Emergency Department EDPMA Practice Management Association

September 6, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1654-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically

Re: RIN 0938-AS81; CMS-1654-P; Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017

Dear Acting Administrator Slavitt:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. Together, EDPMA's members deliver (or directly support) health care for about half of the 136 million patients that visit U.S. emergency departments each year. We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn.

We appreciate the opportunity to provide and share our thoughts and recommendations as you finalize payment and other policies under the Medicare Physician Fee Schedule (MPFS) for CY 2017.

Potentially Misvalued Services Under the PFS
CMS continues its review of potentially misvalued codes with proposals to review 0-day global services typically billed with an Evaluation and Management (E/M) service with a Modifier -25 and begin collecting data on resources used in furnishing 10- and 90-day global services with the intent of revaluing these services on a flow basis, starting in rulemaking for CY 2019.

0-Day Global Services Typically Billed with an E/M Service with Modifier 25
Given concerns that the frequency of E/M services billed with a Modifier -25 on the same day as many 0-day global services indicates a potential problem with the valuation of the 0-day global code, CMS has identified 83 services as potentially misvalued; half, if not more, of these procedures are frequently performed in the emergency department (POS 23).

EDPMA strongly disagrees with CMS' assertion that these services are potentially misvalued simply because they have been billed along with an E/M service. As CMS is aware, use of the Modifier -25 indicates that on the day of a procedure, the patient's condition required a significant, separately identifiable E/M service, above and beyond pre- and post-operative care associated with the procedure or service performed. Patients that present to the emergency department seek acute, unscheduled care for what they believe is an emergency medical condition. Each patient presenting to the emergency department, in accordance with federal EMTALA regulations[1], requires a medical screening examination to rule out the presence of an emergency medical condition, and if one exists, stabilization treatment to prevent further deterioration of that condition. To satisfy that obligation, presenting patients require a full medical evaluation, including a history and physical examination, in order for the emergency medicine physician to establish a diagnosis and select an appropriate course of action, which, depending on the condition presenting, may or may not include the provision of 0-day global service. Given these patients are presenting to the emergency department for *acute, unscheduled care*, it would be impossible for any emergency medicine physician to anticipate or know in advance what service or procedure the patient may or may not require. As an example, a patient seen in the ED after falling from a roof. He/she is examined for possible head injury and a fractured wrist. After a complete history, exam and x-rays, the patient has a cast placed on his/her wrist. In another example, suturing associated with a motor vehicle accident (MVA) requires a whole body examination for trauma associated with the MVA.

Furthermore, CMS' rationale for deeming these 83 codes as potentially misvalued appears to be limited to an analysis of CPT code-level data alone, and does not take into account the use of ICD-10 diagnosis codes, which frequently indicates that the patient presented with more than one problem on the date of service. Not to suggest that more than one diagnosis is a requirement for use of the Modifier 25, but it might have helped narrow the list significantly if CMS had considered this aspect of billing coupled with a stronger understanding of the appropriate use of Modifier 25.

EDPMA urges CMS to withdraw this proposal, or limit its scope to those services identified as scheduled, elective, office-based procedures that are not performed in the emergency department pursuant to EMTALA obligations. We have identified the services that CMS should exclude from its proposal in the table below.

Services Routinely Performed in Emergency Departments That Should Be Excluded From The Potentially Misvalued Services Proposal			
CPT	**Description**	**CPT**	**Description**
11740	Removal of blood accumulation between nail and nail bed	**30903**	Complex control of nose bleed
12001	Repair of wound (2.5 centimeters or less) of the scalp, neck, underarms, trunk, arms or legs	**31500**	Emergent insertion of breathing tube into windpipe cartilage using an endoscope
12002	Repair of wound (2.6 to 7.5 centimeters) of the scalp, neck, underarms, genitals, trunk, arms or legs	**32551**	Removal of fluid from between lung and chest cavity, open procedure
12004	Repair of wound (7.6 to 12.5 centimeters) of the scalp, neck, underarms, genitals, trunk, arms or legs	**32554**	Removal of fluid from chest cavity
12011	Repair of wound (2.5 centimeters or less) of the face, ears, eyelids, nose, lips, or mucous membranes	**51702**	Insertion of indwelling bladder catheter

