PHILIPS

September 27, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue S.W.
Washington, DC 20201

Re: CMS–1715–P Medicare Program: CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations (Proposed Rule)

Dear Administrator Verma:

On behalf of Philips HealthCare (Philips), I am pleased to have the opportunity to respond to the above 2020 Physician Fee Schedule Proposed Rule (the "Proposed Rule"). Philips provides solutions that span the health continuum, including sleep management and respiratory solutions, imaging, patient monitoring, cardiac care systems; medical alert systems; healthcare informatics solutions and services; and a complete range of comprehensive telehealth programs. Of greatest relevance here, Philips provides a wide range of remote monitoring products and services for patients in all health care settings, including acute care and ambulatory settings, as well as a broad range of imaging services and products.

I. Imaging Services

Radiopharmaceutical Tumor Localization SPECT/SPECT-CT (CPT Codes 78800, 78801, 78802, 78803, 78804, 788X0, 788X1, 788X2, and 788X3)

Philips strongly urges CMS to maintain current pricing of the equipment associated with the radiopharmaceutical tumor localization codes described above, and to engage with the industry to reprice this equipment to more accurately reflect current market prices in time for the CY 2021 Physician Fee Schedule (PFS). More specifically, Philips believes that the price reflected

in the CMS direct cost data base for (gamma camera system, single-dual head) (ER032) does not reflect current market prices and that the proposed price for gamma camera system (ER097) of $464,428 (proposed to be reduced from $532,350) is not representative.

> ***Recommendation****: Philips recommends that CMS maintain the CY2019 pricing for the equipment associated with the SPECT/SPECT –CT codes (including the gamma camera system described by ER097), and consider the invoices to be submitted by the industry to revise the equipment costs associated with the radiopharmaceutical tumor localization codes for the CY 2021 PFS.*

> ***Recommendation****: Philips recommends that CMS adopt the RUC's recommendation for the W-RVUs for the SPECT/SPECT-CT codes.*

Ultrasound, complete joint with real-time image documentation (CPT code 76881)

Philips requests that the following equipment be included in the direct costs for CPT code 76881:

- ED050 Technologist PACS workstation
- ED053 Professional PACS Workstation

We note that CPT coding instructions require documentation of recorded images of all joint images, and that the CPT code descriptor requires measurements and annotation (when indicated) that cannot be documented without this equipment.

> ***Recommendation:*** *Philips urges CMS to include PACS technologist and professional PACS workstations (ED050 and ED053) in the equipment cost inputs for the purposes of valuing the PE-RVUs for CPT code 76881*

Intravascular Ultrasound (CPT Codes 37252 and 37253)

37252 (Intravascular us noncoronary 1st) and 37253 (Intrvasc us noncoronary addl)

In the proposed rule, CMS disagreed with the RUC recommendation to maintain the current work RVU of 1.80 for CPT code 37252 and instead, is proposing a work RVU of 1.55. This was based on a crosswalk to CPT code 19084. The RUC recommended work RVU of 1.80 for CPT code 37252 is supported by the survey key reference service (92978) chosen by physicians who perform this service and more accurately compares to CPT 37252.

> ***Recommendation:*** Philips urges CMS to follow the recommendation of the RUC and accept a work RVU of 1.80 for CPT code 37252.

Similarly, regarding CPT code 37253, CMS disagreed with the RUC recommendation to maintain the work RVU of 1.44 and is proposing a work RVU of 1.19.

Recommendation: Philips recommends that CMS rely on the valid survey data to value 37253 and urges CMS to accept a work RVU of 1.44 for CPT code 37253.

II. Remote Patient Monitoring

Philips believes that coordinated remote patient monitoring programs are among the most cost-effective solutions available to systematically manage patient populations with ongoing needs, particularly those with medically complex and/or chronic conditions. Philips' remote patient monitoring and care management programs are designed to enable providers to coordinate care across the continuum for patients ranging from those who require chronic management to patients with complex, high-risk conditions requiring acute intervention. These programs include the Remote Intensive Care Program (eICU®), a comprehensive technology and clinical reengineering program that enables health care professionals from a centralized telehealth center to provide around-the-clock care for critically ill patients; the eAcute Program, which is modeled after the eICU and which monitors high-risk hospitalized patients on medical-surgical floors to prevent avoidable complications, the eConsultant program, which provides remote management services to Skilled Nursing Facilities (SNFs) and emergency department (ED) consults for telestroke, telepsych and trauma triage; and the Intensive Ambulatory Care (eIAC) Program, through which Philips partners with providers to manage high-risk patients with multiple chronic conditions in the home. We believe that CMS increasing recognition of the value of remote patient monitoring will significantly improve the quality of care provided to Medicare patients in all settings.

