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Re: Remote monitoring services in the CY23 Physician Fee Schedule

Dear Administrator Brooks LaSure, Director Seshamani, and Mr. Tee:

Telehealth, remote physiologic monitoring (RPM), and remote therapeutic monitoring (RTM) are at the forefront of the new standard of care that must be available to all Americans, especially Medicare beneficiaries. As the only organization completely focused on advancing telehealth, the American Telemedicine Association (ATA) is committed to ensuring that everyone has access to safe, affordable and appropriate care when and where they need it, enabling the system to do more good for more people.

The ATA applauds the important steps the Centers for Medicare and Medicaid Services (CMS) has taken to include virtual care services as part of America's COVID-19 response while setting a precedent for greater access after the conclusion of the pandemic. CMS has continued that work by introducing coverage of RTM services in the calendar year 2022 Physician Fee Schedule (PFS), as an additional means to support the remote capture of patient data to aid clinician decision making. RPM and RTM (together, "remote monitoring") services enable beneficiaries to remain safely in their homes where they can be properly supported to manage their conditions while also reducing costs and the strain on the healthcare system as a whole.

We ask the agency to consider our recommendations to build upon this foundation by continuing to improve access to remote monitoring services in the calendar year 2023 PFS. Our comments are all made under the theme of ensuring that clinical appropriateness and practice is the guide for the way Medicare coverage policies are developed and implemented.

Remote Physiologic Monitoring

Minimum Monitoring Requirements

In its discussion of RPM in the CY21 PFS, CMS for the first time interpreted language included in the American Medical Association's CPT Professional Edition indicating "do not report 99453 [or 99454] for monitoring of less than 16 days" to mean that "16 days of data each 30 days must be collected and transmitted to meet the requirements to bill CPT codes 99453 and 99454." During the COVID-19 PHE, CMS decreased that requirement to "at least" 2 days of monitoring for COVID-19 positive or suspected positive patients. In the CY21 PFS, CMS stated that post-PHE, the requirement will revert to 16 days of data collection over a 30-day period. We urge you to reconsider this policy.

There is a diverse range of clinical scenarios for which 16 days of monitoring data is not necessary and, in fact, may be clinically contra-indicated. Rather than keep an arbitrary number of days requirement for billing RPM services, or create multiple codes with multiple different number of days requirements, we recommend that CMS defer to the billing provider's medical decision-making on the frequency with which data should be collected and transmitted for RPM services.

Multiple RPM Devices

CMS stated in the CY21 PFS that codes 99453 and 99454 are not to be billed more than once per patient, per 30-day period or by more than one provider even when multiple devices are supplied to a patient. Reimbursing the provision of one device at the same rate as the provision of three devices does not make sense from a practical standpoint and results in limiting access to necessary devices. As we seek to empower individuals to effectively manage their conditions at home, we need to ensure they have all of the devices necessary to generate the data their care team needs to track their conditions, and that the provision of those devices are adequately reimbursed.

The current interpretation of these codes is severely limiting for patients with chronic conditions or acute conditions that may require different devices for monitoring different physiological functions. Given the high prevalence of comorbidities among the 147 million Americans living with chronic conditions, many individuals require multiple devices assigned by various specialists to manage conditions concurrently. We urge CMS to clarify in the FY23 PFS that the codes can only be billed once per device, rather than once per patient. Further, CMS should clarify that additional codes can be billed for monitoring of additional physiological

conditions, as clinically appropriate by a single clinician or across an individual's care team managing multiple conditions.

Nonphysician Provider Billing
ATA urges CMS to create complementary G-codes to allow for RPM treatment-assessment services, which would allow nonphysician providers to bill for RPM. These nonphysician practitioners (NPPs) would be allowed to bill these codes within their benefit categories and scopes of practice.

Software as a Medical Device
Subjective inputs by a patient, collected by a medical device – whether hardware or Software as a Medical Device (SaMD)—and automatically uploaded, are critical for effective remote care management. However, there is currently no clarity on whether such SaMD data would satisfy the requirements of supply codes, particularly 99454, 98976, and 98977.

New and Established Patients
During the COVID-19 public health emergency, CMS has allowed for RPM programs to be initiated by providers for both new and established patients. In subsequent rulemaking, CMS has stated an intention to revert back to established patients only. CMS has also permanently clarified that RPM is allowed for patients with either acute or chronic conditions. Mandating an established patient relationship would result in unnecessary barriers for patients presenting with acute illnesses which may require short-term remote monitoring – e.g., monitoring of patients with infectious diseases or those suspected of having infectious diseases. RPM should not be available only for patients with an established physician relationship, particularly those with acute illness.

