

August 24, 2022

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Comments on the CY2023 Physician Fee Schedule proposed rule (CMS-1770-P)

Submitted electronically on regulations.gov

Dear Administrator Brooks-LaSure:

The American Telemedicine Association (ATA), the only organization completely focused on advancing telehealth, and ATA Action, the ATA's affiliated trade organization focused on advocacy are committed to ensuring 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. CMS has greatly expanded access to telehealth services during the COVID-19 pandemic, but rulemaking has begun to consider what the policies will be post-public health emergency (PHE). We appreciate the opportunity to work with CMS to expand access to telehealth within its statutory authority and based on its clinical judgment, while we also work with Congress to expand said statutory authority appropriately. The ATA and ATA Action strongly support enhanced access to telehealth and digital health services and provide our comments to this Calendar Year (CY) 2023 Physician Fee Schedule proposed rule on how CMS can continue that trajectory.

Medicare Telehealth Services

We appreciate CMS' continual review of codes to determine the appropriateness of coverage of additional services via telehealth. In this proposed rule, CMS did not add any new codes requested by stakeholders to category 1 or category 2¹, including codes for coverage of physical/occupational/speech therapy, but did add new codes to category 3 and for temporary coverage. CMS did not extend the timeframe for coverage of category 3 codes past CY2023, but indicated it would revise the policy if the PHE is still in effect. For codes temporarily covered during the public health emergency, CMS aligned coverage of those codes with the recently enacted policy extending CMS' authority to waive statutory 1834(m) restrictions for 151 days following the expiration of the PHE.

In this rule, CMS also proposes to end coverage of audio only services except for the codes finalized to allow audio only for mental health. CMS also proposes to discontinue direct supervision via audio-visual availability of the supervising practitioner. Lastly CMS proposes updating billing modifiers and point of service (POS) codes post-pandemic to only distinguish between whether the patient is located in the home or non-home, covering only mental health and substance use disorder and ESRD services in the home and reducing rates back to the facility rate rather than the professional fee based on where the service would have been provided in person.

¹ CMS did add GXXX1, GXXX2, and GXXX3 to category 1

Timing of Covered Codes

We appreciate that CMS explicitly temporarily extended the coverage of codes covered during the pandemic to align with the Consolidated Appropriations Act (CAA) extension of all telehealth flexibilities for 151 days post-PHE. We also appreciate the delay of the telehealth services in-person requirement for 151 days post PHE in accordance with the CAA. As discussed in our CY2022 comments, we are hopeful that Congress will repeal this clinically unnecessary in-person requirement prior to its implementation. Similarly, we appreciate the extension of the policy allowing federally-qualified health centers (FQHCs) and rural health clinics (RHCs) to act as distant sites for telehealth. We hope that Congress works to allow this permanently. In the meantime, we urge CMS to continue to align these timeframes should Congress make subsequent extensions of the pandemic flexibilities.

Also, as mentioned in previous comments, we appreciate the creation of category 3 for temporary coverage while codes are under review and encourage CMS to use the category fully. We urge CMS to extend the coverage of codes that are still under review beyond CY2023, and to extend the coverage of temporarily covered codes to 151 days post PHE if that timeframe extends longer than CY2023. We also urge CMS to consider all of the codes temporarily allowed during the PHE for category 3 status such that they can be reviewed for permanent coverage. As an industry, we will continue to collect and provide data to substantiate coverage of services via telehealth.

Telehealth Services Code List Changes

The ATA and ATA Action are disappointed that no new codes were added to category 1 or category 2 in this proposed rule. As offered in previous comments, we continue to recommend the following codes be added to Category 1: inpatient hospital care services (99221–99223); observation admission services (99218–99220); same-day inpatient/observation admission and discharge services (99234–99236); new patient domiciliary, rest home services (99324–99328); and home-visit new-patient services (99341–99345). The ability for hospitals to provide some care via telehealth can help alleviate staffing shortages that we see in hospitals around the nation, and can reduce delayed admissions and improve care coordination.

