September 6, 2016

SUBMITTED ELECTRONICALLY VIA
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Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1654-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 (CMS–1654–P)

Dear Mr. Slavitt:

The undersigned medical specialty societies [hereinafter, "Coalition"] appreciate the opportunity to provide comments on the Medicare Physician Fee Schedule ("MPFS") Proposed Rule for Calendar Year ("CY") 2017 (CMS–1654-P) [hereinafter, "Proposed Rule"]. Below we discuss our comments on a number of proposals regarding payment for behavioral health, cognitive impairment, chronic care management, mobility disorders, and telehealth services made in the above-captioned proposed rule. We commend CMS for its focus on payment for codes that provide additional value and improve quality of care. The members of the undersigned societies provide all of the services discussed in this comment letter and we urge CMS to adopt our recommendations.

E. Improving Payment Accuracy for Primary Care, Care Management Services, and Patient-Centered Services

a. Behavioral Health Services (GPPP1, GPPP2, GPPP3 and GPPPX)

CMS is proposing a family of four G-codes to facilitate separate payment for services covering Behavioral Health Integration (BHI) in the primary care setting. Three of the codes (GPPP1, GPPP2, and GPPP3) parallel recently approved CPT codes. GPPPX describes services furnished using a different application of BHI in the primary care setting.

Recommendation II-E-i

- **The Coalition commends CMS for creating G-codes that parallel the recently approved CPT codes that describe services consistent with the psychiatric Collaborative Care Model (CoCM), which aims to improve the integration of physical and mental health care.**

We commend CMS' decision to propose coverage for the CoCM starting in January 2017. As noted in the American Psychiatric Association's September 8, 2015 letter to CMS "the lack of reimbursement for key components of this model has been the principal barrier to its widespread implementation. Although there may be other treatment models that engage primary care clinicians and behavioral health

specialists, the specific Collaborative Care Model [CoCM] that CMS refers to in the July 15 [2015] Federal Register is the only model that has compelling scientific data supporting its effectiveness."

We appreciate CMS' proposal to adopt the recently approved CPT descriptors for these codes; language which has been vetted through the CPT Editorial Panel process. Further, we support the decision not to restrict eligible diagnoses to a subset of behavioral health conditions. There is sufficient experience to demonstrate that a wide range of mental health and substance use disorders can be effectively treated in a primary care setting that has appropriate psychiatric support and care coordination described by this model.

Recommendation II-E-ii

- **We disagree with the proposed crosswalk (90836, psychotherapy services) for the work of the psychiatric consultant and recommend that CMS crosswalk the work of the psychiatric consultant to the appropriate evaluation and management (E/M) service.**

While we appreciate CMS' proposal to provide coverage for these services and generally support the proposed values as they relate to the primary care physician and behavioral health care manger, we have concluded that the proposed values assigned to the GPPP1, GPPP2, and GPPP3 codes do not adequately reflect the work of the psychiatric consultant and as a result are not sufficient to sustain the model. We think that the CMS proposal to crosswalk the work of the psychiatric consultant in codes GPPP1, GPPP2, and GPPP3 to CPT code 90836, *Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management (E/M) service*, for a work RVU of 0.42, does not reflect the medical work involved.

Absent a RUC survey, we support CMS' proposal to crosswalk the work of the primary care physician to the proposed work values of the complex Chronic Care Management (CCM) codes, 99487 and 99489, which require similar work and take approximately the same amount of time. Pending the survey results, we also support the values proposed for the behavioral health care manager, including the designated type of clinical staff, which are appropriate given the level of responsibility and specific training required.

As we stated above however, we think the proposed work RVU for the psychiatric consultant, which has been crosswalked to a psychotherapy service, is not at all representative of the actual work being performed. The focus of the psychiatrist's work in these services is not psychotherapy as described by the CPT code. Instead, it is inherently medical in nature and equivalent to the medical decision making of an E/M service. Patients enrolled in the collaborative care program are typically those who have not responded to standard care and need additional psychiatric evaluation and involvement to enable the development of an appropriate and effective treatment plan.

