April 20, 2020

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

Submitted online via regulations.gov

RE: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

Dear Administrator Verma:

On behalf of more than 100,000 specialty physicians from 14 specialty and subspecialty societies, and dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care, the undersigned members of the Alliance of Specialty Medicine (the “Alliance”) write in response to proposals outlined in the aforementioned interim final rule.

First and foremost, we thank you for your commitment and dedication to protecting the health and safety of Americans during these unprecedented times. The Alliance applauds you for taking swift action to ensure clinicians and other healthcare providers have the necessary flexibility to continue caring for our patients during the COVID-19 pandemic.

Using “Audio-Only” Functionality for Office/Outpatient E/M Services

CMS heard from clinicians that the ability to provide evaluation and management (E/M) services using “audio-only” functionality was essential for beneficiaries that either 1) did not have both audio and visual technological capabilities, or 2) refused to utilize the “video” component of their audio-visual communication device. To address this concern, CMS “activated” the telephone E/M service codes (CPT codes 98966-98968 and 99441-99443) effective March 1, 2020, and for the duration of the COVID-19 public health emergency.

Members of the Alliance appreciate CMS’ effort to provide flexibility here, but we are concerned that the reimbursement amount for the telephone E/M service codes are not reflective of the work involved in delivering a robust E/M service using “audio-only” functionality. To address this challenge, we urge CMS to use its authority to waive the “video” requirement for furnishing office/outpatient E/M services (CPT 99201-99205 and 99211-99215) via telehealth. This is an important change needed to support physician practices as they seek to deliver medically necessary care under unprecedented conditions, encourage the remote delivery of care to mitigate risk of infection, and provide for appropriate reimbursement for the physician work involved. Additionally, we believe this change would be consistent with CMS’ recent rulemaking that allows for level selection based on time or medical decision
making alone for office/outpatient E/M services delivered via telehealth, with no requirement for
documentation of history or physical exam in the medical record. If CMS is unable to use its authority to
waive the “video” requirement, we urge the agency to increase reimbursement for the telephone E/M
services to a level that is commensurate with the office/outpatient E/M services. Finally, we urge CMS to
monitor implementation of these and other virtual care service policies by the Medicare Administrative
Contractors (MACs).

Direct Supervision by Interactive Telecommunications Technology
CMS has offered considerable flexibility by temporarily revising its direct supervision requirements in a
way that would allow a physician to observe a patient and to furnish assistance and direction to in-
person clinical staff from a remote location. While we appreciate the ability for physicians to temporarily
isolate at home while continuing to provide direct supervision of in-office clinical staff, we are deeply
concerned about the flexibility to provide at-home administration of Part B drugs.

Specialists that manage conditions that rely on Part B drugs, such as cancer, rheumatoid arthritis,
ulcerative colitis and macular degeneration, believe the risks of at-home administration of complex
drugs outweigh the benefits to patients. This is largely due to the fact that drugs used to treat these
conditions have significant side effect profiles, including idiosyncratic infusion reactions. Many of these
medications require advanced clinical skill to administer, special office-based equipment to handle
infusion reactions, and the need for special storage conditions. We also note the policy, if utilized by
practices, would significantly increase their liability.

For the reasons above, we urge CMS to reconsider its policy on providing at-home administration of
Part B drugs, and, if maintained, that CMS ensures this policy will be limited to the period of the
current pandemic.

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We appreciate the opportunity to provide comments on the aforementioned issues of importance to
the Alliance. Should you have any questions, please contact us at info@specialtydocs.org.

Sincerely,

American Association of Neurological Surgeons
American College of Mohs Surgery
American College of Osteopathic Surgeons
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Society for Dermatologic Surgery Association
American Society of Echocardiography
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society