



September 27, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1715-P
PO Box 8016
Baltimore, MD 21244-8016

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

Dear Administrator Verma:

The Heart Failure Society of America (HFSA) appreciates the opportunity to comment on the *CY 2020 Revisions to Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies*. HFSA is a multidisciplinary organization working to improve and expand heart failure care through collaboration, education, research, innovation, and advocacy.

Payment for Evaluation and Management (E/M) Services

The HFSA supports CMS' proposal to revise E/M coding consistent with the framework supported by the AMA CPT Editorial Panel. Under the proposal, effective in CY 2021, CMS would retain 5 levels of coding for established patients, reduce the number of levels to 4 for office/outpatient E/M visits for new patients, and revise the code definitions. CMS would also revise the times and medical decision-making process for all codes and require performance of history and exam only as medically appropriate.

CMS also proposes to adopt the AMA RUC-recommended values for the office/outpatient E/M visit codes and a new add-on CPT code for prolonged service time.

CMS proposes to consolidate the Medicare-specific add-on code for office/outpatient E/M visits for primary care and non-procedural specialty care into a single code describing the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition.

We commend CMS for its efforts to recognize the additional work related to a patient's single, serious or complex chronic condition. We urge CMS to finalize this proposal.

Principal Care Management Services

CMS proposes to create two new codes for Principal Care Management (PCM) services, which would pay physicians for providing care management to patients with a single high-risk disease, while the current chronic care management codes require patients to have two or more chronic conditions. CMS notes that these PCM services would most likely be billed when a patient's condition worsens and disease-specific care management is warranted. CMS states that PCM services would include coordination of medical and/or psychosocial care related to the single complex chronic condition, provided by a physician or clinical staff under the direction of a physician or other qualified health care professional.

The new codes CMS proposes for CY 2020 are GPPP1 (*Comprehensive care management services for a single high-risk disease, e.g., Principal Care Management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: One complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities*) and GPPP2 (*Comprehensive care management for a single high-risk disease services, e.g. Principal Care Management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities*). CMS proposes a work RVU of 1.28 for GPPP1 and 0.61 for GPPP2.

The HFSA commends CMS for its recognition of the need for care management by specialized practitioners and we support the proposal as set forth by the Agency.

Chronic Care Management (CCM) Services

The HFSA supports CMS' intent to increase utilization of chronic care management services for Medicare beneficiaries. These services are especially important for patients with heart failure who require a significant and prolonged amount of care to manage heart failure and the various co-morbid conditions associated with it.

Under this proposed rule, CMS proposes, for non-complex chronic care management services, to adopt two new G codes with new increments of clinical staff time to replace the current

single CPT code 99490 (*chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored*).

CMS suggests a base G code (GCCC1 – *Chronic care management services, initial 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; and comprehensive care plan established, implemented, revised, or monitored. (Chronic care management services of less than 20 minutes duration, in a calendar month, are not reported separately)*) to describe the initial 20 minutes of clinical staff time. CMS proposes a work RVU of 0.61 for HCPCS code GCCC1, which it crosswalked from CPT code 99490.

The second proposed G code (GCCC2) would be an add-on code to describe each additional 20 minutes thereafter (*Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure). (Use GCCC2 in conjunction with GCCC1). (Do not report GCCC1, GCCC2 in the same calendar month as GCCC3, GCCC4, 99491)*). CMS proposes a work RVU of 0.54 for the second add on code, which it crosswalked to CPT 11107 (*Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)*).

CMS intends these would be temporary G codes, to be used for payment under the Medicare physician fee schedule instead of CPT code 99490, until the CPT Editorial Panel can consider revisions to the current CPT code set. CMS suggests it would consider adopting new CPT code(s) once the CPT Editorial Panel completes its work.

While HFSA very much appreciates CMS' efforts to clarify and improve reimbursement for non-complex chronic care management services, we believe that proposing a transitional period using new G codes may be highly problematic and confusing given that CPT will take up this work. We urge CMS to delay these provisions.

For complex chronic care management services, CMS proposes to replace existing CPT codes 99487 and 99489 with GCCC3 and GCCC4.

As CMS notes, existing CPT codes for complex CCM include in the code descriptors a requirement for establishment or substantial revision of the comprehensive care plan. The code descriptors for complex CCM also include moderate to high complexity medical decision-making. CMS suggests the new G codes would not include the service component of substantial care plan revision because the Agency does not believe it is necessary to explicitly

include substantial care due to the fact that patients requiring moderate to high complexity medical decision making implicitly need and receive substantial care plan revision. CMS suggests the service component of substantial care plan revision is potentially duplicative with the medical decision-making service component and, therefore, it is unnecessary as a means of distinguishing eligible patients.

Instead of CPT code 99487 (*Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; establishment or substantial revision of a comprehensive care plan; moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month. (Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not reported separately)*), CMS proposes HCPCS code GCCC3 (*Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored; moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month. (Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not reported separately)*). CMS proposes a work RVU of 1.00 for HCPCS code GCCC3, which is a crosswalk to CPT 99487.

CMS also proposes to replace CPT code 99489 with adoption of HCPCS code GCCC4 (*each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure). (Report GCCC4 in conjunction with GCCC3). (Do not report GCCC4 for care management services of less than 30 minutes additional to the first 60 minutes of complex chronic care management services during a calendar month)*). CMS proposes a work RVU of 0.50 for HCPCS code GCCC4, which is a crosswalk to CPT code 99489.

