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August 28, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1590-P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013; Proposed Rule (Vol. 77, No. 146), July 30, 2012

Dear Ms. Tavenner:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our nearly 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) physician fee schedule (PFS) proposed rule for calendar year (CY) 2013.

While we support a number of the proposed rule's provisions, including the coverage of additional Medicare telehealth services and the more expansive definition of group practice, we have concerns about CMS's proposed implementation of the outpatient therapy G-codes and modifiers. In addition, we are deeply concerned that physician payments will decline by an estimated 27 percent on January 1, 2013 due to the flawed sustainable growth rate formula. Cuts of this magnitude are unsustainable. **We urge CMS to work with Congress to fix the flawed physician payment formula, and to do so in a manner that does not result in reduced payments to hospitals and other providers.** Our detailed comments follow.

OUTPATIENT THERAPY SERVICES

The AHA supports CMS gathering information to develop a long-term replacement to the current arbitrary payment limits (or "caps") on Medicare therapy services, but the agency's proposal is overly complex and burdensome. Beginning Jan. 1, the *Middle Class Tax Relief and Job Creation Act of 2012* requires CMS to implement a claims-based data collection strategy



designed to assist in reforming the Medicare payment system for outpatient therapy services – physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP). CMS is required to collect data on patient function during the course of therapy services in order to better understand patient condition and outcome. The agency proposes that hospitals and other therapy providers include non-payable G-codes and modifiers on the claim to capture data on a beneficiary’s functional limitations at the outset of the outpatient therapy episode, at specified points during treatment, and at discharge. Additionally, the therapist’s projected goal for functional status would be reported on the first claim and periodically throughout the episode.

Non-Payable G-Codes on Beneficiary Functional Status. The AHA recommends that therapists be required to report only a patient’s primary functional limitation; reporting secondary functional limitations should be optional, especially during the early years of the new requirement. Hospital outpatient therapy departments treat very complex patients with multiple comorbidities and functional limitations. These patients often receive therapy services over an extended period of time. It would be costly, time intensive and burdensome to report numerous secondary functional limitations. This burden is magnified given reporting would be required at multiple times throughout the therapy episode. In addition, secondary functional limitations may become primary functional limitations as therapy progresses, adding an additional layer of complexity to claims reporting. The AHA recommends that therapists report only one primary functional limitation for each discipline (PT, OT and SLP) for each patient. Any secondary functional reporting should be optional at this time.

Severity/Complexity Modifiers. We encourage CMS to consider eliminating its severity/complexity modifiers as it is unlikely they would yield valid, reliable and meaningful information. CMS proposes to require therapists to use a modifier to report the severity or complexity for each functional limitation (primary and secondary) using the 12-point scale below:

Modifier	Impairment Limitation Restriction Difficulty
XA	0%
XB	Between 1-9%
XC	Between 10 - 19%
XD	Between 20 - 29%
XE	Between 30 - 39%
XF	Between 40 - 49%
XG	Between 50 - 59%
XH	Between 60 - 69%
XI	Between 70 - 79%
XJ	Between 80 - 89%
XK	Between 90 - 99%
XL	100%

Therapists would be required to translate data from an assessment tool of their choosing to CMS’s severity modifier scale. The AHA is concerned that the proposed modifiers are too cumbersome and subjective. However, if CMS proceeds with this requirement, we encourage the agency to

reduce the number of levels to a more reasonable number of five or seven. Twelve levels are too numerous.

The AHA also is concerned about the number of different instruments therapists may use to translate an assessment tool's score to a percentage. We question whether therapists will be able to do this with any sort of consistency, accuracy or reliability. The AHA encourages CMS to find a better way of identifying whether a patient is complex, such as use of evaluation and management (E/M) codes or comorbidities. Although we do not recommend requiring the use of a single assessment tool at this time (as one instrument does not currently exist to meet the diverse needs of patients receiving therapy services), the AHA would support CMS formally endorsing certain assessment tools to move the field toward greater standardization.