Another set of codes that we would like to particularly flag for consideration in category 1 or 2 coverage is ophthalmologic services (92002, 92004, 92012 and 92014). These codes are generally covered via telehealth by other insurance plans, including Medicare Advantage plans and the Veterans Health Administration, and should also be available to Medicare beneficiaries. The National Association of Vision Care Plans (NAVCP) published its ocular telemedicine policy in 2020². That policy clarifies that ophthalmological services that are typically covered under benefits administered by managed vision care (MVC) plans may be provided using telemedicine that meets the standards established in the policy. Those services are self-referred routine (aka “wellness”) examinations performed by participating optometrists and ophthalmologists in the MVC provider networks. Such services are typically billed to the MVC plan using the codes noted above. In addition to noting the appropriateness of the use of ocular telemedicine for self-referred regular eye care, the NAVCP also noted that the use of telemedicine for patients presenting with complaints or symptoms suggestive of active ocular pathology would be appropriate when, in the eye care provider’s professional judgment, an initial examination by telemedicine would best serve the patient. There are also a number of peer-reviewed studies supporting the effectiveness of telemedicine for these services.

² https://securereservercdn.net/198.71.233.194/5df.048.myftpupload.com/wp-content/uploads/2020/07/NAVCP_PPP_Telemedicine-Policy-Statement_FL_6-29-2020.pdf

However, we appreciate the addition of more than 50 new codes on a category 3 basis as a step toward possible category 1 or 2 coverage.

The ATA and ATA Action believe that physical therapy, occupational therapy, and speech therapy (PT/OT/ST) services can be delivered effectively via telehealth. We appreciate the addition of new PT/OT/ST codes to category 3 for further consideration. We urge continued coverage and full consideration of the therapy codes even though physical therapists, occupational therapists, and speech therapists are not currently permitted by statute to provide telehealth services outside the pandemic. Congress has shown interest in changing this statutory requirement either by explicitly adding these providers or by continuing to give CMS the authority to determine other appropriate providers to deliver telehealth services. We do not believe that a static list written into statute can keep pace with clinical best practices. We urge both Congress to provide, and CMS to use, all flexibility possible to make clinically appropriate services accessible in Medicare.

As outlined in our CY2022 comments, we urge CMS to add cardiac rehabilitation services (CPT codes 93797 and 93798), currently covered temporarily during the pandemic, to category 3. CMS and the Centers for Disease Control and Prevention (CDC) created the Million Hearts 2027 initiative and have identified cardiac rehabilitation as a “high-value, potentially underutilized service”.³ Current evidence on virtual cardiac rehabilitation services supports patient safety and effective use outside the circumstances of the COVID-19 pandemic. The ability to offer cardiac rehabilitation virtually reduces barriers to participation such as travel cost and time, and will thereby increase equitable access to care.

Audio-only

The ATA and ATA Action are technology and modality neutral, meaning that we support the provision of care via all modalities, as long as the modality allows clinically appropriate care to be delivered. The ATA and ATA Action are concerned by the blanket elimination of coverage for audio-only modalities for every service except mental health services. While some types of services may be more appropriate with video or other technology, some services can be delivered effectively using audio only. Because broadband internet and availability of devices is still a challenge for many populations, we urge CMS to use the tools at its disposal to ensure access to services via the audio-only modality.

Modifiers and payment amount

We believe in the concept of fair payment for telehealth services. The time a clinician spends with a patient for a particular service does not vary whether provided in-person or virtually. However, other time and costs can vary significantly, particularly infrastructure costs (whether brick and mortar or technological) and administrative time. Using virtual options can save when reducing administrative costs and time. Fair payment should reflect these factors.

The use of place of service code (POS) 10 indicating whether the patient is at home or 02 for other locations makes sense. We also recommend that CMS update policy to use POS code 10 in Physician Compare Finder. We commend CMS for including nontraditional definitions of home in that category – including homeless shelters and travel locations – and strongly support the ability of providers to reach patients in their actual physical location. We urge Congress to lift the restrictions on the patient location for all services in addition to mental health and substance use disorder services and ESRD services such

³ <https://millionhearts.hhs.gov/about-million-hearts/index.html>

that all services can use the place of service code 10. We urge CMS to continue to consider appropriate payment rates to ensure fair payment.

