



September 10, 2018

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave SW
Washington, DC 20201

Docket Number CMS-1693-P

Submitted Electronically to www.regulations.gov

Dear Administrator Verma:

We appreciate the opportunity to provide comments on the “Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements” proposed rule. Our comments focus on the provisions of the proposed rule that incorporate patient centered connected care and recognize communication-technology based services.

Interoperable, connected health, requires and includes a broad ecosystem of shared digital health information and use of digital health information. It is particularly noteworthy that this proposed rule takes an enormous and important step forward to advance digital, interoperable, connected health care. PCHAlliance members support the advancement of evidence based connected health, and, has created and supports the Continua Design Guidelines which identify open data standards for device to EHR interoperability.

We extend our appreciation for incorporation of evidence based chronic condition remote patient monitoring CPT codes, interprofessional consultation codes, virtual check-in, and remote evaluation of pre-recorded patient information. Together, this set of policies offers opportunities for the modernization of Medicare physician payment.

Specifically, we want to express our support for:

- ***The inclusion of and payment for chronic care remote monitoring***, Current Procedural Therapy (CPT) Codes 990X0, 990X1, and 994X9. Remote monitoring is both a viable and clinically proven means to conduct monitoring. We note that there is extensive literature on the efficacy and value of remote monitoring, reviewed by the Agency for Healthcare Research and Quality (AHRQ) as well as by the AMA’s CPT Editorial Review Board. We

provide specific comments on the valuation of these codes in our detailed comments and ask that CMS adopt the Relative Value Scale Update Committee (RUC) recommended value for 990X1, all of which was and is attributable to a specific patient.

- ***The inclusion and payment for interprofessional internet consultation***, CPT Codes 994X6, 994X0, 99446, 99447, 99448, and 99449. Use of modern communication technology is clearly a viable means for interprofessional consultation and when such consultation is attributable to a specific patient, reimbursement of clinical time is essential to the promotion and practice of the best patient centered care. We provide specific comments on the valuation of these codes in our detailed comments and ask that CMS adopt the RUC recommended value for 994X6.
- ***The inclusion of pulmonary wireless pressure sensor services***, CPT codes 332X0 and 93XX1.
- ***The expanded access to home dialysis therapy through use of telehealth*** for monthly ESRD clinical assessments.
- ***The expanded use of telehealth for individuals with stroke.***
- ***The thought and consideration given to creation of new codes*** for brief virtual check-ins and for remote evaluation of patient generated digitally delivered health information.

Specific Comments:

Services delivered remotely using evidence-based communications technology are essential to modernization of Medicare and are NOT “Medicare telehealth services”:

CMS, in the proposed rule, made an important and well-reasoned policy to allow for the broad utilization of digital health medical technologies (which include medical telecommunication technologies) in healthcare service delivery.

As has long been the case, certain other kinds of services that are furnished remotely using communications technology are not considered “Medicare telehealth services” and are not subject to the restrictions articulated in section 1834(m) of the Act. This is

We agree and encourage CMS to continue to review and consider digital health medical technologies as evidence-based tools for delivery of patient centered care with an eye to continuous modernization of the physician fee schedule. We would welcome the opportunity to engage CMS for further discussions and considerations in future rulemaking on available innovative medical technologies.