Adaptation for G-Codes by Select Categories of Functional Limitations. The AHA strongly urges CMS not to collect **both** category specific-reporting codes and generic reporting codes on therapy services, which would add to the confusion and complexity of CMS's proposed new system. CMS seeks input whether it should collect category specific-reporting in addition to generic reporting so that it may more easily gather data based on type of functional limitation. The agency would identify six specific G-codes to be used at the outset of the outpatient therapy episode, at specified points during treatment, and at discharge (GXXX8-GXXX22) for: walking and moving around; changing and maintaining body position; carrying, moving and handling objects; self-care; communication: reception; and communication: expression. The AHA could support reporting on a subsection of select categories, given the burden and complexity of reporting primary and secondary functional limitations on all therapy claims. This smaller population would allow CMS to better assess whether the new G-codes and modifiers will yield information that is valid, reliable and adequate enough to develop an alternative payment system for therapy services. Alternatively, we would recommend CMS wait to implement functional impairment category reporting.

Reporting Frequency. The AHA recommends requiring claims-based reporting only at the outset of a therapy episode and at discharge. At the onset of this program, we recommend that the agency follow a simplistic approach and not require interim reporting. If CMS proceeds with interim reporting, however, we support its proposed timeframe of at least once every 10 treatment days or at least once during each 30 calendar days, whichever time period is shorter. The 10/30 reporting timeframe is consistent with current requirements for clinician progress reports and billing requirements for hospitals.

Implementation Date. The AHA applauds CMS for proposing a testing and transition period to the new claims-based reporting system. Congress mandated that this provision be implemented Jan. 1, and smartly, the agency is proposing that implementation begin with a testing period from Jan. 1 through June 30, 2013 to help providers transition to the system. Beginning July 1, 2013 hospitals and other providers must include the appropriate G-codes and modifiers on the claim to receive Medicare payment. While we greatly appreciate CMS's proposal to delay full implementation of this provision for six months, we are concerned this timeframe may not be long enough to ensure appropriate provider education and training. Additionally, we are unsure whether six months is sufficient time for Medicare contractors to alter their systems so that they

can receive multiple modifiers on the therapy claim. The AHA recommends that CMS test the new system for the first six months of the calendar year, and then evaluate whether appropriate reporting and claims processing are occurring. If so, then CMS could begin full implementation after nine months, or October 1, 2013.

Additionally, the AHA supports a phased-in approach to the new reporting requirements.

We believe that the agency should simplify the process and begin with a smaller set of patient data. This would allow CMS to more easily make modifications to the program before moving to the next stage of implementation. It also would allow time for CMS to gather and analyze therapy data to determine whether they are sufficient to better understand improvements in patient condition and outcome, and, whether the data collected would help CMS develop an alternative payment system for therapy services.

POST-DISCHARGE CARE MANAGEMENT

The AHA applauds CMS for acknowledging the critical importance of care transitions, especially from the hospital back into the community, as a means of achieving better health, better health care and greater efficiency. CMS proposes to create a new G-code to explicitly pay community physicians and qualified non-physician practitioners (NPPs) for post-discharge transitional care management services in the 30 days following an inpatient hospital (acute care, psychiatric, long-term care, inpatient rehabilitation), outpatient observation or partial hospitalization, skilled nursing facility (SNF) or community mental health center stay. The AHA supports the creation of this code as it will help improve care coordination, and potentially decrease unnecessary emergency room visits and hospital readmissions.

The AHA supports CMS's proposal to include the broader multidisciplinary team in the care management process. CMS proposes to use the new code for non-face-to-face services related to the transitional care management services furnished by a community physician or NPP, or by clinical staff members or office-based care managers under their supervision. We are pleased that CMS's definition would allow the broader multi-disciplinary care team to engage in providing these services. Medical assistants, care navigators, social workers and "health coaches" are often the team members telephoning patients to assist with follow-up appointments, prescription refills, insurance inquires and numerous other social issues. These conversations are critical to ensuring a smooth care transition.

The AHA urges CMS to allow use of the G-code in the 30-day period following each patient discharge. CMS proposes that the community physician or qualified NPP reporting a transitional care management G-code must have billed a face-to-face E/M visit for that patient within 30-days prior to the hospital discharge (the start of the post-discharge transitional care management period), or must conduct an E/M office/outpatient visit within the first 14 business days of the 30-day post discharge period of transitional care management services. We support this proposed timeframe. However, CMS proposes that the G-code would be payable only once in the 30-day period following discharge. We seek clarification of how providers would bill this G-code for patients who have been readmitted to a hospital or SNF. For example, if a patient is discharged

