October 2, 2020

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS- 1734-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Comments Submitted Electronically to **http://www.regulations.gov**

Re: Medicare Program; CY 2021 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Verma:

On behalf of the Alliance of Wound Care Stakeholders ("Alliance"), I am pleased to submit comments in response to the proposed CY 2021 Physician Fee Schedule. The Alliance is a nonprofit multidisciplinary trade association representing physician specialty societies, clinical and patient associations whose mission is to promote evidenced-based quality care and access to products and services for people with chronic wounds. Our specific comments follow.

Surgery and Physical Therapy Payment Reductions

CMS proposes to cut payment for surgical procedures anywhere from 5 – 9 % and specifically 9% for physical therapy services. The Alliance opposes these cuts in payment. The Alliance stands in unison with all physician specialty societies and clinical associations in urging CMS to use its authority and flexibilities under the COVID-19 PHE declaration to waive the requirement to adjust Medicare physician payments for budget neutrality while still implementing the RVU increases to the E/M codes and to explore all avenues, including working with Congress, to prevent drastic cuts from occurring while physicians are still trying to recover and gain their financial footing from the effects of the pandemic.

Evaluation and Management (E/M)

The Alliance appreciates that CMS has accepted the RUC recommendations and provided an increase as a whole to E/M codes but believes that CMS has fallen short. Along with accepting the RUC recommendations for the values of these E/M codes, the Agency must also apply these updated values to the global procedure codes. **The Alliance is adamantly opposed to CMS not adopting ALL of the RUC recommended work and time values for the revised office visit E/M codes for CY 2021 including the**

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RUC's recommendation of commensurately including the updated E/M values in procedure codes with 10 and 90 day global periods. Implementing new values for E/M codes when billed independently but not implementing those same values in the global packages disrupts the relativity in the entire physician fee schedule, not to mention it creates specialty differentials even when performing the same work. Maintaining relativity across codes in the fee schedule is inherent to the resource-based relative value unit (RVU) system. In all previous revaluations of the E/M codes, post-operative visits in the global periods were updated to reflect the new values including in 1997 (the first Five-Year Review), in 2007 (the third Five-Year Review), and in 2011 (when the elimination of consultation codes created budget neutrality adjustments affecting office visits).

The RUC represents the entire medical profession – including many of our Alliance medical specialty societies and clinical associations members. The RUC voted overwhelmingly (27-1) to recommend that the full increase of work and physician time for office visits be incorporated into the global periods for each CPT code with a global period of 10-day, 90-day and MMM (maternity). It also recommended that the practice expense inputs should be modified for the office visits within the global periods. **Should CMS finalize the proposal to adjust the office/outpatient E/M code values, the Alliance urges the Agency to adopt all of the RUC recommendations and apply these updated values to the global codes.**

Telehealth

The Alliance applauds CMS for taking swift action in response to the COVID-19 public health emergency (PHE) to promote access to telehealth services. Telehealth services are critical in maintaining continuity of care, while preventing the healthcare system from being burdened by otherwise avoidable emergency care and face-to-face services throughout the PHE. Improved access to telehealth services also benefits populations rendered vulnerable because they find it difficult to travel for medical care and allows at-risk patients to stay home and maintain social distancing. The benefits of telehealth services for at-risk patients will continue following the PHE. As part of the waivers that CMS has issued, there was the ability to allow a patient's home to be an extension of a PBD. The Alliance urges CMS to maintain a patient's home as an originating site even when the PHE expires. Wound care patients are a particularly vulnerable and at risk population. They often have multiple co-morbid conditions, including diabetes. We submit that continuing to permit the home to be an originating site location will be extremely beneficial to their care.

Furthermore, wound care is performed by a multidisciplinary team of clinicians including physical therapists. As part of the COVID emergency waivers, CMS permitted physical therapists to conduct telehealth visits. The Alliance supported this effort by the Agency. In this proposed rule, CMS is seeking comments on whether services currently not proposed as Category 3 additions to the Medicare telehealth services list should be considered.