[1] Section 1867(a) of the Social Security Act

Services Routinely Performed in Emergency Departments That Should Be Excluded From The Potentially Misvalued Services Proposal			
CPT	**Description**	**CPT**	**Description**
12013	Repair of wound (2.6 to 5.0 centimeters) of the face, ears, eyelids, nose, lips, or mucous membranes	**64405**	Injection of anesthetic agent, greater occipital nerve
20550	Injections of tendon sheath, ligament, or muscle membrane	**64418**	Injection of anesthetic agent, collar bone nerve
20600	Aspiration or injection of small joint or joint capsule	**65205**	Removal of foreign body in external eye, conjunctiva
20604	Arthrocentesis, aspiration or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting	**65210**	Removal of foreign body in external eye, conjunctiva or sclera
20605	Aspiration or injection of medium joint or joint capsule	**65222**	Removal of foreign body, external eye, cornea with slit lamp examination
20606	Arthrocentesis, aspiration or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting	**69200**	Removal of foreign body from ear canal
20610	Aspiration or injection of large joint or joint capsule	**69210**	Removal of impact ear wax, one ear
20611	Arthrocentesis, aspiration or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	**92950**	Attempt to restart heart and lungs
29105	Application of long arm splint (shoulder to hand)	**98925**	Osteopathic manipulative treatment to 1-2 body regions
29125	Application of non-moveable, short arm splint (forearm to hand)	**98926**	Osteopathic manipulative treatment to 3-4 body regions
29515	Application of short leg splint (calf to foot)	**98927**	Osteopathic manipulative treatment to 5-6 body regions
29540	Strapping of ankle or foot	**98928**	Osteopathic manipulative treatment to 7-8 body regions
29550	Strapping of toes	**98929**	Osteopathic manipulative treatment to 9-10 body regions
30901	Simple control of nose bleed	**G0168**	Wound closure utilizing tissue adhesive(s) only

Improving Payment for Primary Care, Care Management Services, and Patient-Centered Services

We appreciate CMS' ongoing effort to improve the ability of physicians to be reimbursed for a variety of primary care, care management and care coordination services; however, it is difficult to discern from the proposed rule whether these proposals would facilitate improvements by emergency department physicians and providers in the provision of the aforementioned services. As we have explained in prior comments, emergency department physicians and providers in addition to providing much needed emergency medical care, serve as safety net providers to an all too frequently underserved and most vulnerable patient population. In doing so, emergency physicians and providers

regularly evaluate and manage patients who present unscheduled to the emergency department, which often includes: coordinating care; referring patients for follow-up care; scheduling follow-up appointments; collaborating with specialists; transitioning patients to inpatient care, observation, nursing homes, and home care; and discharging patients with detailed instructions.

In fact, a 2013 RAND Corporation study entitled "*The Evolving Role of Emergency Departments in the United States*," concluded that emergency department physicians and providers are the major decision-makers in over half of an average hospital's admissions and are critical in helping hospitals fulfill their statutory obligation to provide emergency care without regard to a patient's ability to pay. Primary care physicians rely heavily on emergency departments to evaluate complex patients with potentially serious problems, while providing overflow and after-hours primary care. Increasingly, the emergency department is seen not as a health care resource to be *avoided*, but a key stabilization resource and importantly relied upon decision point for patient disposition, which involves the input of the emergency department physician in finding alternatives to costly hospital admission or observation stays.

We urge CMS to clarify the extent to which CMS' proposals herein would apply to the primary care, care management and care coordination services provided by emergency department physicians and providers. And, if not, we request CMS outline the steps the agency is taking to ensure improved payment for these services when rendered in the emergency department by emergency medicine physicians and providers. As CMS continues to emphasize improved payments for these services, the role of providers rendering care in the emergency department cannot be over-emphasized and therefore, it is important that CMS recognize the unique role the emergency department plays in delivering cost effective primary care to Medicare beneficiaries and the beneficial cost-savings emergency departments bring to the overall delivery system cannot be overlooked.