from a hospital on July 1, but then readmitted on July 15 and discharged on July 20, would the physician be able to bill the G-code only once for the time period from July 1-July 15? Would the physician be able to bill an additional post-discharge care management code after the July 20 discharge? Would the physician need to wait until July 31 (completion of the original 30-day cycle)? We recommend CMS “restart the clock” to allow providers to bill and be reimbursed for care coordination services provided after each patient discharge. Beneficiaries with hospital readmissions are often the most complex patients with significant medical and/or psychosocial problems that require more intensive services during transitions in care. It is these beneficiaries where a successful transition could avoid an unnecessary readmission or subsequent illness, thus improving beneficiary outcomes and avoiding unnecessary costs to the health care system.

The AHA urges CMS to work with Congress to waive the beneficiary copayment for post-discharge care management services. We are extremely concerned that beneficiaries will not understand their coinsurance liability for this service given that the proposed new post-discharge transitional care management code would not include a face-to-face visit. Rather, the physician or NPP would bill and be paid for these services separately from a medical visit without seeing the patient. We also are concerned that this would lead to increased bad debt for the physician. We urge CMS to work with Congress to waive beneficiary cost-sharing responsibilities for post-discharge transitional care management services, similar to how the *Patient Protection and Affordable Care Act (ACA)* waived beneficiary cost-sharing for certain approved preventive services. If the law is not changed, then CMS must provide beneficiaries with significant education about this provision. This should include agency materials that physicians may distribute to patients during their 30-day prior/14-day post face-to-face visit, explaining the new code and a beneficiary’s 20 percent coinsurance responsibility.

Finally, the AHA encourages CMS to re-examine the relative value of the hospital discharge billing codes to ensure they appropriately reimburse for comprehensive care coordination services at discharge. Under current PFS policy, care coordination is a component of E/M services, with the pre- and post- non-face-to-face care management bundled in the calculation of the E/M rate. While not stated explicitly, CMS suggests that this E/M payment rate is not high enough to capture all care coordination activities performed by community physicians. Hence it proposes to create a separate payable G-code for such things as: obtaining and reviewing the discharge summary; reviewing diagnostic tests and treatments; updating the patient’s medical record to incorporate changes in health conditions and treatments; assessing the patient’s health status; and communicating (direct contact, telephone, electronic) with the beneficiary and/or caregiver.

Currently, discharging physicians use an E/M hospital discharge management code (CPT 99238 or 99239) to bill for the care coordination services required to discharge a beneficiary. CMS indicates that payment for this code is adequate to reflect the discharging duties of the physician. The AHA disagrees. As the average hospital stay decreases, the role of the hospital discharge planning process has become more critical and complex. Yet the relative-value units and corresponding payment for the hospital discharge management code have not increased over time. According to CMS’s new Internet look-up tool that provides Medicare PFS payment information

over time, the average national payment amount for CPT 99238 is \$69.78, and this rate has not changed since 2002.

While the AHA appreciates and supports an enhanced payment for community physicians to provide care coordination services on the receiving end, a corresponding increase in payment to those physicians who are discharging patients is critical. Successful transitions rely on both the discharging and receiving physicians and NPPs to communicate and coordinate a patient's care.

CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNA) AND CHRONIC PAIN MANAGEMENT SERVICES

The AHA supports CMS's efforts to establish a consistent national policy among all Medicare contractors as to whether Medicare will reimburse CRNAs directly for chronic pain management services. Since 1989, CRNAs have been eligible to bill Medicare directly for "anesthesia services and related care." Questions have arisen as to whether this includes chronic pain management services separate and distinct from a surgical procedure. Recently, certain Medicare contractors determined that they would no longer reimburse CRNAs directly for furnishing chronic pain management services to Medicare patients, and began to request recoupments from CRNAs performing certain pain management services. Since Medicare regulations and other guidance materials currently do not speak specifically to this issue, and given Medicare contractors have reached different conclusions as to whether the statutory description of "anesthesia services and related care" encompasses chronic pain management services delivered by CRNAs, it is critical for CMS to put forth clear regulations and guidance on this matter.

The AHA is concerned that CMS's proposed regulatory revisions would result in greater confusion among Medicare contractors. In its rule, CMS proposes to revise its regulations to more clearly explain what is meant by the statutory reference to "anesthesia services and related care" for Medicare coverage purposes. Specifically, the agency proposes to add the following language:

"Anesthesia and related care includes medical and surgical services that are related to anesthesia and that a CRNA is legally authorized to perform by the State in which the services are furnished."