The Alliance **recommends that CMS permanently include in the list of covered telehealth services the following CPT codes: 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, and 97530 and 97763.** Permanently adding these CPT codes to the list of covered telehealth services will better ensure a seamless transition when additional practitioners, such as physical therapists, become statutorily eligible to furnish and bill for telehealth services under Medicare. Moreover, by adding these CPT codes, as acknowledged by CMS in the proposed rule, the Agency would thereby allow therapists who work "incident to" physicians to continue to furnish telehealth services when appropriate, therefore, ensuring continued, albeit limited, telehealth access. One of the Alliance members, the

American Physical Therapy Association (APTA), has submitted a more detailed letter regarding this issue. We urge CMS to review and adopt their recommendations.

Also, as related to telehealth, the Alliance supports the proposal to make permanent communication flexibilities by allowing coverage and reimbursement for audio-only E/M. As discovered during the PHE, it is often challenging to establish a synchronous telehealth connection defined as "live, two-way audiovisual link between a patient and a care provider" with patients. There certainly are circumstances which necessitate in-person interaction to determine the current health status of the patient. However, for established patients, clinical decision-making and care planning is well-informed based on the existing relationship and information documented in the medical record. Therefore, telephone E/M should continue to be an available and fully reimbursed option for those patients who need it. The Alliance recommends that CMS finalize the proposal to allow coverage and reimbursement for audio only E/M during a telehealth visit.

Quality Payment Program

The Alliance thanks CMS for recognizing that COVID-19 has significantly impacted the health care community and has proposed two specific provisions within the quality payment program. The Alliance agrees with and supports the proposed delay to the MIPS Value Pathways (MVPs) as well as the proposed reduction to the performance threshold from 60 – 50 percent in order to avoid a negative adjustment. The Alliance recommends that CMS finalize these provisions when the final rule is published.

The Alliance requests that CMS consider creating an MVP for Chronic Wound Management. Establishing a Chronic Wound Management MVP is critical, since it would enable physicians practicing Wound Management, which is not a recognized medical specialty, to use participation in the Chronic Wound Management MVP as a surrogate for specialty designation. Our rationale is that CMS is otherwise unable to identify these practitioners because they have many different board certifications. In order to accomplish this, QCDR measures MUST be included in an MVP *if* they fill a measure gap for the specific MVP. Additionally, quality metrics should also be included for home health, hospice, and inpatient facilities, if appropriate to the MVP. In other words, a needed measure should not be excluded from use in the MVP simply because it is a QCDR measure. There are not enough MIPS measures as it is, especially for wound care in which there are no MIPS measures. The US Wound Registry QCDR measures are the only quality measures available with which to compare the performance of practitioners caring for more than 8.2 million Medicare beneficiaries with chronic wounds. We note the following:

- The GAO reports that CMS has spent an average of $43 million a year on quality measurement programs over the past 11 years, none of which was spent to fill the measure gap in chronic wound management.
- There is no “Meaningful Measures” initiative around chronic wounds, a problem which impacts 5 times more individuals than heart failure and may cost twice as much.
- The USWR currently has 14 wound-management QCDR measures approved by CMS, 3 of which are currently depicted on *Physician Compare*, despite the absence of support from federal or private sources for measure development and testing.

Since CMS may spend as much as $98 billion a year on the 15% of Medicare beneficiaries with chronic wounds we recommend that the Agency considers creating an MVP for Chronic Wound

Management and utilize the QCDR measures which already exist for wound care. The US Wound Registry, a QCDR, has 12 measures, A list of the 12 measures can be found at https://uswoundregistry.com/quality-measures/ Most of these measures have set national benchmark rates and three have been chosen for physician compare: adequate offloading of diabetic foot ulcers at each visit, adequate compression of venous leg ulcers at each visit, and arterial assessment of patients with lower extremity wounds and ulcers at the first visit. The Alliance requests that CMS adopt this recommendation.

Conclusion

On behalf of the Alliance of Wound Care Stakeholders, we appreciate the opportunity to submit these comments. If you have any questions or would like further information, please do not hesitate to contact me.

Sincerely,

Marcia Nusgart, R.Ph.
Executive Director