

September 2, 2019

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Seema Verma  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1715-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

Re: CMS-1715-P Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Verma:

On behalf of the more than 9,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), we appreciate the opportunity to submit comments to the Medicare Physician Fee Schedule proposed rule. AAPM&R is the national medical specialty organization representing physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

A number of provisions in the proposed rule will impact physiatrists nationwide. The comments we've included below are in response to the several issues in the proposal rule which will most significantly impact physiatry in 2020. Understanding that the final rule must be published in early November, AAPM&R recognizes the need to provide detailed comments on these critically important issues well in advance of the September 27 deadline. AAPM&R will be submitting a second comment letter in the next month responding to additional proposals in the rule.



## **II. Provisions of the Proposed Rule for PFS**

### **K. Care Management Services**

AAPM&R continues to appreciate CMS's efforts to reimburse physicians for care management services. We appreciate the several proposals in this rule designed to expand this coverage for 2020. However, we have hesitations, detailed below, regarding the implementation of these coverage expansions without the review of the CPT Editorial Panel. Implementation of guidelines and codes outside of and sometimes directly in conflict with the CPT Codebook have the potential to create confusion and add burden for physicians and coders trying to navigate multiple systems. We urge continued collaboration with the CPT Editorial Panel as well as ongoing engagement with the RUC to provide guidance on appropriate valuation for all care management services.

#### **2. Transitional Care Management (TCM) Services**

***AAPM&R encourages CMS to finalize its proposal to accept the RUC recommended work RVUs for the transitional care management codes, 99495 (2.36 work RVUs) and 99496 (3.10 work RVUs).***

CMS has proposed encouraging additional appropriate billing of the TCM services by revising the coding guidelines for TCM to allow concurrent billing with a list of codes including prolonged services without direct patient contact (99358 and 99359), interpretation of physiological data (99091), and complex chronic care management services (99487 and 99489) among others.

AAPM&R appreciates these efforts to encourage appropriate billing of TCM services. However, we are concerned that making this guideline change without CPT review and implementation in the CPT manual could cause confusion for physicians and coders. ***AAPM&R encourages CMS to work with the CPT Editorial Panel to review the TCM guidelines to determine the extent to which the concurrent billing proposals are appropriate.***

#### **3. Chronic Care Management Codes**

CMS has proposed changes to the chronic care management (CCM) code set for 2020 that would replace existing CCM codes with G codes and create add-on codes; together, these changes would allow providers to bill incrementally to reflect additional time and resources required in certain cases. While we recognize the new G codes would be temporary, we believe that alternating between CPT and CMS-developed G codes will create confusion for physicians and coders. Therefore, ***AAPM&R encourages CMS to work with the CPT***

***Editorial Panel to consider any changes to the CCM code set and related valuations.***

**4. Principle Care Management (PCM) Services**

CMS has proposed the creation of two new G codes to address a perceived gap in coding and coverage for services provided to patients with a single high-risk condition. AAPM&R recognizes that the current CCM codes are limited to patients with multiple conditions. Further, many of our members treat patients with single high-risk conditions and could potentially see benefit from implementation of these codes. However, based on the G code descriptors, we have some concerns that these codes may be duplicative of work already captured by existing CPT codes including the recently revised office and outpatient E/M codes. Furthermore, as with the TCM and CCM codes previously described, we are concerned about the added burden and potential confusion created when codes do not go through the standard CPT Editorial Panel process. ***AAPM&R encourages CMS to work with the CPT Editorial panel to consider development of one or more codes for services provided to patients with a single high-risk condition.***

**N. Valuation of Specific Codes**

**(4) Trigger Point Dry Needling (CPT Codes 205X1 and 205X2)**

***AAPM&R strongly disagrees with CMS’ proposal to designate CPT codes 205X1 and 205X2 as “always therapy” procedures.*** CMS provides no rationale for this proposal, which we find particularly problematic, given that dry needling is not a therapy service and is not generally provided under a therapy plan of care. Rather, CPT approved the two new dry needling codes for inclusion in the 2020 CPT codebook in the surgical section. While exact code numbers have not been published, based on the temporary code numbers and the terminology used, dry needling codes should be placed in the surgical section of the CPT codebook, near the trigger point injection codes. Inclusion of codes 205X1 and 205X2 on the “always therapy” list suggests that physical or occupational therapists will be the most typical providers of this service. AAPM&R strongly disagrees with that suggestion.

