



August 12, 2019

Seema Verma Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

RE: CMS Patients Over Paperwork Request for Information

Dear Administrator Verma,

The American Academy of PAs (AAPA), on behalf of the more than 131,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on reducing unnecessary Medicare regulatory and administrative burdens that drive up costs and impede Medicare beneficiaries from receiving the care they need. The Medicare program authorizes PAs to deliver a wide range of medical services. PAs are committed to providing the highest quality care to all Medicare beneficiaries. To accomplish this goal, it is essential that Medicare's policies authorize PAs to practice at the top of their license. The Medicare program should strive to eliminate rules or regulations that hinder the ability of patients to receive medically necessary care from PAs due to outdated or ineffective policies which do not increase care quality or lead to improved healthcare delivery cost-effectiveness.

The Centers for Medicare and Medicaid Services (CMS) has been actively working to reduce administrative burden through the Patients Over Paperwork initiative. AAPA would like to express our appreciation for recent policy changes adopted by CMS that have enhanced care efficiency and flexibility. These changes include CMS permitting health professionals, such as PAs, to act in the capacity of the required primary care provider on a Programs of All-Inclusive Care for the Elderly (PACE) interdisciplinary team; the removal of requirements for a physician visit in order to be assigned to an Accountable Care Organization if a beneficiary voluntarily identifies a PA as the clinician they want to coordinate their care; and the modification to the Quality Payment Program low-volume threshold, that previously may have restricted some PAs from participating, but now permits most to voluntarily opt-in.

Following the significant progress that has occurred, additional changes can be made that will significantly improve choice and competition and benefit patients. We are providing examples of other Medicare policies that increase administrative burdens, disrupt continuity of care for patients, hinder the Medicare program's data analysis by allowing for the collection of inaccurate information, and reduce patient access to care - especially in rural and underserved communities.

The following is a list of regulatory and legislative obstacles to efficient care and AAPA's corresponding proposed solutions:

Regulatory Barriers to Care

Federal Flexibility to Assist States in Increasing Access to Care

To address state-specific healthcare workforce and delivery system reform needs, especially in rural and underserved communities, many states are pursuing legislative changes to modernize PA practice. To ensure that PAs can practice at the top of their education and training and increase patient access to care, states are changing PA laws to better reflect current capabilities of PAs and the autonomy with which PAs can deliver care. Some of the state law changes replace the term "supervision" with other terms. Other states are eliminating the need for physician supervision altogether.

These state law changes will not alter what services PAs are authorized to deliver under the program, the Medicare PA rate of reimbursement or the professional hierarchy that will continue to exist in hospitals, nursing facilities or medical group practices. Despite state law changes in how PAs function as part of the healthcare team, a PA employed by a hospital, for example, will still be governed by the hospital's bylaws, credentialing/privileging requirements, Medicare's hospital Conditions of Participation, etc. As these potential changes occur, it is essential that Medicare policy regarding how PAs practice be in alignment with state laws.

The December 2018 federal government report on healthcare competition entitled, *Reforming America's Healthcare System Through Choice and Competition*, specifically recommended that 1) "States should consider eliminating requirements for rigid collaborative practice and supervision agreements . . . that are not justified by legitimate health and safety concerns," and 2) "States should consider changes to their scope-of-practice statutes to allow all healthcare providers to practice to the top of their license, utilizing their full skill set."

We are pleased to see language in the proposed 2020 Physician Fee Schedule aligning federal Medicare PA policy with state law in a way that creates flexibility for states to improve access to quality, affordable care. AAPA encourages the agency to finalize this concept in the final rule to assist states in their healthcare workforce development activities and ensure improved access to care for Medicare beneficiaries.

Hospice Constraints on PA Prescribing

Legislation passed by congress in 2018 authorized PAs to be included in the definition of a hospice "attending physician." However, CMS has failed to make appropriate and timely changes to the hospice regulations to allow PAs to fully function as attending physicians.