However, this language does not adequately address coverage of chronic pain management services. In fact, as written, the proposed language appears to make CRNA services *more* restrictive. The language suggests that only those medical and surgical services directly related to anesthesia would be covered. Yet, CMS has acknowledged that chronic pain management services are often not related to anesthesia services. Thus, the proposed new language appears to be in direct contrast to the rule's preamble, which suggests that CMS's intent in changing the regulation is to signal that Medicare would cover chronic pain management services furnished by CRNAs only in states where CRNA scope of practice specifically includes such services.

The AHA believes that if state law allows CRNAs to perform certain services, than Medicare should directly reimburse CRNAs for these services. CMS defers to state scope of practice laws to determine those services that a clinician is legally authorized to perform in the state. Certain states have determined that the scope of practice for a CRNA should include chronic pain management in order to meet the health care needs of their residents. Many rural hospitals, particularly critical access hospitals, rely on CRNAs to provide anesthesia and pain care in the community. A 2011 Institute of Medicine report, “Relieving Pain,” found that more than 100 million Americans suffer from chronic intractable pain and that there are not nearly enough health care professionals available to assess and care for these patients effectively. Many rural communities have a shortage of physicians, including anesthesiologists. To ensure that CRNAs can directly bill and be reimbursed for services determined by the state to be within their scope of practice, the AHA recommends that CMS change its proposed language to state:

“Anesthesia and related care includes medical and surgical services that are related to anesthesia or that a CRNA is legally authorized to perform by the State in which the services are furnished [emphasis added].”

PHYSICIAN VALUE-BASED MODIFIER (VBM)

Beginning in January 2015, the ACA requires CMS to adopt a budget-neutral VBM for groups of physicians to evaluate physicians’ quality of care compared to cost. By January 2017, all physicians who bill under the PFS must participate in the VBM program to receive Medicare payment. CMS proposes to include only groups of physicians with 25 or more eligible professionals (EPs) in the CY 2015 VBM program. CMS proposes to give physician group practices that successfully participate in the CY 2013 physician quality reporting system (PQRS) the *option* of participating in the CY 2015 VBM program. For those groups that elect to participate in the CY 2015 VBM program, a maximum of 1 percent of their Medicare PFS payments would be placed at risk. The agency proposes to automatically penalize group practices that have not successfully participated in the PQRS with the maximum proposed penalty (1 percent) for the CY 2015 VBM program. This penalty would be in addition to the 1.5 percent penalty that will be applied for failure to satisfactorily report quality measures under PQRS. Therefore, for CY 2015, the total penalty for physician group practices that do not successfully participate in PQRS would be 2.5 percent.

The AHA urges CMS to develop a VBM program option that is specifically tailored to hospital-based physicians. CMS seeks comment on whether it should develop a VBM option specifically for hospital-based physicians. The agency suggests that these physicians could elect to be assessed based on the performance of the hospital at which they are based. Today, hospitals employ 212,000 physicians, representing about 20 percent of those practicing. This is a 32 percent increase over the past decade. In addition to direct employment, hospitals contract with a number of physicians on a group or individual basis, such as emergency physicians or hospitalists. For hospitals, greater physician integration represents the potential to better align goals and processes across the care continuum. Given numerous legal and regulatory barriers to clinical integration, hospitals are not able to align incentives with physicians to improve quality and

efficiency. Thus, we are pleased that CMS specifically seeks comment on developing a VBM program for hospital-based physicians and the AHA strongly encourages CMS to pursue this option. Aligning the physician VBM program for hospital-based physicians with the hospital value-based purchasing (VBP) program would be desirable and will accelerate performance improvement by jointly focusing provider efforts.

In developing a VBM program for hospital-based physicians, the AHA supports CMS's willingness to use data from both the inpatient and outpatient quality programs. For hospital-based physicians, it is critical that CMS consider the quality measures that hospitals are required to report under the Medicare inpatient prospective payment system (PPS) and outpatient PPS. The inpatient measures have been in place for more than a decade and are well developed. While the outpatient measures have been adopted more recently, hospitals, and thus hospital-based physicians, are currently focused on reporting these measures and improving their performance. Including the hospital-based measures is a positive step forward in aligning the incentives between hospitals and physicians, which would lead to improved quality and efficiency.

