American Academy of Physical Medicine and Rehabilitation

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September 2, 2014

Ms. Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1600-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule

Dear Administrator Tavenner:

On behalf of the more than 8,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAMP&R), we appreciate the opportunity to submit comments to the proposed rule: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule that was published in the Federal Register on July 3, 2014. Physiatrists are specialists in the field of physical medicine and rehabilitation (physiatry) and treat adults and children with acute and chronic pain, persons who have experienced catastrophic events resulting in paraplegia, quadriplegia, traumatic brain injury, spinal cord injury, limb amputations, rheumatologic conditions, musculoskeletal injuries, and persons with neurologic disorders or any other disease process that results in impairment and/or disability.

Provisions of the Proposed Rule for PFS

Using OPPS and ASC Rates in Developing PE RVUs

In the Proposed Rule, the Centers for Medicare and Medicaid Services (CMS) continues to seek a better understanding of hospital acquired physician offices and treatment of those locations as off-campus provider-based outpatient departments. MedPAC has questioned the appropriateness of increased Medicare payment to beneficiary cost-sharing when physician offices become hospital outpatient department. Additionally,

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CMS expressed concern with the validity of the resource data as more physician practices become provider-based.

The AAPM&R generally supports CMS's proposal to create a Healthcare Common Procedure Coding System (HCPCS) modifier to be reported with codes for physician and hospital services furnished in an off-campus provider based department of a hospital. **The Academy believes that the HCPCS modifier should only be used for data collection at this time and that the information collected needs to be shared with all stakeholders and adequate time for public comment must be given before any changes are made as a result of the data.**

Potentially Misvalued Services Under the Physician Fee Schedule

Proposed Potentially Misvalued Codes Identified through High Expenditure Specialty Screen Medicare Allowed Charges > $10 million

CMS identified 64 high expenditure services as potentially misvalued. **The AAPM&R notes that CPT® codes 97032, 97035, 97110, 97112, 97113, 97116, 97140, 97530 and G0283 are all currently referred to the CPT Editorial Panel as the entire Physical Medicine and Rehabilitation section is undergoing revision.**

Epidural Injection and Fluoroscopic Guidance – CPT® Codes 62310, 62311, 62318, 62319, 77001, 77002 and 77003

For CY 2014, CMS established interim final values for four epidural injection procedures:

- 62310 - Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic
- 62311 - Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)
- 62318 - Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic
- 62319 - Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not

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including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)

The CY 2014 interim final values resulted in significant decreases (up to 58%) from those recommended by the RUC and from the CY 2013 rates for all four procedures.

For CY 2015, CMS is proposing to revert to the CY 2013 input values, specifically, work RVUs, work times, and direct PE inputs to establish payment rates for CPT codes 62310, 62311, 62318 and 62319. The Academy continues to believe that the RUC recommended inputs for workRVUs, work times, and direct PE inputs, established from the surveys of the specialty societies that perform the service is correct. However, we agree with CMS that additional analysis of the services is needed to address CMS's concern that these epidural codes are frequently billed with imaging guidance.

In this proposed rule, CMS also states that these codes are frequently billed with image guidance in the facility setting and propose that injection and imaging guidance codes to be bundled and the inputs for image guidance to be included in the valuation of the epidural injection. The agency states "CPT codes 62310 and 62311 were billed with CPT code 77003, 79 percent and 74 percent of the time, respectively in CY 2013. However, in the facility setting CPT codes 62318 and 62319 were much less frequently billed with CPT code 77003, only 3 percent and 11 percent, respectively. Based on the frequency with which these codes are reported with fluoroscopic guidance codes, it appears that fluoroscopic guidance is both typically used and typically reported separately in conjunction with the epidural injection services."[1]

The Academy does not disagree with CMS's analysis or the bundling of the injection and image guidance and agrees with the agency that "to determine how to appropriately value resources for the combined codes, more information is needed"[2] However, unlike the other injection codes stated by CMS as comparison services including transforaminal injections which include the work and practice expense of image guidance in the injection code; the CY 2013 and current epidural injection codes values do not include the additional physician work, time, and intensity associated with the use of fluoroscopic guidance. **AAPM&R recommends that CMS continue to allow the separate reporting of fluoroscopic guidance until the appropriate stakeholders have had the opportunity to submit these codes to CPT for bundling of imagine guidance and appropriately and accurately include the work and PEs of image guidance in the codes, as was done for the injection codes CMS stated.**

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[1] Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule; page 83.