Medicare Telehealth Services

Among the areas of focus of the EDPMA and its membership is the ability to service a traditionally underserved patient population who are often in remote, rural and hard-to-reach locations. To do so, EDPMA members recognize that quality emergency care can potentially be delivered to these beneficiaries through telemedicine. As a result, telemedicine is a growing enterprise and ultimately, an area for which EDPMA members are becoming more engaged. For this reason, we are pleased to see the proposed addition of *Advance Care Planning* (CPT codes 99497 and 99498) to the list of services Medicare will cover when furnished remotely. We are also pleased that CMS is proposing to include two new Medicare-developed codes for *Telehealth Consultations for a Patient Requiring Critical Care Services, initial and subsequent*, (GTTT1 and GTTT2), to the Medicare telehealth list. We agree with CMS that these new codes create a helpful distinction between telehealth consultations for critically ill patients relative to telehealth consultations for other hospital patients.

While not originally requested by EDPMA, we note that CMS did not agree to add Emergency Department Visits (CPT codes 99281-99285). In the rule, CMS explained that, while the acuity of some patients in the emergency department might be the same as in a physician's office, in general, more acutely ill patients are more likely to be seen in the emergency department, and that difference is part of the reason there are separate codes describing evaluation and management visits in the Emergency Department setting. CMS further goes on to state in its comments that given the practice of emergency medicine often requires frequent and fast-paced patient reassessments, rapid physician interventions, and sometimes the continuous physician interaction with ancillary staff and consultants, which differs from the pace, intensity, and acuity associated with visits that occur in the office or outpatient setting, CMS did not propose to add these services to the list of approved telehealth services

on a category one basis. CMS also noted in its comments that the requester for the inclusion of emergency department visit CPT codes did not provide any studies supporting the clinical benefit of managing emergency department patients with telehealth which is necessary for CMS to consider these codes on a category two basis.

Notwithstanding, EDPMA supports inclusion of ED visits to the Medicare telehealth list. Improving patient access to important emergency medical care through the use of telehealth would have a tremendous benefit for patients, particularly those in rural areas where hospitals are closing at unprecedented levels. CMS' failure to add ED visits to the telemedicine list places this already underserved and vulnerable population at even greater risk, which is unconscionable given there are available technological solutions that could provide these patients with meaningful access to emergency medical care. **We urge CMS to reconsider its proposal and include ED visits on a Category 1 basis.**

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

The Protecting Access to Medicare Act of 2014 (PAMA) directs CMS to create a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. Following CMS' earlier proposals specific to applicable AUC, CMS proposes to define qualified clinical decision support mechanisms (CDSMs) and identifies clinical priority areas for inclusion in the program. CMS also proposes exceptions to the AUC consulting and reporting requirements, which includes the statutory exception for emergency medical conditions.

First, we strongly disagree with CMS' assertion that "most encounters in an emergency department are not for emergency medical conditions". On the contrary, ***in the Medicare population***, nearly universally, beneficiary visits to the emergency departments squarely fit the definition of an emergency medical condition as defined at 1867(e)(1) of the Act, which states:

> *(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—*
> *(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,*
> *(ii) serious impairment to bodily functions, or*
> *(iii)serious dysfunction of any bodily organ or part;*

Specifically, according to the Centers for Disease Control and Prevention (CDC)[2], there were more than 20.3 million visits to the emergency department by patients 65 and older in 2011; more than half of these visits were classified under the Emergency Severity Index (ESI) as Level 3 – Urgent. As an example, a patient who presents with abdominal pain in the right lower quadrant, nausea, and no appetite, would require 2 or more resources, such as exam, laboratory studies, IV fluid, abdominal CT and possible surgery consult. Based on this clinical vignette, which is predicated under the identification and consumption of not less than 2 resources and could be identified on claims associated with the date of service for the visit, it is reasonable to assume that absent immediate medical attention the medical condition could reasonably be expected to result in serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

