American Occupational Therapy Association

AOTA Proposal: Limit PFS Redistribution to Providers Who Bill E/M Services

In the 2020 Physician Fee Schedule (PFS) Final Rule, CMS stated that it will accept the RUC-recommended work values for the revised office/outpatient E/M visit codes without refinement for 2021. In the PFS proposed rule CMS cite the Medicare Payment Advisory Commission's (MedPAC's) "long-standing concerns that office/outpatient E/M services are undervalued in the PFS," and "that the office/outpatient E/M code set has become passively devalued as values of these codes have remain unchanged, while the coding and valuation for other types of services under the fee schedule have been updated to reflect changes in medical practice."

In MedPAC's September 2019 letter to CMS, it said "This mispricing may lead to problems with beneficiary access to these services and, over the longer term, may even influence the pipeline of physicians in specialties that tend to provide a large share of E/M services." The proposed redistribution of the fee schedule is widely seen as an effort to shift money from higher paid physician specialists to primary care physicians.

Yet, it is critical to emphasize that the CMS proposal also substantially cuts many non-physician providers, including occupational therapists, who are not allowed to bill E/M services by virtue of the fact that E/M codes are reserved for billing only by physicians. Further, non-physician providers are much lower paid than even primary care physicians, making the redistribution of up to a potential 8% cut to providers like occupational therapists particularly troubling.

Medical Specialty[1]	**2018/2019 Average Salary Offer**
Cardiologist (Invasive)	$648,000
Orthopedic Surgeon	$536,000
Gastroenterologist	$495,000
Urologist	$464,000
Dermatologist	$420,000
Otolaryngologist	$402,000
Hematologist/Oncologist	$393,000
Radiologist	$387,000
ER Physician	$382,000
OB/GYN	$318,000
Neurologist	$317,000
Psychiatrist	$273,000
Hospitalist	$268,000
Internist	$264,000
Family Medicine Physician	$239,000
Physical Therapist[2]	$67,000
Occupational Therapist[3]	$59,000

[1] Merritt Hawkins; "Physician Starting Salaries by Specialty: 2019 vs. 2018," *Merritt Hawkins*; August 6, 2019. Available from: https://www.merritthawkins.com/news-and-insights/blog/healthcare-news-and-trends/physician-starting-salaries-by-specialty-2019-vs-2018/.
[2] Adkins, William; "Starting Salary of a Physical Therapist," *Chron*; February 12, 2019. Available from: https://work.chron.com/starting-salary-physical-therapist-8447.html.
[3] Lyon, Sarah; "Your Occupational Therapy Salary Guide," *OT Potential*; May 7, 2019. Available from: https://otpotential.com/blog/occupational-therapy-salary-guide.

Remove Providers Who Do Not Bill E/M Codes From the Redistribution

We do not take issue with CMS's desire to better reward primary care physicians with higher E/M volume and who may be seen as undervalued. At the same time, it is entirely inappropriate to substantially cut payments to providers who do not bill E/M codes (and therefore cannot offset any of the procedure cuts) in order to fund this initiative. Charts included in the 2020 PFS show that healthcare professionals who do not bill E/M codes are subject to some of the largest cuts under the CMS proposal. By implementing the new E/M codes value increases within the standard budget neutrality process, lower paid health care professionals bear the brunt of this change, not higher paid specialists. For example, the typical starting salary of an Occupational Therapist is $59,000 while that of a Family Medicine Physician is $239,000 and Internist $264,000.

AOTA proposes limiting the redistribution on the fee schedule to those providers who bill E/M services. Such a policy refinement would exempt 28 provider groups for whom the new codes have no "upside", from the redistribution. The 28 provider groups who do not bill E/M codes represent roughly 21% of fee schedule expenditures (including radiologists and pathologists who are eligible to bill E/M codes but do not bill them). Furthermore, this proposal would still provide for substantial increases for high volume E/M physicians. Under our attached redistribution estimates, physicians who bill E/M codes will see their increase go down by no more than an estimated 1%, while holding harmless non-physician providers who would otherwise see significant decreases.[4] For example, without accounting for the geographic practice cost index (GPCI) Family Physicians would still receive a 4% increase, Endocrinology would receive a 6% increase and rheumatology a 5% increase.

This policy refinement is necessary to ensure patient access to critical services provided by providers, like occupational therapists and physical therapists, who commonly carry out the critical plans of care ordered by primary care physicians for Medicare beneficiaries under the PFS. While the budget neutrality process was not designed to consider issues such as patient access, CMS bears a responsibility to consider the impact of its policies on beneficiaries. As such, shifts in Medicare program payments of this magnitude should not go unexamined. AOTA asserts that the magnitude of this redistribution significantly and unfairly impacts providers who do not bill E/M codes to such an extent that the standard budget neutrality process cannot be applied in this instance. CMS must permit an exception and exempt those providers not eligible to bill these codes.

Reject Add-On Codes

In addition, we are struggling to understand why CMS adopted MedPAC's E/M redistribution recommendation but rejects its assertion that the new add-on code for complex visits (GPCIX) that use additional resources are not necessary. MedPAC appropriately questions how clinicians will document the necessity of this code and the rationale for creating this new add-on code. Further, the creation of this add-on code represents a new policy outside of the standard AMA RUC valuation process, and therefore should not be part of the standard budget neutrality calculation.