In urging fair payment, and with the understanding that the health care system is under considerable strain, we ask that CMS maintains payment at the non-facility-based practice rate for telehealth services provided in office settings through the end of the 2023 calendar year regardless of the disposition of the Public Health Emergency (PHE). Changing payment to the facility rate as proposed would result in a nearly 30% cut, which will have an immediate and dramatic negative impact on provider reimbursement. Such a significant cut to telehealth reimbursement coming out of the pandemic is inconsistent with ATA's support of fair payment and could have a chilling effect on telehealth adoption and use. Most importantly, the proposed cut may reduce access to care and disrupt continuity of care for Medicare beneficiaries with their established providers.

Direct supervision

CMS proposes to allow PHE flexibilities for direct supervision to expire at the end of the PHE but continues to seek comments on whether those flexibilities should be made permanent. The ATA and ATA Action continue to urge CMS to make direct supervision via telehealth a permanent option. As mentioned in previous comments, we believe that CMS should work with stakeholders to identify which services would be the most appropriate for direct supervision via telehealth and that patient safety, as always, should be a top priority for providers, stakeholders, and regulators. We believe physician and nonphysician providers should have the autonomy to determine when direct supervision via telehealth is clinically appropriate and in line with the relevant standard of care and that CMS should avoid adding additional provider requirements that do not otherwise exist for in-person services.

Notably, CMS-established regulations on coverage of supervised services already exist and look to the underlying state law of the beneficiary's state for setting when and how supervision is appropriate. In fact, Medicare Benefit Policy Manual guidance incorporates a modality-neutral structure for physician supervision of a physician assistant when no relevant state law exists.⁴ We suggest supervised services supported with telehealth is no different than how supervised services are carried out within an in-person setting and CMS can and should rely on existing regulatory authority. Specifically, as to physician assistants (PAs), Medicare covers services that are legally authorized to be performed by the state in which the services are performed⁵ and many states allow for remote supervision of PAs by physicians (including through the utilization of telehealth). Regarding advanced practice registered nurses (APRNs), CMS similarly looks to authority for supervision under state law, and in CMS's Medicare Benefit Policy Manual, indicates the collaborating physician does not need to be present with the APRN when the services are furnished or to make an independent evaluation of each patient.⁶ Further, almost 20 states

⁴ Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, § 190.

⁵ 42 U.S.C. § 1395x(s)(K)(i); 42 C.F.R. § 410.74. Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners; Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services; MLN Booklet # MLN901623 <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Information-for-APRNs-AAs-PAs-Booklet-ICN-901623.pdf>.

⁶ 42 U.S.C. § 1395x(s)(K)(ii); 42 C.F.R. § 410.75. Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners; Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, § 200; see also CMS, MLN Booklet # MLN901623 – Advanced Practice Registered Nurses, Anesthesiologists Assistants, & Physician Assistants (March 2022), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Information-for-APRNs-AAs->



now authorize certain APRNs to treat patients independently, without any supervision or collaboration, demonstrating confidence and capable safe and effective care by nonphysician providers. We implore CMS to use this opportunity to harmonize these concepts for on-going value-oriented care supported by non-physician providers aligned with state authority, consistent with continuity and care continuum strategies, and alleviating on-going and critical industry staffing issues.

Remote Monitoring

The ATA and ATA Action continue to commend CMS for adopting coverage of remote therapeutic monitoring (RTM) codes in CY2022 and wishes to continue to work with CMS to ensure RTM codes can be most effectively utilized to serve beneficiaries. In this proposed rule, we appreciate CMS' proposal to create four new HCPCS G codes with one pair of codes aimed at increasing patient access to RTM services and the second pair aimed at reducing physician and non-physician provider (NPP) supervisory burden. However, we have significant concerns with requirements on these new codes being proposed for implementation.