We further note that the CDC estimates, out of the total estimated 136.3 million visits to the

[2] http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2011_ed_web_tables.pdf

emergency department in 2011, an overwhelming 96 percent of patients were triaged as very sick and needing medical treatment within 2 hours[3], up from 92 percent in 2010. In fact, according to a separate CDC data brief, in 2009-2010, 36.5% of emergency department visits made by persons aged 65 and over resulted in hospital admission, and the percentage of emergency department visits that resulted in hospital admission increased as age increased: 32.4% of visits by those aged 65–74, 37.2% by those aged 75–84, and 43.4% by those aged 85 and over.[4] These figures alone should be compelling enough for CMS to recognize the err in their claim that most encounters in an emergency department are not for an emergency medical condition, particularly in the population for which the majority of the Medicare program covers.

As stated previously, pursuant to EMTALA, emergency departments are required to stabilize and treat any patient that presents to the emergency department regardless of that patient's insurance status or ability to pay for such costs. In addition, the "Prudent Lay Person" (PLP) requirements of the Balanced Budget Act of 1997 (BBA '97) mandates coverage of emergency services based on a patient's symptoms upon presentation, not the patient's final diagnosis. Therefore, any CMS imposed program that would require an emergency medicine physician to delay treatment in order to consult a CDSM prior to providing advanced imaging services, and make such a query a condition of payment to the interpreting radiologist, contradicts both EMTALA and PLP requirements and serves no immediate benefit to the well-being of the patient in an emergency setting.

Second, emergency physicians and providers generally provide care in hospital-based emergency departments. Health information technology and Emergency Department Information Systems (EDIS) are purchased by hospital systems and generally made available to the emergency physicians and providers for their clinical use and billing and financial records. CMS has long recognized, both through the Medicare and Medicaid EHR Incentive Program and more recently through proposed requirements associated with the Merit-Based Incentive Payment System (MIPS) (more specifically through proposed exclusions for hospital-based physicians from the Advancing Care Information performance category), that requirements for the use of technology can only be made of the acquiring entity, not the "hospital-based" physician who has no control of the design and operability of that system. CDSM is a form of health information technology that is routinely incorporated into electronic health record systems, which are not purchased by emergency department physicians. Therefore, as CMS is considering how this proposal will be implemented, it must take into account that emergency physicians and providers would not be in the position to purchase at CDSM platform, nor adopt a free CDSM platform, for implementation in the hospital because it does not have the appropriate authority to make such purchases nor implement a new CDSM tool as part of the delivery of emergency medical care provided in the hospital emergency department setting.

In light of the above concerns, **we urge CMS to propose in future rulemaking that it would automatically exclude claims with a Place of Service (POS) code of 23, Emergency Department, from the AUC program.** In addition, given that reporting requirements will not be in place for CY2017, **we urge CMS to refrain from finalizing the AUC program emergency services exclusion in the CY 2017 final rule.**

[3] http://www.cdc.gov/nchs/data/ahcd/NHAMCS_2011_ed_factsheet.pdf
[4] http://www.cdc.gov/nchs/data/databriefs/db130.htm

Medicare Advantage (MA) Provider Enrollment
CMS proposes to require providers or suppliers that furnish health care items or services to a Medicare enrollee who receives his or her Medicare benefit through an MA organization to be enrolled in Medicare and be in an approved status. This represents an expansion of CMS' recently finalized requirement that any physician or other eligible professional who prescribes Part D drugs must either enroll in the Medicare program or opt out in order to prescribe drugs to their patients with Part D prescription drug benefit plans. It is also similar to a pending proposal that would require a physician to be enrolled in Medicare in an approved status or have validly opted-out of the Medicare program, to order, certify, refer or prescribe any Part A or B service, item or drug.

