a code that has made no accommodation for inclusion of that service threatens the relativity of the Medicare Physician Fee Schedule. For instance, there could be a scenario where a car accident patient requires critical care, but the patient also requires an intermediate laceration repair, finger reduction, or shoulder reduction. For the codes that represent the intermediate laceration repair, finger reduction, or shoulder reduction, it makes no sense to make the baseline assumption for those codes the typical patient for those services require critical care services, which is why they should be maintained as separately billable services. In a medical example, you can imagine a patient who is septic (thus requiring critical care services) who had a syncopal episode who requires an intermediate laceration repair from the fall. If the same physician providing the critical care services performs the intermediate laceration repair, it is unclear to us why the physician would be unable to bill for the critical care services delivered to the patient. Does CMS believe that the "typical patient" for intermediate laceration repair requires critical care services?

- Critical Care Services Furnished Concurrently: CMS proposes to clarify the requirements for how to report critical care services when more than one practitioner or specialty is involved in furnishing the service given its observation that the CPT manual does not provide guidance (split (or shared) visit or otherwise). CMS proposes that concurrent care occurs where "more than one physician or qualified NPP furnishes services on the

same day." CMS also proposes that "critical care services may be furnished as concurrent care to the same patient on the same day by more than one practitioner in more than one specialty . . . regardless of group affiliation, if the service meets the definition of critical care and is not duplicative of other services." However, CMS proposes that when critical care is "furnished concurrently by two or more practitioners in the same specialty and in the same group to the same patient on the same day, the individual physician(s) or NPP(s) providing the follow-up or subsequent care would report their time using . . . CPT 99292" so that CPT 99291 would not be reported more than once for these practitioners. Prior to these changes, CMS noted that the services associated with 99291 needed to be furnished by a single practitioner but seeks comment on whether it should retain this requirement. ***EDPMA opposes CMS bringing back this requirement.***

CMS proposes to "allow critical care services time spent by more than one practitioner in the same group with the same specialty to be added together for the purposes of meeting the time requirement to bill for the initial critical care service" (i.e. CPT 99291). ***EDPMA encourages CMS to refrain from requiring that billing for initial critical care services be limited to one claim per specialty/group.*** There are many instances where the work furnished by two emergency department clinicians should be receiving for critical care services provided at the same time given the nature of the work provided in those instances. Some patients are very complex and require the care of two clinicians simultaneously. In the emergency department it is not infrequent that there are only two ED clinicians and no other physician in the hospital to call down, particularly in non-trauma center EDs.

- Critical Care Services as Split (or Shared) Visits: CMS is proposing to change current policy, which does not provide for split/shared billing of critical care services. Noting the shift toward team-based evolution of care, CMS proposes that critical care visits may be furnished as split/shared visits. CMS states,

  > *[W]hen critical care services are furnished as a split (or shared) visit, we are proposing to define the substantive portion as more than half the cumulative total time in qualifying activities that are included in CPT codes 99291 and 99292. Additionally, the billing practitioner would first report CPT code 99291 and, if 75 or more cumulative total minutes were spent providing critical care, one or more units of CPT code 99292.*

  EDPMA generally agrees with the CMS policy on time and billing for split (or shared) critical care visits.

- Same Day Critical Care & Other E/M Services: CMS proposes that "no other E/M visit can be billed for the same patient on the same date as a critical care service when the services are furnished by the same practitioner, or by practitioners in the same specialty in the same group." CMS states,

With respect to hospital visits, hospital ED visits, and critical care services furnished on the same day, the Medicare Claims Processing Manual states, "When a hospital inpatient or office/outpatient E/M service are furnished on a calendar date at which time the patient does not require critical care and the patient subsequently requires critical care both the critical care services (CPT codes 99291 and 99292) and the previous E/M service may be paid on the same date of service. Hospital ED services are not paid for the same date as critical care services when provided by the same physician to the same patient."

However, CMS asks for input on an ED visit and then a later critical care visit. In practice, this is a clinical circumstance that happens, such as when a patient is seen in the ED and admitted to the hospital, but later decompensates. It is not uncommon for the ED doc to be called to the floor to care for the patient. There are other instances in which the patient is held in the ED for many hours and decompensates after the patient has been admitted. In those scenarios, the ED clinician is present and immediately provide the care appropriate care. ***EDPMA firmly believes that Medicare should be providing for all services provided to Medicare beneficiaries that are medically necessary, and CMS should avoid an across-the-board prohibition on E/Ms being provided on the same day as critical care services.***

- Documentation: Given that critical care codes are already time-based codes, CMS proposes to require practitioners to document in the medical record the total time that critical care services were provided by each reporting practitioner (not necessarily start and stop times)." Documentation must also include services furnished to the patient (including concurrent care by practitioners); that the services were medically reasonable and necessary for the "diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member"; the role that each practitioner played in the patient's care; and, if applicable, the documentation required to bill a split (or shared) visit.