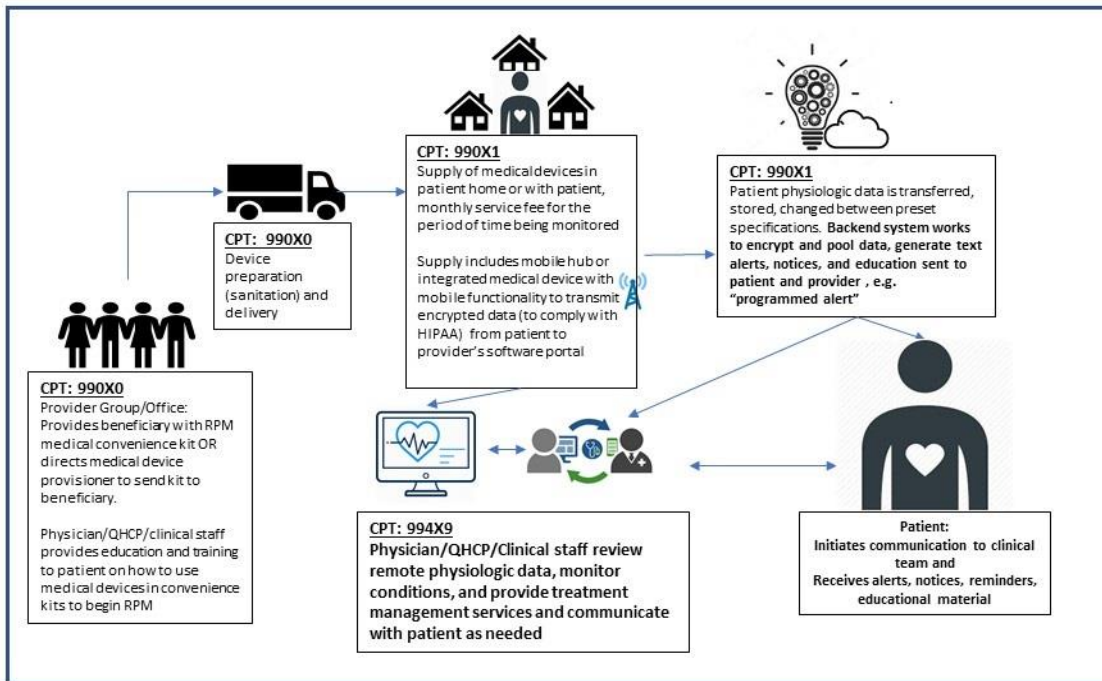
Chronic Care Remote Monitoring CPT Codes 990X0, 990X1, and 994X9 are important new codes that are key to modernizing the physician fee schedule, we urge CMS to consider modifications to the valuation proposed for 990X0 and 990X1:

PCHAlliance supports and applauds CMS for incorporating these three new CPT codes reflecting modern delivery of evidence-based care for patients with chronic conditions as codes that will be reimbursed by Medicare. The evidence base is extensive and clear that remote monitoring for patient's heart failure, chronic obstructive pulmonary disease, sleep apnea, and multiple chronic conditions improves the quality of care and reduces hospitalization rates. We provide specific comments on the CMS proposed valuation of these codes:

990X0 Chronic care remote physiologic monitoring, initial setup and patient education on use of the equipment: We appreciate and support CMS' acceptance of the RUC valuation of this code. The practice expense value attributed to staff time spent on patient education associated with the set up for the equipment is reasonable and appropriate. We recommend CMS add to this valuation the cost of equipment sanitation and reprocessing as a one-time cost that is directly attributable to a patient. FDA device guidelines require that a reusable medical device be 'reprocessed' which includes sanitation or sterilization (as appropriate for device and level of risk) and ensuring that all personal data is 'wiped' or removed from the device. This cost was not considered by the RUC, however, it is routinely part of the 'set up' costs that are onetime costs directly attributable to a patient. We urge inclusion of this practice expense.

990X1 Chronic care remote physiologic monitoring, device supply with daily recordings and programmed alert transmission: We recommend that CMS accept the RUC valuation of this code and include both components that the RUC identified as practice expense (monthly equipment cost and monthly cellular and licensing fee which is the cost of data transmission & monitoring.) Both components identified and valued by the RUC as a practice expense for CPT 990X1 are directly attributable to a patient and should be included as a practice expense. The "monthly cellular and licensing fee" is comprised of the monthly cost associated with encryption of data for safe HIPAA compliant transfer, programmed alerts (e.g. system generated patient specific alerts/notices/education that are based on the patient condition), AND the monthly cost of pre-loaded connectivity used to transmit patient generated physiological data from a specific patient to the provider's software. CMS asserts that these costs are NOT directly attributable to a specific patient, yet, these costs are associated with a specific patient under a provider's care and comprise the data transfer by the patient, communication between the patient and provider, patient specific education, and patient specific programmed alerts. We also note that CPT code 990X1 requires the use of an FDA listed digital device system; such devices include data transmission capabilities that are limited to the patient-provider communication, either through integrated communication technology or an attached/accompanying hub. Reliance upon a patient's cellular connectivity or WIFI, which may or may not be operating based on patient technology capabilities, is not reliable for medical delivery purposes. The following graphic outlines what and how remote patient monitoring is provided and may be helpful to understanding patient attributable costs:

Chronic Condition Remote Physiologic Monitoring: How it works



994X9 Chronic care remote physiologic monitoring, treatment management services of 20 minutes or more: We appreciate and support CMS proposal to reimburse for these clinical services and the current valuation proposed by CMS.

We support and appreciate CMS proposal to reimburse for interprofessional internet consultation, CPT Codes 994X6, 994X0, 99446, 99447, 99448, and 99449 and ask that CMS reconsider the valuation 994X6.

The unbundling and addition of interprofessional internet consultation codes is important to the modernization of the practice of medicine. We were perplexed by the proposal to reduce the RUC recommended valuation of 994X6 and reduce the RVU from 0.7 to 0.5 for the consulting provider. It is clear that the consulting provider must review materials sent by the initiating provider and then conduct the consult. Yet, CMS is proposing to only pay for the time both the initiating and consulting provider communicate. We urge CMS to rethink the valuation of 994X6 and adopt the RUC valuation.

We appreciate and thank CMS for working to create the brief virtual check-ins and for remote evaluation of patient generated digitally delivered health information and have several questions about the proposed brief virtual visit code.

PCHAlliance supports reimbursement for evidence based virtual or digital medicine. We believe strongly in the need for an evidence base to guide patient centered care and appropriate use of new means of

care delivery. The current literature we have seen supports use of in-depth virtual visits as a substitute for in person evaluation and management visits but does not appear to include brief virtual visits. We believe these visits may have value but are concerned that the evidence base currently provides little guidance to providers for appropriate use. The guiderails proposed by CMS – that this may only be billed for established patients and when there is no evaluation and management visit in the 7 days prior or the 24 hours following the brief virtual visit – may in fact be the right approach to appropriate use. However, we remain concerned that there is no evidence base guiding the establishment of the parameters for when this visit is appropriate and helpful to patient care.

PCHAlliance fully supports the new code and ability for a provider to bill for remote evaluation of patient generated digitally delivered health information. We believe that requiring that this must be patient initiated is important to support and incent patient centered care. And we support the proposed guardrail that this may only be billed when there is no evaluation and management visit in the 7 days prior or the 24 hours following the remote evaluation of patient generated and transmitted data.

Virtual care delivery approaches should be explicitly included in the creation of a bundled episode of care for management and counseling treatment of substance abuse disorders.

The evidence base is developed and growing demonstrating efficacy of virtually delivered behavioral health services. According to a 2012 HRSA report, virtual behavioral health may be one of the more successful applications of telehealth across the spectrum of clinical services as outcomes and patient acceptance for virtual behavioral health are comparable to face-to-face visits. The report went on to detail how virtual behavioral health can improve care delivery, expand staff capacity, enhance training capacity and achieve cost savings.ⁱ

Personal Connected Health Alliance (PCHA) extends its support for these new and welcome incentives and standards that promote adoption of evidence based connected care in the Medicare Physician Fee Schedule. CMS' acknowledgement and incorporation of the growing body of clinical evidence supporting the use of telecommunications technology to conduct patient centered evidence-based care is truly heartening. Please continue to work with PCHA and its respective members on ensuring improved communication and exchange of health information between providers and health consumers. Thank you

Sincerely,



Rich Scarfo
Vice President

ⁱ Accessed at:

<https://www.hrsa.gov/sites/default/files/publichealth/guidelines/BehavioralHealth/behavioralhealthcareaccess.pdf>