[2] Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule; page 85.

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Valuing New, Revised and Potentially Misvalued Codes

Initiation Year

In an effort to respond promptly to the call for greater transparency in the valuation process, CMS proposes to shift the consideration of all new, revised and potentially misvalued services to the Proposed Rule (rather than an Interim Final Rule) for implementation in the 2016 Medicare Physician Payment Schedule. Unfortunately, the 2016 implementation date is premature, as it would have a serious impact on the development of new technology and new code bundles which is already underway for the Current Procedural Terminology (CPT®) 2016 code set. The cycle for the CPT® 2016 code set began with code change applications for the May 2014 CPT Editorial Panel Meeting submitted by February 14, 2014 and will conclude on February 7, 2015. The AAPM&R believes that it would be highly inappropriate for CMS to implement this proposal in the November 1, 2014 Final Rule because the CPT Editorial process for the 2016 cycle will already be nearly complete by that date and requiring publication in a proposed rule next summer will delay their implementation in Medicare by another year. Those that have solicited new and/or revised CPT codes deserve timely consideration of their applications. They also deserve fair notice of the implementation date. If CMS were to announce a 2017 implementation date on November 1, 2014, it would provide appropriate notification to those submitting code change applications by the first CPT 2017 deadline of February 13, 2015. **AAPM&R strongly urges CMS to begin implementing the new timeline and procedures for the CPT 2017 cycle and the 2017 Medicare Physician Payment Schedule.**

CPT/RUC Timeline

The CPT® Editorial Panel and the RUC each meet three times per year. Historically, the May CPT/October RUC meetings have been the first meetings of each coding cycle, followed by the October CPT/January RUC meetings, and finally the February CPT/April RUC meetings. Following the last set of meetings, CPT is finalized as a code set for the next calendar year and the RUC submits recommendations to CMS for consideration and implementation. The RUC submits all recommendations no later than May 31 each year for consideration for the next payment schedule. As stated earlier, a CPT code originates with a code change application and the first applications of each cycle are due in February, followed by application deadlines in July and November. The current time required to generate a code/relative value ranges from 14 to 22 months from the time of application.

In order to accommodate the publication of proposed valuation of new, revised and potentially misvalued services, CMS proposes to require that all RUC recommendations be submitted by January 15 of each year. For 2016, this would mean that the May 2014 CPT/September RUC meeting would be the only opportunity for the medical community to offer description and recommended valuation of new technology and

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code bundles, since the RUC will not have the opportunity to consider codes from the October CPT Editorial Panel meeting until January 29, 2015.

In addition, this proposal would extend the time required to generate a code/relative value to 22 to 30 months for each subsequent CPT code set cycle at a time when CMS, the CPT Editorial Panel and the RUC are being asked to reduce the amount of time needed to accommodate changes.

AAPM&R supports the AMA's proposal to expedite the review processes for new, revised and potentially misvalued services. The Academy believes that the AMA proposal is reasonable and would retain the current meeting infrastructure for both CPT and the RUC, while shifting the workflow to accommodate the review of commonly performed services to the May CPT/October RUC and October CPT/January RUC meetings. Under this proposal, the February CPT® meeting would predominantly address editorial changes, clinical lab payment schedule services, and new technology services, with expected low volume. The April RUC meeting would replace the formerly lighter September RUC meeting agenda and would be utilized to review the low volume new technology services and discuss methodological and process issues. AAPM&R believes that CMS should be able to publish consideration of the low volume new technology codes in the Final Rule as interim values, as these changes would have minimal impact on the other services on the Medicare Physician Payment Schedule. The AMA proposes to submit RUC recommendations to CMS within one month of each meeting (each November and February for new, revised and potentially misvalued; and each May for low volume new technology). **AAPM&R strongly urges CMS adopt the AMA proposal for modifications in CPT/RUC workflow to accommodate publication in the Proposed Rule, while ensuring that new technology may be described and valued in an efficient and timely manner.**