  We appreciate that CMS states that start and stop time is not a required element of documenting total time. However, ***EDPMA believes that CMS should add that an exact number of minutes is not required but that documentation of a time range is an acceptable format for documenting time in these circumstances***. This would directly align with the CPT code definition, and also alleviate some documentation burden given how many electronic health records capture time for these codes. In addition, we believe it is in the interest of patient care that clinicians are able to provide the time range rather than count exact minutes. I can see how this might become complicated when care is provided by multiple clinicians over the course of a day and then how can ranges be combined into one time frame. In order to assist CMS and Medicare Administrative Contractors (MACs) with program integrity concerns, for those clinicians who document time as range where there are multiple clinicians involved in the delivery

of care, CMS and the MACs would base the review on the minimum time, but only if time is expressed as a range.

APPROPRIATE USE CRITERIA FOR ADVANCED DIAGNOSTIC IMAGING

Section 218(b) of the Protecting Access to Medicare Act (Pub. L. 113-93, April 1, 2014) (PAMA) directed CMS to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. CMS has taken steps to implement this program over several years, and codified the AUC program in its regulations at 42 CFR 414.94.

Under the program, *ordering* professionals must consult specified applicable AUC through qualified clinical decision support mechanisms (CDSMs) for applicable imaging services furnished in an applicable setting,[1] paid for under an applicable payment system.[2] *Furnishing* professionals must report the ordering professional's AUC consultation information on the Medicare claim in order to be paid for the imaging service. CMS previously established that the following information must be reported on Medicare claims for applicable advanced diagnostic imaging services:

1) The qualified CDSM consulted by the ordering professional;
2) Whether the service ordered would or would not adhere to specified applicable AUC, or whether the specified applicable AUC consulted was not applicable to the service ordered; and
3) The NPI of the ordering professional (if different from the furnishing professional).

Section 1834(q)(4)(C) of the Act also provides for exceptions to the AUC consultation and reporting requirements in the case of: a service ordered for an individual with a suspected or confirmed[3] emergency medical condition, a service ordered for an inpatient and for which payment is made under Medicare Part A, and a service ordered by an ordering professional for whom the Secretary determines that consultation with applicable AUC would result in a significant hardship. In the 2019 PFS final rule, CMS fleshed out the significant hardship exception process to include: 1) insufficient internet access, 2) EHR or CDSM vendor issues, and 3) extreme and uncontrollable circumstances. In this rule, CMS assures ordering professionals that as it moves forward with implementing the AUC program, they may attest to a significant hardship under the AUC program due to extreme and uncontrollable circumstances due to COVID-19 throughout the PHE.

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[1] As defined in section 1834(q)(1)(D) of the Act to mean a physician's office, a hospital outpatient department (including an emergency department), an ambulatory surgical center, and any other provider-led outpatient setting determined appropriate by the Secretary.

[2] As defined in section 1834(q)(4)(D) of the Act to mean the physician fee schedule established under section 1848(b), the prospective payment system for hospital outpatient department services under section 1833(t), and the ambulatory surgical center payment systems under section 1833(i).

[3] As clarified by CMS through rulemaking and guidance, including the 2019 PFS final rule (https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf) and a July 26, 2019 edition of MLN Matters, "Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements" (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11268.pdf).

Under section 1834(q)(5) of the Act, CMS is also required to identify outlier ordering professionals (i.e., those with low adherence to applicable appropriate use criteria) who would be subject to a prior authorization process when ordering advanced diagnostic imaging beginning January 1, 2020. Because the initial AUC consultation and reporting requirements have been delayed, as discussed below, implementation of the prior authorization component also has been delayed. However, CMS did finalize in the CY 2017 PFS final rule the first list of priority clinical areas to guide identification of outlier ordering professionals as follows:

- Coronary artery disease (suspected or diagnosed)
- Suspected pulmonary embolism
- Headache (traumatic and non-traumatic)
- Hip pain
- Low back pain
- Shoulder pain (to include suspected rotator cuff injury)
- Cancer of the lung (primary or metastatic, suspected or diagnosed)
- Cervical or neck pain

The AUC program's effective date has been delayed numerous times due to its administrative complexity. In 2020, CMS launched an educational and operations testing period for the program during which it continued to pay claims whether or not they correctly included AUC consultation information. In 2020, in response to the COVID-19 PHE, the educational and operations testing period was extended through CY 2021, with the penalty phase set to start on January 1, 2022. In this rule, CMS proposes to begin the AUC payment penalty phase of the program on the later of January 1, 2023, or January 1 of the year after the year in which the PHE for COVID-19 ends.