The AHA recommends that CMS wait to implement a VBM program for hospital-based physicians until CY 2017, as allowed by law. There are many issues and details to resolve before the VBM program can be successfully applied to hospital-based physicians. Waiting until CY 2017 would allow CMS to use the CY 2014 PFS proposed rule to solicit public comment on the inpatient and outpatient PPS quality measures that are most appropriate to target for hospital-based physicians in the VBM program. In addition, it would give CMS the opportunity to consult with hospitals, hospital-based physician specialty societies and other stakeholders in designing such a program.

The AHA urges CMS to allow physicians and groups to self-designate whether they qualify as hospital-based. For the Electronic Health Record (EHR) Meaningful Use (MU) program, Congress has defined hospital-based EPs as those providing 90 percent or more of their services in an inpatient or emergency department. Under this definition, approximately 15 percent of physicians are designated as "hospital-based." This definition has been problematic, however, because it excludes certain hospital-based physician specialties. Rather than default to the MU methodology, we recommend CMS allow physicians to self-designate that they are hospital-based and, correspondingly, to allow hospitals to confirm this relationship. CMS could allow physicians to self-designate hospital-based status through a process that is similar to how physician group practices currently self-designate for the PQRS program. If needed, the agency could set parameters that ensure a strong relationship between a physician and hospital. For example, CMS could require active membership on the medical staff or an employment contract. The agency could utilize claims data elements, such as inpatient and hospital outpatient department place of service codes, to validate the relationship.

While developing the VBM program for hospital-based physicians, the AHA urges CMS to exclude hospital-based physicians from any additional performance-based penalties. The majority of hospital-based physicians have reassigned their benefits to hospitals and health systems through employment models. For these employed physicians, a portion of their income is likely tied to the performance of the hospital or health system. In 2015, approximately 10 percent

of Medicare inpatient PPS payments will be at risk due to the inpatient quality reporting, hospital VBP, readmissions, hospital-acquired conditions, and meaningful use of EHR incentive programs. An additional 1 percent cut to hospital-based physicians for not reporting PQRS measures is not warranted.

The AHA urges CMS to adopt the total performance score (TPS) option presented in its VBM program to align methodologies with the hospital VBP program. CMS proposes two different models for scoring measurement domains in the VBM program. CMS will either choose a “quality-tiering model” (QTM) or TPS to derive a score for physicians in the VBM program. In order to best align the hospital VBP program with the physician VBM program, we recommend that CMS choose the TPS option. Or, alternatively, choose this option for hospital-based physicians. Utilizing the TPS model for hospital-based physicians would not only create a consistent path to achieve a common goal, it also would serve to reduce burden by focusing on a similar methodology.

PHYSICIAN QUALITY REPORTING SYSTEM

Definition of Group Practice. The AHA applauds CMS’s proposal to define group practice as two or more EPs. For CY 2012, CMS changed its definition of group practice to include 25 or more EPs. We are pleased that CMS is now proposing to revert back to its original CY 2011 definition of group practice, or that of two or more EPs. This would allow smaller group practices the option of reporting PQRS data through the group practice reporting option (GPRO). This option is the most user-friendly method of data submission and results in the fewest errors. Eligible providers in these smaller groups would no longer be forced to report individuals through claims-based or registry reporting. We support CMS’s proposed change to the definition of group practice and urge CMS not to make any additional changes to this definition in the near future. The agency has defined group practice differently each year, for the past four years, which has added a layer of complexity, confusion and frustration for many EPs participating in the PQRS.

PHYSICIAN COMPARE WEBSITE

The AHA recommends that CMS wait until 2015 to publicly report patient experience data on *Physician Compare*. In the rule, CMS proposes to publicly report patient experience data for all group practices (defined as two or more EPs) participating in the 2013 PQRS GPRO as well as accountable care organizations (ACOs) participating in the Medicare Shared Savings Program beginning in 2014. CMS would administer and collect the survey data based on a sample of group practices’ beneficiaries. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures would be:

- CAHPS: Getting Timely Care, Appointments and Information
- CAHPS: How Well Your Doctors Communicate
- CAHPS: Patients’ Rating of Doctor
- CAHPS: Access to Specialists

- CAHPS: Health Promotion and Education
- CAHPS: Shared Decision Making (for ACOs only)

The agency also solicits comments on whether it should wait until 2015 to publicly report patient experience data and use 2014 to provide confidential feedback to group practices and ACOs using 2013 patient experience data.