If CMS adopts the AMA proposal, this will eliminate the need for CMS to create G codes which essentially duplicate the CPT® codes. The Academy believes that the G code proposal is entirely unworkable and should not be considered in finalizing the new process. The creation and adoption of temporary G codes would unnecessarily add to the administrative burden of physicians, non-physician practitioners, and providers who would be tasked with having to learn and implement new codes to be replaced within a relatively short period. When this applies to large families of codes, the burden is even greater, as is the risk for coding errors. Moreover, this threatens to create a situation of parallel but distinct coding between Medicare and private payers, as private payers are likely to implement new CPT codes as soon as they are published.

<u>Refinement Process/Appeals Process</u>

CMS proposes to eliminate the Refinement Panel process currently utilized by the Agency to consider comments on interim relative values. For nearly two decades, the CMS Refinement Panel Process was considered by stakeholders to be an appeals process. The Refinement Panel was organized and composed by CMS and consisted of

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members from the primary care organizations, contractor medical directors, a specialty related to the commenter and the commenting specialty. For many years, CMS deferred to the vote conducted by the Refinement Panel in finalizing values. Most often, the Refinement Panel would support the original RUC recommendations. CMS states that the Refinement Panel was not convened for the former Five-Year Review processes, as this process always involved proposed rulemaking. However, this is not accurate. CMS even convened multi-day face-to-face Refinement Panel meetings during the first two Five-Year Review processes.

Most recently, CMS modified the process to only consider codes for which new information was provided in the comment letter. CMS also began to independently review each of the Refinement Panel decisions in determining which values to actually finalize. In many cases, the Refinement Panel supported the original RUC recommendation and the commenter's request, yet CMS chose instead to implement their original proposed value. The complete elimination of the Refinement Panel indicates that CMS will no longer seek the independent advice of contractor medical officers and practicing physicians and will solely rely on Agency staff to determine if the comment is persuasive in modifying a proposed value. The lack of any perceived organized appeal process will likely lead to a fragmented lobbying effort, rather than an objective review process. Those organizations with limited resources are disadvantaged in comparison to those vendors or organizations that will spend significant resources to overturn a CMS proposed value. **AAPM&R recommends that CMS consider these issues and create a fair, objective, and consistently applied appeals process that would be open to any commenting organization.**

Chronic Care Management (CCM)

AAPM&R supports payment for chronic care management (CCM) services. In fact, the Academy applauds CMS for working with the American Medical Association (AMA) to develop this progressive model of patient care because physiatrists treat mostly beneficiaries with multiple chronic conditions and disabilities.

The Academy agrees with CMS's proposal to allow more flexibility in supervision of clinical staff providing CCM, requiring a general level of physician supervision which would not require that the physician or practitioner be on-site while clinical staff is performing CCM services. Additionally, AAPM&R agrees that the same flexibility should apply to transitional care management (TCM) services.

However, we remained concerned with CMS's proposal to require the use of an EHR to furnish CCM services including an electronic care plan accessible to all providers within the practice including outside of normal business hours and that can be shared with care team members outside the practice. **AAPM&R believes that the EHR requirements may be difficult for smaller practices, especially in cases where members of the patient's care team are outside of the physician's practice. This becomes increasingly difficult and in some cases unrealistic for small practices**

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because there are no standards for the EHRs that require every providers system to speak to other systems. The Academy urges CMS to delay the implementation of this requirement.

