August 29, 2022

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1770-P

P.O. Box 8016

Baltimore, MD 21244-8016

**Re: Comments on the CY 2023 Physician Fee Schedule Proposed Rule (CMS-1770-P)**

*Submitted electronically on http://www.regulations.gov*

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment on the proposed changes impacting Remote Therapeutic Monitoring rules included in the CY 2023 Physician Fee Schedule Proposed Rule (CMS-1770-P).

I strongly support CMS’ proposal to provide reimbursement for remote therapeutic monitoring (RTM) and remote therapeutic monitoring treatment management services (RTM-TMS) for musculoskeletal (MSK) system status, supply code and associated treatment services.

RTM will help improve arthritis and other musculoskeletal (MSK) care and lead to reductions in unnecessary costly spending, such as surgery, opioids, MRIs, and other imaging. In addition, RTM is extremely important and beneficial for outpatient post-operative visits to insure success of surgery. RTM will also help improve access in rural and underserved areas. Providers typically urge patients to adhere to an at-home MSK therapeutic exercise program to reach treatment goals. In fact, evidence shows much of a patient’s outcome is determined outside of the clinical visit; however, up to 70 percent of patients do not adhere to their home program.

This is a major issue for Medicare beneficiaries where almost 70 percent of people over age 65 have a MSK condition, according to the United States Bone and Joint Initiative. These conditions can make other health issues more difficult to manage. For example, back or joint pain may make it harder for people to get the exercise they need to manage other chronic illnesses, such as heart disease, diabetes, and behavioral health.

I appreciate CMS’ willingness to act upon stakeholder input and strongly support the proposed change allowing physicians and nonphysician practitioners, including physical and occupational therapists, to use “general supervision” to reduce supervisory burden.

However, **I urge changes in 2 areas – which if not revised – will jeopardize patient access to RTM services, especially in rural and underserved areas:**

* **Restore the Large Cut to Physical Therapists’/Occupational Therapists’ RTM Treatment Management Services Payments; and**
* **Drop the Proposed New Requirement that 16 Days of Data Must be Reported in order to bill RTM Treatment Management Services (GRTM 1-4) and drop the proposed requirement that 98975 and 98976 or 98977 must be billed prior to reporting the proposed GRTM 1-4 codes.**

These two issues are explained below.

1. **New G Codes for RTM-TMS Significantly Cut Payments for Physical Therapists/ Occupational Therapists and Represent a Major Disincentive to Perform RTM Services**

CMS is proposing to split the RTM treatment management services codes into 2 groups – GRTM 1 and GRTM 2 for physicians and non-physician providers; and GRTM 3 and GRTM 4 for non-physician qualified health care professionals (e.g., physical therapists (PTs), occupational therapists (OTs), speech language pathologists, licensed clinical social workers).

The proposed rule significantly reduces the practice expense for the proposed GRTM 3 and GRTM 4 codes by removing the clinical staff inputs. **This represents an almost 40 percent payment reduction for the first 20 minutes of RTM treatment management services and another 24 percent payment reduction for the second 20 minutes.** The practical impact of this change would create a significant disincentive for PTs/OTs to perform RTM services and therefore, undermines one of CMS’ aims to increase patient access to RTM services. This is very problematic as evidence shows that early and adherent therapy is critical to improving patient outcomes and lowering Medicare MSK spending by avoiding surgeries, opioids, and MRIs which is why RTM is such a promising and important service.

Most codes billed by physical and occupational therapists include direct practice expense inclusive of duties performed by physical therapist assistants (PTAs) and occupational therapy assistants (OTAs). In the case of the RTM codes, this includes “communications with the patient”, “organizing and preparing data” and “performing procedure/service not related to physician work time”. All the direct practice expense clinical staff duties are performed when PTs and OTs provide RTM treatment management services. To conclude, no matter who the provider is delivering the RTM services, the practice expense should be the same and should not be provider specific because these services require that ALL providers of this service do the same tasks with similar resources.