Recommendation II-E-iii

- **We support the creation of GPPPX, care management services for behavioral health conditions, however, we think the creation of an add-on code may be premature or requires further refinement. We recommend that CMS adopt appropriate but not unduly restrictive billing requirements to delineate practitioner eligibility, supervision requirements, patient eligibility, patient agreement requirements, and the scope or required elements of the service.**

We support the proposed creation of GPPPX, care management services for behavioral health conditions, however, we think the creation of an add-on code may be premature or requires further refinement. Lacking time-specific data from practitioners themselves (which should be supplied in a future RUC survey), we believe the initial proposal for a BHI code with a time interval of 20 minutes appears to be appropriate.

Further clarification is needed regarding the proposed code for "care management services for behavioral health conditions" (GPPPX). We commend CMS' effort to expand Medicare coverage and payment to additional services involving care for patients with behavioral health conditions based on the recognition that significant time and resources are expended on patients with behavioral health conditions that are not currently compensated. However, it is not clear from the proposed rule precisely which services, practitioners, patients, and circumstances would qualify for the billing of the GPPPX code. We generally recommend that CMS adopt appropriate but not unduly restrictive billing requirements which delineate practitioners' eligibility, supervision requirements, patient eligibility, patient agreement requirements, and scope of service elements. Patients eligible for these services would have a psychiatric and/or substance use disorder that requires care management services. Similar to CCM and CoCM services, we would recommend patients be seen for an initiating visit and that general beneficiary consent should be given prior to being enrolled in the program. There should be continuity of care with a designated member of the care team. A written plan of care should be developed and shared with the patient, and a comprehensive assessment of the patient's psychiatric condition as well as any medical, functional, and psychosocial needs should be performed and updated as necessary. At a minimum, patient progress should be routinely evaluated using validated rating scales, with progress tracked using a patient registry. All services should be documented in the patient's medical record and available to other treating professionals.

As with the CoCM codes, we would recommend that if eligible to individually furnish and report services, the care manager may report separate services in the same calendar month. These could include: psychiatric evaluation (90791, 90792), psychotherapy (90832, 90833, 90834, 90836, 90837, 90838), psychotherapy for crisis (90839, 90840), family psychotherapy (90846, 90847), multiple family group psychotherapy (90849), group psychotherapy (90853), smoking and tobacco use cessation counseling (99406, 99407), alcohol or substance abuse structured screening and brief intervention services (99408, 99409) and the GPPP1, GPPP2, and GPPP3 codes. Time spent by the behavioral health care manager on activities for services reported separately may not be included in the services reported using time applied to the GPPPX code.

Recommendation II-E-iv

- **We recommend that CMS modify the proposed requirements to allow the behavioral care manager (BHCM) to work off-site, under the general supervision of the treating physician or other qualified health care professional (QHP).**

We urge CMS to allow the BHCM to work off-site, under the general supervision of the treating physician or other QHP, similar to the current requirements for care managers for CCM services. CMS has indicated in the proposed rule that it expects that the BHCM would furnish services incident to services of the treating physician/QHP; be a member of the clinical staff of the treating physician/QHP; and work on-site at the location where the treating physician/QHP furnishes services to the beneficiary.

For CCM services, CMS originally proposed requiring that care managers be part of the clinical staff of the treating physician/QHP, and that they also be physically on-site with that physician/QHP. However, CMS subsequently decided to allow the care managers to work under general supervision. CMS also specifically allowed the billing physicians/QHPs to arrange to have CCM services provided by clinical staff "external to the practice," including under arrangements with case management companies—so long as all "incident to" and other rules for billing CCM are met and the individuals providing the services are located in the United States.

