



August 24, 2010

Donald Berwick, M.D.  
Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

***RE: CMS-1503-P, Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Proposed Rule; (Vol. 75, No. 86), July 13, 2010.***

Dear Dr. Berwick:

On behalf of our 86 member hospitals and the 45,000 people they employ, the Nebraska Hospital Association (NHA) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services' (CMS) regarding the physician fee schedule (PFS) proposed rule for calendar year (CY) 2011.

Physician reimbursement is critical to the sustainability of the delivery of health care in Nebraska. Physicians are critical partners with Nebraska's hospitals. Hospitals are paid for certain outpatients services, such as physical and occupational therapy, under the Medicare PFS. In addition, the proposed rule discusses payment changes under the clinical laboratory fee schedule (CLFS). Our concerns related to the physician payment formula, the application of a multiple procedure payment reduction (MPPR) to therapy services and the proposal to require the signature of a physician or qualified non-physician practitioner (NPP) on requisitions for clinical diagnostic laboratory tests paid through the CLFS are described in detail below.

## **PHYSICIAN PAYMENT FORMULA**

**The NHA supports a permanent, long-term replacement to the physician payment formula. The appropriate fix must be done in a non budget-neutral manner so that it does not result in reduced payments to other providers.**

The Medicare physician payment formula is severely flawed and, in recent years, would have resulted in significant payment cuts for physicians without legislative intervention. Over the past seven months, Congress has intervened on four separate occasions to delay a 21.2 percent cut in physician payments, which was to take effect on January 1, 2010. Beginning December 1, 2010, absent any additional congressional action, the conversion factor will drop by approximately 23.4 percent. In the proposed rule, CMS indicates that the conversion factor will decline an additional 6.1 percent beginning January 1, 2011. This will result in a cumulative decrease in physician payments of almost 30 percent from present levels.

A 30 percent reduction in physician payments is unacceptable. The level of success or failure of health care reform depends to some degree on the ability of the newly insured to obtain health care services. Many physicians report they are limiting the number of Medicare patients in their practices due to inadequate government payment rates. Many experts are projecting a significant shortage of physicians over the next 15 years. The uncertainty around Medicare physician payment rates and the ongoing risk of future cuts is threatening patient access to quality health care services. **Congress cannot continue to provide short-term, temporary fixes to the flawed physician payment formula. It must be fixed permanently, and we urge you to work with Congress to solve this problem.**

## **MULTIPLE PROCEDURE PAYMENT REDUCTION (MPPR) FOR THERAPY SERVICES**

CMS proposes to apply the MPPR policy to therapy services beginning January 1, 2011. This policy would apply to outpatient therapy services – including physical therapy (PT), occupational therapy (OT) and speech language pathology services – that are delivered in the physician office setting, as well as in hospital outpatient departments, comprehensive outpatient rehabilitation facilities, home health agencies, and other entities. Specifically, CMS proposes to make full payment for the separately payable “always therapy” service with the highest practice expense (PE) value, and apply a 50 percent reduction to the PE component for any second or subsequent therapy service provided to the same patient on the same day. The agency estimates this policy would reduce payments for therapy services delivered in hospital outpatient departments by approximately 13 percent in CY 2011. This estimate does not account for the almost 30 percent additional reduction in PFS payments due to the flawed physician payment formula, which would make the total cut to therapy services provided by hospitals about 43 percent.

**The NHA strongly urges CMS to withdraw the flawed and unjustified application of a multiple procedure payment reduction (MPPR) to therapy services.** In the rule, CMS states that the CY 2009 PFS claims data show that when multiple therapy services are billed on a claim for the same date of service, the median number is *four* services per day. There is not enough data or information in the proposed rule to understand or replicate this analysis. **The 50 percent PE reduction is arbitrary and excessive.** While we believe CMS’ data analysis is flawed, even the agency’s own analysis suggests that a 50 percent reduction is too high. In the preamble, CMS states:

For five high volume therapy code pairs that each occur over 2 million times in PFS claims for multiple therapy services and account for almost half of such claims, we estimated that the resulting reduction in the PE for the lower paying code would range from 28 to 56 percent.

CMS’ proposal to apply a 50 percent reduction to all multiple procedure claims when, at its highest estimate, the agency itself indicates that the resulting reduction would be at most 56 percent, is excessive.