EDPMA appreciates that in the CY 2019 PFS final rule, CMS clarified that the program includes an exception to the AUC consultation and reporting requirements in the case of a service ordered for an individual with a ***suspected*** or confirmed emergency medical condition.[4] CMS also issued guidance in July 2019, instructing clinicians to use modifier "MA" on the same line as the CPT code for the advanced diagnostic imaging service in cases there the service is "being rendered to a patient with a suspected or confirmed emergency medical condition."[5]

Nevertheless, hospitals have already begun to put pressure on emergency physicians to consult appropriate use criteria before ordering advanced imaging services in preparation for a program that has not yet been implemented. The rule had recognized that it is important to ensure that diagnostic studies can be ordered quickly in the emergency department. Yet,

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[4] 83 Fed. Reg. 59699 (November 23, 2018).

[5] MLN Matters, "Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements," available at: https://www.cms.gov/Outreach-and-Education/Medicare-LearningNetwork-MLN/MLNMattersArticles/Downloads/MM11268.pdf.

hospitals are ignoring the AUC exception for emergency care and this is increasing the time it takes to order diagnostic studies, which often need to ordered quickly in the emergency setting. Pressure to prematurely comply with this program is yet another regulatory hurdle that emergency practices must overcome at an uncertain time when they continue to feel the strain of COVID-19 in the form of abnormal patient volumes, staffing shortages and other adjustments to workflow despite their best efforts to "get back to normal." This situation also highlights that hospitals remain confused about the status of the program and need better messaging from CMS about not only the ongoing delays in the program, but CMS' earlier clarification regarding the exclusion of emergency medical conditions.

EDPMA supports CMS' decision to delay the AUC program another year and urges CMS to work with Congress to fully repeal the program. It has been seven years since enactment of PAMA and during that time, CMS has adopted numerous programs that address appropriate use of imaging, including the Quality Payment Program and multiple alternative payment models (APMs) launched by the Center for Medicare and Medicaid Innovation (CMMI)—making the value of this program questionable. In addition, this program is plagued with technical challenges that have not yet been fully resolved, such as inconsistencies between the priority list of conditions and ICD-10-CM coding conventions, as well as the lack of relevance to emergent presentations. The chronic implementation delays highlight the hurdles that CMS is facing in trying carry to out this mandate as spelled out in law. As noted earlier, the cost and administrative burden on physician practices that are being told to prepare for a program that is complex, whose future is uncertain, and whose necessity is questionable.

Quality Payment Program (QPP)

MIPS Value Pathways (MVPs)

General Concerns

In this year's rule, CMS proposes to continue to move forward with its MVP framework, which aims to streamline MIPS reporting, reduce clinician burden, and provide a glidepath to APM participation. CMS proposes to make available an introductory set of 7 MVPs, including an Emergency Medicine MVP, which would be available for reporting at the individual, group and/or APM Entity level beginning with the 2023 performance period. Participating in MIPS through an MVP would be voluntary, although CMS seeks feedback on potentially sunsetting traditional MIPS and making MVPs mandatory starting in 2028.

MVP participants would be required to report on 4 quality measures offered through the MVP, one of which must be an outcome/high priority measure (rather than the current requirement of 6). They also would be required to select a population health measure from the MVP, which CMS would calculate automatically based on claims data if the participant met the case minimum. MVP participants also would be required to attest to either 1 high-weighted improvement activity or 2 medium-weighted activities offered under the MVP, versus 2-4 activities under the traditional MIPS pathway. For the cost category, each MVP include 1-2 cost measures, which CMS would score if the MVP participant is attributed a minimum number of beneficiaries under each measure. Finally, all MVP participants would be required to report on

the full set of Promoting Interoperability measures, unless they qualify for an exemption under traditional MIPS rules (e.g. hospital-based clinicians and groups).