The AHA supports transparency and the ability of patients to view hospital and physician quality and performance data so they may make informed health care decisions. But we urge CMS to first confidentially share this information with providers before making the data public. This would give physicians the ability to review the data for accuracy, as well as the opportunity to improve their performance before it is publicly reported. In addition, it would allow CMS a year of testing to make sure that its contractors are able to administer, collect and process the survey data timely and accurately.

The AHA urges CMS to adopt measures, including patient-experience of care measures, that reflect how hospital-based physicians deliver care. Many of the CAHPS measures on patient experience of care do not apply to hospital-based physicians, such as hospitalists, anesthesiologists, radiologists, pathologists and emergency medicine physicians. For example, the CAHPS measure *Getting Timely Care, Appointments and Information* is not relevant for these providers. Other measures are often not reflective of the care these physicians provide, such as the CAHPS measures *Access to Specialists* or *Health Promotion and Education*. We strongly encourage CMS to adopt PQRS and other measures that reflect the care provided by all types of physicians.

The AHA recommends customizing a section of the *Physician Compare* website to reflect the unique characteristics of hospital-based physicians. The quality of care and service delivered by hospital-based physicians may be best reflected at the hospital-level rather than the individual practitioner level. We recommend that CMS create a link between the *Physician Compare* and *Hospital Compare*. Specifically, we recommend that hospital-based physicians be easily identified so that patients seeking information about their quality or efficiency may either view results on the *Physician Compare* website or click a link to view these same data for the hospital where the physician practices. This would further harmonize physician and hospital performance reporting.

ELECTRONIC PRESCRIBING (eRx) INCENTIVE PROGRAM

The AHA is pleased that CMS has added additional hardship exemption categories and extended to Jan. 1, 2013 the deadline to request an exemption from the 2013 payment penalty. Previously, CMS finalized a rule allowing EPs or group practices to request a hardship exemption by June 30, 2012 if they met one of the following four significant hardship exemptions:

- Practice in a rural area with limited high-speed Internet access;
- Practice in an area with a limited number of pharmacies with the capability for e-prescribing;

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- Are unable to electronically prescribe due to local, state or federal law; or
- Prescribe fewer than 100 prescriptions during a six-month, payment adjustment reporting period.

In the rule, CMS proposes to add two additional significant hardship exemption categories for the 2013 and 2014 payment adjustment for EPs or group practices who:

- Achieve meaningful use during certain eRx payment adjustment reporting periods; or
- Demonstrate intent to participate in the EHR Incentive Program and adopt certified EHR technology.

To request a significant hardship exemption under the two new categories, the agency proposes that EPs provide their certified EHR technology product number when registering for the EHR Incentive Program or, if not operationally feasible, submit a letter to CMS requesting the exemption. The AHA supports these two additional hardship exemption categories.

CMS proposes that a significant hardship exemption request to avoid 2013 payment penalties would need to be submitted by "October 15, 2012 or the effective date of the final rule for this provision, whichever is later (p. 44986)." Given that the effective date of the final rule is Jan. 1, 2013, we assume this means that the application date is Jan. 1, 2013 and request that CMS clarify the deadline date in its final rule, due out around Nov. 1, 2012.

COLLECTION OF INFORMATION REQUIREMENTS

The AHA recommends CMS re-examine whether it made an error in its proposed requirement that the medical record and the laboratory requisition be signed by the physician or qualified NPP. In a June 30, 2011 proposed rule CMS proposed to retract a policy requiring the signature of a physician or qualified NPP on a requisition for clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule. In the CY 2012 PFS final rule, CMS formally stated that the signature of the physician or NPP is not required on a requisition for a clinical diagnostic laboratory test. Thus, we were surprised to see in the "Collection of Information Requirements" section of this proposed rule a proposal to require "both the medical record and the laboratory requisition (order)" to be signed by the physician or qualified NPP. We believe this is a simple mistake and ask the error be corrected in the final rule.

If you have any questions concerning our comments, please feel free to contact me or Ashley Thompson, director for policy, at (202) 626-2288 or athompson@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President