Conditions Regarding Permissible Practice Types for Therapists in Private Practice

For CY 2015, CMS proposes to revise regulations related to outpatient physical therapy, occupational therapy and speech-language pathology services, ostensibly to create consistency and simplify the regulatory language. The current regulatory language at 42 CFR Sections 410.59, 410.60 and 410.62 list the types of practice entities through which therapists can provide services. The regulation for physical therapists (410.60) states that a physical therapist in private practice must

Engage in the private practice of physical therapy on a regular basis as an individual, in one of the following practice types:

- An unincorporated solo practice
- An unincorporated partnership or unincorporated group practice.
- An unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated physical therapy practice
- An employee of a physician group.
- An employee of a group that is not a professional corporation

CMS's proposes to eliminate these examples and substitute: "Engage in the private practice of physical therapy on a regular basis as an individual, in one of the following practice types; a solo practice, partnership, or group practice; or as an employee of one of these."
AAPM&R is concerned that although CMS states that the proposal simply clarifies its existing policy (which clearly allows for therapists to practice as employees of a physician practice), the proposed language amendment may be interpreted as no longer allowing therapists to practice as employees of a physician group. The Academy believes that the proposed change does not simplify, but makes something ambiguous which was previously clear. **AAPM&R urges CMS to clarify that the proposed language change still allows therapists to be employed by physician practices.**

Other Provisions of the Proposed Regulations

Reports of Payments or Other Transfers of Value to Covered Recipients

The AAPM&R is generally supportive of CMS's proposal to enhance transparency around physician-industry interactions. However, the Academy believes it is important to strike a balance between reporting what is meaningful for patients to make informed choices about their care provider, and reporting what is not meaningful. The reporting of meaningless information inflates and skews the credibility of the data, and the AAPM&R believes will create the unintended consequence of hindering physician continuing education (CE). The Academy believes that it is vital that physicians be able

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to present at and attend accredited CE programs without risking the stigma and reputational impact that accompanies a listing in the Open Payments system, a concept consistent with Congressional intent.

Specifically, the Academy is concerned that, in an attempt to be more inclusive of accrediting bodies, CMS has proposed eliminating the section of the current policy that requires events to be accredited by one of five specific accrediting bodies in order to be "sunshine exempt." The Academy agrees that it is not the place of CMS, or any government body to endorse specific organizations, nor to limit a market where there is demand. However, after eliminating the accrediting body provision, the current proposal may make it difficult to keep valuable continuing medical education (CME) events exempt because of the current provision which exempts third party transfers to CE only where an industry donor is unaware of the recipients/beneficiaries before and after the funds are transferred. This raises serious concerns as industry could learn the identities of speakers/faculty and participants after the funds have been transferred through brochures, websites, programs, and other publications, or through their physician-employees' participation in CE activities (either as speakers/faculty or attendees).

Continuing medical education is a vital component of our healthcare system and allows our nation's doctors and healthcare providers to remain up to date with the latest in medical science and accredited CME is the gold standard of continuing medical education. The AAPM&R believes that incorporating strong criteria that would ensure the education being provided to learners is firmly based in science, as opposed to requiring the use of specific accrediting bodies or eliminating the requirement altogether, is ideal to striking the appropriate reporting and education access balance. Accredited CME guarantees that any supporter bias - be it commercial or otherwise - is eliminated from the curriculum. This ensures that the intent of CMS to avoid limiting private markets, to continue to exempt high quality CE, to encourage physicians to participate in learning opportunities, to uphold Congressional intent, and to sustain the integrity of the reportable data, will be realized.

Physician Compare Website

CMS is continuing its phased in approach to developing the Physician Compare website, which includes information on physicians and eligible professionals (EPs) enrolled in the Medicare program. CMS proposes to make a broader set of quality measures available for publication on the website in 2015. The 2015 proposed phased in approach includes publicly reporting 20 of the 2013 PQRS individual measures reporting through a registry, EHR or claims. In 2016, CMS proposed to publicly report all 2015 PQRS GPRO measures reported via the web interface, EHR, and Registry for group practices of 2 or more EPs, 2015 CAHPS for PQRS for groups of 2 or more EPs, and publicly report all 2015 PQRS measures for individual EPs collected through a Registry, EHR, or claims.