The AIMS Center at the University of Washington has trained practices of all sizes, including solo practices and small rural clinics, in the CoCM. In small to medium sized practices, a single BHCM may work for two or more clinics or practices. Additionally, practices in rural and some urban/suburban areas may be unable to find a qualified person in their region to fill the position. A number of sites that have successfully adopted the model—and demonstrated its effectiveness in improving care—have shared a BHCM who functions out of one office and visits the other sites on an as needed basis and/or who works remotely using the telephone and telemedicine/video technology to accomplish the work of this model. For psychiatric CoCM services, the BHCM must be available at all times to serve their entire patient population, even when they are physically working at another practice or clinic. Thus, it is crucial that the BHCM be allowed to work under general supervision and off-site. We believe these considerations should also apply to the care manager for the GPPPX code.

Recommendation II-E-v

- **We recommend that CMS finalize its proposal to require the initial visit. Specifically, we support CMS' proposal to allow the same types of services to serve as the initiating visit for CCM services and the BHI codes (GPPP1-GPPP3, GPPPX). Additionally, CMS should finalize its proposal to adopt a beneficiary general consent standard for BHI services.**

We agree there should be an initial visit with the beneficiary before the BHI codes (GPPP1, GPPP2, GPPP3 and GPPPX) can be billed. We also support allowing the same types of services to serve as the initiating visit for CCM services and the BHI codes. Likewise, beneficiary consent should be consistent for all the BHI codes. We support CMS' proposal to adopt a general consent standard for the BHI codes. Prior to initiating these services, the primary care physician or QHP would be required to obtain and document that the beneficiary has consented to consultation with relevant specialists, which would include conferring with a psychiatric consultant, and was informed of the beneficiary cost-sharing (deductibles and coinsurance). While we acknowledge the statutory restrictions regarding coinsurance, we think that coinsurance is counterproductive and is an impediment to patient engagement in collaborative care. We recommend moving ahead with coverage while also simultaneously establishing a CMMI demonstration project to assess the impact of co-insurance on beneficiary participation.

b. Assessment and Care Planning for Cognitive Impairment (GPPP6)

Proposal

CMS proposes to establish a G-code (GPPP6) for CY 2017 that parallels a new CPT code for CY 2018 that describes assessment and care planning for Medicare beneficiaries with cognitive impairment. CMS is

proposing a physician work value of 3.3 based on the sum of the work for 99204 and half the work RVU from G0181. CMS is also proposing 70 minutes of clinical staff time for this code.

In order to be reported, the service requires a number of required elements including the presence of a caregiver, a cognition focused history and physical examination, functional assessment, safety assessment, medication reconciliation, neuropsychiatric evaluation, advanced care planning, development of a care plan, medical decision making of moderate or high complexity, and assessment of the caregiver's knowledge, needs and abilities, by a physician or other qualified health care professional in office or other outpatient setting or home or domiciliary or rest home.

CMS also proposed that GPPP6 cannot be billed with 90785 (Psytx complex interactive), 90791 (Psych diagnostic evaluation), 90792 (Psych diag eval w/med srvcs), 96103 (Psycho testing admin by comp), 96120 (Neuropsych tst admin w/comp), 96127 (Brief emotional/behav assmt), 99201-99215 (Office/outpatient visits new), 99324-99337 (Domicil/r-home visits new pat), 99341-99350 (Home visits new patient), 99366-99368 (Team conf w/pat by hc prof), 99497 (Advncd care plan 30 min), 99498 (Advncd care plan addl 30 min), planning services, such as care plan oversight services (99374), home health care and hospice supervision (G0181, G0182), or GPPP7 but that it can be billed on the same date-of-service or within the same service period as 99487, 99489, 99490 (CCM services), 99495, 99496 (Transitional Care Management (TCM) services), and the psychiatric care collaboration codes (GPPP1, GPPP2, GPPP3, GPPPX).