Dry needling is described as the use of solid needles (contrasted with the use of hollow hypodermic needles that are used for injections) to treat muscle pain and spasms by stimulating and breaking muscular knots and bands. Dry needling is an invasive procedure, where needle length can range up to 4 inches in order to reach the affected muscles. Adverse sequelae may include hematoma, pneumothorax, nerve injury, vascular injury, and infection. Post-procedure

analgesic medications may also be necessary. Since it is an invasive procedure using needles, AAPM&R asserts it should only be performed by licensed medical physicians (MD or DO) or licensed acupuncturists. ***AAPM&R recommends that CMS finalize its recommended work RVU values for CPT codes 205X1 and 205X2, adding the codes to the physician fee schedule without designating them as “always therapy” procedures.***

(22) Radiofrequency Neurotomy Sacroiliac Joint (CPT Codes 6XX00, 6XX01)  
Work RVU Proposals

The two new sacroiliac joint codes describe injection of the nerves innervating the sacroiliac joint (6XX00) and radiofrequency neurotomy of the nerves innervating the sacroiliac joint (6XX01). We appreciate CMS’s proposal to implement RUC recommendations regarding the work RVU values for these codes. ***AAPM&R recommends CMS finalize its proposal to accept the RUC recommended work RVU values for 6XX00 (1.52 work RVUs) and 6XX01 (3.39 work RVUs).***

Practice Expense Refinements

AAPM&R is disappointed in CMS’s proposed refinements to the practice expense for 6XX00 and 6XX01. We believe these refinements reflect a misunderstanding with respect to the work done when these procedures are performed. The services performed as described by these two codes reflect injections and neurotomy to four nerves including the dorsal rami of L5 and the lateral branches of S1, S2, and S3.

CMS recommends decreasing the quantity of supply item SC028 (*needle, 18-26g 1.5-3.5in, spinal*) from three needles to one needle for CPT code 6XX00. Four separate needles are required to inject the dorsal rami of L5 and the lateral branches of S1, S2, and S3. While the original RUC recommendation indicates only three needles are needed, this was an error and should in fact be four needles. Standard practice is to place the four needles, then simultaneously inject. If one needle is used, there would be additional time required to account for the sequential fashion of the injections which was not taken into account in the CMS code valuation. ***AAPM&R urges CMS to adjust the quantity of supply item SC028 to four units for CPT code 6XX00 in order to appropriately reflect the supplies required for the procedure.***

CMS also recommends decreasing the quantity of supply item SD011 (*cannula (radiofrequency denervation)*) from four to two for CPT code 6XX01. CMS does not believe that the use of four cannula would be typical for the procedure,

as the reference code currently used for destruction by neurolytic agent contains only a single cannula. The Agency believes that the nerves would typically be ablated one at a time using this cannula, as opposed to ablating four of them simultaneously. Similar to the injection code (6XX00), however, the radiofrequency ablation of the nerves innervating the sacroiliac joint requires four cannulas for simultaneous ablation of the four nerves. These cannula are placed and then guided simultaneously to allow for fewer fluoroscopic images and a safer total radiation dose for the patient and staff. As with the injection codes, this is standard procedure and the physicians surveying this code accounted for their time accordingly. It is also important to note that the comparison code used and referenced in the proposed rule is an ablation of a single nerve. Therefore, while this was an excellent base comparison, code 6XX01 reflects four times that work. ***AAPM&R urges CMS to adjust the quantity of supply item SD011 to the RUC recommended four units for CPT code 6XX01 in order to appropriately reflect the supplies required for the procedure.***

(25) Somatic Nerve Injection (CPT Codes 64400, 64408, 64415, 64416, 64417, 64420, 64421, 64425, 64430, 64435, 64445, 64446, 64447, 64448, 64449, and 64450)

The CPT Editorial Panel reviewed the entire somatic nerve injection code family in May 2018. At that time, several changes were made to the codes including deletion of three codes. Many of the codes were subsequently resurveyed in October 2018. Due to the typical billing patterns of physiatrists, AAPM&R participated in the RUC surveys for some but not all of the somatic nerve injection codes. Our detailed comments on this issue pertain solely to the services physiatrists perform typically. However, AAPM&R strongly supports the RUC recommendations for all codes in the somatic nerve injection family.