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While AAPM&R appreciates CMS's attempt at phasing in the public reporting on the Physician Compare website, carefully evaluating the accuracy and utility of the data publicly reported is crucial. Ensuring the accuracy of data collected and its utility from larger practices during the first roll out of physician compare is needed prior to adding additional burden to small and individual practices that may not have the resources to continually monitor the data shared from their practices. Any pitfalls in data accuracy and utility need to be analyzed prior to expanding the data reported publicly from even more physicians. For example, physiatrists practice in large urban areas as well as in small rural areas where the population of patients may be similar but the amount of resources available may vary. Making comparisons across these practice settings without risk adjusting for factors not in the provider's control is inappropriate.

Therefore, AAPM&R urges CMS to slow down its phased in approach of publicly reported data on the Physician Compare website for individual and small practices by first carefully evaluating the accuracy and utility of the data reported from larger practices to ensure data can be truly compared across physician practice sites. Further, AAPM&R urges CMS to ensure a transparent appeals process with appropriate guidance is available for physicians.

Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System

The AAPM&R remains concerned over the lack of meaningful measures in the PQRS program for the PM&R specialty. CMS is proposing to remove many of the measures applicable to physiatrists for the 2015 PQRS program year, including the back pain measures group, and urinary incontinence. Removal of these measures will greatly reduce the number of relevant measures physiatrists can report on resulting in their difficulty satisfying PQRS requirements. CMS recommends removal of the back pain measures group due to this measure representing clinical assessments commonly utilized to provide effective treatment for patients diagnosed with back pain. CMS is also recommending the removal of measures due to eligible professionals consistently meeting performance on a measure with performance rates close to 100% suggesting there is no gap in care. According to data available through the 2012 Physician Quality Reporting System and Electronic Prescribing (eRx) Experience Report, only 36% of eligible professionals were participating in PQRS. With such low participation, it is premature to make a statement that a 100% performance rate is applicable across all eligible professionals.

Although CMS states it would consider re-instituting a measure when performance declines after the measure being removed from PQRS, it will be impossible to gather such data once CMS ceases to collect this information. AAPM&R is fully supportive of moving towards more robust measures that measure outcomes and appropriately risk adjust. However, developing robust measures will require appropriate planning, time and resources. In the meantime, physiatrists will continue to struggle to meet PQRS reporting requirements.

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Another rationale CMS provides for removal of measures is the "measure represents a clinical concept that is initiated within the inpatient setting and does not add clinical value to PQRS as an outpatient based measure" and "CMS recommends removal due to this measure representing a clinical concept that is currently included within inpatient standard of care." However, it is a fact that the PQRS program does not just apply to physicians practicing in an ambulatory setting. Many physiatrists who practice in Inpatient Rehabilitation Facilities (IRF) are expected to participate in the PQRS program when they individually bill for Part B services. They are also required to meet the IRF quality reporting requirements. This is a clear overlap in quality reporting requirements for physiatrists in IRF settings.

Finally, CMS is proposing frequent submissions of data for PQRS rather than one submission of data in 2015. While in theory it is ideal to allow reporting more than once in a year in order to track data in real time, the reality is reporting is currently a burden. Many eligible professionals use third party registry vendors for reporting and these options are paid for on a one-time use basis. Adding additional data submissions will increase the cost for eligible professionals who use these types of registries. Until reporting becomes seamless for eligible professionals, mandating reporting more than once a year will require more time and resources adding to the current burden.

