

February 1, 2021

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The Honorable Elizabeth Richter
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1734-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE) Interim Final Rule Policy

Dear Acting Administrator Richter:

DIRECTORS

Fariha Abbasi-Feinberg, MD

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The American Academy of Sleep Medicine (AASM) appreciates the opportunity to comment on the interim final rules regarding coding and payment for virtual check-in services and coding and payment for personal protective equipment (PPE). The comments included in this response reflect the needs of our over 9,000 individual members and 2,500 accredited sleep centers, providing sleep medicine services to the Medicare and Medicaid population.

Coding and Payment for Virtual Check-in Services

The AASM applauds the Agency's efforts to ensure appropriate reimbursement for the provision of telephone services, throughout the duration of the public health emergency. In the March 30th Interim Final Rule, CMS established separate payment for audio-only telephone evaluation and management services:

Steve Van Hout
Executive Director

99441 Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

99442 11-20 minutes of medical discussion

99443 21-30 minutes of medical discussion

After establishing the separate payment for these services and discovering that the use of audio-only services had been more prevalent than projected, the Agency also realized that the telephone services are being used in place of in-person or telehealth visits, which led to increased RVUs. Although this temporary increase has been beneficial, the AASM strongly supports establishing separate payment for these codes permanently, beyond the end of the public health emergency (PHE), since the shift to telehealth services continues to increase. Given that at the conclusion of the public health emergency, CMS will assign a status of “bundled” and post the RUC-recommended RVUs for these codes in accordance with their usual practice, we support the establishment of the G2252, *Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion*. The establishment of this code will allow medical professionals to continue reporting audio-only visits beyond the PHE. The AASM suggests that CMS also considers establishing a code comparable to CPT code 99443, for 21 – 30 minutes of medical discussion, as the AMA CPT Editorial Panel and RVS Update Committee (RUC) addresses coding and payment for audio-only services.

Coding and Payment for Personal Protective Equipment

While the AASM is excited that CMS finalized 99072, we are disappointed that CMS decided to finalize CPT code 99072 *Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious diseases* as a bundled service, on an interim basis. When the AASM originally signed on to the letter submitted by the AMA, we agreed that CMS should immediately implement and reimburse CPT code 99072 to recognize the increased costs to physician practices, while providing essential patient care during the PHE. As was obvious from the previously submitted RUC survey data, many physician practices are struggling to continue providing services during the PHE, due to both direct and indirect additional costs for PPE, changes to offices and facilities, additional cleaning supplies, etc., required for infection control. These extra costs to practices are in addition to reduced revenue, as patient volumes have dramatically decreased during the PHE. A recent survey completed by more than 500 members of the AASM showed that roughly 46% of those sleep medicine practices are concerned about remaining financially solvent through the end of the year due to the impact of the novel coronavirus.¹ The additional expenses are not currently included or captured in any other existing CPT codes, including the Evaluation and Management (E/M) services codes. Therefore, we, again, urge CMS to immediately implement and provide separate payment for CPT code 99072, with no patient cost-sharing, and that the code not be subject to budget neutrality. We continue to seek the Agency’s support in providing fair compensation for the essential precautions implemented to provide safe environments for both clinicians and patients, as providers ensure the provision of medical care, including but certainly not limited to COVID-19 vaccine distribution, throughout this ongoing pandemic.

Thank you for your consideration of these comments. The AASM appreciates the Agency's efforts to address the needs of clinicians throughout and beyond the PHE, as they continue to provide essential, high quality care to patients during this global pandemic. We encourage the Agency to adopt the recommendations summarized in this letter. Please feel free to contact Diedra Gray, AASM Director of Health Policy, at dgray@aasm.org or 630-737-9700, for additional information or clarifications.

Sincerely,

Kannan Ramar, MD
AASM President

cc: Steve Van Hout, AASM Executive Director
Sherene Thomas, AASM Assistant Executive Director
Diedra Gray, AASM Director of Health Policy

ⁱ Ramar K. (2020). AASM takes the pulse of the sleep field and responds to COVID-19. *Journal of Clinical Sleep Medicine*. Advance online publication. <https://doi.org/10.5664/jcsm.8846>