As described in parenthetical language introduced by CMS in Table 28 of the proposed rule, a provider will be required to bill/report the CPT supply codes prior to billing any of the work RTM codes. No such linkage exists according to CPT descriptions, guidelines, and parentheticals. Solely the CPT supply codes (98975, 98976, and 98977), not the current CPT work codes (98980, 98981), require at least 16 days of data in a 30 day period before billing the code. Now, under the proposed rule, if a provider does not first collect 16 days of data, they are precluded from billing the CPT supply and work codes.

Secondly, there are only two CPT supply codes for two identified medical specialties, musculoskeletal and respiratory, so this now limits RTM Treatment Management Services (TMS) billing to those two medical specialties. Although CMS explicitly acknowledges that CPT has now added cognitive behavioral therapy (CBT) to the family of RTM services, the omission of the new CBT supply code (989X6) would infer that CMS will not allow providers of behavioral therapy to bill work performed in furtherance of CBT services – resulting in a very significant lack of services for those beneficiaries who would greatly benefit from remote therapeutic monitoring of behavioral therapy.

Moreover, we disagree in principle with the concept that 16 or more days of data needs to be collected to effectively provide remote monitoring services (both RPM and RTM). In fact, we are aware that the CPT Editorial Panel will be considering a proposal to create new CPT supply codes for RPM and RTM during their upcoming September meeting as publicly posted under “Tab 11 – RPM/RTM less than 16 days,” a code change proposal to create new/additional CPT supply codes (RPM 9X055, RTM 9X056, RTM 9X057, and RTM 9X058) to report monitoring of less than 16 days⁷. We urge CMS to consider the foregoing while contemplating the proposal to condition all payments on 16 days of data. The ATA and ATA Action describe below a number of different clinical scenarios for which 16 days of monitoring data is not the appropriate amount. As outlined in our CY2021 comments, rather than keep an arbitrary requirement for days of data generated by the patient, we recommend that the requirement be consistent with physician or clinical staff orders as detailed in a patient's treatment plan for each patient. This ensures that the days of data collection over a 30-day period is clinically appropriate.

[PAs-Booklet-ICN-901623.pdf](#). See Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, § 200.

⁷ <https://www.ama-assn.org/system/files/cpt-panel-september-2022-agenda.pdf>

Some clinical scenarios where remote monitoring is beneficial, but 16 days of monitoring is not the appropriate number in a 30-day period:

- A patient needing to be monitored for a continuous short-term period following surgery. This could include, for example, a patient prescribed a narcotic for pain whose breathing could be monitored while on the medication. This could also include patients who could benefit from remote monitoring to prevent readmission;
- A patient with a chronic condition like diabetes may have their weight monitored over a longer period of time, but it is not clinically relevant to have the patient step on a scale 16 or more times in a month;
- A patient whose blood pressure or oxygen levels are monitored during physical therapy may not necessitate 16 days of monitoring. Physical therapy is often ordered twice weekly, which would result in fewer than 16 days of monitoring in a month;
- Patients who wear heart monitors to measure palpitations may wear the monitor continuously, but the data only needs to be collected when the individual is experiencing symptoms;
- Heart monitors to measure palpitations may be worn for 30-days, but data may only be needed when the patient is experiencing symptoms; and
- Patients with hypertension are often monitored for long-term management of their condition on more of a weekly basis, only needing more frequent data collection for active monitoring with changes in medication or dosages.

We are extremely concerned with the application of the 16-day requirement, both for RTM services as described above, and for remote physiologic monitoring (RPM) services, as described in a number of letters and comments (the ATA's public comments to the CY2021 fee schedule⁸, a letter from the ATA to CMS in advance of the CY2022 fee schedule⁹, the ATA's public comments to the CY2022 fee schedule¹⁰, and a letter from the ATA to CMS in advance of the CY2023 fee schedule). In this proposed rule, CMS still does not address issues related to RPM despite stakeholder feedback. Instead, CMS has chosen to apply a more stringent requirement premised on 16 days to remote therapeutic monitoring treatment management services. We remain hopeful that the upcoming CPT consideration of the new supply codes for less than 16 days¹¹ will bring a more realistic payment pathway in this space and will help clarify reimbursement for these services. Additionally, we urge CMS to explicitly affirm that flexibilities for RPM services allowed during the PHE are extended through the end of CY2023 or 151 days following the expiration of the PHE, whichever is later. Congress is also interested in this issue and has introduced a bill to permanently continue the pandemic flexibility of accepting a minimum of two days of RPM data, which we would support.¹²