For this reason, we very much appreciate CMS' interest in expanding the use of remote patient monitoring/management. We note that while utilization is increasing, the adoption of remote patient monitoring/management is somewhat stymied by provider confusion regarding the requirements for billing for these codes, especially with respect to equipment requirements.

Recommendation: *In order to further increase utilization of remote patient monitoring, we urge CMS to issue subregulatory guidance or a Q&A that addresses common provider concerns and questions.*

New Remote Patient Monitoring Code (CPT code +994X0)

Philips fully supports CMS' proposal to establish a second remote patient monitoring intervention code (994X0) to facilitate reporting and payment for an additional 20 minutes per month as deemed clinically necessary (as an extension of existing CPT code 99457). We believe that recognition of this CPT code and the provision of Medicare payment will help increase utilization of remote patient monitoring by providing additional payment for medically appropriate patients.

However, we believe that the Proposed Rule undervalues this code, by providing .50 RVUs, .11 RVUs less than the principal code. We do not believe that the services involved in the additional 20 minutes are any less resource intensive than those involved in the provision of remote patient

monitoring under CPT code 99457, and for this reason believe that valuation of the new add-add code should be commensurate with CPT code 99457.

> ***Recommendation:*** *Philips recommends no limitation on the number of times +994X0 could be utilized per month as deemed clinically necessary and tied to RPM alerts, and that 994X0 carry the same RVU as 99457.*

> ***Recommendation:*** *Once the valuation and payment for CPT codes 99457 and +994X0 are finalized, we suggest that these codes be included in the Summary of Special Care Management Codes detailed in Table 16, and to clarify the distinction between these codes and CPT code 99091*

We also note that the reduction of RVUs for add-on remote monitoring codes is not unique to the CPT 99457/+994X0 code set. The new G codes proposed to be established by CMS for Chronic Care Management also reflects a similar reduction in RVUs for the add-on codes used to report additional monitoring time: In that case the difference is .61 RVUs (principal code) versus .54 (add-on code.). Likewise, the new Principal Care Management Services, the initial 30 minutes is valued at 1.28, with the additional 30 minutes at .61.

> ***Recommendation****: We urge CMS to equalize RVUs for principal and add-on remote monitoring services at the higher levels currently associated with the principal codes, because we believe that this change would further incentivize the use of medically appropriate remote monitoring..*

General Supervision of Remote Physiological Monitoring.

> ***Recommendation****: For the reasons set forth in the Proposed Rule, we support CMS' proposal to clarify that general, rather than direct, supervision is required for CPT 99457. This clarification will provide for more streamlined contracting by providers and health systems and positively impact workflows.*

Transitional Care Management Services (CPT codes 99495 and 99496)

> ***Recommendation:*** *We strongly support CMS' proposals to increase the valuation of the Transitional Care Management codes and to allow them to be billed with the other remote patient monitoring/management codes, as described in the Proposed Rule. We also urge CMS to allow transitional care management to be billed along with the new Principal Care Management Code, assuming that the Proposed Rule provisions with respect to Principal Care Management are finalized.*

Chronic Care Management (CCM) and Complex Chronic Care Management (CCCM)

As indicated above, Philips believes that remote patient monitoring has an especially important role in the management of patients with multiple chronic conditions. Our eIAC program is especially designed to address these needs and to ensure greater care coordination for these vulnerable patients.

Recommendation: *Philips supports ongoing efforts to increase utilization of CCM and CCCM codes and, to this end, supports finalizing the new G codes as described in the Proposed Rule, along with the proposed valuations*.

The Proposed Rule specifically requests comment on whether a limit should be placed on the number of times Proposed HCPCS Code GCCC2 – (additional 20 minutes of CCM) should be billable per month, noting that providers could instead utilize CCCM code GCCC3 for more complex patients.

Recommendation: *We recommend that no limit be placed on the number of times HCPCS Code GCCC2 may be billed, so that the time actually spent on the remote management of non-complex but nonetheless time-consuming patients can be accurately recognized.*

Principal Care Management (PCM Services)

Philips supports the introduction of a specialist-driven, single chronic care approach through the recognition of new PCM services. We believe that, to minimize administrative complexity, the definitions and requirements for billing the new PCM services should parallel the definitions and requirements for billing CCM services. For example, the new TCM services should be provided under general supervision and the types of specialists qualified to provide PCM services should not be limited.