#### Work RVU Proposals

We note that CMS has proposed to reject the RUC recommended work RVU for 12 of the 18 services in this code family. The range in work value reduction for the rejected codes, from -5 percent to -25 percent, greatly collapses the variance in work values for this family of services without providing any clinical rationale that the work is much more homogenous than the RUC or the performing specialties have asserted. The physician work for this family of services varies based on the anatomic location of each nerve, whether the service is typically performed in the facility setting, the typical approach used by the dominant specialty to access the nerve that performs each service and whether the service involves continuous infusion by catheter. CMS' proposed

values unfortunately do not sufficiently account for the specific attributes involved in performing each service. Further, CMS has identified alternatives to the RUC recommendations which are not founded in standard valuation process. This trend is very concerning and shows a disregard for the formalized process the RUC follows or for the amount of effort put forward by the specialty societies and the RUC. ***AAPM&R recommends CMS finalize the RUC recommended work RVUs for all somatic nerve injection CPT codes.***

### **64420**

CMS has proposed a work RVU of 1.08 for CPT code 64420. This is less than the RUC recommend work RVU of 1.18. It is our understanding that this is based on the change in total time for the code multiplied by the RUC recommended value. We do not believe this is an appropriate approach for valuing this code, particularly since the previous total time attributed to this code is a Harvard study time. The RUC recommendation for CPT code 64420 is based on the current work RVU and supported by the 25th percentile work RVU from the specialty societies' survey. This recommendation was vetted by the RUC and also supported by a comparison to several comparator codes. ***AAPM&R urges CMS to finalize the RUC recommended work RVU of 1.18 for CPT code 64420.***

### **64421**

CMS has proposed a work RVU of 0.50 for CPT code 64421, while the RUC recommended a work RVU of 0.60. CPT code 64421 is one of the codes that was most significantly revised at the CPT 2018 meeting. This code is now an add-on code for 64420. As we understand it, CMS used a time ratio methodology for this code, which was based on the codes current value. As with code 64420, the previous time input for code 64421 is Harvard-based. Additionally, this methodology is particularly inappropriate for code 64421 because of the significant revisions made to it, which include a change to the global period from 000 to ZZZ. There is no rationale for valuing 64421 based in any way on its previous value. ***AAPM&R urges CMS to finalize the RUC recommended work RVU of 0.60 for CPT code 64421.***

### **64425**

CMS has proposed a work RVU of 1.00 for CPT code 64425, while the RUC recommended a work RVU of 1.19. It is unclear in the rule exactly what mechanism was used to identify the CMS recommendation. We are extremely disappointed in CMS's lack of consistency and willingness to create justification for recommendations based on randomly selected comparison CPT

codes. The RUC process for valuing CPT code 64425 was based on the current work RVU, which is supported by the 25th percentile work RVU of the specialty societies' survey. ***AAPM&R urges CMS to finalize the RUC recommended work RVU of 1.19 for CPT code 64425.***

### **64445**

CMS has proposed a work RVU of 1.00 for CPT code 64445, while the RUC recommend a work RVU of 1.18. Similar to code 64425 described above, it is unclear exactly what mechanism was used to identify the CMS recommendation. The RUC recommendation was based on the current work RVU, which is supported by the 25th percentile work RVU from the specialty societies' survey. AAPM&R supports the RUC methodologies for identification of the appropriate value for this service. ***AAPM&R urges CMS to finalize the RUC recommended work RVU of 1.18 for CPT code 64445.***

### Practice Expense Refinements

CMS has proposed several refinements to the practice expense for the somatic nerve injection code family. Specifically, CMS has proposed to modify clinical activity CA011 from three minutes to two minutes, which is noted as a refinement of time to the standard for this clinical task. We have confirmed with RUC staff that the RUC PE Subcommittee does not have a standard time allocated for this clinical activity. As this code family includes only 000-day global services, the pre-service period for this activity, CA004, is zero minutes. All time for this task is included in CA011. The specialty societies that surveyed this code family agree that three minutes is the appropriate time input for clinical activity CA011. Further, many of the additional refinements CMS identified for the somatic nerve injection family are a direct result of the adjustment to clinical activity CA011. ***AAPM&R recommends CMS finalize the RUC recommended three minutes of clinical activity CA011 and not implement the associated additional refinements for the somatic nerve injection family.***

(26) Genicular Injection and RFA (CPT Codes 64640, 64XX0 and 64XX1)

### Work RVU Proposals

***AAPM&R recommends CMS finalize its proposal to accept the RUC recommended work RVUs for 64640 (1.98 work RVUs) and 64XX0 (1.52 work RVUs).*** For CPT code 64XX1, CMS is proposing a work RVU of 2.50, which is lower than the RUC recommended work RVU of 2.62. CPT code 64XX1 describes the destruction of three nerve branches at three locations in the knee. CMS has proposed a work RVU of 2.50 based on a crosswalk to