[4] Note that the attached redistribution analysis (appendix) do not include the Geographical Price Cost Index, which will have to be applied by CMS as part of its standard budget neutrality calculation.

Legal Authority to Limit Budget Neutrality to Those Providers Who Bill E/M Codes

AOTA asserts that the Centers for Medicare and Medicaid Services (CMS) has the legal and statutory authority to apply a budget neutrality calculation only to those providers who bill Evaluation and Management (E/M) codes. The Social Security Act statute does not prohibit CMS from limiting application of the fee schedule distribution intended to increase payments for E/M services to those providers who perform and bill such services. Section 1848(c)(6) specifies that the "Secretary may not vary the conversion factor or the relative value units for a physicians' ***service*** based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician". This means that the key factor in determining the statutory requirements is the definition of a "service"**.**

Throughout the statute, the term "service" is used to identify what was specifically performed. The definition of service is typically equated to the corresponding HCPCS/CPT code. As such, CMS has the authority to create a distinction between different CPT codes (services) in different ways. **While CMS cannot vary a physician's "service" payment based on *specialty*, the statute does not prohibit varying the manner in which it applies budget neutrality to *different services*.** CMS has the authority to create a distinction between different CPT codes, but cannot vary payment for CPT codes by specialty. As such, CMS can limit the services included in the calculation of budget neutrality, to those services billed by providers who bill evaluation and management services (as related to the application of budget neutrality to account for the increased payments for E/M services).

In fact, the following example provides a CMS precedent for such an approach.

On page 37241 of the Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology; Notice published on June 29, 2006, CMS applied budget neutrality only to work RVUs "because the need for a budget neutrality adjustment would be largely due to changes proposed as a result of the 5-Year Review of work RVUs."[5]

In this precedent, CMS treats different sets of CPT codes differently. It explains that the decision was made in order to be more equitable, and **to exempt those services that were essentially unintended consequences of a policy that involved only services with work RVUs.** This situation is analogous to the current situation, where we are asking CMS to exempt providers that do not bill E/M services because of the negative unintended consequences to certain providers of the decision to drastically increase the values of outpatient E/M services, which overall impact such a large volume of the fee schedule. This decision shows that CMS **can** exempt specific services from budget neutrality and has previously acted upon that authority when budget neutrality did not yield equitable results.

While CMS cannot vary payment for an individual service (or CPT code) based on specialty, the statute does not prohibit varying how it applies budget neutrality to different services (CPT codes in this case). AOTA is asserting that CMS can limit the services included in the calculation of budget neutrality (for purposes of implementing the new E/M policy) to those codes/services performed by providers who bill evaluation and management services. **In other words they can exempt those services billed *predominately* by specialties who do not bill E/M services.**

AOTA acknowledges that this proposal would require CMS to conduct a code-by-code analysis to determine if a particular service/code is billed predominately by specialties who do not bill E/M services,

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[5] Center for Medicare & Medicaid Services. (2006). the Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology; Notice. Federal Register, 71(125), 37169–37430.

and therefore can be exempted from the budget neutrality calculation. In that regard, AOTA reviewed the 2018 specialty billing by CPT codes and recommends that CMS exempt those services (codes) that are billed predominantly (e.g. 75% of the time or more) by providers that do not bill E/M codes. This approach honors the CMS policy of supporting the E/M code increases, while at the same time holding harmless those practitioners who have no "upside" because they do not bill E/M codes, and who would otherwise face up to an 8% cut to Medicare Part B services in 2021.

AOTA further acknowledges that when the services described above (those exempted from the budget neutrality calculation) are billed by practitioners who also bill E/M codes, the payment rate would be the same as when that service is billed by a practitioner who does not bill E/M codes. This is because the statute does not allow the payment rate for a given service (or code) to vary by specialty.

In conclusion, even if there was no precedent, CMS should use its authority to implement the budget neutrality policy in a manner that will achieve:

1. The policy goal of shifting resources from higher paid specialists to lower paid primary care physicians, while
2. Limiting the unintended consequences of substantially cutting payments of lower paid non-physician providers that are not eligible to bill E/M codes.

Appendix

In order to help determine solutions and options for mitigating the negative effects of utilizing the budget neutrality process to implement the new E/M codes, AOTA contracted with Dobson|DaVanzo Health Economics Consulting (D|D) to model the CMS budget neutrality process as closely as possible.

Column 2: Represents the CMS Table 124 projected impact of the new E/M codes after budget neutrality is applied.

Column 3: Represents the projected value changes for each specialty under budget neutrality as modeled by D/D, but does not account for the adjustments that CMS would make based on the geographic practice cost index.

Column 4: Represents the projected value changes for each specialty **when those providers who do not bill E/M codes are removed from the budget neutrality calculation**, as modeled by D/D but does not account for the adjustments that CMS would make based on the geographic practice cost index. *Note, this calculation includes removing radiologists and pathologists from the budget neutrality calculations.

