September 10, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1693-P; Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Administrator Verma:

The American Academy of Sleep Medicine (AASM) appreciates the opportunity to comment on the proposed rule for the 2019 Physician Fee Schedule, as the proposed revisions will have a significant impact on AASM member participation and reimbursements, going forward. 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 population.

Valuation of Specific Codes: Home Sleep Apnea Testing CPT codes (95800, 95801, and 95806)

The AASM strongly opposes the proposed work RVUs for the home sleep apnea testing (HSAT) codes (95800, 95801, and 95806), which are not aligned with the RUC recommendations, despite the unanimous approval by the RUC for work RVUs of 1.00, 1.00, and 1.08, respectively, after the codes were resurveyed in 2017. The rationale for the CMS recommendations can be attributed to CMSs identification of two crosswalk codes, 93281 and 93260. It is unclear why CMS chose these two codes, which are not at all similar to the home sleep apnea test codes as they are cardiovascular implantable recording device codes (related to monitoring), not diagnostic studies. It is noteworthy that 95800, 95801, and 95806 are all sleep apnea diagnostic service codes which include recording, interpretation, and report of these sleep studies. There in an innate difference in the intensity of work when comparing monitoring of a condition as compared to the diagnosis of one or more conditions.

CMS highlighted the fact that they did not intend to imply that the decrease in time, as reflected by the survey values, should equate to a linear decrease in the valuation of work RVUs. However, the proposed rule suggests that a 5% reduction in the work RVUs for 95800 and 95801, and the 14% reduction in work RVUs for 95806, were insufficient based on the amount that surveyed work times decreased. The AASM strongly disagrees with this approach for the determination of work RVUs and believes that all modifications to work RVUs should be based on empirical evidence, gathered through the survey process, taking into consideration the amount of time required to provide a service as well as the complexity/intensity of each service. Additional information can be gleaned from the comparison of RVUs to codes with similar technical and professional components, but the codes CMS identified in this instance do not meet these criteria. The AASM believes that the RUC recommended work RVUs correctly captured the current relativity between the procedures in this code family.

During the original survey, HSAT diagnostic tests were new, accounting for the higher pre-, intra- and post-service times. Since then sleep medicine professionals have become more efficient at performing these procedures, justifying a slight decrease in the times. However, it must be noted that HSATs have not fundamentally changed and require the same amount of effort. The AASM strongly urges CMS to finalize the RUC recommendations 1.00, 1.00, and 1.08 for the three HSAT codes 95800, 95801, and 95806, respectively, as they are based on physician survey data and were developed using crosswalk and reference codes that are similar to the home sleep apnea testing codes and endorsed by physician experience.

Evaluation & Management (E/M) Visits

The AASM continues to support the decision of CMS to revise the 1995 and 1997 E/M guidelines, which have become administratively burdensome and are in direct contrast to the Patients over Paperwork initiative. Current documentation guidelines are also flawed in that they do not support non face-to-face time (e.g., review of prior records) and it can be time consuming to document the care of the more challenging/complicated patients. The current documentation guidelines are also currently geared towards billing and do not prioritize the provision of high quality clinical care. The AASM supports immediate adoption of the following proposals:

1. Changing the required documentation of the patient's history to focus only on the interval history since the previous visit;
2. Eliminating the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient; and
3. Removing the need to justify providing a home visit instead of an office visit

That said, the AASM disagrees with the proposals to collapse payment rates for new and established patients and encourages CMS to support the work of the American Medical Association's newly created E/M Workgroup, a multi-specialty workgroup of health professionals with expertise in establishing, valuing, and reporting codes, to identify feasible solutions for implementation in the 2020 calendar year. In the meantime, the AASM encourages CMS to continue to vet all potential changes through the AMA CPT Editorial Panel and RBRVS Update Committee processes.

Modernizing Medicare Physician Payment by Recognizing Communication Technology -Based Services

The AASM supports CMSs efforts to expand access to medical care using medical services furnished via communication technology. This initiative will also make the provision of care more convenient for both patients and clinicians and may lead to a reduction in the number of patients lost to follow up.

Brief Communication Technology-based Service, e.g., Virtual Check-in (HCPCS code GVCI1)

The AASM specifically supports the addition of GVCI1, as it will allow for separate reimbursement for brief non face-to-face visits. Sleep medicine professionals are increasingly using telehealth, for patient education/coaching, insomnia therapy recommendations (as part of Cognitive Behavioral Therapy for Insomnia or CBT-I), troubleshooting for positive airway pressure (PAP) therapy devices, and to assess PAP adherence, mask leak and efficacy of therapy. The AASM agrees with the plan for CMS to bundle brief communication technology-based service visits with an E/M visit, if the non face-to-face visit is related to an E/M visit that occurred within the past 7 days, consistent with the code descriptor language for CPT code 99441. However, we do not agree with bundling if the original brief communication technology-based service visit leads to an E/M in-person service, as this would be a separate visit and would not take the place of the additional pre-service time required to prepare for the E/M service. Since it is likely that there would still need to be pre-service time for the E/M visit, the AASM believes that each visit should be billed separately.