An additional concern we would like to raise in the remote monitoring section is the proposed changes to the Practice Expense Relative Value Units (PE RVUs) for physical therapists, occupational therapists, and speech language pathologists (PTs/OTs/SLPs) remote therapeutic monitoring. CMS is proposing a

⁸ https://www.americantelemed.org/wp-content/uploads/2020/09/PFS-CY2021_ATA-comments_9.24.20-FINAL-1.pdf

⁹ <https://www.americantelemed.org/wp-content/uploads/2021/05/RPM-Letter-on-FY22-PFS-ATA.pdf>

¹⁰ <https://www.americantelemed.org/wp-content/uploads/2021/09/ATA-PFS-comments-CY-2022-9-1-2021-Final-.pdf>

¹¹ <https://www.ama-assn.org/system/files/cpt-panel-september-2022-agenda.pdf>

¹² <https://www.congress.gov/bill/117th-congress/house-bill/4347>



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work RVU of 0.62 for the base code (HCPCS code GRTM3), which is equivalent to the RUC-recommended work RVU established for CPT code 98980 in the CY 2022 PFS final rule. Similarly, for the add-on code, HCPCS code GRTM4, CMS proposes a work RVU of 0.61, which is the RUC-recommended value CMS established for CPT code 98981 in the CY 2022 PFS Final rule. However, CMS proposes a non-Facility PE RVU of 0.24 for both the base code (GRTM3), and for the add-on code (GRTM4) – a remarkable difference from the CY 2022 PFS final rule non-Facility PE RVU of 0.82 (for 98980) and 0.52 (for 98981). When comparing the 2022 PFS final rule approximate national geographic practice cost index (GPCI) payment amounts for non-Facility (CPT code 98980=\$50.18; CPT code 98981=\$40.58) to the proposed 2023 PFS approximate national GPCI for non-Facility (HCPCS code GRTM3=\$29.44; HCPCS code GRTM4=\$29.11), the amounts represent an unreasonable decrease of 41%, and 29%, in payment rates, respectively.

However, the work performed in 2022 by nonphysician qualified health care professionals through 98980/98981 is the same work providers will furnish in 2023 via GRTM3/4. There is absolutely no difference in the scope of work, complexity, time, or intra-service requirements that PTs/OTs/SLPs have performed and will continue to provide. These changes will result in a significant cut to those providers offering these services. CMS must not implement these sharp reductions in reimbursement for GRTM3/4.

Lastly, as we did in a letter in advance of this rule, we recommend that CMS make it clear that the same patient could benefit from both RPM and RTM simultaneously.

Virtual Diabetes Prevention Program

As we have outlined in previous comments, we continue to urge CMS to allow virtual providers offering CDC-recognized Diabetes Prevention Programs (DPPs) to enroll in the Medicare DPP.

Artificial Intelligence and Software as a Medical Device

Finally, CMS indicates continued interest in understanding artificial intelligence (AI) and machine learning applications for health care. We are concerned with how the current Practice Expense (PE) methodology categorizes Software as a Medical Device (SaMD) as “computer software,” Indirect PE and not necessarily an allocable expense. The ATA and ATA Action encourage CMS to issue a specific request for information (RFI) in order for the agency to learn more about this topic from a broader group of stakeholders, separate from this proposed rule.

Thank you very much for the opportunity to provide our detailed feedback on this year’s Physician Fee Schedule proposed rule. If you have any questions or would like to discuss our recommendations further, please contact kzebley@ataaction.org, Executive Director of ATA Action.

Kind regards,

Kyle Zebley
Executive Director
ATA Action