Discussion

As CMS notes, a CPT code with the identical descriptor will be included in CPT for CY 2018. As part of the CPT/RUC evaluation process, work and practice expense input recommendations were made by multiple medical specialty societies after a work survey and an expert panel process. These recommendations were presented to the RUC where they underwent extensive review and close scrutiny. Based on this review, the RUC recommended 3.44 work RVUs for the code.

CMS also seeks comment on the following issues:

- *Are there circumstances where multiple care planning codes could be furnished without significant overlap?*

Response

The required components of GPPPX (and the parallel CPT code) are face-to-face services and do not overlap with the physician work or clinical staff time spent on CCM services because CCM services are all non-face-to-face services. Although CCM does involve developing, revising and/or maintaining a care plan, we believe that the overlap with GPPP6 is minimal and that if GPPP6 and CCM are billed in the same month that the medical record should support that any work on the care plan performed as part of the CCM service is distinct from the care planning work reported under GPPP6.

Similarly, GPPP6 does not overlap with TCM services because the face-to-face portion of TCM services is related to the recent facility discharge and would not include an assessment or care plan for cognitive function because such a service would be inappropriate to perform in such close proximity to a hospitalization or other facility stay. Further, TCM does not involve developing a care plan.

In addition, we note that CMS is proposing to establish an add-on code (GPPP7, see discussion below) to provide additional payment for developing a care plan at the time of the visit that initiates CCM services. We agree that GPPP6 and GPPP7 should not be billed on the same date of service for the same patient as there is substantial overlap in those codes.

- *Even though CMS proposes that GPPP6 may serve as a companion or primary E/M code to the prolonged service codes (those that are currently separately paid, and those proposed for separate payment beginning in 2017), it is interested in public input on whether there is any overlap between GPPP6 and these other E/M services.*

Response

Face-to-face prolonged-services codes can only be reported after GPPP6 (or another E/M) is performed and at least 30 minutes of additional face-to-face physician time has been spent on patient care. Therefore, we do not believe there is any overlap between GPPP6 and the face-to-face prolonged services codes. However, we agree that it is possible may be some overlap between the post-service work of GPPP6 and the non-face-to-face prolonged service codes proposed for separate payment. We believe that CMS should not allow billing of non-face-to-face prolonged services with GPPP6.

With respect to other E/M codes, we agree with the CMS proposal to not allow GPPP6 to be reported on the same date as the other E/M codes it lists (see above) in the proposed rule.

- *CMS seeks comment on how to best delineate the post-service work for GPPP6 from the work necessary to provide the prolonged services code.*

Response

We do not believe there is any overlap between the work.

- *CMS seeks comment on potential overlap between GPPP6 and existing PFS billing codes, as well as the other primary care/cognitive services addressed in this section of the proposed rule.*

Response

We believe the proposed payment policies for GPPP6 address the potential overlap with other proposals in this section of the proposed rule.

<u>Recommendation II-E-vi</u>

- **The Coalition commends CMS for proposing to create a G-code for assessment and care planning for patients with cognitive impairment in CY 2017 and for accepting the CPT language.**

- **We disagree with the CMS proposals for physician work and clinical staff time and strongly recommend that CMS accept the RUC recommended physician work RVU of 3.44 and the RUC recommended clinical staff times and types.**

c. Assessment for Chronic Care Management (CCM) Care Plan (GPPP7)

CMS is proposing an add-on payment for the visit during which CCM services are initiated to reflect the time and resources associated with the assessment for, and development of, a new care plan. The proposed code descriptor is: "Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services (billed separately from monthly care management services) (Add-on code, list separately in addition to primary service)."

