September 8, 2015

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1631-P
PO Box 8013
Baltimore, MD 21244-8013
Letter Submitted On-Line at www.regulations.gov

RE: CMS-1631-P: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016

Dear Mr. Slavitt:

On behalf of the American College of Nurse-Midwives (ACNM) I am pleased to submit these comments in response to the proposed rule titled "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016," published in the *Federal Register,* on July 15, 2015.[1] We hope that you find our comments helpful and look forward to your response in the final rule.

COMMENT

CMS has proposed to revise the requirements of its incident to policy so that the billing physician or provider must be the supervising physician or provider.[2]

We believe this proposal creates barriers to care for Medicare beneficiaries by greatly complicating scheduling in an average medical practice. For example, in a physician/midwife group, it would not be uncommon for a physician or midwife to be in the clinic 2-3 days per week and on call or at a hospital for a 24-hour shift during the week as well in order to attend births. If a physician or provider initiates a course of treatment for a woman and then is at the hospital when the patient needs to be seen for follow-up, it would be most convenient to permit the patient to be seen by auxiliary personnel in the practice, supervised by another physician or provider whose schedule results in their availability in the clinic. CMS' proposal will thus require more complex scheduling and will curtail the times when patients can be seen.

A significant motivation for physicians or providers to engage in incident to billing is the payment disparity that exists between physicians and other providers. This payment disparity, based on licensure and without any grounds in the clinical data with regard to outcomes of care,

[1] 80 FR 41686
[2] See preamble discussion at 80 FR 41785 and proposed regulatory text at 42 CFR 410.26 found at 80 FR 41952.

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amounts to statutory discrimination and violates the guiding principle for RBRVS that a single payment is established for a single service. We note as well that there is inconsistency with how providers other than physicians are treated, with some receiving 100 percent of physician rates and others receiving a reduced percentage of those rates. We recognize that this arises from statutory provisions that CMS cannot change, however, this situation ought not to be. We encourage CMS to advise the Congress to modify the statute to ensure equitable payment among all providers whose scopes of practice permit them to render a given service.

ACNM has serious concerns with the practice of incident to billing. Specifically, it:

- obscures the rendering provider, which seriously undermines CMS' ability to accurately calculate cost and quality performance and calls into question the agency's ability to operate fair and accurate value-based reimbursement approaches;
- potentially creates patient safety issues because of the discontinuity of care between providers;
- creates the possibility for inadvertent billing mistakes based on misunderstanding of complicated requirements, which can lead to serious penalties for providers;
- creates the possibility for fraud by unscrupulous individuals who choose to not comply with applicable requirements;
- creates liability issues for providers under whose numbers the services are billed, when they did not personally perform those services; and
- prevents providers from being individually responsible and accountable for the care they actually render.

We believe CMS should engage in a concerted effort to gather accurate data allowing an understanding of the extent and nature of incident to billing before proposing any significant changes to its implementation.

Recently ACNM attempted to conduct a study of claims data to determine the cost of midwifery care. In speaking with various data warehouses, one of which had access to the Medicare claims data, we discovered that none of them could definitively say when a certified nurse-midwife or certified midwife had rendered a given maternal care service because the nature of incident to billing confounded the data.

We understand that the current instructions for filling out the HCFA-1500 form require the inclusion of the rendering provider's NPI in box 24J, however, the instructions for box 24J available in both Chapter 26 of the Medicare Claims Processing Manual and from the National Uniform Claim Committee (NUCC) indicate that box 24J could be filled out with the NPI of the "supervising" provider. Specifically, the Claims Processing Manual states that:

> Item 24J - Enter the rendering provider's NPI number in the lower unshaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, **enter the NPI of the supervisor** in the lower unshaded portion [emphasis added].

The NUCC's instructions state that:

> The Rendering Provider is the person or company (laboratory or other facility) who rendered **or supervised** the care [emphasis added]. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b.[3]

We are concerned about the concept of filling out box 24J with the NPI of the provider who supervises care, rather than the one who actually renders the care. We are unsure as to how billers are understanding the language of the NUCC's instructions and we believe it may be resulting in data coming to CMS that does not clearly identify who actually rendered the care.

In addition, there may be multiple lines on a claim form and it will not be possible to know if the rendering provider shown in box 24J was responsible for all lines on the claim or a subset thereof.

We request the opportunity to meet with CMS to discuss specific measures the agency could take to ensure Medicare claims accurately reflect the rendering provider. We specifically recommend that CMS establish a mechanism for clearly identifying, with regard to each line item on the claim, whether it is being billed incident to and the NPI of the actual rendering provider.[4] Without establishing a mechanism to gather this type of clear data, not only will CMS be unable to examine the extent and nature of incident to billing, but also will be unable to use claims data to accurately calculate value-based performance adjusters at a provider-specific level.

CONCLUSION

We thank you for the opportunity to comment on this proposed rule. Should you have any questions regarding our comments, please reach out to me directly.

Sincerely,

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[3] See NUCC instructions available at: http://www.nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2012_02-v3.pdf
[4] We note that the OIG, in the second recommendation of its August 2009 report encouraged the agency to take steps to ensure that an appropriate modifier be used to identify incident to claims. See: OEI-09-06-00430, available at: https://oig.hhs.gov/oei/reports/oei-09-06-00430.pdf