December 29, 2012

Marilyn B. Tavenner  
Acting Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-1590-FC  
P.O. Box 8013  
Baltimore, MD 21244–8013

Re: Re: CMS-1590-FC 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

Dear Acting Administrator Tavenner:

On behalf of our 83,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Final Rule on the revisions to Medicare payment policies under the Physician Fee Schedule for calendar year 2013, published in the November 16, 2012 Federal Register. The APTA has several sections representing various specialties within the profession of physical therapy, including a section on Clinical Electrophysiology. This section represents physical therapists with certification to provide electrophysiologic (EDX) procedures such as electromyography (EMG) and nerve conduction studies (NCS) to evaluate the integrity of the neuromuscular systems. The results of these tests are used by physicians to aid in the diagnosis of patients with neurologic illnesses ranging from common mononeuropathies like carpal tunnel syndrome to devastating disorders like amyotrophic lateral sclerosis (ALS) and muscular dystrophies.

APTA is deeply concerned about the significant cuts in payment ranging from 40-70% to EMG tests and nerve conduction studies that will occur on January 1, 2013 if CMS does not revise its policies. We strongly urge CMS to take immediate action to prevent these drastic cuts from occurring. In the final 2013 physician fee schedule rule, CMS set forth work relative value units and practice expense relative value units that significantly lower the values for the newly rebundled 7 levels of nerve conduction studies, CPT codes (95907-95913). In addition, CMS rejected and changed the work relative value units for
electromyography CPT codes (95886 and 95887), resulting in severe payment cuts for these codes.

Given the magnitude of these cuts and the detrimental impact they will have on patient care, we strongly recommend that CMS take immediate action to stop these draconian payment cuts. If CMS believes that it is not feasible to completely halt these cuts in 2013, we recommend that CMS transition in the new payment rates for the nerve conduction codes over the next four years to allow time to reexamine the values for these codes during that time frame, and convene a refinement panel this year to discuss these codes. In addition, we recommend that CMS accept the RUC recommended values for CPT codes 95886 and 95887. We recognize that we are asking for an extraordinary solution but this is an extraordinary circumstance given the devastating impact on patients and providers.

I. The 2013 payments reductions recommended by CMS will have a detrimental impact on Medicare patients served by physical therapists and other providers who perform EDX procedures

The reduction in the reimbursement for nerve conduction studies by 40%-70% will have a significant, negative impact on patients and will adversely affect access to care for Medicare beneficiaries. Nerve conduction studies, performed by qualified physical therapists, neurologists, and physical medicine and rehabilitation (PMR) physicians, are essential in the diagnosis of conditions such as ALS, muscular dystrophy, carpal tunnel syndrome, neuropathy, and radiculopathies. CMS indicates in its final rule that the recommended payment cuts only would impact neurologists by negative 7% and PMR physicians by negative 4%; however, these numbers are not an accurate reflection of the impact of these payment cuts. CMS draws conclusions regarding the impact based on an analysis of the entire population of neurologists and PMR physicians, including those who do not perform any of electrodiagnostic tests in their practices. In fact, approximately 40% of neurologists and 55% of PMR physicians perform EMG tests and NCS; therefore, the impact is much greater for those who specialize in EDX testing.

In addition, the magnitude of these cuts will make it near impossible for the majority of physical therapists that perform EDX tests to continue to treat Medicare beneficiaries. Physical therapists who perform these EMG/NCS tests must attain and maintain a rigorous national board certification through ABPTS to become a Medicare provider. This requires a strong dedication focused on electrodiagnostic tests. In fact, most physical therapists that provide these services are in small practices that devote 100% of their practice to EMG and NCS. These small practices face overall cuts of 40%-70%. For those practices that are able to stay open, many are at risk of instituting staff layoffs to survive. Fewer practices and providers to perform these services will threaten access for Medicare beneficiaries to receive these services.

Further, many physical therapists are the sole providers of these services in rural areas. Physical therapists performing these tests frequently travel long distances involving overnight stays to reach and properly serve patients in rural areas. In these instances the
physical therapists provide the local referring physicians and critical access hospitals the only access for their patients to EMG/NCS services. These physical therapists often serve a mix of lower income residents and a higher proportion of persons with Medicare and those with medical disabilities. As an example, a recent survey showed that 20 physical therapy practices reached nearly 200 small rural towns across the country. The 2013 payment cuts will cripple the small practices that serve these rural towns, creating a severe patient access issue for EDX services. In some cases, Medicare patients will have to travel up to 3 or more hours to receive these important services. For the elderly, this may preclude access to reasonable and timely services needed to properly diagnose the common and rare neurologic disorders.