In response to the CMS request for comment regarding the inclusion of a frequency limitation for GVCI1, the AASM believes that it may be helpful to include a frequency limitation for more complicated patients. Some patients that are being treated for sleep disorders may have comorbidities that impact their response to treatment and may need to be seen more frequently by a clinician. It may be helpful for those patients to have a face-to-face visit with a clinician after having several brief technology-based service visits. This may be addressed by including a frequency limitation which requires a face-to-face visit after a specific number of non face-to-face visits or may be addressed by establishing the visit schedule for complicated patients up front, to include both telehealth visits and face-to-face E/M visits.

CMS is also seeking comments regarding how clinicians may best document the medical necessity of the services, which is challenging, as the documentation guidelines for E/M visits may potentially be revised. The current documentation guidelines for E/M visits are extremely burdensome and challenging, and as these guidelines are revised it would be ideal to harmonize these guidelines for the telehealth codes as well.

Interprofessional Internet Consultation (CPT codes 994X6, 994X0, 99446, 99447, 99448, and 99449)

Sleep medicine professionals come from many medical disciplines, but a large number of patient referrals come from primary care physicians (PCPs) to specialists, including but not limited to bariatric surgeons, otolaryngologists, cardiologists, etc. These requests for consultations can occur at any time

throughout the care pathway, as sleep medicine professionals may receive referrals or consultation requests when primary care physicians suspect sleep disorders and/or as a part of managing a patient's treatment plan. Given the increased national focus on improving care coordination, the AASM fully supports the CMS proposal to make separate payments for these services. CMS may also potentially align documentation requirements to demonstrate that services were reasonable and necessary with those required for E/M services, once they are updated and implemented.

Submitted Requests to Add Services to the List of Telehealth Services for CY 2019

The AASM fully supports the addition of the adoption of Chronic Care Remote Physiologic Monitoring codes 990X0, 990X1, and 994X9 for payment under the Physician Fee Schedule (PFS), in lieu of adding them to the list of Medicare Telehealth services, as they are distinct services furnished via communication technology and they describe series that are inherently non face-to-face. These codes address a need in the management of sleep medicine patients requiring chronic care and current technology allows for assessment of patient treatment plans using remote downloadable data, such as measurement of compliance and efficacy of PAP devices. We also support the addition of the Interprofessional Internet Consultation codes, 994X0 and 994X6, for payment under the PFS as they too are distinct services furnished via communication technology and are inherently non face-to-face.

CY 2019 Updates to the Quality Payment Program

Claims measures

The AASM agrees that the proposal to make Medicare Part B claims-based measures available to MIPS eligible clinicians in small practices beginning with the 2021 MIPS payment year will expand the availability of measures for groups which do not currently have the claims-based reporting option. Sleep medicine professionals and many other specialists in small group or solo practices have challenges submitting data to CMS through an electronic reporting option and this revision to the program will provide the opportunity for program participation. However, to ensure transparency, we encourage CMS to provide a definition for a small practice in the final rule.

Topped-out measures

The AASM understands that CMS intends to reduce administrative and data collection burden while ensuring that measures included in the Quality Payment Program provide value to clinicians and patients. However, despite the data collection and analyses performed by CMS to determine benchmarks and determine the topped-out status of measures included in the program, AASM does not support the removal of measures based solely on the benchmarking data without CMS demonstrating that the clinicians reporting on the measures are a nationally representative sample. It may be helpful for CMS to consider requesting supplemental data from a specialty, to substantiate continued inclusion in the program, particularly in the instance that a specialty is collecting their own specialty-specific measure performance data. Additionally, it is important to avoid the unintended consequence of declining performance, in the event that performance measures are removed from the program. If CMS decides to move forward with removing measures deemed topped-out from the

program, it would be helpful to consider options for specialties that are limited in reporting options and whose applicable measures which may be topped out are not included in an Qualified Clinical Data Registry (QCDR) accessible by that specialty. Smaller specialties are limited in their ability to participate in the Quality Payment Program and we encourage CMS to make participation easier or to provide an exemption if there are few or no measures available for specific groups of specialists to report.