This obstacle to efficient provision of patient care under Medicare's hospice program, which is clearly within the power of CMS to directly and expeditiously address, is CMS' reliance on an outdated Medicare hospice Condition of Participation (CoP), 42 CFR 418.106(b), that prohibits PAs from ordering medications for hospice patients. The CoP lists physicians and nurse practitioners (NPs) as being able to order medication for the hospice population but makes no mention of PAs. Now that PAs are authorized as attending physicians for hospice, there is no reason they should be excluded from ordering medications, which is a restriction codified in the CoPs before PAs were given attending physician status by federal legislation. We simply cannot understand why a CoP would carry more weight than statutory authority. PAs are authorized to prescribe in all 50 states and the District of Columbia and have been safely prescribing to Medicare beneficiaries outside of the hospice benefit for decades.

AAPA requests that CMS authorize PAs to prescribe medications to Medicare hospice patients similar to physicians and advanced practice registered nurses, thereby allowing PAs to fulfill their responsibilities as attending physicians. This can be achieved immediately by CMS stating that it will not enforce hospice CoP language limiting PA prescribing for hospice patients since such a prohibition is in direct conflict with existing statutory language. AAPA also requests that CMS expeditiously reopen 42 CFR §418.106(b) in order to include PAs in official CoP language which identifies who is authorized to prescribe medication to Medicare hospice patients. AAPA appreciates the language in the proposed 2020 Physician Fee Schedule that, if finalized, would authorize PA prescribing for hospice patients for non-hospice related conditions. However, in order to provide the range of services necessary to appropriately care for Medicare beneficiaries who have selected the hospice benefit PAs must be able to prescribe medications for hospice-related conditions.

Attempts at Student Documentation Burden Reduction Create Disparities

Prior to March 5, 2018, for Medicare billable evaluation and management (E/M) services, clinical preceptors (teachers) had to re-document the clinical notes of medical students, NP students and PA students. The release of CMS Transmittal 3971 (subsequently rescinded and replaced by [Transmittal 4068](#) - bottom of page 6), revised the Medicare Claims Processing Manual to allow teaching physicians to verify in the medical record medical student documentation of the components of E/M services, rather than re-document the work. CMS, unfortunately, (1) did not apply this same burden reduction to NP and PA preceptors, even though they fulfill the same educational role as teaching physicians, and (2) has interpreted that only the notes of medical students can be used by teaching physicians.

The updated policy removed burdens for teaching physicians but had the unintended consequence of exacerbating the disparity between teaching physicians and precepting (teaching) PAs and NPs. Reports suggest this transmittal has created a preference for medical students being accepted by preceptors and heightened the challenges of securing preceptors for PA and NP students. While we

understand that the initial action had the intent of burden reduction, the net impact put PA and NP preceptors and students at a significant disadvantage.

A coalition of affected stakeholders met with CMS in February and we are pleased to see language in the proposed 2020 Physician Fee Schedule that, if finalized, would resolve the problem.

AAPA requests that CMS fully support efforts to resolve this matter as expeditiously as possible by 1) clarifying the ability of PAs to act as preceptors similar to teaching physicians and 2) indicating in the CMS manual and any subsequent transmittals that documentation by PA (and NP students) can be used on the preceptor's medical record for billing purposes.

Hospital Admission Co-Signature Requirements

Medicare policy permits PAs to determine the necessity of an inpatient hospital admission, write the admission order, and perform the accompanying history and physical examination. However, it has been interpreted in the past that such admission orders must be co-signed by a physician, potentially days later, prior to a patient's discharge from the facility. Requiring a physician to take the time to co-sign an admission order, after the PA's determination of medical necessity has already been deemed sufficient, is an inefficient use of a physician's time. If a physician is not available, the patient's discharge may be delayed, resulting in an increased length of stay in the hospital. We note that changes to requirements for documentation of hospital admission under the Hospital Inpatient Prospective Payment System may correct this problem. However, CMS has yet to explicitly clarify that a physician co-signature is not required when a PA admits a patient to the hospital.

CMS should clarify that when a PA makes the admission decision (order) for a hospital admission, no physician co-signature is required.