Recommendation: *We recommend that CMS finalize its proposal to provide payment for PCM services (including both a principal and an add-on code) and that the valuation of the add-on code be commensurate with that of the principal code.*

Recommendation*: We recommend that PCM services, like CCM and CCCM services, be billable with TCM services.*

Patient Consent and Documentation of Remote Patient Monitoring Services.

We agree with CMS that a more streamlined, patient/caregiver approach is needed with respect to patient consent, especially with respect to consulting physicians. We note that HCPCS code G2012 (virtual check-ins fee) currently requires only verbal consent, but does require that the verbal consent be entered into the patient record. Also this fall, AMA CPT Editorial Board has put forth six new codes for patient-initiated digital communication with a physician (CPT 99421, 99422, 99423) or another Qualified Health Professional (CPT 98970, 98971, 98972), and these CPT codes likewise have the potential to raise significant patient consent issues.

Recommendation: *We support CMS' proposal to allow patient consent to be established through a six-month or an annual consent process. We also recommend that CMS authorize Physician Assistants to perform patient consent responsibilities and associated documentation.*

III. Telehealth

We note that CMS on its own initiative has proposed to include on the telehealth list a set of codes for opioid treatment that include a broad range of services that are not ordinarily bundled. Bundled services face-to-face (via telehealth) and non-face-to-face services, medication costs and toxicology tests. .

> ***Recommendation:*** *Philips supports CMS implementation of the SUPPORT Act through the use of telehealth HCPCS codes GYYY1, GYYY2, GYYY3 as described in the Proposed Rule. However, we caution that the use of broad bundling under the PFS should be limited to situations where this approach is necessary to meet a pressing public health emergency that requires immediate and extraordinary action, such as the opioid crisis.*

IV. Request for Information (RFI) on Incorporation of Patient-generated Health Data into CEHRT

The Proposed Rule includes a RFI on incorporating patient-generated health data (PGHD) into CEHRT. We urge CMS to consider this issue in terms of Patient Reported Outcomes (PROs).The use of automated PRO surveys, integrated into EHRs, is a patient-centric approach that reinforces the drive toward value-based care and its focus on patient outcomes and is consistent with Executive Order emphasizing the importance of transparency and on putting patients first.

We recognize that CMS has struggled with the integration of PGHD into CEHRT, and believe that it may be worth considering a simplified approach that utilizes tailored and templated patient-reported outcomes in the context of various "use cases." Examples may include:

- Intake – Patients can complete questionnaires while in the waiting room or at home prior to a visit to a provider, which makes more information available to the provider at the beginning of a visit and can streamline the gathering of information and the documentation process.
- Post-procedure – Patients' answers to questionnaires can help identify patients who are not doing well or may be developing a problem, so the issue can be addressed before it becomes significant.
- Post-discharge – Patients' responses can help providers and care teams ensure that patients recently discharged from the hospital are progressing as expected and reduce the risk of readmission. Patients "pushing" this information to the providers reduces staff workload and overhead.
- Chronic disease management – PROs for patients with chronic illnesses, such as diabetes, congestive heart failure, etc. can help providers manage their patients between visits, know when a face-to-face evaluation may be needed, and decrease the risk of disease progression and hospitalization.

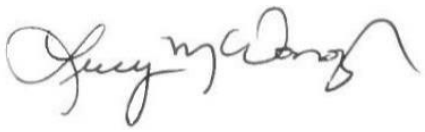
- Pediatric – PROs for pediatric patients are based on age-appropriate questionnaires, which can help keep these patients and their parents engaged and the providers informed.

Originally developed at the Mayo Clinic, Philips' Vital Health solution, for example, is a cloud-based interactive survey allowing patients to submit PROs through secure apps and tablets creating mobile data with established integration into EHRs. These specialty-specific patient questionnaires utilize branching logic, can trigger alerts and can be compiled/analyzed in a manner that improves clinical pathways and patient outcomes. This and other patient-centric technologies in the marketplace can establish PGHD tied to outcomes. This approach can be complemented through increased use of remote patient monitoring/ management, which can integrate other types of important clinical data into CEHRT

> ***Recommendation:*** *Philips recommends that CMS embark upon a simple PROs measure across its quality programs that rewards clinicians and health systems for utilizing PROs and integrating the results into CEHRT,*

We appreciate the opportunity to comment on the Proposed Rule. If you have any questions or if we can be of further assistance, please do not hesitate to contact me at Lucy.McDonough@Philips.com.

Sincerely yours,



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