The code would be billable for beneficiaries who require extensive face-to-face assessment and care planning by the billing practitioner (as opposed to clinical staff), through an add-on code to the initiating visit. CMS proposes that the billing practitioner initiating CCM must personally perform extensive assessment and care planning beyond the usual effort described by the billed E/M code (or AWV or IPPE code), in order to bill GPPP7 in addition to the E/M code for the initiating visit (including if the initiating visit is the AWV or IPPE). CMS is proposing to require the initiating visit only for new patients or patients not seen within one year instead of for all beneficiaries receiving CCM services. The proposed code is specifically designed to capture the additional physician work not captured in the initiating visit code that is required to do care planning. CMS proposes a physician work value of 0.86 (half the work of G0181) for this code. The care plan that the practitioner must create in order to bill GPPP7 would be subject to the same requirements as the care plan included in the monthly CCM services.

Per CMS, this code may be appropriate to bill when the initiating visit is a less complex visit (level 2 or 3 E/M visit), although could be billed along with higher level visits if the billing practitioner's effort and time exceeded the usual effort described by the initiating visit code. It could also be appropriate to bill GPPP7 when the initiating visit addresses problems unrelated to CCM, and the billing practitioner does not consider the CCM related work he or she performs in determining what level of initiating visit to bill.

Consistent with general coding guidance, the work that is reported under GPPP7 (including time) could not also be reported under or counted towards the reporting of any other billed code, including any of the monthly CCM services codes. The care plan that the practitioner must create in order to bill GPPP7 would be subject to the same requirements as the care plan included in the monthly CCM services, namely it must be an electronic patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues. This would distinguish it from the more limited care plan included in the BHI codes GPPP1, GPPP2, GPPP3 or GPPPX which focus on behavioral health issues, or the care plan included in GPPP6 which focuses on cognitive status.

Discussion

We appreciate CMS recognition of the time and work it takes to develop and implement a care plan for patients with two or more chronic conditions and we agree with this proposal.

CMS specifically solicits comments on the following:

- *Potential overlap between GPPP7 and GPPP1, 2, 3, and X.*

Response

We do not believe GPPP7 should be billable in the same month as GPPP1, 2, 3, and X as developing and implementing a comprehensive care plan which is billable under an initiating face-to-face visit, GPPP7 where needed, and 99490, 99487, and 994889 inherently includes the care plan developed under GPPP1, 2, 3, and X. We are concerned that there is significant overlap among the physician work involved in these codes.

- *The potential intersection of the prolonged service CPT codes 99358 and 99359 with proposed code GPPP7. Specifically, regarding how distinctions among these services can be clearly delineated, including how the prolonged time can be clearly distinguished from typical pre- and post-service time, which is continued to be bundled with other codes.*

Response

As an initial matter we note that GPPP7 as an add-on code should not have any pre- or post-service time. We believe it would be very unusual for GPPP7 to be billed with 99358 and 99359 because of the time requirements that must be met to bill for prolonged services. However, if those time requirements are met (e.g., for patients where extensive medical record review and communication with multiple health care professionals or caregivers is required in order to develop the care plan) then we believe that 99358 and 99359 should be billable if the time requirements are met. In other words, if the sum of the time of the underlying E/M, GPPP7, and the additional 30 minutes beyond the time of the underlying E/M are met, then 99358 and 99359 should be billable. Of course the time and work for all services must be documented in the medical record.

- *Requiring the initiating visit only for new patients or patients not seen within one year instead of for all beneficiaries receiving CCM services; especially whether a period of time shorter than one year would be more appropriate.*

Response

We agree with requiring an initiating visit for new patients (i.e., patients who have not been seen by the practice for any services for three years). However, we believe that requiring an initiating visit for established patients every year may be onerous, especially if that patient has had CCM services provided during the previous year. Specifically, if a patient has been seen face-to-face or has received CCM in the previous year, an initiating visit should not be required. However, if a patient has not received any E/M services (including CCM services) in over a year, then an initiating visit to "re-establish" the care plan and assure that CCM is necessary and provided appropriately, should be required.