Remote Therapeutic Monitoring
The ATA commends CMS's swift action to newly adopt, cover, and reimburse RTM service codes in the CY22 PFS.

Nonphysician Provider Billing
The ATA further appreciates CMS's recognition that only a specific set of provider types can bill the codes and that clinical staff time is not able to be billed incident -to physician/nonphysician practitioner services under General Supervision.

The ATA agrees with CMS's concern about the construction of the RTM codes. Specifically, CMS questioned whether the RTM codes as constructed could be used by therapists because the Medicare benefit does not include services provided incident to the services of a therapist. Despite those concerns CMS finalized a policy that permits therapists and other QHPs to bill the RTM codes as described. The ATA appreciates CMS' intention to ensure that therapists are able

to bill these services, but believes the policy should still be updated to ensure the full range of appropriate providers may bill these services.

However, by using exclusively general medicine codes for RTM services, the codes now negate the possibility for RTM to be billed by physician and practitioners who may bill codes "incident to", from using clinical staff under general supervision to assist with care coordination and management of these patients. Unlike with E/M codes, a direct consequence of general medicine codes is that the billing provider (even physicians, nurse practitioners, physician assistants, clinical nurse specialists, and certified midwives) may not employ the use of clinical staff or auxiliary personnel to assist in the performance of RTM services. In specialties such as pulmonology and respiratory care, much of the work performed with patients is accomplished by respiratory therapists (RTs). Under general medicine, the use of RTs is strictly under direct supervision, thereby limiting the use of RTs in the provision of RTM services. The ATA appreciates CMS's recognition of this challenge.

The ATA recommends CMS consider creating complimentary parallel HCPCS E/M codes for the existing general medicine RTM Treatment Management Service code family, thereby allowing physicians/QHP's to bill the E/M codes directly, allowing them the use of clinical staff time to be counted "incident to" the practitioner's services, and keeping the general medicine RTM codes to allow nonphysician providers the ability to report those codes. Another possibility, as previously recommended, would be creating parallel temporary HCPCS G-codes modeled after 98980 and 98981. These G-codes will allow for incident-to billing and are essential to ensuring auxiliary personnel and clinical staff are able to assist in the provision of RTM services under general supervision of the billing provider.

Condition-agnostic Device Coverage

Currently, the codes providing reimbursement for supply of devices are limited exclusively to devices addressing musculoskeletal and respiratory conditions. However, behavioral, mental health, vascular, endocrine, neurological, gastrointestinal/digestive, and other conditions already have applicable RTM uses. The ATA urges CMS to consider the broader needs for RTM services by creating a condition-agnostic CPT supply code for RTM, similar to the general RPM supply code 99454.

RPM, RTM, and Telehealth Alignment

ATA urges CMS to align RTM and RPM coverage and payment. One way to better align RTM and RPM coverage and reimbursement is to extend RTM the regulatory flexibilities that were recently allowed for RPM. These should include flexibilities that are currently temporary during the COVID-19 pandemic, as well as provisions that have recently been made permanent. These policies should include provisions related to acute and chronic patients, obtaining consent at the time of service, general supervision, removal of cost-sharing requirements, and enabling access for new and established patients.

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We also urge CMS to address the comments contained herein on our concerns with the existing RPM codes and not translate them to RTM. We urge CMS not to reflect RPM's minimum-days-of-monitoring requirement, nor its single provider and device policy in RTM. Additionally, the same patient in the same month could and should benefit from both RTM and RPM. The ATA would urge CMS to make that provision clear in future rulemaking.

Finally, we urge CMS to align the timelines associated with policies for telehealth with those available for RTM and RPM. The policies that have been amended for the purposes of responding to the public health emergency – including allowing a practitioner to order RPM for a patient during an initial visit and obtaining consent at the time of the initial service -- should extend beyond the expiration of the PHE and align to match the same time frames as telehealth policies: December 31, 2023.

Thank you for your continued dedication to ensuring Medicare beneficiaries have access to quality health care regardless of where they live. We look forward to your response and urge you to continue working with Congress to expand access to these important technologies beyond the pandemic. If you have any questions or would like to further discuss the telehealth industry's perspective, please contact me at kzebley@americantelemed.org.

Sincerely,

Kyle Zebley
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