American Academy of Physical Medicine and Rehabilitation

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April 13, 2020

Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1744-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-1744-IFC Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

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 in response to the above-referenced interim final rule with comment period. 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.

We would first like to thank the Administration for the speed at which you have announced critical flexibilities during the pandemic. The numerous waivers and policy changes made are allowing physicians to continue important work in this challenging time. However, we have concerns that the policies addressing evaluation and management (E/M) services do not go far enough to enable our members to safely, responsibly, and sustainably deliver medically necessary care to our patients. While CMS has finalized separate coverage and payment for telephone only evaluation and management services (CPT 99441 - 99443), payment for these services in insufficient, and the codes do not sufficiently encapsulate all of the telephone-only care that our members provide, or the accompanying work required.

AAPM&R appreciates that CMS chose to use existing CPT codes for telephone services and the associated RUC-recommended values. However, the ways in which physicians are being asked to provide telephone services during the COVID-19 pandemic do not coincide with the original intention of the telephone codes, nor do they coincide with the way those codes were valued by the RUC. We assert that in many instances the way our members are providing care to their patients by telephone is far more akin to a standard, face-to-face E/M visit, or a visit when it is conducted using real-time audiovisual technology. While a physical exam is not taking place, many of our members report asking detailed questions to assess functional status. Additionally, the medical decision making and time associated with the visits that are beyond services that call for use of the telephone-only codes can far exceed the intention of and reimbursement associated with the telephone codes. ***For these reasons, AAPM&R recommends that CMS waive the requirement specifying that office and outpatient E/M visits furnished via telehealth must include a video component.*** This change will allow physicians to receive reimbursement for E/M services furnished via audio only that is better aligned with the care they are furnishing, while strengthening incentives to furnish medically necessary services via telecommunications technology as needed to slow the spread of the novel coronavirus. Furthermore, we believe that CMS' recent rulemaking regarding selection of office and outpatient E/M visit levels furnished via telehealth – under which level selection may be based on either time or medical decision making, and CMS removed requirements regarding documentation of history and/or physical exam in the medical record – established a foundation on which such a change can be built.

Physiatrists who are conducting telephone services during the COVID-19 pandemic are doing so out of necessity and with the understanding that real-time visits with both audio and visual capabilities would likely be easier to conduct. The beneficiaries they are caring for either do not have access to or agility with real-time audiovisual technology. This may be due to age, socio-economic status, or the lack of internet access available in remote areas. It is also important to highlight that because of the nature of the specialty of physiatry, many of our members see patients suffering from cognitive impairment, which may further increase challenges in utilizing real-time audiovisual technology.

Our members have reported using telephone-only visits in place of standard telehealth for a variety of different types of patient encounters. For example, it has been a way to conduct comprehensive follow-up visits with their spinal

cord injury patients they typically would have seen in the outpatient hospital setting. These patients can verbally report on their function, improved or worsening spasticity, and bowel issues even though a physical exam is not completed. A historical account of these conditions can result in a process of medical decision making similar if not identical to when a service is provided face-to-face.

A large portion of our members practice in the musculoskeletal and/or pain management space. Due to the non-urgent nature of many of the procedures these physicians perform, many of these practices are either closed to in-office visits or are seeing only the most urgent cases. For these members, the telephone has become their primary tool with patients who do not have access to or agility with real-time audiovisual technology. As with the spinal cord injury patients previously described, these patients can be assessed verbally with respect to their function in a way that approximates a physical exam such that our members can confidently consider changes to their plan of care including medication management.

To date, we understand our members are using the telephone as a means to remove barriers to care for their patients during this challenging time. Unfortunately, the payment rate now associated with these services is not commensurate with the care being provided. With the many actions CMS has taken to remove barriers to care during this challenging time, AAPM&R urges CMS to consider our recommendation to appropriately reimburse physicians for this work.

Thank you for the opportunity to comment on this important interim final 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 for further information.

Sincerely,

Annie D. Purcell DO

Annie Davidson Purcell, D.O.
Chair
Reimbursement and Policy Review Committee