Co-Signature Prior to Discharge

Longstanding Medicare policy has indicated that when a PA discharges a patient from the hospital, a physician's co-signature is required on the discharge summary within 30 days of the patient's discharge. This must be done for all hospital inpatient and observation stays and emergency department services. Requiring that all discharge summaries be co-signed by a physician is an enormous administrative burden for facilities and an inefficient use of a physician's time. There is no clear value being provided to the patient or the healthcare system from this requirement. Recently, CMS has communicated to AAPA that co-signature on discharge summaries is no longer required. However, no such indication has ever been put into official regulatory language.

AAPA requests that CMS publicly clarify this policy and update the [State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals](#) page 292, that the co-signature requirement is no longer in effect.

Unnecessary Restrictions on the Supervision of Diagnostic Tests

PAs are authorized to request and perform diagnostic tests consistent with their state law scope of practice. However, only a physician may supervise ancillary staff performing these tests. PAs are highly qualified, by training and education, in the performance of diagnostic tests, as well as in emergency services that may be required during testing. Authorizing PAs to supervise diagnostic tests will improve efficiency in the healthcare system by expanding access to care.

CMS policy should authorize PAs to supervise diagnostic tests within their state law scope of practice when performed by other office technicians/certified personal. AAPA requests that Medicare reopen 42 CFR §410.32 in order to include PAs in official CoP language which identifies who is authorized to supervise diagnostic tests.

Restrictions on PA Practice in Skilled Nursing Facilities

For many years, PAs have been authorized to deliver care to Medicare beneficiaries in skilled nursing facilities (SNFs). However, PAs are not recognized by Medicare regulation for the purposes of performing the comprehensive visit to SNF patients. Also, PAs and physicians are required to alternate every other required visit to SNF patients. There is no reason and no medical evidence that would support such restrictions on PAs (and NPs) from performing the comprehensive SNF visit and each required visit. This Medicare requirement is simply a vestige of old, outdated policies that need to be modernized to reflect current medical practice and bring efficiencies to the system.

CMS should remove regulatory restrictions and authorize PAs to perform the comprehensive visit, as well as to perform all required visits, in SNFs. AAPA requests that Medicare reopen 42 CFR §483.40 to allow for greater use of PAs in SNFs.

Licensed Independent Practitioner

Medicare policy uses the confusing term “licensed independent practitioner” when referring to those health professionals who are authorized to order restraint and seclusion in hospitals. This terminology limits the ability of PAs to order restraint and seclusion. CMS, in a June 2016 hospital and critical access hospital [proposed rule](#), proposed to eliminate this term and replace it with “licensed practitioner,” which would prevent PAs from being excluded. CMS also proposed to remove the term “physician assistant” from the current provisions at §482.13(e)(12)(i)(B) and (e)(14) to reduce confusion and allow PAs to more efficiently use medically necessary restraint or seclusion. However, the overarching final rule which contains this proposed updated language has yet to be released. Recently, CMS has [extended](#) the timeline for the finalization of the June 2016 proposed rule until June 2020.

AAPA supports the changes proposed in CMS’ June 2016 proposed rule that seek to remedy the complications created through use of the term “licensed independent practitioner.” CMS

should continue to work toward elimination of the term "licensed independent practitioner" and use "licensed practitioner" or refer to the specific health professional being discussed to avoid confusion. CMS should also proceed with removing the term "physician assistant" from the current provisions at §482.13(e)(12)(i)(B) and (e)(14) as proposed. We request that the agency make such changes as expeditiously as possible.

Limitations on Care Delivery in Inpatient Rehabilitation Facilities (IRF)

At present, certain Code of Federal Regulations (CFR) sections regarding IRFs use physician-centric language when establishing care delivery requirements. For example, §412.622(a)(3)(iv) indicates a rehabilitation physician must conduct face-to-face visits with an IRF patient three days a week to assess medical status and functionality, and to modify the course of treatment as necessary. Meanwhile, §412.622(a)(4)(ii) requires a rehabilitation physician to conduct a post-admission evaluation within 24 hours of admission, and document that evaluation in the patient's medical record. However, to address a concern about regulatory burdens in IRFs, CMS has expressed interest in amending requirements under §412.622(a)(3)(iv) and §412.622(a)(4)(ii) to permit PAs and NPs to fulfill some of the requirements previously assigned only to rehabilitation physicians. AAPA fully supports CMS' proposal to expand the role of PAs in IRFs by authorizing PAs to fulfill many of the CMS "physician-only" requirements currently in place in rehabilitation hospitals. Allowing PAs to provide care they are educated and qualified to perform will ease both regulatory burden, as well as increase patient access due to the availability of additional health professionals.