PTs/OTs are in a unique position as they are not a physician or NPP, but they are also unlike other professionals who may be able to bill the RTM-TMS codes and do not rely on assistants (e.g., clinical social workers, registered dieticians, nutrition professionals), and hence are not using clinical staff when billing the proposed G-codes (GRTM 3/4). Even though PTAs and OTAs do not function “incident to” (as used in context by CMS regarding the RTM codes) a PT or OT, respectively, a PTA and an OTA are still a clinical staff person functioning under the direction and supervision of a qualified healthcare professional (PT, OT). In fact, I would argue that the RTM codes are not “incident to” when provided by clinical staff under the supervision of a physician/NPP and that “incident to” should not be used when discussing RTM services and billing.

**Recommendation: I ask CMS to adopt one of three options to address this problem**:

1. Create 2 additional GRTM codes – GRTM 5 & 6 for PTs/OTs that recognize the use of clinical staff time and use the same non-facility work and practice expense values as 98980 and 98981. GRTM 3 and 4 would remain for other non-physician professionals that do not use clinical staff in performing their functions. **OR**
2. Restore the Practice Expense RVUs for non-facility payments for GRTM 3 and GRTM 4 **OR**.
3. Maintain the current CPT codes of 98980 and 98981 with their current work and practice expenses relative value units.

**In addition, I ask CMS to allow the use of “general supervision” in Options 1, 2, and 3.**   
  
Since CMS is proposing general supervision for GRTM 1 and GRTM 2 codes, it would only make sense to have the 3 options discussed above to also be allowed to be provided with general supervision. RTM is ideally suited for general supervision; by definition, RTM-TMS services focus on remotely reviewing/analyzing data, communicating with the patient, and do not involve hands-on services or physical exams. In a private practice setting, this does not require a physical therapist (PT) or an occupational therapist (OT) to be in the same office suite as a physical therapist assistant (PTA) or an occupational therapy assistant (OTA), respectively, when the PTA or OTA is reviewing and organizing data, communicating with the therapist, and/or communicating with the patient.

If CMS does allow general supervision as requested above, I also ask CMS to clearly state in the final rule that RTM services billed by a PT or an OT in the private practice setting can be provided under general supervision and the direct supervision requirement listed in CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Service, Section 230.4 does not apply to RTM services provided by a PT or an OT in the private practice setting.

I appreciate CMS asking for comment in this proposed rule about the possibility of permanently  
 allowing “immediate availability for direct supervision through virtual presence” for a subset of   
 services. I believe the virtual presence rule should be made permanent for RTM when provided by a  
 PT or OT in a private practice setting. RTM is ideally suited for “virtual presence” supervision; by  
 definition, RTM-TMS services focus on remotely reviewing/analyzing data, communicating with the  
 patient, and do not involve hands-on services or physical exams. I ask that this option be a last resort   
 as I want to stress that the 3 options discussed above should all be able to be provided via general   
 supervision in all practice settings, including physical and occupational therapists in private practice.

1. **Harmful Proposal to Require Billing the Education and Device Supply CPT Codes (98975, 98976, or 98977) – Including 16 Days of Data Requirement – Prior to Reporting Treatment Management Services.**

In the proposed codes for all RTM-TMS (GRTM codes 1, 2, 3, and 4), there are new parenthetical requirements that codes “98975 and 98976 or 98977” (the set-up/education and device supply codes) must be billed prior to billing the proposed new G codes GRTM 1/2/3/4 and that 16 days of data are required.

There are two critical practicality issues:

* **First, if the proposed rule were finalized, clinicians would not be able to start a patient on RTM services mid-month**. This is a significant concern as evidence shows that early and adherent therapy is critical to improving outcomes and avoiding expensive surgeries, opioids, and MRIs.

RTM rules allow the education codes to be billed once per episode of care and device codes to be billed once during a 30-day period, while the treatment management services codes are billed on a calendar month basis.

In other words, a patient who enrolled in the latter half of the month would not be eligible for any billable monitoring for the remainder of the month (as the 16 days of data would be impossible to achieve before the end of the calendar month and there would not be a 30-day period). This is currently allowed under 2022 rules with CPT Codes 98980 and 98981.

To illustrate this problem, a provider starts a Medicare beneficiary on RTM on January 23, 2023 and from January 23 – 31, the patient records 8 days of data points (8 days of monitoring). During that same time frame, the provider spent 25 minutes analyzing the transmitted data, making adjustments to the program and conducting various interactive communications with the patient. Under current coding, coverage, and payment through 98980 and 98981, the provider could bill one unit of 98980 even though they could not bill 98975 and 98976 or 98977. Under the CMS 2023 proposal, the provider would not be able to bill the new GRTM codes.