Column 5: Represents the percentage change to payments by specialty if the AOTA proposal to remove providers who do not bill E/M codes from the budget neutrality calculation were followed.

Column 6: Represents the projected value changes for each specialty **when those providers who are not eligible to bill E/M codes are removed from the budget neutrality calculation**, as modeled by D|D but does not account for the adjustments that CMS would make based on the geographic practice cost index. *Note, this calculation does not remove radiologists and pathologists from the budget neutrality calculations.

Column 7: Represents the percentage change to payments by specialty if the AOTA proposal to remove providers who are not eligible to bill E/M codes from the budget neutrality calculation were followed.

Specialty	**Table 124 Impact**	**Approximation of CMS Proposal (without GPCI)**	**Removing Providers who do not bill E/M (without GPCI)**	**Difference**	**Removing Providers not eligible to bill E/M (without GPCI)**	**Difference**
Allergy/ Immunology	6%	2%	1%	-1%	1%	-1%
Anesthesiology	-4%	-3%	0%	3%	0%	3%
Audiologist	-4%	-3%	0%	3%	0%	-3%
Cardiac Surgery	-5%	-2%	-3%	-1%	-2%	0%
Cardiovascular Disease (Cardiology)	1%	0%	-1%	-1%	0%	0%
Chiropractic	-7%	-3%	0%	3%	0%	3%
Clinical Psychologist	-4%	-3%	0%	3%	0%	3%
Clinical Social Worker	-4%	-3%	0%	3%	0%	3%
Colorectal Surgery (Proctology)	-1%	-1%	-2%	-1%	-1%	0%
Critical Care (Intensivists)	-3%	-2%	-2%	0%	-2%	0%
Dermatology	2%	0%	-1%	-1%	0%	0%
Diagnostic Testing Facility	-3%	-3%	0%	3%	0%	3%
Emergency Medicine	-4%	-2%	-3%	-1%	-3%	-1%
Endocrinology	10%	7%	6%	-1%	6%	-1%

Family Practice	7%	5%	4%	-1%	5%	0%
Gastroenterology	-1%	0%	-1%	-1%	0%	0%
General Practice	5%	3%	2%	-1%	3%	0%
General Surgery	-2%	-1%	-2%	-1%	-2%	-1%
Geriatrics	2%	0%	1%	1%	1%	1%
Hematology-Oncology	8%	5%	4%	-1%	5%	0%
Independent Laboratory	-2%	-3%	0%	3%	0%	3%
Infectious Disease	-3%	-1%	-2%	-1%	-1%	0%
Internal Medicine	2%	2%	1%	-1%	2%	0%
Interventional Pain Management	4%	2%	1%	-1%	1%	-1%
Interventional Radiology	-4%	-3%	-4%	-1%	-3%	0%
Nephrology	-1%	-1%	-2%	-1%	-1%	0%
Neurology	6%	1%	1%	0%	1%	0%
Neurosurgery	-3%	-2%	-2%	0%	-2%	0%
Nuclear Medicine	-2%	-3%	-3%	0%	-3%	0%
Nurse Anest./ Anest. Asst.	-6%	-2%	0%	2%	0%	2%
Nurse Practitioner	4%	3%	2%	-1%	3%	0%
Obstetrics & Gynecology	4%	2%	1%	-1%	2%	0%
Occupational Therapist in Private Practice	-5%	-3%	0%	3%	0%	3%
Ophthalmology	-7%	-2%	-3%	-1%	-2%	0%
Optometry	-2%	-3%	-1%	2%	-1%	2%
Oral Surgery	-1%	-2%	-2%	0%	-2%	0%
Orthopedic Surgery	1%	0%	-1%	-1%	0%	0%
Otolaryngology	3%	1%	0%	-1%	1%	1%
*Pathology	-5%	-3%	0%	3%	-3%	0%
Pediatric Medicine	3%	2%	1%	-1%	2%	0%
Physical Medicine	0%	0%	-1%	-1%	0%	0%
Physical Therapist in Private Practice	-5%	-3%	0%	3%	0%	3%
Physician Assistant	4%	2%	2%	0%	2%	0%
Plastic and Reconstructive Surgery	-2%	-1%	-2%	-1%	-2%	-1%
Podiatry	4%	0%	0%	0%	1%	1%
Portable X-Ray Supplier	-3%	0%	0%	0%	0%	0%
Psychiatry	3%	3%	2%	-1%	2%	-1%
Pulmonary Disease	1%	0%	0%	0%	0%	0%
Radiation Oncology	-2%	-3%	-3%	0%	-3%	0%
*Radiology	-5%	-3%	0%	3%	-3%	0%

Registered Dietitian or Nutrition Professional	-2%	-3%	0%	3%	0%	3%
Rheumatology	9%	6%	5%	-1%	5%	-1%
Speech Language Pathologist	-2%	-3%	0%	3%	0%	3%
Thoracic Surgery	-5%	-2%	-3%	-1%	-2%	0%
Urology	5%	2%	1%	-1%	2%	0%
Vascular Surgery	-3%	-2%	-3%	-1%	-2%	0%