NATIONAL ASSOCIATION OF
CLINICAL NURSE SPECIALISTS

September 4, 2012

Submitted via www.regulations.gov

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS–2370–P
P.O. Box 8010
7500 Security Boulevard
Baltimore, MD 21244-8010

RE: CMS–1590–P – Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule

Dear Ms. Tavenner:

On behalf of the National Association of Clinical Nurse Specialists (NACNS), we submit the following comments concerning the proposed rule, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule (77 Fed. Reg. 146, July 30, 2012). The NACNS is a national organization representing Clinical Nurse Specialists (CNSs).

The CNS contributes services as an independent provider and/or as a member of the health care team in a range of settings including, but not limited to primary care, accountable care organizations, hospitals, long-term care and home care. These advanced practice registered nurses (APRNs) hold their masters or doctorate degrees in nursing. The CNS has prescriptive authority in 36 states and focuses on the management of complex patients in a variety of settings. The CNS is an expert clinician, and may be seen in practices that are identified in terms of population, (i.e. Pediatrics), a setting (i.e. Emergency) and/or a disease or medical subspecialty (i.e. Diabetes). The CNS works to improve patient outcomes through direct patient care as well as improvements in health system policies and procedures. The CNS role has the potential to find significant cost savings in the health care system.

We acclaim CMS for recognizing the role APRNs have in providing care to Medicare beneficiaries. Our comments address the following areas:

- Medicare reimbursement for transitional care management services;

- Direct Medicare reimbursement for chronic pain management services by CRNAs;
- Clarification that NPs and CNSs may order portable X-ray services;
- New policies allowing NPs and CNSs to order durable medical equipment and conduct the face-to-face encounter for their patients.

Section II, H. Primary Care and Care Coordination; Post-Discharge Transitional Care

NACNS supports CMS's proposal to create a code and provide reimbursement for post-discharge transitional care management services, including those that are provided through communications with the patient or caregiver within two business days of discharge. We advocate that CMS ensure that APRNs and other qualified providers are eligible for payment for non-face-to-face transitional care management services.

CNSs have demonstrated their ability to prevent readmissions as documented in a study of discharge planning from hospital to home care for the elderly. The studies showed fewer readmissions and fewer days of re-hospitalization in the group who received the service from the gerontological CNSs.[i] Studies have also shown that programs developed by CNSs assist congestive heart failure patients with self-care to prevent hospital readmissions.[ii],[iii],[iv],[v]

K. Certified Registered Nurse Anesthetists and Chronic Pain Management Services

NACNS strongly urges CMS to continue direct Medicare reimbursement to CRNAs who provide valuable chronic pain management services. Patient access to these services provided by Certified Registered Nurse Anesthetists (CRNAs) is important nationwide but particularly critical in rural and frontier parts of the country. Beneficiaries' access to these services, especially in remote areas of the country is essential. As healthcare professionals, we are pleased that Medicare will no longer be in the role to interfere between patients and the qualified healthcare professionals responsible for their care.

L. Ordering of Portable X-Ray Services

NACNS applauds CMS for clarifying that nonphysician practitioners and physicians acting within the scope of their Medicare benefit and State law are allowed to order

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[i] Naylor, M, et.al. (1994). Comprehensive discharge planning for the hospitalized elderly. *Annals of Internal Medicine*, 120(12), 999-1006

[ii] Newman, M. (2002). A specialist nurse intervention reduced hospital readmissions in patients with chronic heart failure. *Evidence-Based Nursing*, *5*(2), 55-56.

[iii] Creason, H. (2001). Congestive heart failure telemanagement clinic. *Lippincott's Case Management*, July/August, 146-156.

[iv] Knox, D. & Mischke, L. (1999). Implementing a congestive heart failure disease management program to decrease length of stay and cost. *Journal of Cardiovascular Nursing*, 14(1), 55-74.

[v] Ryan, M. Improving self-management and reducing readmissions in heart failure patients. *Clinical Nurse Specialist*, 23(4) 216-221.

portable X-ray services. There are many instances in the practice of a CNS where this authority will contribute to the patient's quality of care. As examples CNSs working in long term care and home care will often evaluate patients who have had a fall or who have had heart failure and may need a portable X-Ray to determine their status.

Section III. C. Durable Medical Equipment (DME) Face-to-Face Encounters and Written Orders Prior to Delivery

NACNS understands that the requirement for physician documentation is a statutory requirement, and that it is the responsibility of CMS to develop the rules to implement this provision of the Act. However, NACNS cannot support any of the proposed options because of this fundamental flaw, and urges reconsideration of this wasteful and unnecessarily narrow requirement.

There is no evidence that requirements for physician oversight or supervision increases quality or reduces fraud. We do know that unwarranted requirements for physician supervision lead to delays in care and duplication of services. During the past 15 years, there is little evidence that NPs and CNSs engage in fraudulent or abusive ordering of DME and there is little efficiency or true accountability in relying on documentation by a physician who has not evaluated the patient rather than the NP or CNS who has.

Some facilities only have a physician round weekly or monthly with CNSs managing the remainder of the time. Does CMS wish to establish a system that would require additional physician visits and related costs, as well as MDs signing documents without truly being aware and informed?

If we think that fraud is on the physician/non-physician provider side, then having strong rationale for the DME equipment in their encounter note should provide the paper trail to determine the medical need for the DME and establish the trail of the request and justification for each piece of DME. No additional paperwork would need to be transmitted and no interpretation of the encounter note (by non-clinician DME suppliers) would need to be done. This process could create a clear auditing trail for investigators.

NACNS appreciates the opportunity to comment on these proposed regulations. We would be happy to discuss these issues further, if you should have any questions. You may contact Pamela Mittelstadt, Consultant to NACNS at pammittel@aol.com, 703-403-4489.

Sincerely,

Rachel Moody, MS, CNS, RN
President
NACNS