As a result of these payment cuts, we expect that there will be delays in diagnosis, incorrect diagnoses of conditions, and an increase in use of more costly methods to determine a diagnosis. With limited access to these tests in the future, we anticipate there will be a natural tendency for the primary care physician to make referrals to alternate expensive and often less effective anatomical type testing. This will result in a rise in the use of imaging, genetic testing, and unnecessary surgeries. The number of MRI, CT, ultrasound and even doppler scans will increase in areas where access is limited to traditional electroneurodiagnostic tests. These anatomical tests show structures rather than function and thus are less sensitive for identifying neurophysiologic abnormalities. Not only is current imaging less specific or unremarkable for use in diagnosis of a neurogenic disorder, using these modalities will result in a higher cost due to a high false negative rating with these applications. In other words, a normal anatomical test finding can also be abnormal on physiological testing. EMG/NCS tests remain the gold standard method for the diagnosis of treatable and terminal neurogenic diseases. Any trend to discourage or minimize the use of these tests will impede quality of care and without a cost savings.

Ultimately, these cuts will have a catastrophic consequence for all patients who depend on providers such as physical therapists, neurologists, and PMR physicians to care for complex and often chronic neurologic diseases. With such drastic impacts on EDX practices, we fear that few providers will be able to continue to provide these important services. This decrease in providers creates concerns of patient access to services that are invaluable in diagnosing and treating diseases such as carpal tunnel, ALS, muscular dystrophy, and neuropathies.

II. The methodology used to determine these values is flawed and therefore the cuts should be stopped or transitioned over the next four years to allow time to reexamine the values of these codes.

Flawed Methodology For Valuing NCS Codes

APTA fundamentally disagrees with the methodology used to value the new NCS CPT codes (95907-95913) for 2013. In the final rule, CMS stated that it found that the progression of the 25th percentile work RVUs and median times from the RUC survey appropriately reflected the relativity of these services. They further state that the two
CPT codes in the nerve conduction series that describe the fewest nerve conduction studies, 979907 and 95908, are the exception to this trend as the 25th percentile work RVUs are too low relative to the other fee schedule services. Based on these assumptions, CMS creates a linear progression of work RVUs as nerve conduction studies increase, assigning CPT code 95907 to a work RVU of 1.00, CPT code 95908 to a work RVU of 1.25, CPT code 95909 to a work RVU of 1.50, CPT code 95910 to a work RVU of 2.00, CPT code 95911 to a work RVU of 2.50, CPT code 95912 to a work RVU 3.00, and CPT code 95913 to a work RVU of 3.56.

CMS concludes that the 25th percentile for all codes except for two is accurate without providing any information that supports this contention. During the RUC process, a decision was made based on clinical expertise that these codes should be valued higher than the 25th percentile of the survey. The RUC used magnitude of estimation to value these codes rather than the survey data as a basis.

CMS’s methodology is flawed because it fails to recognize that as nerve testing increases, the complexity of the patient’s issues do not show a linear progression. In contrast, as the number of nerve conduction studies increase, the issues become exponentially more complex and greater time is involved. For example, when a patient requires 10 or more NCS, that patient could have ALS or another severe neuromuscular disease. It is imperative that the provider utilize the time and clinical expertise necessary to determine the specific issues and impairments prior to making the decision that the patient has a terminal illness. The following case example demonstrates the exponential progress of complexity and time in a patient presenting with numb hands from a simple to very complex case:

**Typical simple case:** A patient with numb hands was referred to a qualified physical therapist to rule out carpal tunnel syndrome. The physical therapist performed an initial NCS of 2 motor and 2 sensory nerves, which confirmed a moderate abnormal median N problem at the wrist. EMG testing confirms the degree and chronicity. In total, 4 NCS were provided along with 1 limb EMG.

**Typical complex case:** A patient with numb hands was referred to a qualified physical therapist to rule out carpal tunnel syndrome. The initial nerve conduction testing of wrist 2 motor and 2 sensory nerves were normal. Then, the physical therapist checks the opposite side with 2 motor and 2 sensory tests, which were also normal. A needle EMG test of both upper limbs finds upper arm changes. A cervical spine paraspinal EMG exam shows abnormalities at the C7 level. The diagnosis changes the clinical focus from the patient’s hands to a neck disorder. In total, 8 NCS were provided along with 2 limb EMG tests.

**Typical more complex case:** A patient with numb hands was referred to a qualified physical therapist to rule out carpal tunnel syndrome. The initial NCS of wrists showed that both the median and ulnar nerve values were abnormal. On testing the opposite side, the physical therapist found the same abnormalities (total 4 motor and 4 sensory nerve tests). As the upper limb findings unfolded
and were nonconclusive, NCS of the lower limbs was needed in order to better interpret the physiologic picture. This also demonstrated abnormal values both proximal and distal in 2 motor + F-wave, 1 H reflex study and 2 sensory studies. An EMG test of the limbs and related paraspinals showed borderline changes in distal limbs. The diagnosis changes from suspected carpal tunnel syndrome to moderate polyneuropathy of undetermined etiology and the focus for treatment changes from the wrists to focus on better management of diabetes or a thyroid disorder. In total, 12 NCS were provided along with 3 limb EMG tests.

