October 5, 2020

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Attn: CMS-1734-P
Mail Stop C4-26-05
7500 Social Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1734-P; CY 2021 Revisions to Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies

Administrator Verma:

On behalf of our membership, the American Thoracic Society (ATS) and the American College of Chest Physicians (CHEST) appreciate the opportunity to submit our shared comments on the proposed Medicare Physician Fee Schedule for 2021. Our societies represent more than 40,000 pulmonary, critical care, and sleep specialists dedicated to prevention, treatment, research, and cure of respiratory disease, critical care illness, and sleep-disordered breathing. Our members provide care to Medicare beneficiaries for a wide range of conditions including critical care illness, asthma, COPD, lung cancer, alpha-1 antitrypsin deficiency, pulmonary fibrosis, pulmonary hypertension, and other disorders of the lung, as well as sleep disorders. The proposed rule includes several policy changes and payment revisions that are of direct interest and impact to our members. We offer the following comments to help CMS craft the final 2021 Medicare Physician Fee Schedule rule.

Medicare Payment for Critical Care Services

Our societies represent the physicians who provide care to our nation's most critically ill patients in intensive care units. During the COVID pandemic, our members and the other members of the critical care team have risen to the occasion to treat patients most stricken with this novel and deadly infectious disease. At times, our members have been forced to work in less than ideal conditions, without adequate protective gear, through equipment and drug shortages. Our members have put themselves at significant risk of infection with SARS CoV-2. Sadly, some critical care providers have contracted COVID-19 and died while others continue to deal with challenging and unpredictable lingering aspects of this novel disease.

We note that during the initial COVID lockdown phase, many other medical specialties had the option to suspend their practice, postpone elective services, or move to telemedicine platforms

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to continue treating patients. Many of these specialties will enjoy significant projected increases in 2021 Medicare payments. These options are generally not available to critical care providers. When patients are critically ill, our members are at the bedside. And for this, Medicare reimbursements for critical care services is projected to be reduced by 8%.

The reduction is being driven almost entirely by budget neutrality adjustments in the conversion factor dictated by payment changes for office visit E/M services and primary care bonus payments. It is important to recognize what is not driving the reduction: the work values for critical care medicine have not been altered; the pre-service, intra-service, and post-service times have not been adjusted; practice expense inputs have remained the same; and malpractice insurance costs have not been reduced.

We recognize the factors that are leading to the projected 8% reduction in Medicare critical care provider payments and we **support** the payment increases for cognitive services. The payment reduction to critical care providers in the middle of a COVID pandemic that has pushed the specialty to its limits is both emotionally demoralizing and financially challenging.

As societies representing critical care physicians, we strongly urge HHS to utilize its authority under the public health emergency declaration to preserve patient access to care and mitigate financial distress due to the pandemic by implementing the office visit increases as planned while waiving budget neutrality requirements for the new Medicare office visit payment policy. More than 100 physician organizations, representing nearly all medical specialties, have already contacted CMS expressing support for using the public health emergency authority to waive budget neutrality to avert the further financial hardship on physician providers. If CMS chooses not to waive budget neutrality requirements to implement the important policy changes, we would urge them to at least consider steps to ease the burden on critical care providers by phasing in the proposed critical care payment cuts over 3 years. The ATS and CHEST note that CMS has adopted a phased approach to other abrupt payment changes in the Medicare program. For critical care physicians on the frontlines of the COVID response, relief from the impact of proposed cuts to critical care payment is essential.

E/M Payment Changes

As noted above, the ATS and CHEST **support** the proposed changes to E/M office visits and the accompanying increased reimbursement for office visit E/M services. We believe the proposed changes will help address the persistent under-valued cognitive component of E/M medicine. However, we continue to be troubled by the legislative requirement that these payment changes must be implemented under budget neutrality. As noted above in the critical care payment discussion, implementing these E/M change will have substantial negative impacts across a range of physician services. We join with our other medical specialty

colleagues in calling on CMS to use its authority under the COVID public health emergency declaration to waive the budget neutrality requirements for the purpose of implementing these E/M policies.