EDPMA appreciates CMS' attempt to create more cohesive sets of measures and activities focused around a single specialty, condition, or patient population. We also appreciate the reduced reporting burden that would be associated with this pathway. However, we are concerned that the MVPs, as proposed, would not sufficiently address some more fundamental concerns with MIPS. EDPMA believes it is premature to consider retiring traditional MIPS and potentially making MVPs mandatory by 2028, until these more foundational issues, discussed below, are adequately addressed. While we are in favor of reducing reporting requirements and providing clinicians with a more meaningful participation experience, we need to better understand the landscape, including nuanced scoring and reporting rules and the extent to which relevant MVPs are available to all specialties, prior to supporting a decision to sunset traditional MIPS.

- <u>The ongoing failure to break down the four silos of MIPS</u>. While we appreciate CMS' effort to offer more cohesive sets of measures and activities focused around a single specialty, condition, or patient population, the initial set of MVPs continue to rely on four siloed performance categories rather than recognizing cross-cutting actions that could simultaneously meet the requirements of multiple categories. For example, clinicians who report electronic clinical quality measures (eCQM) through their EHR or have integrated their EHRs with a Qualified Clinical Data Registry (QCDR) should be able to get credit towards the Promoting Interoperability category. Similarly, many of the quality measures capture actions that are already built into Improvement Activities and should also be eligible for cross-category credit. We are also concerned about the ongoing disconnect between what is being measured on the quality side and what is being measured on the cost side. The Emergency Medicine MVP relies on a total cost measure that has not tie to any of the quality measures in the set (see next bullet). However, even in MVPs where CMS has developed more focused, episode-based cost measures, they often do not pertain to the same aspect of care as the quality measures in the set. Ideally, cost and quality measures should be aligned under a single metric of value.
- <u>Ongoing reliance on population health measures.</u> While we support shared accountability and team-based approaches to care, the population health measures attempt to hold our members accountable to aspects of care that are outside of their direct control. Even Acumen, through its cost measure development work, has recognized that the Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure would not apply to emergency physicians. Emergency physicians are the entryway, stabilizing patients when they are unstable, but they do not follow these patients over time. They simply cannot influence performance on most population health measures. If CMS insists on employing these measures, we request that it only apply them in the form of confidential feedback and hold clinicians harmless from them.

- Ongoing lack of flexibility in the Promoting Interoperability (PI) category. For specialties like emergency medicine, it is critically important that CMS accommodate more innovative thinking and the rapid testing of new ideas when it comes to the use of digital technologies and sharing of health information. CMS' insistence on requiring all MVPs to comply with the exiting PI measure set does not reflect the kind of flexibility needed to best recognize the diversity of clinical practice. In the interim, we support CMS' proposal to extend special status exemptions, such as automatic re-weighting of the PI category to 0% for hospital-based clinicians and groups, to MVP participants, as well as application-based PI exceptions for clinicians who lack control over the availability of certified EHR technology (CEHRT).

Subgroup Reporting

As part of the MVP framework, CMS also proposes a subgroup reporting option that would be voluntary for the 2023 and 2024 performance years**.** CMS does not anticipate the need to require single specialty groups to form subgroups in order to report an MVP. Subgroups would be subject to the same reporting and scoring rules as all MVP participants. Subgroups would also inherit the eligibility and special status determinations of the affiliated group (TIN). For example, to participate as a subgroup, the TIN would have to exceed the low-volume threshold at the group level. The subgroup would also inherit any special statuses held by the group, even if the subgroup composition would not meet the criteria. CMS also proposes that although APM Entities can report to MIPS through MVPs, they may not break out into subgroups.

CMS also notes there may be instances where some clinicians in a multispecialty group may have a relevant MVP available for reporting, while other clinicians within that same multispecialty group may not. In this scenario, the clinicians within the multispecialty group that have an MVP available may form a subgroup to report the MVP, while the group continues to report traditional MIPS.

The intent of the subgroup reporting proposal it to move away from large multispecialty groups reporting on the same set of measures, which may not be relevant or meaningful to all specialists that participate within a multispecialty group. CMS is concerned that some current group submissions do not accurately reflect the performance of all clinicians within the group, do not provide all clinicians with results that lead to data-driven improvements in quality, and do not provide patients and caregivers the granularity of data needed to make informed decisions. CMS also believes that transitioning multispecialty groups to subgroup reporting will address some inherent gaming risks, where clinicians in a group may rely on the performance of other clinicians (of a different specialty) within the group to meet quality reporting requirements. Overall, CMS believes that subgroup reporting will provide more direct attribution of quality measure data and results to clinicians, which would lead to more valuable, meaningful, and actionable results that contribute to patient care and improvement.