As we have said before, these proposals do not consider the unique nature of emergency medical care and delivery, nor does it consider requirements under the Emergency Medicine Treatment and Labor Act (EMTALA), whereby emergency departments are required to provide stabilizing treatment for patients with emergency medical conditions, including active labor, regardless of the patients' ability to pay.

For this reason, **we urge CMS to exclude emergency medicine physicians from its enrollment requirements.** If exclusion is not possible**, at the very least, CMS must revise its proposal similar to that of its requirements set forth in § 423.120(c)(6), which would allow CMS to provide reimbursement for covered items, services or drugs ordered, certified, referred or prescribed by emergency medicine physicians on a provisional basis (i.e., for a period of 90-days from the date of service).** This is particularly important given the lengthy process associated with enrolling providers in Medicare. Furthermore, if a providers' enrollment application is pending with the Medicare Administrative Contractor (MAC), they should be excluded from these requirements.

Value-Based Payment Modifier and Physician Feedback Program
CMS proposes to update its informal review policies and establish in rulemaking how the quality and cost composites under the VM would be affected if unanticipated issues arise. The proposals CMS outlines are intended to help groups and solo practitioners better predict the outcome of their final VM adjustment and reduce uncertainty as CMS continues to improve its systems.

In general, we continue to be concerned about the Valued-Based Payment Modifier (VM) program, and its ability to fairly assess and attribute beneficiary costs and resource use to emergency medicine physicians. As noted above, we fully acknowledge the key role emergency medicine physicians play when it comes to the *decision* to admit patients to the hospital. However, emergency medicine physicians have little, if *any* control, over the cost and resource use once the patient has been admitted. These costs would largely be driven by the patients' condition and decisions made by the physician managing the patient during the course of the associated hospital stay. We also request that CMS consider the complexities impacting the VM attributable to the intricacies associated with physician attribution by recognizing the nature of emergency medicine staffing often involves the placement of physicians and providers in multiple group entities with varying tax identifiers, which in turn, often yields misleading results related to cost and value measurement reflected at the group level for care delivered at the individual provider level.

While we support CMS' proposals herein, we are concerned they do not go far enough to addressing longstanding concerns with the use of grossly imperfect cost and resource use measures. **We urge CMS to use its discretion and limit the application of downward performance-based payment**

adjustments under the VM in CY 2017 and CY 2018, particularly as physicians are trying to learn and understand how similar measures will be applied under the new MIPS.

Regulatory Impact Analysis

Under the Medicare Access and CHIP Reauthorization Act (MACRA), Congress provided a 0.5 percent update to the Medicare physician fee schedule conversion factor to stabilize payments as physicians transitioned into a new physician payment system. However, significant changes in relative values due to the infusion of new codes and other payment policy changes, coupled with CMS' budget neutrality requirements, have resulted in a proposed negative payment update for CY 2017. Specifically, CMS estimates the CY 2017 PFS conversion factor to be $35.7751, down from the CY 2016 conversion factor of $35.8043. Despite a proposed 0% impact on total allowed charges by emergency medicine, we are concerned about the obvious bias in how PFS funding is being targeted toward primary care providers, notwithstanding the supplementing role emergency medicine physicians serve in the delivery of these types of services. This is particularly frustrating to emergency physicians who are frequently serving as primary care providers after hours and on weekends, when primary care physicians are unavailable to care for their patients. In fact, many primary care physicians are ill-equipped to rapidly assess, diagnose and manage their most acutely diseased patients and will direct them to the emergency department for immediate care. CMS must work toward addressing this gross bias and ensure payment boosts to primary care physicians are not at the expense of emergency medicine and other specialty care providers who are just as essential to the health care system.

The EDPMA appreciates the opportunity to provide input on the proposed rule. If you have any questions, please contact Elizabeth Mundinger, Executive Director of EDPMA, at emundinger@edpma.org if we can be of further assistance.

Sincerely,

Timothy Seay, MD, FACEP
Chairman, EDPMA Board of Directors