Adoption of RUC Recommended Values for Pulmonary Services

The ATS and CHEST appreciate CMS's proposed decision to adopt the recommended physician work values for a range of pulmonary services recently reviewed by the RUC. Specifically, we urge CMS to finalize the values for the below services:

CPT Code	Descriptor	Current RVU	RUC RVU	CMS Proposed RVU
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	0.17	0.17	0.17
94060	Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration	0.27	0.22	0.22
94617	Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry; with electrocardiographic recording(s)	0.70	0.70	0.70
94618	Pulmonary stress testing (eg, 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed	0.48	0.48	0.48
94621	Cardiopulmonary exercise testing, including measurements of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings	1.42	1.42	1.42
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device	0.00	0.00	0.00

94667	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation	0.00	0.00	0.00
94668	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent	0.00	0.00	0.00
94669	Mechanical chest wall oscillation to facilitate lung function, per session	0.00	0.00	0.00
946X0	Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry; without electrocardiographic recording(s)	NEW	0.49	0.49
95012	Nitric oxide expired gas determination	0.00	0.00	0.00

Telehealth Services Added During the PHE and ATS-CHEST Recommendation

The ATS and CHEST commend CMS for proposing and quickly implementing a number of policy changes to respond to the unprecedent public health emergency (PHE) caused by COVID-19. CMS showed flexibility and nimbleness in its response to the evolving public health emergency. Some of the policies adopted by CMS under the PHE, particularly those policies supporting coverage and payment for remote office E/M services, will likely endure and may help shape the future practice of medicine. We particularly appreciate CMS's clarification that remote certification of oxygen prescriptions and other durable medical equipment for patients with respiratory disease, while not specifically listed as a PHE telehealth service, could qualify under existing CMS policy. While we support the telehealth services decisions CMS has made to date, we also believe that some of the PHE telehealth determinations should be temporary. Specifically, we urge CMS to sunset the critical care telehealth PHE decision. During the early phases of the COVID outbreak and the ensuing surge in cases in cities like New York, granting PHE telehealth status to critical care services was appropriate – namely to address the projected and/or actual acute shortage of critical care beds and critical care providers to care for patients hospitalized with COVID. However, as the COVID pandemic has progressed, and providers have acquired additional experience with treating COVID, the likelihood of acute shortages of critical care providers has subsided. We believe it is appropriate for CMS to now sunset the PHE telehealth listing for critical care services.

Telehealth Services Added During the PHE and ATS-CHEST Recommendation

Type of Service	CPT Codes	ATS-CHEST Specifically Recommended Adding or Retaining
Smoking Cessation	99406, 99407	Retain
Outpatient Pulmonary Rehabilitation	G0424	Retain
Lung Cancer Screening Visit	G0296	Retain
Telephone Visit	99441, 99442, 99443	Retain
Critical Care Services	99291 - 99292	Sunset PHE listing
Domiciliary, Rest Home or Custodial Care Services, new and established patients	99327 - 99328, 99334 - 99337	Retain
Home Visits, new and established patient, all levels	99341 - 99345; 99347 - 99350	Retain
Assessment and Care Planning for Patients with Cognitive Impairment	99483	Retain
Group Psychotherapy	90853	Retain
Therapy Services, Physical and Occupational Therapy, all levels	97161- 97168; 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507	Retain
Oxygen certification/recertification	No code	Retain

GPC1X Descriptors and Utilization Projections

We share the concern noted in the RUC panel comment letter about the inconsistent GPC1X descriptor and utilization assumptions. We urge CMS to clarify which of the following descriptors they intend to finalize and then seek additional comments on the finalized descriptor.

NPRM for 2021Table 8: CY 2021 Proposed Additions to the Medicare Telehealth Services List on a Category 1 Basis

GPC1X Visit complexity inherent to evaluation and management associated with **primary** medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to an evaluation and management visit)

Final Rule for 2021, Text of NPRM for 2021 page 50138, Table 24 of NPRM for 2021

GPC1X Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services **and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition.** (Add-on code, list separately in addition to office/ outpatient evaluation and management visit, new or established)

We also support the RUC Panel in its call for CMS to release the methodology the agency used to project GPC1X utilization projections.

The ATS and CHEST appreciate the opportunity to comment on the proposed Medicare Physician Fee Schedule for 2021. We hope CMS will use our comments to revise and improve the final 2021 rule.

Sincerely,

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Chair, Joint ATS/CHEST Clinical Practice Committee

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