Therefore, AAPM&R urges CMS to modify the proposal to allow for a one year grace period when proposing eliminating measures from the PQRS program, especially when there are only a few or zero measures remaining that address the same topic, such as the low back pain measures group. This will give CMS time to identify and incorporate appropriate substitute measures into the PQRS program, and reduce the overall impact to all eligible professionals. Further, AAPM&R urges CMS to provide an exemption from PQRS to those eligible professionals who are mandated to report both PQRS and IRF reporting requirements because physicians in IRF settings mainly report on measures that initiated within the inpatient setting and should not be held accountable to PQRS requirements, especially when PQRS is moving towards eliminating inpatient initiated measures to outpatient based measures. Lastly, AAPM&R urges CMS to delay mandating frequent submissions of data to not add to the current burden of reporting once.

Other Recommendations

For many years, IONM services were paid under CPT code 95920 which allowed for providers to monitor multiple surgical cases simultaneously. In 2012, the American Medical Association's (AMA's) Current Procedural Terminology (CPT) Panel established two CPT codes for IONM services to replace code 95920: (1) CPT code 95940 for time spent by a provider in the operating room monitoring a single patient; and (2) CPT code 95941 for time spent by a provider monitoring one or more patients from outside of the operating room. Subsequently, the AMA's Relative Value Unit (RVU) Update Committee (RUC) developed valuations for these codes. In the

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calendar year 2013 Medicare Physician Fee Schedule (MPFS) Final Rule (published November 16, 2012); CMS declined to adopt code 95941 for Medicare and instead created HCPCS code G0453, which provides for Medicare payment for IONM services provided from outside the operating room billed in 15 minute time increments for continuous monitoring with "attention directed exclusively to one patient". It is our understanding that CMS felt that code 95941 would allow providers to bill Medicare for monitoring provided to more than one beneficiary during the same time interval and that this would be inconsistent with Medicare payment policy.

Unfortunately, the requirement that G0453 may only be billed for continuous time spent exclusively monitoring one patient is inconsistent with a standard of care that recognizes that more than one surgery can be monitored simultaneously. It is inconsistent with a standard of practice whereby multiple surgeries are monitored at the same time, with the on-duty monitoring professionals organizing and sharing their workload in a manner that ensures close attention at all appropriate times during the surgical procedures. The practical result of the decision to use code G0453 is that most providers cannot currently bill for IONM services provided to Medicare patients when delivered (as is commonly the case) remotely and simultaneously.

AAPM&R believes that CMS's view that if more than one Medicare beneficiary is billed for monitoring performed during a 15 minute increment, and then the same time has been "billed twice", constitutes a fundamental misunderstanding of the service that is being rendered. In our view, both beneficiaries are receiving monitoring services concurrently and both are appropriately billed for services rendered concurrently. This was inherently recognized by the AMA CPT process in creating the original code 95941. This is how IONM is practiced, how services are rendered and, other than under G0453, how they are billed.

We therefore think that what makes the most sense is for CMS to reinstate the use of code 95941. We note that code 95941 has a number of safeguards built in to clarify the conditions under which concurrent monitoring may occur, including:

- It is inapplicable to any form of automated monitoring device that does not require continuous attendance by a professional qualified to interpret the testing and monitoring.
- The monitoring professional must be solely dedicated to the monitoring and must be available to intervene at all times during the reported time period. No other clinical activities can be provided during the same period of time.
- There must be a provision for continuous and immediate communication with the surgical suite team.
- When monitoring more than one procedure, there must be the immediate ability to transfer patient monitoring to another professional should exclusive attention be required to another procedure.

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- Time spent on the baseline study is not included under code 95941 and the baseline study is only reported once per operative session regardless of whether the procedure spans the midnight hour.

Therefore we would strongly encourage CMS, to reinstate CPT code 95941, in replacement for the temporary code G0453, to assure continuity of access to IONM care,

We appreciate the opportunity to comment on this proposed rule. The AAPM&R looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Jenny Jackson, Manager of Finance and Reimbursement in the AAPM&R Division of Health Policy and Practice Services. She may be reached at jjackson@aapmr.org or at (847)737-6024.

Sincerely,

Phillip Bryant, DO
Chair
Reimbursement and Policy Review Committee
American Academy of Physical Medicine and Rehabilitation