11622, a code describing excision of a malignant lesion. AAPM&R believes this is an inappropriate work RVU crosswalk since 64XX1 is a more intense and complex procedure with significant potential complications. Code 64XX1 requires careful placement of three needles requiring fluoroscopic guidance for accurate placement while the soft tissue lesion excision requires only direct observation on a single object of attention. AAPM&R supports the RUC recommended crosswalk of 11642 as it is a far more appropriate comparison. ***AAPM&R urges CMS not to finalize its proposed work RVU for CPT code 64XX1 and instead to accept the RUC recommended work RVU of 2.62.***

#### Practice Expense Refinements

CMS has proposed refinements to the practice expense inputs for 64XX1. CMS recommended decreasing the quantity of supply item SD011 (*cannula (radiofrequency denervation)*) from three to one for CPT code 64XX1. CMS does not believe that the use of three of this supply item would be typical for the procedure as the nerves would typically be ablated one at a time using this cannula, as opposed to ablating three of them simultaneously. As with the sacroiliac joint code, the 64XX1 procedure does require simultaneous ablation of the three genicular nerves. This is standard practice and was therefore the way in which the survey respondents would have completed the survey. ***AAPM&R urges CMS to accept the RUC recommendation of three units of SD011 for CPT code 64XX1.*** CMS is also proposing to refine the equipment time for the equipment item *radiofrequency kit for destruction by neurolytic agent* equipment from 141 minutes to 47 minutes. The equipment time recommendation was predicated on the use of three of the SD011 supplies for 47 minutes apiece, and CMS is refining the equipment time to reflect its supply refinement to one cannula. The same concept as above applies here as well. Three individual kits are required to do this work simultaneously ***AAPM&R urges CMS to accept the RUC recommendation of 141 minutes for the equipment item radiofrequency kit for destruction by neurolytic agent for code 64XX1.***

#### **P. Payment for Evaluation and Management (E/M) Services**

AAPM&R appreciates CMS's consideration of the CPT and RUC proposals related to office and outpatient E/M coding. AAPM&R participated throughout the CPT and RUC processes tied to the revision of the office and outpatient E/M code family and guidelines as well as to the resurvey of the revised codes. We are appreciative of CMS's support for these proposal as we believe they are reflective of a consensus among the medical community. ***AAPM&R encourages CMS to finalize for 2021 the proposed CPT code and guidelines***



***changes as well as the work RVU values for CPT codes 99202-05 and 99211-15.*** However, AAPM&R has significant concerns about the impact of implementing higher work RVU values for E/M services. While we support these new values, we recognize that they will result in a significant redistribution across the fee schedule which will negatively impact many physicians, including some of our members. We recognize the constraints of the Physician Fee Schedule. ***Therefore, AAPM&R encourages CMS to urge Congress to implement changes, including positive base updates to the conversion factor, which could mitigate these negative impacts.***

#### Office Visits Included in Codes with Global Periods

Rather than extend updated values to E/M visits included in global codes, as recommended by the RUC, CMS maintains the current E/M values throughout the codes with global periods. AAPM&R strongly disagrees with CMS's decision on this issue. Implementing new values for E/M codes when billed independently but not implementing those same values in the global packages disrupts the relativity in the entire physician fee schedule. Maintaining relativity across codes in the fee schedule is inherent to the resource-based relative value unit (RVU) system. Furthermore, it is our understanding that in all previous revaluations of the E/M codes, post-operative visits in the global periods were updated to reflect the new values including in 1997 (the first Five-Year Review), in 2007 (the third Five-Year Review), and in 2011 (when the elimination of consultation codes created budget neutrality adjustments affecting office visits). ***AAPM&R encourages CMS to follow its own past policy and finalize for CY 2021 the RUC's recommendation of commensurately including the updated E/M values in codes with global periods.***

#### Proposed Add-On Code GPC1X

AAPM&R appreciates CMS's efforts to consolidate and simplify the two add-on G codes described in the CY 2019 Medicare Physician Fee Schedule. The proposed code, GPC1X, is a Medicare-specific add-on code for E/M office visits describing the complexity associated with visits that serve as a focal point for all medical care or for ongoing care related to a patient's single, serious, or complex chronic condition. AAPM&R was concerned to learn, upon review of the CMS impact tables, more than \$1.5 billion will be redistributed between specialties if this code is implemented. While we appreciate CMS's efforts to compensate physicians adequately for the additional work included in caring for single, serious, or complex chronic conditions, we do not feel that the code has been sufficiently defined to clarify appropriate use. AAPM&R believes

that clarification on this type of code could be achieved through the CPT process. *AAPM&R encourages CMS to work with the CPT Editorial Panel to consider coding options to meet the intended needs of code GPC1X.*

### **III. Other Provisions of the Proposed Regulations**

#### **K. Updates to the Quality Payment Program**

For the 2020 MIPS performance year, CMS proposes to remove 55 quality measures, which represents over 20 percent of the quality measures in the program. Overall, the AAPM&R is very concerned about CMS' proposal to remove such a large number of measures in one year since this will interfere with program consistency and drastically reduce the number of relevant measures available to specialists at a time when many specialties are already struggling to identify meaningful measures.