**This policy would have a significant impact on patient care and access to therapy services.** This is especially true for those patients with multiple chronic conditions who might benefit the most from intensive therapy treatment programs, and for patients with certain diagnoses, such as stroke, who may be receiving PT, OT and speech language pathology services. While the NHA

supports the evaluation of potentially misvalued codes in the PFS, and we acknowledge that there are efficiencies when two or more therapy services are delivered to the same patient during the same *session*, the majority of therapy service codes already have been reduced to account for duplication in practice expenses and, thus, are not inappropriately valued. **The NHA urges CMS to drop its proposal to apply an MPPR to therapy services.**

## **CLINICAL LABORATORY FEE SCHEDULE: SIGNATURE ON REQUISITION**

CMS proposes to require the signature of a physician or qualified non-physician practitioner (NPP) on requisitions for clinical diagnostic laboratory tests paid through the CLFS. CMS claims this policy change would result in less confusion because a physician's signature would be required for both requisitions and orders; uncertainty would be eliminated regarding whether the documentation is a requisition or an order and whether the type of test being ordered requires a signature.

**The NHA strongly opposes this policy change and believes it will actually cause additional confusion.** It is unnecessary, redundant with common practice, and contrary to the agreement struck in the Clinical Laboratory Negotiated Rulemaking. It could result in delays in hospital laboratory testing that would be harmful to beneficiaries, and would unfairly hold hospital laboratories financially accountable for non-compliance that is outside of their control.

The November 23, 2001 Clinical Laboratory Negotiated Rulemaking Final Rule (66 *Federal Register* 58787) reflected the negotiated rulemaking committee's decisions that a physician's signature not be the only permissible way to document the ordering of a test, and that physician signatures not be required on requisitions for clinical diagnostic laboratory tests. These decisions, arrived at through a comprehensive process involving 18 laboratory and health care organizations and CMS, should not be overridden by a misguided attempt to eliminate confusion about CMS policy. We do not believe that requiring physician signatures on requisitions would accomplish this goal. Rather, the confusion that exists regarding the difference between an order and a requisition and under what circumstances a physician's signature is required is primarily a result of unclear and contradictory language in CMS manuals and related correspondence, which we believe could be addressed without mandating an additional and repetitive policy requiring a physician to sign all requisitions.

**The proposal would significantly increase administrative burden for both physicians and hospital laboratories,** leading to unnecessary duplication of effort as a physician would have to sign both the original order in the patient's medical record as well as the requisition. For instance, in many physician offices, office employees collect laboratory specimens from patients based upon the physician's charted orders and use pre-printed requisition forms for specifying the required tests. Imposing a new requirement that the physician also sign the requisition layers another redundant process upon the implied approval gained through on-site office specimen collection and the use of the pre-printed requisitions. The proposed policy also would create additional and unnecessary administrative burden in skilled nursing facilities, where staff would have to obtain physician signatures for daily laboratory orders and for urgent requests, without any patient benefit or improvement in the order validation process.

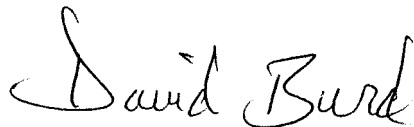
**At a time when more providers are using electronic health records and electronic signatures, imposing redundant signature requirements is burdensome, unnecessary and does not benefit patient care.** Many hospital and reference laboratories utilize electronic systems in which physician orders are entered from the patient's medical record or from a signed written order, resulting in an electronic requisition. This requisition is transmitted directly to the hospital's laboratory to initiate testing. Since most physicians do not yet utilize electronic physician order entry, a requirement to have the ordering physician sign the resulting requisition would be tremendously burdensome and could result in delays in testing for beneficiaries.

If CMS' proposed policy is finalized, unsigned requisitions would place the hospital laboratory in the unreasonable position of either having to delay providing the testing service in order to obtain a physician signature or being unable to bill for the services rendered. Delaying testing would conflict with the laboratory standard of care, which requires that once a written request is received, regardless of whether it is signed by the ordering physician or not, the laboratory is obligated to perform the test immediately. Immediate testing is in the patient's best interest and, ultimately, is a quality of care issue, as laboratory specimens tend to degrade over time.

**Instead of creating an unnecessary, redundant and burdensome new requirement for physician signature on requisitions, CMS should carefully review and resolve the inconsistencies and ambiguous language in its Medicare manuals.**

The NHA appreciates the opportunity to submit these comments on the proposed rule. If you have any questions about these comments, please feel free to contact me at (402) 742-8144 or [dburd@nhanet.org](mailto:dburd@nhanet.org).

Sincerely,

A handwritten signature in cursive script that reads "David Burd". The signature is written in black ink and is positioned below the word "Sincerely,".

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