CMS anticipates that at a future time, when subgroup reporting is mandatory, there will need to be criteria to determine which specialty is a primary specialty of clinicians and potential

limits around how clinicians can participate and be assessed as subgroups. One consideration is to limit clinicians in multi-specialty groups to participate through single-specialty subgroups. However, at this time, CMS is not putting limitations on which specialty will be considered the primary specialty for purposes of subgroup reporting. CMS also recognizes that individual eligible clinicians may practice or be a part of multiple specialties as a part of their scope of practice and that eligible clinicians may have more than one specialty designation in PECOS. For example, if CMS does require single-specialty subgroups, how would CMS determine specialty designation?

EDPMA recognizes that an important element of transitioning to MVPs is allowing clinicians the ability to report and be assessed on measures and activities which are meaningful to their practice and that subgroup performance data would provide more detailed and clinically relevant information than the group reporting option available under traditional MIPS for both clinicians and patients. However, we oppose CMS' proposal to mandate that multispecialty groups that report MVPs form subgroups starting with the CY 2025 MIPS performance period/2027 MIPS payment year. We also strongly recommend against requiring subgroups to be single specialty for purposes of MVP reporting since this could discourage team-based care and disenfranchise clinician types whose primary specialty designation is related to their clinical degree and not to the type of care they provide (such as PAs, NPs, hospitalists, etc.). CMS should provide group practices with the flexibility to decide the most clinically appropriate way to organize its clinicians into subgroups for purposes of MIPS value-based assessments.

<u>Reporting and Scoring Policies: Traditional MIPS and MVPs</u>

EDPMA recognizes that, as required under section 1848(q)(6)(D)(i) of the Act, CMS must compute a performance threshold with respect to which the final scores of MIPS eligible clinicians are compared for purposes of determining the MIPS payment adjustment factors for a year. Starting with the 2022 performance year/2024 payment year, the performance threshold for a year must be either the mean or median (as selected by CMS and which may be reassessed every 3 years) of the final scores for all MIPS eligible clinicians for a prior period specified by CMS. In this rule, CMS proposes to use the 2019 MIPS payment year as the prior period and the rounded mean final score of 75 points as the year six performance threshold, which is consistent with CMS' annual performance threshold increases if 15 points for year two to five of the program. ***Ideally, EDPMA would like CMS to maintain the current performance threshold of 60 points in light of recent disruptions to our healthcare system as a result of COVID-19. We urge CMS to consider ways that it can do this through emergency authorities, such as the Public Health Emergency (PHE) or the Extreme and Uncontrollable Circumstances Hardship exception policy. If CMS does not believe it has this authority, then we recommend that it use a performance threshold of 75 points for the 2022 performance year, which represents the lowest possible value it could select based on historical performance. However, as discussed below, we request that CMS ensure that other MIPS scoring policies account for this increase in the performance threshold.***

Section 1848(q)(6)(D)(ii) of the Act also requires CMS to compute, for each year of the first six years of the program, an additional performance threshold for purposes of determining the additional MIPS payment adjustment factors for exceptional performance. A MIPS eligible clinician with a final score at or above the additional performance threshold will receive an additional MIPS payment adjustment factor and may share in the $500 million of funding available for the year. For each such year, CMS may set the additional performance threshold at either: (1) the 25th percentile of the range of possible final scores above the performance threshold, or (2) the 25th percentile of the actual final scores for MIPS eligible clinicians with final scores at or above the performance threshold with respect to the prior period described in section 1848(q)(6)(D)(i) of the Act. CMS' selection of the mean for the methodology and the final score data from the 2019 MIPS payment year leaves it with two options for where it could set the additional performance threshold: at 81.26 points or 88.94 points. Since 81.26 points would represent a lower exceptional performance threshold than its present value of 85 points, CMS proposes to set it at 88.94 points rounded to 89 points.

In this rule, CMS also proposes to maintain the data completeness criteria threshold of at least 70% for the 2022 MIPS performance period/2024 MIPS payment year, but to increase it to at least 80% for the 2023 MIPS performance period/2025 MIPS payment year. CMS believes that it is important to incrementally increase the data completeness criteria as MIPS eligible clinicians and groups gain experience with MIPS. However, CMS is opting to maintain the current threshold through the 2022 performance year to account for the strain of the COVID-19 PHE on healthcare systems.