* **Second, clinicians are likely to be reluctant to perform RTM-TMS as they will be unsure whether they will be paid, at all, for any increment of their work.** As the RUC noted in its report recommending values for RTM services, the RTM-TMS should be provided throughout the month to achieve its desired goals.

Providers will not know whether 16 days of data are achieved until the end of the month but will need to continue ongoing treatment management services from the beginning and throughout the month. Any provider will be concerned that they are allocating time and intra-service work for activities when they run a significant risk that they may not be paid – at all. Again, it is important to note that for MSK therapy to be effective, early, ongoing, and adherent therapy are critical to achieve optimal results.

Here is an example of the problem:

|  |  |  |
| --- | --- | --- |
| **One Month** | **# of Days Data Transmitted** | **Clinician RTM Work Minutes** |
| Week 1 (partial week) | 3 days | 10 minutes |
| Week 2 | 4 days | 6 minutes |
| Week 3 | 4 days | 10 minutes |
| Week 4 | 3 days | 9 minutes |
| Week 5 (partial week) | 1 day | 8 minutes |
| Total | 15 days | 43 minutes |

In this above example, the provider spent 43 minutes over the calendar month reviewing and analyzing the patient’s transmitted data, making adjustments to the program and having several interactive communications with the patient to discuss the program and encourage adherence. However, since only 15 days of data were transmitted during the month, none of the time spent would be paid (i.e., initial 20 minutes of time through either GRTM 1 or GRTM 3; nor an additional 20-minute increment through GRTM 2 or GRTM 4) – a significant risk and deterrent for any provider.

However, under current 2022 rules, 98980 and 98981 may be billed/reported by the provider under the same scenario. Further, CPT code 98975 is presently allowed to be billed only once “per episode of care.” However, the way the parenthetical is phrased “CPT codes 98975 and 98976 or 98977 must be billed prior to reporting GRTM 1/2/3/4”, one could infer that since 98975 may only be billed once, the GRTM codes would be constrained by the CPT guideline and only be billed once, per patient, per episode of care.

I cannot stress enough how the proposed parentheticals would have the unintended effect of discouraging RTM treatment management services.

**Recommendation: I ask CMS to delete the following parentheticals that appear in Table 28:**

* (CPT codes 98975 and 98976 or 98977 must be billed prior to reporting GRTM 1, GRTM 2, GRTM 3 and GRTM 4)
* (At least 16 days of data must be reported).

**Clarifications:**

I ask for five clarifications regarding billing of RTM services:

* Since Medicare beneficiaries may receive outpatient therapy in their home, I am seeking confirmation that RTM services are reimbursed when place of service code 12 is used on a 1500-claim form.
* I also ask to clarify that physical and occupational therapists who practice in a facility setting and provide RTM services can bill and be reimbursed for RTM services submitted on a UB-04 claim form.
* Can 2 different disciplines (PT and OT) each bill for RTM services during the same time- period if they are in the same practice/organization?
* Can 2 providers of the same discipline (e.g., PT) that each practice at a different clinic/organization each bill for RTM services during the same time- period?
* Can 2 different providers (e.g., PT and OT) who each practice in a different clinic/organization (PT practices in Clinic A and OT practices in Clinic B) each bill for RTM services during the same time- period?

In addition, I ask for CMS to clarify what counts as an interactive communication that would allow the supplier or provider to bill CPT code 98980 and 98981. Based on Remote Physiological Monitoring, would interactive communication be achieved via the following methods?

* Phone call between the supplier/provider and Medicare beneficiary
* 2-way audio/visual telecommunication between the supplier/provider and Medicare beneficiary (e.g., FaceTime, Zoom, etc.)
* In-person visit between the Medicare beneficiary and the supplier/provider where the time being counted towards 98980/98981 is not being counted towards other billable services (e.g., CPT codes 97012 – 97763)

Thank you for your consideration of these critical changes to ensure Medicare patients have access to important remote therapeutic monitoring services.

Sincerely,

Insert Name Here