Again, CMS acknowledges these would be temporary codes utilized until the CPT Editorial Panel complete its work. The HFSA appreciates the intent of CMS to enact payment changes to help spur adoption of these codes, but we believe this would result in confusion for providers. We urge CMS to finalize new proposals after the AMA CPT Panel completes its work.

Chronic Care Remote Physiologic Monitoring Services (CPT 994X0)

The HFSA is concerned with the proposed work RVU of 0.50 for the new add-on CPT code 994X0 (*Remote physiologic monitoring treatment management services, clinical*

staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes).

CMS notes that it first considered the work RVU of 0.61 for the base code 99457 (*Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes*) when assessing the appropriate work RVU for CPT 994X0. Given that 99457 has a work RVU of 0.61, CMS does not accept the RUC recommended value of 0.61 for the add-on code CPT 994X0.

As noted by CMS, the work RVU of 0.50 is at the 25th percentile work RVU. CMS references for comparison CPT code 88381 (*Microdissection i.e., sample preparation of microscopically identified target; manual*); work RVU = 0.53 and 20 minutes intraservice/total time) for support.

The HFSA supports the position of the American College of Cardiology (ACC) in its comments to the Agency regarding valuation of CPT 994X0. Work and time are the same for the first 20 minutes and each additional 20 minutes for this remote physiologic monitoring treatment. There is no pre-service or post-service work associated with the base code so there are no efficiencies that would be gained when entering the additional 20 minutes. If a patient requires more than the first 20 minutes of remote physiological monitoring treatment management, then this patient is part of a subgroup of patients that require more care and extra attention. As noted by the ACC, these patients have fluctuating physiologic parameters. For example, if patients with pressure monitors data are completely consistent, then less work is required, but if there are great fluctuations as in code 994X0, the clinician will need to provide more work analyzing and addressing these differences with medication modifications or other adjustments.

We respectfully request that CMS move forward and accept the work RVU of 0.61 for CPT code 994X0, as recommended by the AMA RUC.

Transitional Care Management Services

HFSA applauds CMS for recognizing the need for transitional care management services (TCM) and the important role such services fill to improve outcomes for Medicare beneficiaries. We strongly support the policy and payment changes proposed by the Agency that should help to increase utilization of these services, which are critically important for patients with heart failure.

CMS notes that the provision of TCM services is low compared to the population eligible to receive them, but that claims increased from 300,000 professional claims in CY 2013 to 1.3 million professional claims in CY 2018. Additionally, CMS notes a study of beneficiaries who received TCM services that demonstrated reduced readmission rates, lower mortality, and decreased health care costs.

We applaud the Agency's efforts to remove coding restrictions associated with TCM services, to allow the billing of the following codes concurrently with transitional care management codes.

Prolonged Services Without Direct Patient Contact

99358 Prolonged E/M service before and/or after direct patient care; first hour; non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service;

99359 Prolonged E/M service before and/or after direct patient care; each additional 30 minutes beyond the first hour of prolonged services.

Home and Outpatient International Normalized Ratio (INR) Monitoring Services

93792 Patient/caregiver training for initiation of home INR monitoring;

93793 Anticoagulant management for a patient taking warfarin; includes review and interpretation of a new home, office, or lab INR test result, patient instructions, dosage adjustment and scheduling of additional test(s).

End Stage Renal Disease Services (patients who are 20+ years)

90960 ESRD related services monthly with 4 or more face-to-face visits per month; for patients 20 years and older;

90961 ESRD related services monthly with 2-3 face-to-face visits per month; for patients 20 years and older;

90962 ESRD related services with 1 face-to-face visit per month; for patients 20 years and older;

90966 ESRD related services for home dialysis per full month; for patients 20 years and older;

90970 ESRD related services for dialysis less than a full month of service; per day; for patient 20 years and older.

Interpretation of Physiological Data

99091 Collection & interpretation of physiologic data, requiring a minimum of 30 minutes each 30 days.

Complex Chronic Care Management Services

99487 Complex Chronic Care with 60 minutes of clinical staff time per calendar month;

99489 Complex Chronic Care; additional 30 minutes of clinical staff time per month.

Care Plan Oversight Services

G0181 Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities within a calendar month; 30+ minutes;

G0182 Physician supervision of a patient receiving Medicare-covered hospice services (Pt not present) requiring complex and multidisciplinary care modalities; within a calendar month; 30+ minutes.

HFSA also strongly supports CMS' proposal to increase the physician work RVUs for the provision of TCM services:

CPT 99495 (Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; medical decision making of at least moderate complexity during the service period; face-to-face visit within 14 calendar days of discharge) AND

CPT code 99496 (Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; medical decision making of at least high complexity during the service period; face-to-face visit within 7 calendar days of discharge).

As CMS notes, these codes were resurveyed during 2018 as part of a regular RUC review of new technologies or services. The RUC recommended an increase in work RVUs for both codes. We thank the Agency for accepting the RUC-recommended work RVU of 2.36 for CPT 99495 and work RVU of 3.10 for CPT 99496.

Thank you for your consideration of these views. If you have questions or require additional information, please contact John Barnes, HFSA Chief Executive Officer, at jbarnes@hfsa.org.

Sincerely,

A handwritten signature in blue ink, appearing to read "Biykem Bozkurt".

Biykem Bozkurt, MD, FHFA, FACC
President
Heart Failure Society of America