AAPA requests that CMS make all regulatory changes suggested in its 2018 proposed rule on the matter to promote the expanded use of PAs (and NPs) who are willing and fully qualified to work in these settings.

A Refusal to Reimburse for Certain Required Services in PA-owned Rural Health Clinics (RHC)

Federally certified RHCs must have a PA, NP or certified nurse midwife staff the clinic 50 percent of the time the clinic is open. Medicare requires RHCs to offer specific diagnostic tests to be performed in RHCs. Unlike the payment methodology for the typical RHC patient visits, these diagnostic services require billing and reimbursement through Medicare Part B. Medicare does not allow direct payment to PAs through Part B. Therefore, PA RHC owners are not paid for these required services and that lack of payment could threaten the financial viability of the RHC. PAs are essential healthcare providers in RHCs and Medicare should provide a means to assure payment to PA RHC owners for required Part B services.

AAPA recommends that CMS establish a payment method for when PAs in RHCs are performing CMS-mandated diagnostic tests to beneficiaries.

Regulatory and Interpretive Limitations on the Provision of Certain Psychiatric Services

PAs provide psychiatric services to Medicare patients in outpatient settings, consistent with state law scope of practice. Inpatient psychiatric services, however, are highly restricted, as patients are required to be under a physician's supervision and progress notes must be recorded by an MD/DO. These restrictions create delays and inefficiencies in the care and treatment of inpatient psychiatric patients. Authorizing PAs to provide and document care to patients in psychiatric hospitals would improve access to care for these patients.

AAPA recommends that CMS remove regulatory restrictions regarding services PAs may perform and document in psychiatric hospitals by updating [Medicare Benefit Policy Manual Chapter 2 - Inpatient Psychiatric Hospital Services](#).

Discrepancies in Medicare Administrative Contractors (MAC) Policies

MACs are contracted to implement national Medicare policy at the state level. However, some MACs have created local policies that are not in alignment with national Medicare policies. Consequently, health professionals are subject to Medicare practice variability based on divergent MAC interpretations. Examples include documentation requirements for split/shared visits, co-signature requirements for "incident to" billing, and the ability of PAs to submit claims for initial hospital encounters, discharges, and certain services and procedures, such as ophthalmology services.

CMS should identify and actively respond to reports of discrepancies between MAC interpretations of national Medicare policies and correct any ambiguous language in order to foster more uniform and accurate implementation of CMS coverage policy.

Promoting Best Practices in the Medicaid Program

Unlike the Medicare program, which has federal laws mandating the coverage of medical services provided by PAs, each state can determine the various boundaries of practice of health professionals, such as PAs and NPs, under the Medicaid program. Some states currently include restrictive language regarding PA practice that impedes efficient provision of care, including restrictions on PAs acting as an assistant at surgery, the ordering of DME, and providing psychiatric care and substance abuse treatment. Further, there are policies adopted by some states that restrict the transparent delivery of care, including requiring that claims for services provided by PAs be billed under and attributed to the collaborating physician, not reimbursing for professional services provided by hospital-employed PAs and the omission of PAs from provider directories.

AAPA recommends that CMS release a series of recommended best practices for state Medicaid program policies regarding PAs emphasizing burden reduction and transparency, and promoting that PAs be permitted to practice to the full extent of their education, competency and training.

Legislative Barriers to Care

“Incident To” Billing

“Incident to” is a Medicare billing provision that allows reimbursement for services delivered by PAs and NPs at 100% of the physician fee schedule, as opposed to the typical 85%, provided certain criteria are met. When “incident to” billing is utilized, care provided by a PA is attributed to a physician with whom they work.