As demonstrated in the case examples, the more nerve conduction studies needed for a patient, the greater the severity and the complexity of the patient’s condition and the greater the intensity of the service provided. As the number of nerve tests increases linearly for each 2 nerve code level, the data to review in a real time analysis increases by much more than a factor of 2. This is clearly the case since earlier collected test data must be revisited and compared to the current data being captured and repeated with each nerve test. Also the cognitive work increases as varied diagnosis possibilities must be considered as the referral and provisional diagnosis is either confirmed or ruled out and correct ones are established. In over half the referrals to rural EMG practices where less services and delayed access is common, patients have increased complexity as the incidence of comorbidities increases in the peripheral nervous system of those with poorer health profiles. It is not uncommon to conclude several diagnoses from a single EMG/NCs test encounter. For example, carpal tunnel syndrome is often superimposed on symptoms related to C6/C7 radiculopathy and polyneuropathy in many persons having otherwise good health. The challenge in EMG/NCs testing is to identify the generator of the patients presenting symptoms in order to institute the correct treatment.

The new codes bundle nerve conduction studies that are provided together on the same date of service. During the RUC deliberations, it was recognized that certain efficiencies in practice costs occur when services are bundled together and therefore the RUC recommended a 9% decline in physician work RVUs from the current reporting of these services. However, CMS further increased these cuts in the physician work by an additional 27% from the RUC recommendations. In addition, this decision by CMS resulted in further cuts to the practice costs, resulting in a total cuts ranging from 40-70% for these services.

Because the methodology for valuing these NCS codes in 2013 is fundamentally flawed, we ask that CMS allow an opportunity to reexamine the code values to ensure that the values represent the complexity of the services provided prior to implementation. We request that CMS convene a refinement panel this year to reexamine these code values for 2014.

Lack of Meaningful Notice

APTA is deeply concerned about the lack of meaningful notice of these drastic payment changes. Notice of this change in reimbursement was given on November 1, which gives affected physical therapists, other providers, and their practices only 60 days to prepare
for these significant cuts. Furthermore, affected parties were given no opportunity to submit public comments on the impact of a cut of this magnitude prior to implementation in 2013. Such draconian cuts that impact patients should not be instituted without the chance to provide feedback on the impact.

**Phase In 2013 Payment Rate**

Because of the magnitude of these cuts, the flawed methodology, and the impact on patient care, we believe that there is a need to reexamine the values for these nerve conduction codes. **If CMS chooses not to halt these payment cuts in 2013, we urge CMS to phase in the new payment rates to mitigate the negative impact on patient care. This would allow additional time to reexamine the values.**

Specifically, we recommend that the payment rates be phased in over a four year period as follows:

**2013:** Rates could be calculated using 75% of the 2012 relative value units for practice expense and work and 25% of the relative value units for practice expense and work identified in the 2013 final physician fee schedule rule.

**2014:** Rates could be calculated using 50% of the 2012 relative value units for practice expense and work and 50% of the relative value units for practice expense and work identified in the 2013 final physician fee schedule rule.

**2015:** Rates could be calculated using 25% of the 2012 relative value units for practice expense and work and 75% of the relative value units for practice expense and work identified in the 2013 final physician fee schedule rule.

**2016:** New payment rates would be fully phased in.

Because the 2013 codes (95907-95913) have different descriptors than the 2012 codes (95900, 95903, 95904, and 95934), the 2012 codes need to be crosswalked to the new 2013 CPT codes. We recommend CMS develop a methodology to crosswalk the 2012 codes to the new codes based on the frequency of allowed charges in 2012 and the 2012 relative values. As another alternative CMS could consider developing temporary G codes that mirror the descriptors used for the 2012 nerve conduction codes.

**III. CMS should accept the RUC recommended values for CPT codes 95886 and 95887.**

In the final rule, CMS disagreed with the RUC recommendation for work relative value units (RVUs) for CPT codes 95886 and 95887 based on the time for the services. Respectfully, we disagree with the CMS decision to base the work values on time.

During the RUC process, the panel members and provider association representatives explained that a comprehensive study is more than twice the work and intensity of limited study. A comprehensive study deals with a patient who presents with a complex set of
issues. These patients often have been to a number of providers previously without answers to their impairments. The amount of work and time needed to test these types of patients to discover the diagnosis is significant. These patients often require testing in very difficult areas, such as areas near the spine, near the lungs, in the muscles of the throat, or in the tongue. The RUC panel recognized the complexity of the service represented by CPT codes 95886 and 95887.

If CMS chooses to value these codes based on time alone, this methodology will not recognize the complexity of the services provided. Therefore, we strongly urge CMS to accept the RUC recommended values for CPT codes 95886 and 95887.

**Conclusion**

Thank you for your consideration of these comments. We look forward to opportunities to continue to provide input to CMS on refinements to the values for these codes in the future. If there are any questions about our comments or additional information is needed, please contact Gayle Lee, J.D., Senior Director, Health Finance and Quality, at 703-706-8549 or gaylelee@apta.org or Gillian Russell, J.D., Senior Regulatory Affairs Specialist at 703-706-3189 or gillianrussell@apta.org.

Sincerely,

Paul Rockar, Jr., PT, DPT, MS
President

PR/grl, glr