EDPMA appreciates CMS' proposal to maintain a data completeness threshold of 70% for the 2022 performance period. However, we oppose CMS' proposal to increase the threshold to 80% beginning with the 2023 MIPS performance period. Emergency medicine practices face many unique challenges related to satisfying this threshold. Our practices often provide services across multiple sites (and multiples sites of service) that are affiliated with the same NPI/TIN, but not all of these sites may participate in MIPS, the registry, or the EHR that the clinicians opt to use for MIPS data collection. It is particularly challenging for our hospital-based clinicians to obtain data in a timely manner such that current thresholds can be met. EHR systems are often not controlled by our member practices, and revisions to accommodate the new measure requirements take time to design and implement. Additionally, sub-regulatory guidance is usually not available until late in the performance year, which disrupts reporting strategies. ***Until reporting is more seamlessly integrated across providers and settings, we recommend against increasing the data completeness threshold.***

In this rule, CMS also proposes to modify some of its current scoring polices, beginning with the 2022 performance period/2024 payment year, in an effort to move away from transition year policies and to simplify the program. These proposals would impact measures under traditional MIPS, as well as MVPs, and include:

- Ending the policy of offering bonus points for reporting additional outcome and high priority measures and for end-to-end electronic reporting of quality measures, beginning with the 2022 performance period/2024 MIPS payment year.

- Removing the 3-point floor for each measure that can be reliably scored against the benchmark and score the measure from 1 to 10 points if it has a benchmark, meets the case minimum requirement, and meets the data completeness requirement.
- Removing the 3 point floor for measures that cannot be scored based on performance because they do not have a benchmark or do not meet the case minimum (generally 20 cases). Small practices would continue to earn 3 points on these measures, but practices of other sizes would now receive zero points.
- Adding a 5-point floor for new measures in the program for all collection types for their first two years in the program so long as they meet the data completeness requirement (measures without a benchmark would receive 5 points).
- CMS does not propose any changes to the current 7 point scoring cap for topped out measures.

EDPMA is concerned about CMS implementing these policies while simultaneously increasing the MIPS performance threshold and exceptional performance threshold for 2022/2024. Taken together, these policies will make it challenging for practices to meet the MIPS performance threshold and avoid a penalty, particularly at a time when practices will still be dealing with the strain of COVID related disruptions and facing other Medicare payment cuts. Many of our members take the time to report on additional outcome and high priority measures, often reporting on more than 6 measures. The removal of these bonus points would disincentivize such data collection. Additionally, many of the measures relevant to our specialty would be subject to scoring caps or eligible for 0 points, which would put emergency practices at a scoring disadvantage and disincentivize the use of our specialty's measure. For example, of the ten quality measures being proposed for the Emergency Medicine Specialty Set for 2022, three (#93, 187, 254) are currently topped out and subject to the 7-point scoring cap. Of the nine CQMs and QCDR measures being proposed for inclusion in the Emergency Medicine MVP, one is topped out (#254) and four currently have no benchmark (ACEP #50 and 52 and ECPR #46 and 55). While we appreciate CMS proposing a 5-point floor for new measures in the program for their first 2 years in the program, this proposal would do nothing to incentivize the use of existing measures in the program that continue to lack a benchmark. ***EDPMA urges CMS to reconsider making these proposed changes to its MIPS scoring policies in 2022, particularly as practices are still dealing with the aftermath and resurgence of COVID-19. We also request that CMS extend its proposed policy of awarding 5 points for new measures that lack a benchmark to existing measures that lack a benchmark to encourage clinicians to use these more meaningful and focused measures going forward.***

Finally, CMS discusses how it intends to score MVP participants that do not meet the quality category requirements. For traditional MIPS, CMS implemented a validation process to determine if measures are available and applicable (i.e., the Eligible Measures Applicability or EMA process). However, CMS does not believe it needs a validation process to determine the availability and applicability of measures for MVP Participants because MVPs will focus on a condition or specialty, and CMS believes MVPs will be selected and reported because of the MVP applicability to their practice and patients. ***EDPMA requests that CMS provide additional clarification on the implications of this policy. For example, if an MVP participant opts to***

report an MVP using a QCDR and the MVP only includes two QCDR measures, would CMS require the participant to report on only those two measures or would CMS expect the clinician to report additional measures through a different data collection mechanism to meet the four measure requirement?

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We thank you for the opportunity to comment on these issues. If you have any questions or comments, please do not hesitate to contact Elizabeth Mundinger at emundinger@edpma.org.

Sincerely,

Bing Pao, MD, FACEP
Chair of the Board, EDPMA