Removal of Quality Measures

While AASM understands the national priority to transition away from process measures and move towards focusing on outcome measures, we do not support CMSs plan to significantly reduce the number of process measures, in general. It is the opinion of the AASM that if measure stewards can demonstrate a direct link to improved outcomes, through data analyses and/or the medical literature, their measures should be allowed to remain in the program, especially in the instance that a specialty has limited measures to report for program participation. If measures are removed that could potentially impact participation in the program by a specific specialty, we urge CMS to consider also reducing quality reporting requirements for that group. Additionally, while risk adjustment is addressed in the CMS Blueprint, more guidance and resources are needed for measure developers to perform risk adjustment for outcome measures.

Quality Measures Proposed for Removal in the 2021 MIPS Payment Year and Future Years

The AASM supports the proposed inclusion of QPP measures 277 - Sleep Apnea: Severity Assessment at Initial Diagnosis and 279 – Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy in the Internal Medicine and Otolaryngology specialty measure sets for the 2021 payment year and future years. However, the AASM strongly opposes the proposed removal of QPP measures 276 – Sleep Apnea: Assessment of Sleep Symptoms and 278 – Sleep Apnea: Positive Airway Pressure Prescribed from both the Internal Medicine and Otolaryngology specialty measure sets and from the overall MIPS program for 2021 and future years. While it may be easier to see the value in calculating the severity of sleep apnea, as required in measure 277, in accordance with the AASM evidence-based Clinical Practice Guideline for Diagnostic Testing for Obstructive Sleep Apnea, diagnostic testing for obstructive sleep apnea should be performed in conjunction with a comprehensive sleep evaluation and adequate follow up[i]. Measure 276 captures the original assessment of sleep symptoms that is captured in a comprehensive sleep evaluation. A comprehensive sleep evaluation not only allows for diagnosis of obstructive sleep apnea, but also helps to identify whether the patient has additional sleep disorders or other comorbidities. Additionally, we urge CMS to reclassify this measure as a patient safety measure, given that patients with untreated sleep disorders have declines in daytime function which can lead to higher rates of job-related and motor vehicle accidents[ii]. Patients with untreated obstructive sleep apnea are also at an increased risk of being diagnosed with cardiovascular disease, difficult-to-control blood pressure, coronary artery disease, congestive heart failure, arrhythmias, and stroke[iii]. Measure 278 captures whether the clinician prescribed CPAP therapy, which is indicated in moderate to severe obstructive sleep apnea and in symptomatic patients with mild obstructive sleep

apnea, according to the AASM Practice Parameters for the Use of Continuous and Bilevel Positive Airway Pressure Devices to Treat Adult Patients with Sleep-Related Breathing Disorders[iv]. Positive airway pressure therapy is also considered the first-line treatment for obstructive sleep apnea, and patients are at risk of continuing to experience symptoms and have negative outcomes if this therapy is not prescribed upon diagnosis. This also substantiates a reclassification of this measure to the patient safety high priority measure group. Additionally, the four Sleep Apnea quality measures currently included in the Quality Payment Program are the only sleep medicine-related measures appropriate for sleep medicine eligible clinicians to report and their removal will leave AASM members with an even smaller number of measures to report for participation in MIPS for 2021. For these reasons, we encourage CMS to allow all four sleep apnea measures to remain in Quality Payment Program.

Thank you for your consideration of these comments. The AASM appreciates the Agency's efforts to revise the Medicare Physician Fee Schedule in order to prioritize clinical care for patients, while reducing administrative burden. We encourage the Agency to adopt the changes outlined 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,

Douglas B. Kirsch, MD
AASM President

cc: Steve Van Hout, AASM Executive Director
Sherene Thomas
Diedra Gray

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[i] Kapur VK, Auckley DH, Chowdhuri S, Kuhlmann DC, Mehra R, Ramar K, Harrod CG. Clinical practice guideline for diagnostic testing for adult obstructive sleep apnea: an American Academy of Sleep Medicine clinical practice guideline. J Clin Sleep Med. 2017;13(3):479–504.

[ii] Jackson ML, Howard ME, Barnes M. Cognition and daytime functioning in sleep-related breathing disorders. *Prog Brain Res*. 2011; 190:53–68.

[iii] Budhiraja R, Budhiraja P, Quan SF. Sleep-disordered breathing and cardiovascular disorders. *Respir Care*. 2010;55(10):1322–1332; discussion 1330-1332.

[iv] Kushida CA, Littner MR, Hirshkowitz M, Morgenthaler TI, Alessi CA, Bailey D, Boehlecke B, Brown TM, Coleman J Jr, Friedman L, Kapen S, Kapur VK, Kramer M, Lee-Chiong T, Owens J, Pancer JP, SwickTJ, Wise MS. Practice parameters for the use of continuous and bilevel positive airway pressure devices to treat adult patients with sleep-related breathing disorders. Sleep. 2006' 29(3):375-380.