Recommendation II-E-vii

- **CMS should implement GPPP7 for CY 2017, and should clarify in the final rule the number of minutes of services that are included in the code descriptor.**

- **CMS should finalize the proposed work RVUs but should solicit comment on revisions to the work RVUs two years after implementation so that appropriate changes can be made once physicians have gained experience using the code.**

- **CMS should allow 99358 and 99359 to be reported with GPPP7.**

- **CMS should not require an initiating visit for CCM in patients who have received any E/M service from the practice in the previous year.**

d. Improving Care for Patients with Mobility Disorders (GDDD1)

CMS is proposing payment adjustments for routine visits furnished to beneficiaries whose care requires additional resources due to their mobility-related disabilities. CMS proposes the following code descriptor: "Resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lifts, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient evaluation and management visit (Add-on code, list separately in addition to primary procedure)."

CMS proposes that the value of the code be based on a crosswalk to 99212 and that the practice expense inputs include the following items: a stretcher, a high/low table, a patient lift system, a wheelchair accessible scale, and a padded leg support positioning system.

CMS proposes that GDDD1 can be billed with new and established patient office/outpatient E/M codes (99201-99205 and 99212-99215), as well as TCM (99495, 99496), when the additional resources described by the code are medically necessary and used in the provision of care.

Discussion

The Coalition appreciates CMS' concern about providing appropriate care to patients with disabilities and agrees with the intent of the code. That said, we have some concerns with the proposal as written.

First, as this is a new category of service that Medicare has never recognized for separate payment, budget neutrality adjustment should not apply to it, at least initially.

Second, we believe that CMS needs to clarify whether it intends for this code to be reported for patients with a temporary mobility disorder due to fracture or other temporary condition. The utilization of this code could vary dramatically depending on its intended use.

Third, CMS needs to clarify whether the assistive equipment it discusses in the proposal (see above) are required to be used in order to report the service. Requiring use of the equipment will dramatically limit reporting of the code (see below).

Most physicians do not have the equipment listed above in their offices. Further, for practices that do have these items, it is unusual for more than one of them to be used for any given patient. Due to the above considerations, we believe that CMS has drastically overestimated the utilization of this proposed code and that $700 million in expenditures is at least a 10 fold overestimate of utilization. We note that in the very recent past CMS has dramatically overestimated the utilization for TCM and CCM and we believe this is a similar overestimate. If CMS finalizes this code, we ask that CMS assume utilization of no more than 200,000 services to reflect use of between 50 and 100 times a year for 1,000-2,000 physician

practices that own the equipment required for this service. CMS should trim its cost estimate accordingly, and exclude this new utilization from budget neutrality adjustments.

If CMS finalizes the code, we agree that the code should be reportable with any covered face-to-face E/M service in the physician office.

Recommendation II-E-vii

- **If CMS finalizes GDDD1 it should not require the use of the assistive devices discussed in the proposed rule and it should allow the code to be billed with any face-to-face E/M service provided in the physician office setting.**

- **CMS should closely monitor the use of the GDDD1 code to make sure it is being used appropriately in accordance with the policies articulated in the final rule.**

- **If CMS finalizes the GDDD1 code it should clarify when the code should be reported with respect to patient condition, and equipment used.**

- **If CMS finalizes the GDDD1 code it should finalize a crosswalk to 99212 and solicit comment in two years as to whether that crosswalk is appropriate. This will allow physicians to gain experience using the code before revaluation occurs.**

e. Prolonged Service Without Direct Patient Contact (CPT codes 99358 and 99359)

CMS is proposing to pay for two existing CPT codes (99358, 99359) that describe prolonged E/M services before and/or after direct patient care. These codes describe significant additional non-face-to-face work performed by the physician in the review of medical records and other clinical information and are needed to care for patients with chronic illnesses that are complex and/or patients who are severely ill and have multiple comorbid conditions. Currently, these codes are considered bundled into the base E/M service being reported and no separate payment is being made. These codes have the following descriptors:

99358 – Prolonged evaluation and management service before and/or after direct patient care; first hour
99359 – Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes

CMS proposes that time counted toward the provision of 99358 or 99359 and for the provision of these services cannot be counted toward the provision of any other PFS service. CMS also proposes to accept the RUC recommendations for physician work for these codes; specifically: 99358 – 3.17; 99359 – 1.52.