More specifically, we are concerned about CMS' proposal to remove **measure #131: Pain Assessment and Follow-Up**, which evaluates the percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present. CMS proposes to remove this measure, which was first adopted for MIPS in 2018, due to controversy surrounding the potential correlation between assessment of pain and increase in prescriptions for opioid medications. CMS believes this measure may have the unintended consequence of encouraging excessive prescribing of pharmacologic therapies to assist with pain management.

The AAPM&R understands and respects concerns about the need to proceed carefully with the measurement of pain management, particularly when there is a link between scoring well and higher payments. This issue has come up in the context of the Hospital CAHPS (HCAHPS) survey, where CMS recently removed the Pain Management questions because of this link and the potential for it to result in perverse incentives by putting pressure on clinicians to prescribe more opioids in order to achieve higher scores on the pain management dimension. However, we believe that the risks associated with measure #131 are minimal compared to the risks associated with pointed questions from HCAHPS that ask specifically about "how often was your pain well controlled?" and "how often did the hospital staff do everything they could to help you with your pain?" In contrast to the HCAHPS survey questions, Measure #131 is intentionally flexible and allows for a range of assessments and follow-up pathways. It does not require an opioid prescription and because

it does not specify a pain assessment tool, it also does not dictate the use of any specific questions that might unintentionally incentivize opioid prescriptions. Furthermore, the measure allows designing treatment plans to consist of a planned follow-up appointment or a referral, a notification to other care clinicians as applicable OR indicate the initial treatment plan is still in effect. These plans may include pharmacologic interventions, but also interventional therapies, behavioral, physical medicine and/or educational interventions. As such, we believe that any potential link between this measure and the unintentional promotion of the overuse of opioid therapy is tenuous, at best.

We also remind CMS of ongoing gaps in pain assessment and management. Evidence shows that there is considerable variation in pain assessment and treatment among racial and ethnic populations and across different types of pain (e.g., acute, chronic, cancer-related) and medical settings (e.g., emergency departments and primary care) (Green, 2003; Green, 2007; Todd et al., 2007). Research also shows gender differences in pain treatment with evidence showing that women's pain complaints tend to be poorly assessed and undertreated (Green, 2003; Chronic Pain Research Alliance 2011, Weimer 2013). More recent literature has found that structured pain assessment using a variety of validated measures can be an important aid to assist with evaluation, diagnosis and treatment of pain and that assessment of acute pain severity is crucial for effective perioperative management and to reduce the risk of chronicity (Bendinger et al., 2016).

Finally, we request that CMS consider the applicability of this measure to multiple specialties. This measure is currently included in the following specialty measure sets: Orthopedic Surgery, Physical Medicine, Urology, Rheumatology, Physical Therapy/Occupational Therapy, Geriatrics, and Urgent Care. In this rule, CMS proposes to also include it in the following specialty sets: Chiropractic Medicine, Clinical Social Work, Audiology, and Speech Language Pathology. The applicability of this measure to a variety of specialties, clinician types, and settings demonstrates that it is a high value measure that also supports CMS' goal of moving towards more aligned sets of measures under the MIPS Value Framework.

In conclusion, CMS must not lose focus of the fact that the primary aim of this quality measure is to assist clinicians with identifying patients experiencing pain and providing a follow-up plan that is most appropriate for the patient. It targets two of CMS' highest priority areas— measures based on outcomes and measures targeting opioid use, management, and treatment— at a time when

CMS is trying to streamline the MIPS measure set to focus on high value areas. ***The AAPM&R believes that measure # 131 is a clinically appropriate and critically important tool for encouraging high quality pain assessment and management practices and that it should remain in MIPS for 2020 and beyond.***

Thank you for the opportunity to comment on this important proposed rule. If the Academy can be of further assistance to you on this or any other rule, please contact Carolyn Millett at 847-737-6024 or by email at [cmillett@aapmr.org](mailto:cmillett@aapmr.org) for further information.

Sincerely,

A handwritten signature in black ink that reads "Annie D. Purcell, D.O." The signature is fluid and cursive, with the initials "D.O." written in a larger, more stylized font at the end.

Annie Davidson Purcell, D.O.

Chair

Reimbursement and Policy Review Committee