For patients, this has numerous detrimental effects. For example, “incident to” billing requires that a series of conditions be met to receive 100% reimbursement for PA or NP services. The fulfillment of these conditions, which if not for the use of “incident to” would not be required, adds additional obligations for both PAs/NPs, and physicians, that may negatively affect the efficiency of care provided. This increased burden at the expense of efficiency in patient care works counter to the objectives of the Patients Over Paperwork initiative. In addition, each patient receives an Explanation of Benefits (EOB) notice after receiving care. The EOB identifies the service the patient received and who delivered the care, among other details of the visit. “Incident to” billing often leads to patient confusion because the name of the health professional who provided their care does not appear on the EOB notice. This can cause patients to question who their actual care provider is, and whether they need to correct what appears to be erroneous information regarding their visit. Finally, use of “incident to” billing may threaten a PA’s or NP’s ability to be listed along with other health professionals on performance measure websites, such as Physician Compare, thus restricting a patient’s awareness of available care options. If health professionals such as PAs and NPs are included on Physician Compare, but not all services are attributed to them as a result of “incident to” billing, patients, while aware of the existence of these providers, will not be able to make fully-informed comparisons between them as these health professionals are not accurately portrayed in the available data.

“Incident to” also masks the positive impact of PAs and NPs on the healthcare system. Consequently, it is nearly impossible to accurately identify the type, volume or quality of services delivered by PAs and NPs. The absence of data attributed to PAs and NPs for the services they provide affects their ability to appropriately participate in performance measurement programs, such as the CMS Quality Payment Program. The inability to demonstrate economic and clinical value, both within the Medicare program and to an employer, will influence an employer’s analysis of PA/NP contribution to the healthcare organization.

Patients and health professionals are not the only stakeholders who are disadvantaged by “incident to,” as healthcare researchers and the Medicare program itself stand to suffer from inaccurate data collection. In the 2019 Physician Fee Schedule Final Rule, CMS stated that estimates of burden reduction and the impact on practitioner wages due to documentation of evaluation and management services were unclear due to the ability to report services “incident to” a physician when furnished by an NP or PA. The Medicare Payment Advisory Commission (MedPAC), in its

report released on June 14, 2019, similarly recognized the problem and unanimously voted to recommend to Congress the elimination of “incident to” for PAs and NPs.

AAPA supports MedPAC’s recommendation that “incident to” billing be eliminated by Congress. However, recognizing that legislative action on this issue may take time, AAPA encourages CMS to both explicitly recognize the numerous problems that result from the current use of “incident to” billing as it relates to PAs and NPs and to publicly solicit input in a proposed rule from affected stakeholders as to how to best resolve those concerns until the billing provision is legislatively removed.

Outdated Hospice Constraints on PA Provision of Patient Care

AAPA remains concerned regarding the inability of PAs to perform the face-to-face encounter prior to recertification after a patient has been under the hospice benefit for 180 days. The omission of PAs from being able to provide the face-to-face encounter falls short of continuity of care goals as hospice patients receiving care and care direction from PAs will be required to have another health professional, who the patient may not have interacted with, provide the face-to-face encounter. While AAPA continues to seek legislative modification to resolve this situation, we request that CMS explore any regulatory options to remedy this problem.

In addition, there are some aspects of hospice care that PAs are still not permitted to provide that are currently reserved for a physician. For example, only a physician or medical director may certify terminal illness, only a medical director may admit a patient to a hospice, and PAs cannot take the position of a physician as one of the required members of an interdisciplinary group (hospice physician, registered nurse, social worker, and pastoral or other counselor). These restrictions apply to NPs as well.

AAPA requests that CMS communicate to Congress the increase in efficiency that would result from allowing PAs and NPs to certify and recertify terminal illness, admit a patient to hospice, and act in the capacity of a required member on an interdisciplinary group in place of a physician. AAPA also requests that CMS support change in statute to allow PAs to perform any required face-to-face encounters.

Exclusions on Ordering Medicaid Durable Medical Equipment (DME)

Recently, state Medicaid agencies have been moving to restrict PAs and NPs from ordering DME for patients. This stems from the fact that there is no stand-alone federal Medicaid language that allows for PAs and NPs to order DME, as exists under Medicare. Rather, the only mention of DME in federal Medicaid regulations is under the section on home health, which has traditionally been restrictive for PAs and NPs. Some states are interpreting this to mean that the restrictive nature of home health policies now pertain to DME as well.