Importantly, CMS also proposes to require these prolonged services be furnished on the same day by the same physician or other billing practitioner as the companion E/M code. Further, CMS proposes that these codes should not be reported during the same service period as complex CCM (99487, 99489) or TCM (99495, 99496) but that they can be reported during the service period of 99490.

Discussion

The Coalition strongly supports the CMS proposal to make separate payment for 99358 and 99359 and we also strongly support the proposal to value these services using the RUC recommended physician work RVUs.

However, we note that the CMS proposal to require that 99358 and 99359 be performed on the same date as the underlying face-to-face E/M is contrary to CPT instructions and could be confusing which could lead to miscoding.

If CMS finalizes its proposal to require that 99358 and 99359 be performed on the same date as the underlying E/M then we strongly disagree with the proposals to not allow these codes to be reported during the service period of complex CCM or TCM. This is because, under current policy physicians are not allowed to count any physician or clinical staff time toward CCM or TCM on the date of a face-to-face E/M service and under the CMS proposal, 99358 and 99359 would have to be performed on the same date as a face-to-face E/M service and therefore, time and work for those services cannot be counted toward any other service.

Recommendation II-E-viii

- **CMS should finalize its proposal to make separate payment for 99358 and 99359.**
- **CMS should finalize its proposal to make payment for 99358 and 99359 based on the RUC recommendations for physician work.**
- **CMS should allow reporting of 99358 and 99359 during the service period of other non-face-to-face services such as all CCM and TCM services.**

f. Expanded Payment and Improved Access for Chronic Care Management (CCM) (CPT codes 99487, 99489, and 99490)

CMS proposes to make separate payment on the Medicare Physician Fee Schedule for complex CCM services described by 99487 and 99489 at the RUC-recommended values for direct PE inputs and work, 1.00 work RVUs for CPT code 99487 (Complex CCM, 60 minutes of clinical staff time per month) and 0.50 work RVUs for CPT code 99489 (Complex CCM, 30 minutes of clinical staff time per month).

CMS also proposes, consistent with CPT guidelines, to require 60 minutes of services for reporting CPT code 99487 and 30 additional minutes for each unit of CPT code 99489, and may only be reported once per service period (calendar month) and only by a single practitioner for the service period.

CMS proposes to require the same CCM service elements, described in Table 11 in the proposed rule, for CPT codes 99487, 99489 and 99490. In comparison to 2016, where Medicare pays for 99487 but not for the other two codes, CMS proposes changes in the requirements for the initiating visit, 24/7 access to care and continuity of care, format and sharing of the care plan and clinical summaries, beneficiary receipt of the care plan, beneficiary consent, and documentation.

We appreciate that the CMS proposed changes are intended to make CMS policy much more consistent with CPT guidelines and instructions on reporting the CCM codes.

Discussion

We appreciate and agree with all the CMS proposals except one – as described below. We appreciate that CMS acknowledges that the utilization of 99490 is low and recognizes the need to make separate payment for 99487 and 99489. We believe that the availability of all these services will significantly improve access to CCM services and will allow the sickest, most frail beneficiaries access to the complex CCM services they need. We also appreciate that CMS is proposing to revise its policies on CCM to make them more consistent with CPT guidelines and instructions.

That said, as we have previously commented to CMS, we continue to be concerned that the requirements for reporting 99490 are excessive and burdensome, and would remain so even with the proposed changes to the scope of service elements. We believe that these requirements are, in part, responsible for the low utilization of this service.