AAPA, along with a coalition of other interested stakeholders, has recently met with CMS on this issue. We were informed that the cause of this expanding prohibition is statutory, although we've received no direct evidence of this.

If CMS is not able to identify a statutory justification for this restriction on PA and NP practice for a service these health professionals are qualified to and experienced in providing, the agency should modify its federal regulations to establish stand-alone language explicitly identifying the ability of PAs and NPs to order DME for patients under Medicaid.

Restrictive Policies on PAs and NPs Providing Home Health Care

PAs are authorized to treat Medicare beneficiaries for virtually all illnesses and medical problems. However, Medicare does not recognize PAs (and NPs) for the purposes of certifying or ordering home health services or signing the home health plan of care for these same patients. This inability to certify or order home health for Medicare patients leads to a lack of continuity of care for Medicare beneficiaries, especially in rural and underserved communities, because the patient's primary care provider, the PA, is unable to order medically necessary services for the patient. The inability to sign the plan of care results in the inability of PAs to write orders related to caring for their patient. Ensuring patients have the right level of care at the appropriate time often prevents an escalation in the patient's condition and the need for more acute and expensive healthcare services. Certifying the need for home health services is clearly within a PA's education, training and state law scope of practice.

AAPA suggests that CMS should advocate for statutory language to allow PAs to certify, order and sign the plan of care for home health services.

Direct Payment

PAs are the only health professionals authorized to bill Medicare for their services who can't receive direct reimbursement for those services. This barrier limits the flexibility of PAs to work in new and evolving practice and care models, and does not allow PAs to assign their reimbursement to other entities in the same manner as physicians, advanced practice nurses and other healthcare professionals such as physical therapists, anesthesiologist assistants, registered dietitians, occupational therapists, and others.

AAPA requests that CMS petition Congress to change statutory language to authorize PAs to receive direct payment from Medicare.

A Prohibition on Ordering Diabetic Shoes

PAs are already authorized to order DME. The exclusion of diabetic shoes is a rare exception to this authority. PAs commonly manage the care of diabetic patients. Medicare, however, requires a physician to certify the need for diabetic shoes and requires a physician to order diabetic shoes. These Medicare requirements result in additional physician visits of a PA's diabetic patient, who needs diabetic shoes, so that a physician can fulfill Medicare's requirements for the certification and order. Authorizing PAs to certify and order diabetic shoes will improve access to care and eliminate unnecessary physician visits, certifications and orders.

AAPA requests that CMS support changing the statute to authorize PAs and NPs to certify the need for, and order, diabetic shoes.

Inability of Patients to be Aligned with an Accountable Care Organization (ACO) Through the Claims Process When All of Their Care is Provided by a PA

ACOs are critical to the success of Medicare's shared savings payment models and the ability to lower costs while improving care continuity. PAs are listed by Medicare as one of three types of health professionals who deliver primary care services. However, only patients who have had at least one visit by a physician are eligible to be assigned/attributed to an ACO. Medicare beneficiaries treated solely by PAs and advanced practice registered nurses (APRNs) can't be automatically assigned to an ACO. This issue is especially problematic for patients in rural and underserved areas where a PA is the only health professional in the community. Patients treated by an ACO physician are automatically attributed to the ACO through the claims process. That same process is not available to PAs and APRNs. Patients must take the extra step of going online to select a PA (or ARNP) as their ACO provider in order to be assigned to an ACO.

AAPA recommends that CMS support changing the statute to allow patient attribution to an ACO when a patient has received all of their medical care from a PA or an NP.

PAs Are Not Authorized to Supervise or Prescribe Cardiac, Intensive Cardiac, Pulmonary Rehab Services until 2024

Studies have shown that Medicare patient outcomes are improved when they have access to cardiac and/or pulmonary rehabilitation services. Currently, only physicians are authorized to supervise and prescribe Medicare beneficiaries for cardiac and/or pulmonary rehabilitation services. When a physician is not available, the beneficiary does not have access to these important services. Supervising these services (establishing an exercise program, counseling, education, outcomes assessment, etc.) is within the scope of practice and level of expertise of appropriately trained PAs. Legislation has passed Congress to authorize PAs to supervise cardiac and pulmonary rehab services beginning in 2024. Medicare has also [interpreted](#) "physician prescribed" exercise to mean that a patient must have a referral or order that is signed or co-signed by a physician. AAPA and

other stakeholders believe that a referral/order to cardiac and pulmonary rehabilitation is different than a physician-prescribed exercise plan and is an additional barrier to Medicare patients receiving these services.