With respect to the scope of services elements for CCM, we enthusiastically support CMS' proposals to remove or modify the following requirements: 1) to create a structured clinical summary record using certified EHR technology (CEHRT), 2) to maintain 24/7 access to the electronic care plan, 3) to share care plans electronically 24/7, 4) to give beneficiaries an electronic copy of the care plan, and 5) to document both beneficiary consents and the coordination of physician services with home- and community-based providers using CEHRT.

While making separate payment for 99487 and 99489 will theoretically allow physicians to report 99487/99489 on months where complex CCM is required and 99490 on those months where complex CCM is not required, we believe that 99490 will continue to be underreported as long as CMS requires all the elements listed in Table 11 of the proposed rule.

Patients who receive CCM described by 99490 do <u>not</u> require all those elements every month. For example, in looking at the required elements, patients who only require 20 minutes of staff time for CCM do not typically require management of care transitions, home and community based care coordination <u>and</u> comprehensive care management. They simply aren't that sick. It is only patients who require 60 minutes of clinical staff time for CCM (and thus would qualify for complex CCM) who require all those elements.

We specifically request that CMS clarify in the final rule that for 99490, not all elements listed in Table 11 be required and, in particular, that, for 99490, only one of the following three elements is required: comprehensive care management, management of care transitions, or home and community based care coordination. This clarification will align the requirements of 99490 with the needs of patients who receive that service.

<u>Recommendation II-E-ix</u>

- **We strongly recommend that CMS finalize its proposals to make separate payment for CPT codes 99487 and 99489 and to base payment on the RUC recommendations for physician work and practice expense inputs.**

- **We strongly recommend that CMS finalize all its proposals to facilitate access to CCM services.**

- **We strongly recommend that CMS reduce the required elements for performing 99490 such that only one of the following is required in order to report 99490: comprehensive care management, management of care transitions, or home and community based care coordination.**

g. Telehealth for Critical Care (GTTT1 and GTTT2)

CMS proposes to establish, and make payment for, two new G codes describing telehealth consultations for critical care. Proposed GTTT1 would cover the initial 60 minutes of communication with the patient via telehealth, while GTTT2 would cover subsequent 50 minute periods of communication with a physician via telehealth. The proposed descriptors are as follows: "GTTT1: Telehealth consultation, critical care, physicians typically spend 60 minutes communicating with the patient via telehealth (initial); GTTT2: Telehealth consultation, critical care, physicians typically spend 50 minutes communicating with the patient via telehealth (subsequent)." CMS proposes work RVUs of 4.00 for GTTT1 and 3.86 for GTTT2 based on crosswalks from Hematopoietic progenitor cell; allogeneic transplantation per donor, and G0427, respectively. CMS proposes no PE inputs for these codes.

CMS also proposes that these services would be added to the telehealth list and would be subject to the geographic and other statutory restrictions that apply to telehealth services. In addition that would be limited to once per day per patient.

Discussion

We agree with these proposals and believe that these services will improve care for beneficiaries in those areas where Medicare makes payment for telemedicine services. We agree that these codes more accurately describe the types of services provided to critically ill patients via telemedicine than to the critical care codes 99291 and 99292.

Recommendation II-E-x

- **We recommend that CMS finalize its proposal to create GTTT1 and GTTT2 and that it finalize the proposed payment amounts.**

- **We also recommend that CMS solicit comment on the payment for GTTT1 and GTTT2 in two years, after physicians have an opportunity to become familiar with the procedures.**

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We thank CMS for the opportunity to comment on this proposed rule. Please call Alanna Goldstein at the American Geriatrics Society at 212-308-1414 or Paul Rudolf at Arnold & Porter at 202-942-6426 if you have any questions about these comments.

Signed:

- American Academy of Home Care Medicine
- American Academy of Hospice and Palliative Medicine
- American Academy of Neurology
- American College of Physicians
- American College of Rheumatology
- American Gastroenterological Association
- American Geriatrics Society
- American Psychiatric Association
- American Society for Blood and Marrow Transplantation
- The Society for Post-Acute and Long-Term Care Medicine