AAPA recommends that CMS request that Congress move up the implementation date to authorize PAs to supervise and prescribe cardiac, intensive cardiac and pulmonary rehabilitation programs. AAPA also requests that CMS change its interpretation of physician-prescribed exercise and immediately allow PAs to refer eligible Medicare beneficiaries to these rehabilitation services.

Exclusions on Providing Medical Nutrition Therapy (MNT)

PAs are professional medical providers for patients with diabetes, cancer, kidney disease and other conditions in which MNT may be a necessary part of the treatment plan. Currently, however, only physicians are authorized to order MNT service. This physician-only requirement results in administrative burden and delay in care for patients in need of these services, as patients must wait for a physician order. Authorizing PAs to order these services will improve care for patients while reducing administrative burdens and inefficiencies. AAPA suggests that CMS request Congress change the statute to authorize PAs to order MNT. Language in the Social Security Act reads as follows: “(vv)(1) The term “medical nutrition therapy services” means nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional (as defined in paragraph (2)) pursuant to a referral by a physician (as defined in subsection (r)(1)).”

AAPA suggests that CMS support adding “or a PA (as defined in subsection (aa)(5))” after (r)(1).

Restriction of Mammography Interpretation to a Physician

The Social Security Act limits the interpretation of results of a screening mammography to a physician. However, PAs are authorized by state law, education, clinical training, licensure, and the Medicare program to perform services of the type “that are considered physician’s services if furnished by a doctor of medicine or osteopathy (MD/DO)” including the ordering, performing, and interpreting of diagnostic tests. A delay in interpretation can cause unnecessary stress to a patient and potentially delay referral to an appropriate provider if results are abnormal. Delay in care could also affect healthcare efficiency, increase cost of care, and result in health complications. AAPA recommends that CMS support changing the statute to authorize PAs to interpret the results of a screening mammography. Language in the Social Security Act reads as follows: “(jj) The term “screening mammography” means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician’s interpretation of the results of the procedure.”

AAPA recommends that CMS support changing the statute to allow PAs to interpret screening mammography.

Restrictions on Interpreting Bone Mass Measurement Results

The Social Security Act limits the interpretation and reimbursement of bone mass measurement to a physician. However, PAs are authorized by state law, education, clinical training, licensure, and the Medicare program to perform services of the type “that are considered physician’s services if furnished by a doctor of medicine or osteopathy (MD/DO)” including the ordering, performing, and interpreting of diagnostic tests. Without timely interpretation, appropriate care to Medicare beneficiaries may be delayed. Delayed treatment of osteopenia/osteoporosis and initiation of fall prevention behaviors could result in falls and fractures, increased hospitalizations, avoidable procedures, increased healthcare costs, and disability. AAPA recommends that CMS support changing the statute to authorize PAs to interpret bone mass measurement results. Language in the Social Security Act reads as follows: “(2) for the purpose of identifying bone mass or detecting bone loss or determining bone quality, and includes a physician’s interpretation of the results of the procedure.”

AAPA recommends that CMS request that Congress change the statute to allow PAs to interpret bone mass measurements.

Thank you for the opportunity to provide feedback on the Patients Over Paperwork Request for Information. AAPA welcomes further discussion with CMS regarding our position and comments. For any questions you may have in regard to our comments and recommendations, please do not hesitate to contact Michael Powe, AAPA Vice President of Reimbursement & Professional Advocacy, at 571-319- 4345 or michael@aapa.org.

Sincerely,

A handwritten signature in blue ink that reads "Tillie Fowler". The signature is written in a cursive, flowing style.

Tillie Fowler
Senior Vice President
Advocacy and Government Relations